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Psychiatric Unit Operational Procedures

(Revised Edition 1954)

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PSYCHIATRIC UNIT OPERATIONAL PROCEDURES

(Revised 1954)

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HISTORY AND BACKGROUND

The neuropsychiatric selection program at all U. S. Naval Training Centers was inaugurated by the letter (P3-1 P19-1(123):MFD) of January 2, 1941, addressed to the Senior Medical Officer at all U. S. training stations, from the Surgeon General on the subject of "the inauguration of a procedure to eliminate the neuropsychiatric unfit," and accompanied by an enclosure entitled, "Outline of a Procedure for the Determination of the Neuropsychiatric Unfit." This letter, with its enclosure, defined the objectives and philosophy of the neuropsychiatric selection program, outlined roughly the form it was to take, and defined the duties of the psychiatrist in its execution. It established a neuropsychiatric examination as an integral part of the initial medical examination for all recruits undergoing training, as well as providing for the subsequent psychiatric evaluation of such recruits as might later be referred to the psychiatrist because of difficulty in adjusting to the demands of the training period.

Neuropsychiatric selection was envisaged as both positive and negative, since not only were the frankly unfit to be eliminated from the service, but the neuropsychiatric examination also was to serve as an aid to selective placement in order that borderline individuals would not be "placed under service conditions in which they are likely to break down." This anticipates the current stress upon "screening in" as well as "screening out."

The rationale for "screening out" is clear. Obviously unfit individuals do find their way into the training centers. They contribute nothing through their own efforts, distract and hinder their shipmates, and lower the effective combat potential of the service. The retention on duty of such cases not only is detrimental to the efficiency of the Navy, but is harmful to the man himself since the continual demand that he measure up to requirements that he cannot possibly meet exacerbates his basic condition and may shatter whatever tenuous adjustment to reality he has been able to achieve in ordinary civilian living. Both humanitarian and practical reasons necessitate the removal from the service of such individuals as soon as possible.

The rationale for "screening in" is equally clear. The military strength of this country lies in its technical development rather than its manpower resources. These last are limited and necessitate the efficient use of every individual during a military emergency. Nor should we forget that the basic principles of our democracy posit that all citizens shall share its responsibilities as well as its benefits. Thus it is neither fair nor possible to limit military service to a few individuals of superior physical and

psychological makeup, and one of the functions of the neuropsychiatric selection program is to assist in assuring that the burden of military service is spread as widely among the available citizens of our country as is practicable and possible within the specific needs of the several services.

In the event of war or mobilization in a national emergency the strain upon our manpower resources increases tremendously and it becomes necessary for the services to induct individuals who might not be considered suitable under peace time conditions. In such crises some utilization of the marginal man must be faced as an inevitable necessity. The neuropsychiatric selection program proposes to approach this problem through the identification of such marginal men at the time of the original screening examination so that the full resources of modern mental hygiene can be applied to assisting them in their adjustment to military service. Selective placement, special training, trial duty, out-patient therapy, etc., are but a few of the specific means utilized to this end.

The selection program originally was conceived as being flexible to meet special conditions that might arise, and flexibility also was permitted in the choice of those specific psychiatric examination techniques to be used. The necessary participation of some type of administrative board in determining the elimination of recruits from the service was recognized, as well as the necessity for indoctrination lectures for cooperating personnel and departments if the program was to function effectively.

The original letter also designated clinical psychologists as part of the personnel of the Psychiatric Unit. The part to be played by the clinical psychologist was further defined by the Surgeon General's letter (P3-1/P19-1(123): S:CRM) of February 1, 1941, which dealt with the use of psychologists and which included an "Outline of Procedure." The duties of the psychologist were defined as the evaluation of abilities and temperamental traits. It was recognized that in such evaluation not only would the psychologist employ standard objective techniques such as psychological tests, but he also would make his evaluation in the light of the recruit's "personal reactions, his history, and his attitudes." It was suggested that group tests might be used to facilitate the psychiatric examination if necessary. Specific attention was given to the need for a constant gathering and processing of research data for the continued improvement of the examination techniques in use. In recognition of the necessity for emphasizing the responsibility of the medical officer in a medical examination, the psychologist was placed in chain of command under the senior psychiatrist, who in turn is responsible to the Senior Medical Officer.

Within this general framework, subsequent directives have altered the specific de-

tails of the selection program from time to time, reflecting changing manpower and administrative demands, as well as the availability of increasing professional knowledge with its attendant improvement in techniques. As the value of neuropsychiatric selection to the general training program has become increasingly clear with time, the duties of the training station psychiatric unit have expanded. It may assist in the selection of men for literacy training, may be called on to examine recruits who have become disciplinary problems, and may be assigned many other selection and social psychiatric responsibilities by the local command and the Bureau as the occasion arises. The basic directions setting this forth may be found in the instructional letter issued by the Bureau of Medicine and Surgery and appearing in the Appendix of this guide. Reference also should be made to Chapter 18, Manual of the Medical Department.

The elimination of the unfit is at best only a part answer to the problem of psychiatric attrition during military operations. We can eliminate those individuals who under no conditions could possibly render efficient service, but the successful adjustment of thousands of others will depend upon their occupational placement, motivation, leadership, group morale, and many other subtle psychological factors. The training center psychiatrist and psychologist can be of great help here, and they should conceive of their duties as extending beyond the mere elimination of the unfit. In this connection it must be remembered that the Pulhes number may be revised upward as well as downward, and that such upward revision may reflect not only a correction of the original evaluation but also the active utilization of therapeutic opportunities during the recruit's training. The press of duties may not allow much time for formal therapy of the conventional type with individual recruits, but the alert medical officer will find many ways in which social psychiatric principles can be used with line personnel to further the adjustment of many borderline individuals, by strengthening the positive assets of the group situation which carries them.

This philosophy has been stated excellently in a report of the Committee on Neuropsychiatry of the Division of Medical Sciences of the National Research Council:

"In the development of a military plan for the assignment, training and operation of its available man-power, the medical evaluation of a person's fitness requires a high regard for functional effectiveness. Compensatory skills, developed through strong motivation and persistent application, may counterbalance anatomical faults of pathological conditions. The significance of functional fitness is especially great in respect to mental and emotional considerations. To only a limited extent can one depend upon medical screening or upon psychiatric examination at any one time to evaluate one's emotional attributes and one's capacities for sustained military effectiveness, because such characteristics are influenced in very large degree by the variable factors of motivation, morale and leadership. Psychiatric disabilities are a major cause for loss of man-

power, when measured either in terms of medical discharge, or temporary total incapacitation, or lessened effectiveness. This problem cannot be solved by a selection procedure. The way in which men are treated and cared for and the manner in which they are led are of crucial importance in determining their emotional fitness and functional effectiveness. The selection of officers and their proper orientation and skill in dealing with men constitute, therefore, the most fundamental psychiatric measure for conserving man-power.

"It is beyond the power of the medical or psychiatric profession to select or to prepare personnel which will be psychiatrically immune to the hazards of poor leadership or poor morale. Granted good command-leadership (in training, in operations, and in combat) psychiatrists can, in collaboration with command, contribute much to the general development and maintenance of high effectiveness, to the restoration of effectiveness after impairment, and to wise reassignment. Selection or assignment should not be viewed as simply an event, fixing one's assignment once and for all; repetitive or continuous re-evaluations should be made, based upon actual performance. Such re-evaluations require close collaboration between psychiatrist and unit commander."

THE BASIC SELECTION PROCEDURES

The neuropsychiatric selection program rests solidly upon certain key procedures. Each of these will be discussed at length later, but it will help in understanding the program if we outline them here and show the importance of each in the total selection process.

The Original Screening Examination

Every recruit receives a psychiatric examination upon his arrival at a training center. The core of this examination is the brief psychiatric interview. This examination is given shortly after the recruit's arrival and before he is assigned to a recruit training company in order to identify as soon as possible both the unfit and the marginal recruit. Such early identification assures the rapid separation from the service of the obviously unfit recruit both as a protection to the service and to the man himself. The immediate spotting of the marginal man whose adjustment to the service is doubtful is equally vital, since it not only makes is possible to keep a watchful eye upon his subsequent development during training, but guarantees the immediate application where necessary of the full mental hygiene resources of the Psychiatric Unit in assisting him to adjust to the service.

The Psychiatric Ward

Men who seem in need of further, more intensive study can be referred to the psychiatric observation ward where they receive a careful psychiatric, psychological, and medical case work-up. This makes possible a detailed check upon the psychiatric judgments made during the interview. It insures that no recruit will be separated from the service on the sole basis of the brief examination, but only after an exhaustive study on the observation ward has clearly verified his unsuitability.

Trial Duty

If, either as a result of the original examination or of later, more careful study on the ward, the recruit's ability to adjust remains in doubt, he can be sent to trial duty in a recruit company. Here he can be observed under actual service conditions during training. This trial duty provides a "work sample" of the recruit's adaptive potential for the service. By thus giving the marginal man a fair opportunity to demonstrate his ability to adjust in a recruit company it is possible to make sure that his discharge, if finally necessary, results not merely from the application of arbitrary psychiatric criteria but from a further behavioral criterion obtained directly from his performance in

the training situation itself.

The Aptitude Board

If, after careful study, the Psychiatric Unit concludes that a recruit is unsuitable and should be separated from the service, it may refer him to the Aptitude Board. The Aptitude Board is convened by the Commanding Officer. Its personnel includes both line and medical officers. Its function is to review the evidence presented to it and to make a recommendation concerning the actual disposition of the case in question. This recommendation is then forwarded to the Commanding Officer for his consideration and action. The provision for both line and medical officers on the Aptitude Board guarantees that the question of the recruit's suitability for service will be considered from both a medical and an operational point of view. To the considered opinion of competent medical authority is added the judgment of those who would be operationally responsible for the man under actual service conditions. This joint representation is also invaluable in furthering understanding and cooperation in integrating the neuropsychiatric selection program in the total activity of the Training Center.

Ancillary Mental Hygiene Duties

Of vital importance to "screening in" or fitting the marginal man to the service are the many ancillary mental hygiene duties assigned to the Psychiatric Unit for the purpose of assisting the doubtful recruit in adjusting to the service. These include outpatient therapy, consultation with the Classification Department in the selective placement of problem cases, cooperation with literacy training programs, psychiatric orientation lectures to Company Commanders of recruit training companies, educational lectures for other cooperating personnel, consultative service with disciplinary cases, and such other special mental hygiene functions as the Senior Medical Officer or the Commanding Officer may designate.

The Improvement of Present Techniques

The constantly changing needs and requirements of the Naval service will demand continual changes and improvements in our selection procedures if psychiatric medicine is to grow apace with the demands that will be made upon it. It is to meet these ever changing needs and the new problems they present, to insure the application to them of the best and latest psychiatric knowledge, that the Psychiatric Unit is assigned a definite research function as an important part of its responsibility. Only by the full utilization of research and scholarly investigation can the constantly increasing knowledge of modern medicine be applied to the practical problems of military service. The

research function must be viewed as a continuing responsibility whose practical fruit will issue in the form of improved selection techniques and an ultimate improvement in the combat efficiency of the service.

THE VALIDITY OF NEUROPSYCHIATRIC SELECTION

The original Naval neuropsychiatric selection program developed in 1940 and activated in 1941 was instituted on a purely *a priori* basis without much evidence of its assumed efficacy except for the experience of World War I plus an empirical trial in the field. There was no chance for an experimental investigation of its validity. It represented the application of the best psychiatric and psychological thinking at that time, but the pressure of the military emergency made it necessary to put it into operation immediately without any further check. It was as though a design coming from the drafting board of a skilled engineer were rushed into immediate production without any attempt to test its performance and suitability under actual operating conditions. Minor bugs appeared and were ironed out, indirect evidence of its value to the Naval service began to accumulate, but at no point during the exigencies of WW II were time and manpower available to carry out the extensive research which might have been expected to serve as a basis and justification for a program of such magnitude and importance. It seemed to work ,but the scientific evidence of its assumed success was not forthcoming until the close of the war.

When hostilities ended, and time and facilities again became available, the Neuropsychiatric Branch of the Professional Division of the Bureau of Medicine and Surgery undertook a large scale program of research into the efficacy of its selection program. Part of this, involving a running assessment of current procedures then in use, was carried out within the Bureau with the active cooperation of the various training installations. Such continual evaluation of current procedures has now been incorporated into standard practice and regular provision has been made for it in the organization of the several field units. Another part of the research program concerned itself with the evaluation of the selection process as carried out during the war. This was accomplished with the cooperation of the Office of Naval Research and involved the careful study of the medical and service records of over 30,000 individual recruits who passed through the selection program. The result of these studies has been the scientific validation and justification of neuropsychiatric selection as practiced in the Naval service.[1]

The Basic Validity of Screening

There have been many statistical studies indicating the efficacy of neuropsychiatric selection, but most of them are fragmentary, report somewhat scattered data,

1. Hunt, W. A. "An investigation of naval neuropsychiatric screening procedures." Groups, Leadership, and Men (Guetzkow, H., ed.), Pittsburgh, Pa.: Carnegie Press, 1951, 245-256.

and hence are inconclusive. Their data were gathered under the restrictions of war time operations and often analyzed at a much later date far removed from the conditions actually affecting the study. It has been difficult if not impossible under these conditions for them to observe all the desirable niceties of experimental design and control of relevant variables.

One of the studies done under the auspices of the Bureau of Medicine and Surgery, however, meets the demands of experimental design and seems to offer scientifically acceptable validation for Naval screening as practiced during the war.[2] Samples totalling some 17,000 recruits subjected to neuropsychiatric screening upon their arrival at three Naval Training Centers during several successive months were followed for two and a half years of subsequent active duty. The follow-up was accomplished by careful examination of their individual health and service records. The quality of the recruits entering each center, the screening procedures used in each, and the professional level of the three staffs who did the screening were all roughly comparable; but the total rejection rate varied among the centers owing to differences in the acceptance of the program by the local commands. These circumstances made it possible to study the relations between the screening rejection rate at each center and the subsequent neuropsychiatric attrition during active service of the men handled at the center. The prediction was made that the more men eliminated from each recruit sample through neuropsychiatric screening, the less subsequent neuropsychiatric attrition during service there would be. The results verified the hypothesis and confirmed the basic validity of the Naval selection program.

Curve of Diminishing Returns

Careful inspection of the data in the study referred to above, however, revealed the existence of a curve of diminishing returns. Beyond a certain point, increasing the number of men screened out begins to give less and less decrease in subsequent attrition. This suggests that there is an optimal point, or discharge rate, beyond which increased screening yields only diminishing returns in later improved combat efficiency. Neuropsychiatric screening apparently can be practiced too enthusiastically. There are many possible explanations of this. The optimal point may well represent the point at which screening passes beyond the mere elimination of the obviously unfit and begins to reject not simply on the basis of currently, demonstrable inability to adjust, but on the basis of a prediction of future maladjustment. The problem then becomes not merely

2. Hunt, W. A., Wittson, C. L., & Burton, H. W. A further validation of naval neuropsychiatric screening. J. consult. Psychol., 1950, 14, 485-488.

the recognition of present maladjustment but the prediction of future difficulty. This is a much more difficult diagnostic judgment to make. As one moves into the marginal areas of maladjustment, symptomatology becomes more subtle, greater skill is demanded of the screening psychiatrist, and the ultimate adjustment of the individual becomes more and more a function of the specific environmental conditions which he will undergo. These last are largely a chance function of the individual's service and the psychiatrist cannot be expected to predict them with any exactitude. As we move into the area of prediction in borderline neuropsychiatric cases all our findings indicate the necessity for great caution and emphasize the importance of supplementing psychiatric opinion with the criterion of actual military performance in the training situation.

The Serviceability of the Neuropsychiatrically Borderline Man

Research also indicates that the ability to undergo military service without breakdown is a function of the severity of the maladjustment in the case in question. The better adjusted a man is, the better his chances of successful service. This makes sense. Herein lies the value of "screening in." If we arbitrarily eliminate at the training center level every recruit whose personality adjustment appears questionable we will lose many men who are capable of service adjustment if given the chance. The Neuropsychiatric Branch of the Bureau of Medicine and Surgery sponsored several studies of groups of borderline individuals whose personality difficulties were recognizable but mild enough to merit the opportunity to serve. While the subsequent psychiatric attrition rate among these groups was always greater (from 3 to 10 times in those groups studied) than the rate among a normal control group, many of the marginal group did survive. Particularly in times of manpower shortage it may be profitable to attempt the utilization of such marginal cases. Thus one study showed an attrition rate during subsequent service of 13 per cent for such a psychiatrically borderline group as compared with only 2 per cent for a control group.[3] Nevertheless 87 out of every 100 recruits in the borderline group did complete their period of service. It is in such groups that the "screening in" techniques of out-patient therapy, selective placement, and mental hygiene lectures, etc., can pay valuable dividends in preserving manpower. Until our predictive ability with such borderline groups can be improved, it will be well worth the effort for the military services to concentrate time and attention upon salvaging as many of these cases as is possible. In times of acute manpower shortage the utilization of such material may even become a necessity.

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3. Hunt, W. A., Wittson, C. L., & Burton, H. W. A validation study of naval neuropsychiatric screening. J. consult. Psychol., 1950, 14, 35-39.

The Cost of Utilizing the Borderline Case

In attempting to utilize psychiatrically borderline manpower, however, we must remember that they are costly and that their use is expensive to the services. Not only is the discharge rate abnormally high in such a group, but there are further "hidden" costs in terms of the extra medical and disciplinary attention they demand. A study was made of 500 such borderline cases each of whom served successfully for three years with subsequent honorable discharge at the termination of hostilities.[4] Ordinarily a man who serves three years and receives an honorable discharge would be adjudged to have rendered acceptable and valuable service. Nevertheless a careful study of the medical and service records of these men showed, depending upon diagnosis, from 4 to 7 times as much hospitalization during their service and from 2 to 6 times as many major disciplinary infractions as did a normal control group. If the borderline groups are utilized, added hospital and disciplinary facilities will be necessary, and a large share of these added burdens will fall on Naval psychiatry. Whatever we can do by applying the best methods of modern mental hygiene with this group will pay us valuable dividends in whittling down these hidden costs.

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4. Hunt, W. A., Wittson, C. L., & Hunt, E. B. Military performance of a group of marginal neuropsychiatric cases. Amer. J. Psychiat., 1952, 109, 168-171.

STANDARDS

The basic objective of the neuropsychiatric selection program is the furtherance of the avowed purpose of the Medical Department of promoting physical fitness through "selecting or retaining only those whose physical and mental condition is such as to maintain or improve the military efficiency of the service." The public law governing the assimilation of men into the armed services further proposes under the principle of "equal distribution" that each of the armed services shall receive their fair share of the various categories of men available. The special operational needs of some of the services are recognized, however, and the principle of equal distribution is qualified by a further principle of "equitable distribution" which provides that equal distribution must be tempered by such special operational requirements so that the final distribution of manpower between the various branches of the service will be realistically geared to the actual operational needs of each in maintaining combat efficiency.

The Pulhes System of Profiling

The selection standards set up for the maintenance of military efficiency are contained in AR 40-115, the revised Army regulations of "Physical Standards and Profiling for Enlistment and Induction," which was designated as official for Naval use by BuMed Circular Letter No. 48-101, dated 23 September, 1948. The backbone of AR 40-115 is the PULHES system of classification which provides a profile of the recruit's physical abilities.[1] These abilities are separated into six categories or dimensions represented by the letters of the word PULHES. P stands for physical capacity, U for upper extremities, L for lower extremities, H for hearing, E for vision, and S for neuropsychiatric. Each dimension is conceived of as extending over a four-point range of ability running from the completely normal category (designated one) through intermediate grades of relative disability (designated two and three) to the frankly disqualifying (designated four). Essentially, each dimension of the Pulhes profile thus consists of a quantitative four-point scale for recording one aspect of the physical and mental status of the recruit, and the scores resulting from the recruit's rating on each of the six dimensions constitute a "profile" of his total assets.

"Disability" and "Unsuitability"

Only those recruits who are graded with the number four fail to meet the acceptable standards for service, unless it can be demonstrated that military service would re-

1. Germain, G. L.; Browne, C. G.; and Bellows, R. Physical profiling systems. **Occupations**, May 1952, 579-583.

sult in the exacerbation of conditions which originally might be classified as two or three, with the resulting threat to the recruit's health; or unless the existing condition, while not being severe enough to merit a grade of four, would nevertheless jeopardize the health or safety of service associates. The recruit who thus fails to meet the Pulhes standard is considered a case of medical disability and is rejected for service. If his condition is not discovered until he arrives at a training center or if it develops subsequently in service, he is separated from the Navy through a medical survey board. The Pulhes system does recognize, however, that not all the borderline cases in the two and three categories will be able to serve adequately under military conditions. Thus a mild physical condition might not be incapacitating in itself, but existing in a mildly hypochondriacal individual who is poorly motivated it might so interfere with his efficient functioning as to render him of no value to the military services. Such individuals are considered as "unsuitable for service" but not "medically disabled," and their separation is accomplished through administrative channels, of which the Aptitude Board is an example, rather than by a medical survey board.

The Psychiatric or "S" Dimension

The neuropsychiatric examination is concerned with the "s," or neuropsychiatric, dimension of the Pulhes profile. The "s" dimension of the Pulhes chart and pertinent neuropsychiatric sections of AR 40-115 are reproduced in the appendix of this guide. The "s" dimension runs from a grade of one, or no psychiatric disorder, through the grade of two, which includes mild transient psychoneurotic reactions and mild character and behavior disorders as well as borderline intelligence, and three, which includes mild chronic psychoneuroses, transient psychoneurotic and psychotic reactions, and mild mental deficiency, to the disqualifying grade of four, which includes the frank psychoses, moderate or severe chronic psychoneuroses, severe situational transient psychoneuroses, and marked degrees of character and behavior disorder as well as marked mental deficiency. While its recommendation was not officially acted upon, the Committee on Neuropsychiatry of the Division of Medical Sciences of the National Research Council has recently proposed that the "s" dimension of Pulhes be elaborated by expanding it into three dimensions — N for neuropsychiatric disturbances, I for intellectual capacity, and C for character (including motivation, morale, and performance). 'S" would then become "NIC" and PULHES would become PULHENIC. The Committee's description of these three dimensions is mentioned here to further clarify the meaning of the present "s" dimension. However, these recommendations were not officially adopt-

ed by the Defense Establishment.

As with the other dimensions only a grade four is considered as a medical disability, unless the condition constitutes a definite threat to the recruit's health or to the health or safety of his associates. Categories two and three are considered acceptable unless an evaluation of the recruit's total personality assets reveals such a lowering of functional potential that he cannot contribute to the efficiency of the service. Such cases of "unsuitability for service" may be presented to the Aptitude Board and receive a general discharge. No absolute symptomatic criteria are set up, as it is desired that the decision be rendered not in terms of defect *per se,* but in the light of its significance in the total functioning of the individual.

Some Characteristics of the Pulhes System

The Pulhes scale may be thought of as a flexible, or relative, scale with the boundaries of its categories not fixed and immutable but shifting upward or downward with the exigencies of the manpower situation. In times of plentiful manpower the boundaries might shift upward with some consequent raising of medical requirements. In a manpower shortage when the services are "scraping the bottom of the barrel" requirements would be revised downward. Always it must be remembered that any neuropsychiatric disorder uncovered must be considered within the total context of the individual's overall personality structure and physical condition. The disorder by itself is not all important, but rather the question of whether or not it significantly hinders the quality of the individual's functioning as a whole person and lowers his performance below the point where he can make a positive contribution to the efficiency of the military service.

In establishing only those disabilities of function which can be clearly classified as grade four as disqualifying, the Pulhes system is recognizing the need of making as extensive as possible a use of the limited manpower that is available. There is a frank acceptance of the fact that many borderline conditions or mild disabilities exist, which, if viewed in the light of the total functioning potential of the individual, do not preclude adequate adjustment to the military service and a positive contribution to its effort. By the same token, however, there is recognition that such conditions may, in certain individuals under certain circumstances, result in an impairment of functional potential that will impair the efficiency of the individual's performance to the extent that he becomes a detriment to the efficiency of the services. Such cases are not considered, however, as instances of incapacitating medical disability, but as instances of "unsuitability for service" to be handled through special administrative channels. It is for

handling such cases that the aptitude boards were established at training centers. Cases of incapacitating medical disability are handled by medical survey boards.

In view of this philosophy it becomes clear why no specific symptomatic criteria of disability are set up. The question of disability for service is seen to be a complex one involving the consideration and balancing of many factors. It is the duty of the examiner to be aware of these factors and to consider them in arriving at that solution that best protects the health of the recruit in the light of the necessary demands of the military situation. The final criterion must always be the professional judgment of the medical officer, guided by the basic directives and his own intimate knowledge of the needs of the Naval service, a knowledge that comes only with field experience in a Naval installation.

The Training Center Reexamination

The reexamination of all Naval recruits upon arrival at a training center serves as a valuable verification of the original Pulhes classification at enlistment or induction. To the uninitiated it may seem inconceivable that frankly unfit individuals meriting a Pulhes rating of four would survive the recruiting station or induction center screening and reach a training center before being discovered. Such, however, is not the case. Limitations of time and personnel, the demand for the filling of quotas, and occasional errors of judgment all result in some incapacitated individuals being forwarded for training. The great importance of the reexamination at the training center is accented by a recent, unpublished opinion from the Judge Advocate General's Office (JAG:I:5:WLS: vn., 14 April, 1952) stating the basic authority of this examination in establishing the recruit's medical conditions upon entering the service.

The training center screening examination is also invaluable in establishing "unsuitability for service" because of impairment of functional potential, as opposed to "incapacitating" medical disability. Such medically incapacitating conditions as frank psychosis, severe chronic neurosis, and marked mental deficiency, all of which disqualify the recruit for service can be much more readily established at the original examination than can the "impairments of functional potential." Some mild psychoneurotics may be able to adjust to the special conditions of service, others may not. Borderline mental deficiency is not incapacitating providing the recruit is capable of benefiting from training, and his actual performance in the recruit training curriculum is the real criterion. The unsuitability of such recruits may not manifest itself until they have arrived at the training center. Sometimes it will be evident in the early days of training. In other

cases, the decision will be a more difficult one and can only be rendered after an adequate period of trial duty for the recruit. All these considerations stress the necessity of an active neuropsychiatric selection program at the training center level. It is in the actual duty situation that the best evaluation of functioning potential can be made.

The pages to follow will outline some suggested procedures for accomplishing an efficient neuropsychiatric screening program.

THE SCREENING INTERVIEW

As required by the basic directive, the first contact of the recruit with the psychiatric unit will come during his physical examination upon arrival at the Training Center. At some point during this examination, every recruit is given a brief psychiatric interview, usually at the end of the regular medical examination. It is imperative that this interview be conducted in privacy, both for the protection of the recruit and for encouragement of the necessary frankness and uninhibited communication with the examiner. Small rooms or cubicles should be provided for this purpose. Previous results have indicated that if the recruit remains unclothed, the examination will proceed more rapidly and efficiently. This is not always practicable, but when possible seems to facilitate the interview. Clothes are a psychological defense and without them the recruit is apt to offer less resistance to questioning. Under the added stress of nudity the recruit finds it more difficult to marshal his psychological defenses against the examiner.

The Interview as Stress Situation

Much of the efficacy of the original screening interview stems from the fact that it is conducted while the recruit is under stress. Rather than being a handicap this stress contributes to the success of the examination. The recruit is uncertain, confused in his orientation, and unable to organize his usual defenses. As a result, the task of the examiner is made much easier.

For most recruits, entering the military service means a radical change in their way of living. They are abruptly separated from family and from friends, suddenly removed from the familiar, self-created little world in which they have been existing and over which they have had some control, and plunged directly into a strange, confusing, and upsetting milieu. The authority and regimentation typical of the military services represent new and threatening environmental limitations that must be adjusted to. The excitement attendant upon the enlistment or induction procedures has been followed by an arduous trip to the training station where they usually arrive thoroughly fatigued. At this time they are shorn of their usual defenses, latent anxieties tend to become manifest, and the interviewer's task of examination and evaluation is much easier than it would be at a later date when they have begun to reestablish themselves in their new world.

This is an important reason for conducting the original screening examination shortly after the recruit's arrival at the Training Center. He is tired, confused, and deprived

of his psychological armor. He has not yet begun to adjust to his new environment and to build up defenses against its demands. Under these conditions the brief interview will operate with maximal efficiency.

The Significance of the Psychiatric Interview

This psychiatric screening examination is of basic importance to the selection program. For most of the recruits this interview is their only contact with a psychiatrist during the training period. The examiner should be alert not only for cases of frank medical disability and obvious unsuitability for service, but for borderline cases which should be watched during their training period. These latter may often be helped during their stay on the station. The purpose of neuropsychiatric screening is not merely the negative one of eliminating unfit recruits from the service, but also the positive one of fitting the marginal recruit into the service. The screening interview has the further potentiality of being used to assess the positive assets of a recruit's personality as well as his liabilities. The recognition of these positive assets could be an important aid in the selection of recruits for special billets, positions of leadership, etc. This would necessitate some further qualification or revision of the Pulhes category I before being put in practice, however, as not all the men failing in category I as presently defined would qualify for positions of leadership, etc. Such a use of the interview is an interesting possible development for the future.

The psychiatric interview is often of psychological importance to the recruit himself. The average recruit is unsophisticated in psychiatric procedures and may regard the psychiatrist with no little awe and apprehension. This is increased by the intimacy of the personality and developmental areas that are frequently investigated. Moreover, for many recruits this will be their first contact with an officer in a peculiarly personal situation. Both motivation and identification with the Naval service can be enhanced and this increases the importance of establishing rapport in the interview itself.

The interview is also of therapeutic significance. If it is mishandled, latent anxieties may be exacerbated, symptoms may be fixated, and weak motivation may be destroyed. If it is conducted skillfully, it may contribute to future adjustment. One experimental study during the last war demonstrated that the mere use of the brief psychiatric interview administered by skilled clinicians resulted in a significant lowering of subsequent psychiatric attrition during training among the groups interviewed as compared with control groups who were not so interviewed.

The Technique of Interviewing

The interview is not a casual and superficial technique. It involves a clinical situation of the most difficult and demanding sort which calls for the best clinical skill and understanding of the interviewer. The psychiatrist who has not had experience in the field of brief interviewing should approach his duties with humility and a willingness to learn. Trained in the use of the longer clinical interview, most psychiatrists will face in the brief interview a task that may seem impossible at first. For a while, at least, he should follow his results by checking against the later clinical records of those men studied on the observation ward or re-interviewed during the training period. This will aid him in correcting his mistakes and understanding his successes. Learning is rapid in this situation and the clinician who masters the brief interview technique will find himself in possession of a powerful and rewarding clinical instrument.

The interview must be brief and of necessity flexible. It should average two or three minutes. In some cases much more time must be spent, in others much less, but the good interviewer will be able to handle twenty or thirty men in an hour. While the interview is structured around a series of questions, these will vary from examiner to examiner and will depend upon the demands of the specific recruit. The answers elicited by the questioning are important, but even more important is the total reaction of the recruit. Subtle omissions may be more significant than obvious revelations and the general behavior exhibited may be more revealing than the actual verbalized replies.

The immediate impression in the interviewing situation is valuable and the actual appraisal will begin with the recruit's entrance into the room. The examiner should note abnormalities of gait, significant physical defects, indications of personal cleanliness, deviations of psychomotor activity, revealing facial expressions, evidence of confusion, stupidity, antagonism, unusual tension and anxiety, and tics and mannerisms. The average recruit says nothing until spoken to, but the jovial alcoholic, the anxious neurotic, the surly psychopath, or the irrepressible manic not infrequently assist the psychiatrist by spontaneous comments. The clinical acumen of the medical examiner is all important in assessing such signs.

It has been mentioned that good rapport is essential, yet a minimal amount of time is provided for its establishment. Opening the interview by asking the recruit his name, rather than launching immediately into direct questioning, is usually sufficient to establish rapport. The rapid questioning follows. The examiner must set the pace, maintain clinical vigilance, and carefully avoid the tendency toward becoming hasty or perfunctory. In general, a straightforward professional approach with a display of confidence

rather than authority is indicated.

The Use of Questions in the Interview

The specific questions to be asked will vary both with the examiner and with the particular recruit being interviewed. As in routine clinical interviews, it is wise to cover in some way the areas of education, work adjustment, social adjustment and health. Poor progress in school, frequent shift in occupation, police contacts, history of enuresis, somnambulism, convulsions, etc., psychosomatic complaints, motivation towards service, and reasons for enlistment are illustrative of typical revelatory areas in the interview.

For one primarily trained in the usual clinical interviewing, some time may be required to establish a basic brief interviewing technique which assuredly will elicit the most data in the limited time available. Some basic questions developed at one training station during WW II, and subquently validated by follow-up studies as being highly effective, follow. They are included here for illustrative purposes, as many others would serve as well.

How far have you gone in school?
What have you done since you left school?
When is the last time you had a fainting spell?
How often do you have headaches?
Did you ever have a fit?
When was the last time you walked in your sleep?
Do you have any trouble with your kidneys?
Have you ever been to a doctor for nervousness?
What was the worst jam you were ever in?
Have you ever had any trouble with the police?

A positive reply to any of these questions or suspicious behavior on the part of the recruit in answering is an indication for secondary questioning along the specific lines indicated. Subsequent questions are carefully asked so as to make it easy for the recruit to answer them. It is wise to avoid implying that the question is significant and one should always avoid forcing the recruit to lie. Clinical hunches, objective symptoms, and subtle deviations from the normal recruit responses also are frequently a signal for special lines of investigation, even though all replies to routine questions have been negative. The recruit who mincingly enters the office may arouse a suspicion of homosexuality, overt or sublimated, although the mere exhibition of feminine manner-

isms is not in itself an indication of sexual deviation. If in addition he gives a history of certain types of employment, the possibility of homosexuality may need further investigation. Needless to say ,a seemingly innocuous line of questioning is employed: "Was it an older or younger boy who taught you to masturbate?" followed by "Do you now masturbate with older or younger boys?"

Such an indirect line of questioning is often more productive than a direct approach. Thus, a psychopath suspected of nomadism might be asked, "Have you traveled very much, son?" Difficulty in school might be approached by the question, "Were you good at playing hooky in school?" If the recruit is suspected of giving evasive answers, it may help to ask him, "How often do you masturbate?" since this embarrassing question may serve as an indicator of lying. At other times a sudden and direct approach may be best. An abrupt and unexpected, "How many times have you been arrested?" may surprise a suspect into confession. Similarly, by firing a series of questions at him rapidly and preventing him from giving a considered answer, he may be led into revealing statements which he otherwise would not make.

Questions which can be directly answered by a flat "yes" or "no" often may be less desirable than questions which demand that the recruit formulate a more involved answer. Simple affirmative or negative responses offer an easy out to the evasive recruit who is trying to avoid giving any significant material about himself. If he is forced to give a more complicated answer (as with the question, "What is the worst jam you were ever in?") he may unwittingly reveal extraneous information of significance to the examiner. Moreover, the extra effort involved in formulating his response may produce tensions and emotional indications that will help the questioner in evaluating the recruit's total personality structure.

The Dynamic Nature of the Interview

It is obvious that such questions in themselves do not constitute the basis for an adequate appraisal of the individual and it is to be emphasized that the recruit's manner in answering these questions is just as important as the actual verbal response. The essence of the examination is its dynamic qualities. The human and spontaneous aspects essential to all psychiatric examinations should never be overlooked in the brief interview. The late Harry Stack Sullivan in writing on the psychiatric interview nicely illustrates the dynamic nature of the interview situation when he says, " . . . during an interview one may learn that a person is married, and if one is feeling in some very quiet and, I trust, very mildly satirical mood, one can say, 'And doubtless happily?' If the

answer is 'yes,' that 'yes' can have anything in the way of implication from a dirge to a paean of supreme joy. It may indicate that the 'yes' means 'no,' and everything in between. The logical question, I suppose, after learning how happily the person is married, might be, 'Was it your first love?' The answer may be 'yes,' at which one says, 'Is that so? That's most unusual.' Now, nobody cares whether it's most unusual or not. In fact, it is fairly unusual, but it isn't most unusual. The 'most unusual' at least makes for an issue, with the result that the informant feels, 'Well, by God, if it was my first love, it requires a little explanation; or it may even be something to be proud of.' And at this point you may begin to hear a little about his history of interpersonal intimacy with the other sex."[1]

It should always be remembered that during the psychiatric interview the recruits are under tension. While this tension may contribute to the revealing nature of the interview, it will also produce situational behavior which must be discounted by the examiner. The alert interviewer also will not be misled by the culturally determined differences which may apear. The shy farm boy from a rural area may give a first impression of mild mental deficiency or schizoid personality. A history of frequent absence from work might be significant in a recruit from a northern industrial area, but not be so significant in a recruit from a southern rural area. The belief in "voices" and "visions" may be indicative of a hallucinatory tendency or it may merely reveal the background of superstition found among the culturally unenlightened. With time and experience the interviewer will learn to recognize and discount such factors.

Special Aids in Interviewing

As a special aid in interrogation, various "projective" questions may be asked which plunge the recruit into an imaginary situation, the responses to which may be particularly significant to the examiner while remaining innocuous to the recruit. The questions used may be of many types. Particularly popular with many examiners is this one: "If you could have three wishes, all of which would come true, what would you wish for?" This is of interest in revealing emotional maturity, socialization versus egocentricity, intellectual level, motivation, etc. Another one is the "island" question: "If you had to spend the rest of your life on a deserted island and could take only one person with you, whom would you take?" The naming of another man may indicate homosexual tendencies, while the immature recruit often may select his mother. One group of examiners during the last war experimented with the question, "What would you do if some-

1. Sullivan, H. S. The psychiatric interview. **Psychiat.**, 1951, 14, 361-373.

one gave you a pet elephant?" The exact answers were of course never taken seriously, but the peculiar nature of the question might annoy the belligerent psychopath, upset the anxiety-ridden individual, present a demanding problem to the over punctilious and compulsive, or elicit a grin from the individual with good psychomotility. Every experienced interviewer will develop his own "trick of the trade" of this sort.

The Danger of Counter-Transference

The interviewer must be constantly on guard to prevent his own biases and personal attitudes from influencing both his conduct of the interview and his interpretation of the material obtained during it. Counter-transference is a phenomenon not limited to therapy, and it can be just as damaging to the patient-doctor relationship when it intrudes in the interview situation. This is particularly true of the brief interview where every bit of data gathered is vital, and where any perceptual distortion introduced by one's personal attitudes toward the interviewee may be much more disastrous than it would be in a longer, continuing relationship.

A hostile, critical, or negatively emotional reaction to material produced by the recruit may shut off the flow of significant revelations. The recruit will inhibit and conceal in trying to please the examiner. He becomes aware of dangerous areas and deliberately strives to avoid them. Moreover, such an aggressive response may frighten the recruit and reinforce and fix his own negative attitudes toward certain areas of his personality. This may arouse and reinforce latent guilt feelings and place the man under an added handicap in his already difficult problem of adjusting to the demands of the training situation.

On the other hand, an overly affiliative, ingratiating attitude on the part of the examiner may be unduly reassuring to the recruit. It may allay tension, remove revealing anxiety, and encourage the recruit to attempt to dominate the interview. He may even interpret it as a sign of weakness in the examiner and be encouraged to deliberately conceal and dissimulate.

The interviewer's personality may intrude itself in many other ways to hinder an efficient examination. Personal reticence and difficulty in interacting with others may make the interview difficult and distasteful to him with the result that he attempts to hurry it and dispose of each recruit as quickly as possible. Social embarrassment may cause him to fail to follow through when delicate areas of sexual behavior and marital adjustment are being explored. His own inhibitions and unconscious defenses may even cause him to miss vital cues and to overlook the significance of revelatory material.

The interview functions best when the interviewer has a thorough knowledge of his own personality, has worked through his own conflicts to the point where he can understand and resolve them without the assistance of untoward defense mechanisms of his own. Only when he can operate impersonally in the interviewing situation, can act as a controlled and efficient probing and evaluating mechanism, can he derive the most from the potentialities of the examination.

Interviewing is difficult, and the brief interview used in the military services is particularly demanding. As Sullivan has so vividly commented on psychiatric interviewing, "If you try to get fun out of it, you pay a considerable price for your unjustifiable optimism. If you don't feel equal to the headaches that it induces, you are in the wrong business. It is work — work the like of which I do not know. True, it ordinarily doesn't require vast physical exertion, but it does require a degree of alertness to a sometimes very rapidly shifting field of signs which are remarkably complex in themselves and in their relations. And the necessity for promptness of response to what happens proves in the course of a long day to be very tiring indeed." Nevertheless, it is a peculiarly rewarding technique and the psychiatrist who masters it has equipped himself with an extremely valuable clinical tool.

The Use of Screening Adjuncts

Where the pressure of work is sufficiently great, it may be desirable to facilitate matters by supplementing the interview with group psychological tests, such as the Cornell Selectee Index, administered before the individual interview takes place. These "screen tests" are in essence check lists of significant behavior, depending heavily upon conventional psychiatric symptomatology and recognized significant factors in developmental history. High scores on such tests are frequently indicative of maladjustment. While the tests are efficient in detecting maladjustment, they also pick up large numbers of false positives or adjusted men who, for one reason or another, falsely score high on the test. Because of this, such tests can never be considered a final criterion but should be used as a preliminary screening device to select certain men for more intensive personal interviews. When used in this fashion, the test is given to the entire group to be examined. The high scorers are then checked for special psychiatric interview while the others go through the line routinely. During the interview it is the task of the psychiatrist to differentiate the maladjusted recruits from the false positives. One large research study has indicated that the use of such preliminary screen tests may reduce the number of men to be interviewed by three quarters without

losing any significant number of unsuitables, but the final separating of the truly maladjusted from the falses positives must always be accomplished by the more flexible clinical interview.

Another way in which such tests may be helpfully employed is to administer them before the individual interview and allow the interviewer to use the results in conducting his questioning. In this way the examiner is saved the time and effort of a great number of routine questions since by quick inspection of the examination blank he can ascertain whether or not there are any suspicious answers that should be followed up by further questioning. Such tests are not difficult to administer, either in terms of the objective facilities necessary or of the necessary professional or technical personnel for administration. The development and improvement of such instruments is one of the basic research duties provided for in the original directives, and it is anticipated that any psychiatric unit employing them will be alert to the necessity of their improvement and their adaptation to special local requirements.

A variant of this technique is the use of an information sheet to be filled out by the recruit before his interview and brought in with him to the examination. This should contain space for such information as the recruit's name, age, highest school grade completed, marital status, previous enlistment and last occupation. Some examiners find it convenient to have such information before them when they begin the interview. The Naval Medical Research Forms currently incorporated in the selection program are typical examples of such adjuncts to the psychiatric interview. Their use and significance will be discussed at greater length later in this guide.

It is desirable to have a psychologist available when the screening examination takes place in order that he may administer abbreviated intelligence tests in questions of intellectual retardation. The clinical psychologist also will get clues as to possible organic deficit or functional derangement from these test materials. Another helpful technique is to have a second psychiatrist or psychologist check on all cases of suspected unfitness before the recruit is admitted to the observation ward. This will cut down the number of false positives admitted to the ward and increase the efficiency of the screening process.

Disposition of the Recruit

Depending on the results of the examination, the recruit will be handled in one of three ways. If he appears suitable for the Naval service he will be approved, marked 1 or 2 on the Pulhes, and sent on to duty. If strong evidence of disability is uncovered

he will be marked 4 on the Pulhes and admitted to the psychiatric ward for further careful study and possible elimination from the service. If there is some question of his ability to function efficiently he may be marked 3 on the Pulhes, sent to trial duty but recalled for reexamination at some later date after such duty has given further evidence to both the training officer and the psychiatrist of his true functioning potential.

In the case of all recruits suspected of disability or unsuitability, some immediate record should be made at the time of examination. The record should contain accurate identification of the man, his family with their home address in case a social history is desired, and the significant material uncovered by the interview. A special "control" card can be prepared for this purpose, or the Standard Medical Screening Form A, Personal Information may be used for this purpose. This form will be discussed in a later section of this guide. The importance of the service number as a means of identifying the man cannot be too strongly stressed, particularly if any later research is to be done in evaluating and improving the efficiency of the examining technique. Occasionally the examiner may wish to record on the "control" card some significant material which, while not indicating the necessity of either trial duty or ward admission by itself, is important to have on file for research and follow-up purposes.

TRIAL DUTY

Recruits exhibiting clear evidence of medical disability or unsuitability at the time of the screening examination are admitted directly to the psychiatric ward for a complete work-up and possible separation from the service. These cases will be relatively few. There will remain, however, a large number of doubtful cases about whose ability to adjust to the Naval service the examining psychiatrist will have some genuine doubt. These men will be graded Pulhes 3 and sent to trial duty where they will have a chance to demonstrate their ability to adapt to the training situation. At a later date, usually after approximately three weeks, they will be recalled to the Psychiatric Unit for reexamination and an evaluation of their progress during training. The importance of trial duty lies in the fact that it gives the borderline recruit an actual opportunity to demonstrate his adaptability in a military environment under service conditions. It offers a performance measure of the "functional potential" we have discussed under the chapter on "Standards." It assures that cases of borderline adaptability will not be discharged on the basis of an arbitrary psychiatric judgment but only when there is added evidence of inability to adjust deriving from a direct trial in an actual duty situation.

Revision of Pulhes Rating

The overwhelming majority of these trial duty cases will be men clearly in the Pulhes 3 category, individuals who meet the minimum standards for service but who may lack the integrative strength to function efficiently in the military. These are cases where the total personality assets are not sufficient to meet the adjustmental demands of the service. They constitute the body of cases being separated from the service through the Aptitude Boards.

Occasionally, however, a case will arise where the interviewing psychiatrist has difficulty at the time of the screening examination in making a clear decision as to whether the recruit fails to meet minimum standards and should be labeled a Pulhes 4 and separated from the service by a medical survey board as a case of medical disability. Such a man might be neither clearly a 4 nor a 3, and the psychiatrist might feel that a trial at duty, provided that it did not threaten a serious exacerbation of the recruit's condition, would be desirable in order to furnish further diagnostic criteria for final classification.

This situation might arise for instance in making a diagnosis of marked mental deficiency severe enough to warrant a Pulhes rating of 4. The recruit in question might

exhibit a mental retardation, further complicated by a cultural and educational handicap (or possible language difficulty) which would render an exact psychometric determination of his native ability either difficult or impossible to obtain. The psychiatrist might feel that a test of actual performance on duty was indicated as an aid in establishing a definite diagnosis. Cases might also arise in making a distinction between mild and severe chronic psychoneurotic conditions in establishing the degree of character or behavior disorder, etc. Such recruits might be classified Pulhes 3 and sent to duty. Reevaluation at the end of a trial period of three weeks might convince the psychiatrist that the recruit in question really was a Pulhes 4, below the minimal medical standards for service. In such a case the recruit's Pulhes rating would be revised downward and changed from 3 to 4. He would then be presented to a survey board for discharge on the grounds of medical disability. Such men should not be presented before an Aptitude Board, as the Aptitude Board discharge is reserved for those men who do meet the minimal medical requirements for service but nevertheless are unable to adjust and hence are labeled unsuitable for service rather than cases of medical disability. This distinction is an important one administratively and should always be observed.

Disposition of Trial Duty Cases

In the case of those men who at the original screening examination are marked Pulhes 3 for trial duty, a record is made for the files of the Psychiatric Unit in order that each man may be located and recalled for reexamination at a later date. The men are then sent to duty through the usual channels without any special designation. In order that each man may have a fair and adequate trial it is essential that neither he nor the Company Commander have knowledge of his trial status when he goes to duty. This will obviate any damage to the morale of the recruit, and preclude any bias in treatment at the hands of the Company Commander.

The Reexamination

At the time of the reinterview the psychiatrist in reappraisal of the recruit, will not only note any current indications of maladjustment but will consider as well the actual progress made in the training company. Since the psychiatrist will not have been able to observe the recruit directly in the training situation he must have some evidence of the recruit's performance. This is furnished by a form, the Company Commander's report, filled out by the Company Commander for each recruit, when the recruit is recalled for reinterview. In order that the recruit's trial duty status may remain unknown, requests for such reports are not sent to the Company Commander until the time comes

to request the appearance of the trial duty recruits at the Psychiatric Unit. The report forms may be forwarded along with a list of names of those requested to report for re-examination. In order to assist the Company Commander in preparing his report and to direct his attention toward the more important aspects of the recruit's behavior, a formal, standardized report form is utilized. The Medical Research Form, Standard Medical Evaluation Form A, is currently in use, and is discussed at greater length in a later chapter on "The Improvement of Present Techniques." A thorough discussion of it also may be found elsewhere in the guide. *The Utilization of Naval Medical Screening and Evaluation Forms for Psychiatric Units.*

The psychiatrist may also wish a social history on the recruit in order that his present difficulties may be evaluated in the light of his past developmental history. A social history can be obtained by the social service worker. In order that a contact may be made with the proper sources in the recruit's home community, time must be allowed for gathering this material and it is always best when possible to anticipate the need for a social history at the time of the original examination, and to request it then in order that it may be on hand by the time the reexamination takes place.

Of particular interest in the reexamination are the recruit's adjustment, the demands of training, the number and quality of the inter-personal relationships he has established in his company, changes in the level of his motivation, and the perseveration of any residuals from conflict situations existing prior to his enlistment. Any attendance at sick call and the persistence of physical complaints noted at the original interview should be checked. All of these must then be evaluated in the light of the social history data available and integrated with the Company Commander's report on the recruit's progress in training.

It is to be expected that some deviations may occur in the actual procedures utilized for trial duty cases. While a period of three weeks before reexamination is prevalent, special considerations such as the training schedule, etc., may dictate a longer period, say of four or five weeks. The time limits are flexible but it should always be remembered that once it is definitely possible to establish that a recruit is not suitable for service, it is in both his and the Navy's best interests that he be separated as soon as possible.

One training installation finds it efficient to subject all trial duty cases to a reinterview after only one week of training, and without bothering to obtain the Company Commander's report on the man. This reinterview enables the Psychiatric Unit to remove approximately two-thirds of the men from trial duty status and to concentrate on the remaining one-third who are then returned for further trial duty and recalled once

more after a suitable interval, this time with the full Company Commander's report available on their progress during training. Such a procedure also lessens the work demanded of the Company Commanders in filling out reports on doubtful recruits. As with all the selection procedures it is desirable to permit some local initiative in adapting to local circumstances and to special problems.

As a result of the reexamination the recruit may either be removed from the "suspected" list and returned to duty, or, if he is not adjusting, he may be admitted to the ward for further study and possible separation from the service. In some cases it may be desirable to return the recruit to his company but to continue him on a further trial status. It may even be decided if feasible to institute some brief individual or group psychotherapy, and it is usually possible to arrange such interviews with the assistance of alert and cooperative line training officers.

THE PSYCHIATRIC WARD

The psychiatric ward serves as the physical center of the Psychiatric Unit's many activities. Here are the offices of the professional staff, the necessary facilities for special examination services, and room for the clerical staff necessary for processing the voluminous records demanded by the Unit's activities. It is here that the reexamination of trial duty cases takes place, as well as the examination of other referrals; and the many out-patient duties, including therapy and education, that a busy Psychiatric Unit will find delegated to it. It will be the organizational nerve center, the home base of the Unit's work.

One of its most important services will come through the facilities for an observation ward with its provision for bed space where cases needing close observation under hospital ward conditions may be held for a complete and comprehensive examination to determine their aptitude for the Naval service. The importance of the thorough examination facilities afforded by the observation ward cannot be over-emphasized. It is here that the complete facilities of modern psychiatric examination are brought to bear upon the doubtful recruit in order that no man may suffer the injustice of unnecessary separation from the service, that all possible manpower be preserved for military duty, and that the final disposition of any recruit may be determined by the best medical and psychological information that can be assembled. Separation from the service has manifold and serious consequences for both the recruit and the Navy, and the careful study possible upon the observation ward will insure, insofar as is medically and humanly possible, that no recruit will be discharged unless his condition truly warrants it.

It should be stressed that not all recruits admitted to the ward will be separated from the service. Many of them will be "false positives" recruits who upon further study prove able to render adequate service and will be returned to duty. Thus the ward acts to salvage men for the service as well as to separate them from it. The number of men returned to duty will vary with the quality of the incoming recruits and the standards set for acceptable service at that time. In one unit during the last war the number of men finally returned to duty from the observation ward ran as high as one-third of all admissions. Many of these men would have been lost to the Navy had it not been for the careful examination facilities that provided an opportunity for the differential diagnosis and full psychological understanding of the recruit under study. It is here that simple nostalgia may be differentiated from the more severe endogenous depression, that temporary deviant behavior may be differentiated from basic psycho-

pathy, and that true mental deficiency may be differentiated from mere cultural and educational handicap. In this last respect it is safe to say that the complete psychological examination facilities of the observation ward have saved more men from a false diagnosis of mental deficiency than they have caused to be separated for this reason.

Nor are the activities of the ward limited to examinations. There will be many chances for therapy. Not all therapy need be deep, long-term therapy. Often sympathetic understanding and discussion within the limited time available can impart the necessary self insight which will enable the recruit to overcome his difficulty. Supportive therapy and even simple encouragement may be effective. This is particularly true with many of the reactive disorders where the application of modern therapeutic techniques will salvage for the Naval service many men who otherwise would be lost to it. Many of the recruits on the ward will be there because, while an orientation to the service may be possible for them, they have not as yet been able to achieve it. The transition from civil to military life has been too abrupt and too overwhelming for them. Psychologically they are "lost," but only for the moment. With these cases sympathetic understanding and wise guidance will make it possible for the man to find himself and adjust. His attitudes may be guided in a positive direction and service identifications may be established in preparation for his return to duty.

Sources of Admissions

Admissions to the ward will come from many sources. Some men may be admitted directly from the original screening examination because they demonstrate manifest neuropsychiatric symptomatology of a nature severe enough to indicate immediately their unsuitability for the military service. Ordinarily the number of these will not be large. It will vary with the varying efficiency of recruiting activities, and the efficiency of the Armed Forces Examining Centers responsible for the examination of the men when they are first selected for military service. Many of the admissions will be trial duty cases who did not succeed in making an adjustment in the company. Still others will be direct referrals from company during the training period. These men represent cases that are not detected during the original screening examination and whose difficulties become evident only after a period of duty. They are men whom the psychiatrist thought it unnecessary to stop at the time, or to follow-up later. They represent the "misses" in screening, the errors in judgment that are inevitable, not only because of the fallible human factor involved in screening, but because of the calculated risks that must be taken if every attempt is to be made to achieve the utmost utilization of avail-

able manpower.

Many of these direct referrals will come from the Company Commanders in immediate charge of the recruit's activities during training. They represent troublesome cases not succeeding in their training duties for whom the Company Commanders feel the need of psychiatric advice and assistance in handling the problem. The other non-psychiatric medical facilities will also be a source of referrals, particularly for psychosomatic cases. Some may come from the Chaplain's department, and many certainly will appear through disciplinary channels. Psychological maladjustment manifests itself in many ways and may result in behavior difficulties in any field of activity. A recent study of psychiatrically borderline men in the Naval service shows that these men contribute more heavily to the sick list and to military courts than do the well-adjusted men even though the borderline cases involved may appear to be making an adequate service adjustment.[1]

Since such direct referrals from Company represent men that the Psychiatric Unit has no previous knowledge of, it is important that the men in immediate contact with these cases not only recognize them, but realize and understand the role of the Psychiatric Unit in handling the problem, and know clearly the operational means and procedures by which a recruit who is not adjusting may be referred to the Unit for help. This means that a close and sympathetic liaison must be maintained between the Psychiatric Unit and those training facilities from which such referrals spring. This can be aided by cooperation and communication between the Psychiatric Unit and the activities involved, and can be further assisted by formal and informal educational activities, particularly with the Commanders of recruit training companies. More will be said later concerning these educational opportunities. Here we need only stress the necessity of indoctrinating key personnel in all the various Training Center departments. They should be helped to understand the philosophy, the goals and the activities of the Psychiatric Unit, to realize its mental hygiene role in salvaging men for the service as well as its administrative role in disposing of cases who do not make good and to know how to avail themselves of the resources of the Unit when necessary.

The present philosophy of "screening in," of attempting the full utilization of all available manpower, necessitates the taking of calculated actuarial risks. Not all borderline cases can successfully adjust even with help. Some "marginal" men will fall back into the "unsuitable" category. When this occurs, channels of psychiatric referral must

1. Hunt, W. A., Wittson, C. L., & Hunt, E. B. Military performance of a group of marginal neuropsychiatric cases. Amer. J. Psychiat., 1952, 109, 168-171.

be available, and their use must be clearly understood, if the Psychiatric Unit is to exercise its full potential in the best interest of both the recruit involved and the Naval service itself.

Admissions Procedures

Upon admission to the observation ward each recruit is passed through the record office where, in addition to being logged in, he is interviewed and necessary information such as name, company, service number, home address, name and address of next of kin, and other pertinent material is obtained. This is entered on a "control" card suitable for filing in the permanent records of the Unit. This card should also contain room for such matters as diagnosis, psychiatric commentary, test findings, and final disposition. A typical card is included in the Appendix. The exact form of the card may vary to take account of local differences in examination and test procedures and research interests. The information may be obtained directly from the recruit or from the slip made out during the original screening examination, or from the Standard Medical Screening Form A, Personal Information, if this is available. These last may replace the control card completely if desirable, but they are most suitable for use as work forms for punching the IBM cards made out for each recruit at the original examination (as detailed in the guide, *The Utilization of Naval Medical Screening and Evaluation Forms for Psychiatric Units*) and are not as suitable for convenient permanent filing as is a stiff, smaller card. It is also wise to have such control cards filled out, not only for ward admissions, but for every recruit on whom it seems desirable to have a permanent record. These include referrals from other training facilities, trial duty cases, etc. Further cross files by service number, diagnosis, disposal, etc., may be added as time and clerical assistance is available. Such cross files are helpful in research, although their basic function may be fulfilled by the IBM punch card recording process mentioned above.

Upon admission of the recruit, the senior psychiatrist will be responsible for seeing to it that the recruit is assigned to a staff member who becomes responsible for the case work-up on him. The designated staff member will then be responsible for examining the recruit; requesting such supplementary material as psychological tests, case history, and medical examination if necessary; and for completing the final case evaluation and write-up. An illustrative psychiatric examination form for this purpose is included in the Appendix. The form illustrated is printed on the inside covers of a manilla folder which then becomes the recruit's case folder and is suitable for permanent filing. Into it may be slipped any Company Commander report, psychological test blanks, laboratory re-

ports, social history material, or correspondence concerning the case that it seems desirable to preserve. Experience has shown that printing the examination forms thus on the inside of the case folder makes for more convenient reference, saves filing space, and reduces the loss of records.

Filing

The provision of some careful, orderly filing system for the records of the Unit is essential. It is obvious that the material on "open" cases, such as trial duty recruits, must be easily and quickly available. Closed cases may also be reopened, and not infrequently other departments may wish whatever information the Unit has available on some questionable recruit. The files, of course, also will be invaluable for research.

Current directives (the Manual of the Medical Department) make provision for the local maintenance of case records for a period of two years. After this time has elapsed the records should not be disposed of, but should be forwarded to the Medical Records Management Branch, Garden City, Long Island, New York.

Ward Organization

Current directives call for a ward of at least thirty-five beds per one thousand incoming recruits per month. Medical corpsmen will be provided for performing the necessary duties in maintaining the ward, and as many as possible of these should be trained in neuropsychiatric work, as their observations of ward behavior will contribute to the evaluation of each case. As the current understanding of "total push" therapy makes clear, the duties of maintaining morale, discipline, and proper organization on a ward such as this, are not only difficult, but are exceedingly vital to the welfare and progress of the patient. They demand the best ability and effort that the ward personnel can bring to their task. The senior psychiatrist will find that only the careful organization and delegation of responsibility among the corpsmen will enable the ward to operate efficiently. He may well choose a member of his professional staff to function as "first lieutenant" and be immediately responsible to him for the functioning of the ward and for the daily medical rounds.

A senior corpsman, a chief if available, should be placed in charge of all hospital corpsmen detailed to the ward. Depending upon the size of the ward and the number of admissions, further organization and detailing of responsibility for various ward activities may be necessary to insure the smooth working of the organization. Such activities include the checking and storing of sea bags and personal property, the feeding of the recruits on the ward, recreational activities, and work details. The specific

form of such organization must always depend upon local conditions and needs.

In this connection it should be remembered that the recruits admitted to the ward for observation are not considered as patients — they are not admitted to the sick list, and they do not show in the official statistics of the Bureau of Medicine and Surgery. They are carried on the duty list of the Training Center and technically are still in a training status.

Experience has shown that it is highly desirable that some form of training be carried on for the recruits under observation on the ward. All Psychiatric Units regularly furnish working parties for medical activities. These will account for a large amount of the recruit's free time on the ward but they should be supplemented by other training activities wherever and whenever possible. Thus one Unit has a chief quartermaster assigned to the Unit in charge of all training activities. He conducts drills, calisthenics, organizes and assigns working parties, etc. Such provision for regular activity will not only increase morale and motivation by keeping the recruits busy but through the provision of normal and useful labor will help to keep up the sense of responsibility and social participation that will counteract the natural anxieties and possible hypochondriacal tendencies that might otherwise arise in the "medical" setting of the ward.

At this point something should be said about the complicated problem of providing personnel to stand watch on the observation ward. While the recruits on the ward are not classed officially as patients, consisting as they do largely of behavior problem cases, they will present constant problems of care and discipline not encountered in the ordinary recruit company barracks. The problem is further complicated by differing local watch arrangements and each Unit will have to work out its own procedure with the approval of the local command.

As a part of the Administrative Command, Medical Department, all medical officers and hospital corpsmen are subject to AdCom watches in all medical facilities. It is highly desirable that those corpsmen assigned to the Psychiatric Unit for regular duty stand watches at the Unit rather than elsewhere. Their experience and familiarity with both neuropsychiatric procedures and the types of recruit problems handled, render this almost a necessity to insure both the orderly functioning of the ward during the off hours and the adequate care and treatment of the recruits under observation. It also is imperative that enlisted personnel ordinarily assigned to duty elsewhere be not assigned watches at the Psychiatric Unit where their lack of familiarity with both the procedure and the type of recruit population involved may lead to serious and disturbing consequences. Usually the supply of enlisted personnel is sufficient to make these arrange-

ments possible.

The picture for medical officers is more complex and troublesome, however. All too often the pool of medical officers available for watch duty within the AdCom at any Training Center is not sufficient to allow psychiatrists to be assigned solely to Psychiatric Unit watches, since they are needed for the various other medical watches and must be placed on the general medical watch list. If Psychiatric Unit watches are added to their other obligations they are forced to stand double watches, which is discriminatory and undesirable. One unit currently utilizes MSC psychologists with the psychiatrists in a single continuous watch list. This alleviates the problem by diluting the burden but does not solve it. If sufficient MSC Psychiatric Unit personnel are available, a watch list can be provided from them. This again is not a complete solution as the MSC officer can only play a limited part in any medical emergency that arises and must call upon the MOOD if the responsibility is a strictly medical one. On the other hand in the ward management of the personality disorders which constitute the great bulk of the Unit's responsibilities, many problems will arise of a disciplinary and purely management nature which can be handled adequately by an MSC officer, and the mere presence of an officer on the ward during the night hours will be reassuring to the recruits and contribute to the stability and morale of the ward.

Command and Medical Responsibility

The newly commissioned medical officer or the reservist recalled to active duty must remember that the Navy is a highly organized social unit. Without organization any complex social structure tends to fall apart and anarchy results. With organization even a huge and complex social structure such as the Navy may function efficiently in the intricate performance of its innumerable duties. In civilian life as in military life a vital aspect of this organization is the delegation of authority. If the group is to function efficiently there must be a clearly defined structure of authority dictating the responsibilities of each member of the group and establishing a hierarchical order in the chain of command. This is particularly necessary in the military services. The responsible officer must understand and assume his responsibility, and his responsibility must be recognized and respected by those individuals acting under his command. In the medical service these responsibilities are of two sorts, military responsibility or the chain of command necessitated by military organization, and medical responsibility or the professional responsibility of the medical man to his patient.

Military responsibility is recognized in the chain of command. Within the medical

department this chain of command runs from the senior medical officer through his executive officer to the senior psychiatrist as head of the Psychiatric Unit. While the senior psychiatrist is in charge of the Psychiatric Unit and is responsible for its activities it remains an integral part of the Medical Department under the authority of the senior medical officer. Approaches to the Commanding Officer of the Training Center, contacts with other, non-medical facilities of the Center, reports of the Unit's activities, etc., all proceed through the senior medical officer unless he has given permission otherwise. Within the Unit the chain of command proceeds from the senior psychiatrist down to the individual staff member. The exact chain will be dictated by such organizational structure as the senior psychiatrist may establish within the Unit. Thus if an individual psychiatrist is designated as being in charge of the observation ward, all ward matters are forwarded through him to the senior psychiatrist; also an individual psychologist would report through the chief psychologist, and all matters pertaining to psychology would be handled through him as responsible to the senior psychiatrist. As with all matters of responsibility, authority can be delegated to others but it should not be assumed without such delegation, and ultimate responsibility resides with the officer making the delegation.

Medical responsibility also must be recognized. The classical responsibility of the medical man for his patient's welfare is as binding in the military services as it is in civilian practice. It must never be forgotten. Certain medical duties are the responsibility of the medical officer. The prescription of drugs, practice of surgery, application of the healing arts in illness are all a medical function and must be recognized as such. They are assigned to the medical man by virtue of his special training and this assignment is recognized by social custom and backed by social legislation.

The non-medical members of the staff of the Psychiatric Unit are bound to accept this assignment of responsibility. They must recognize that in many medical situations they cannot act independently. If they take responsibility outside their field of accepted competence such responsibility can only be delegated by a medical officer, and the ultimate responsibility remains his if aynthing goes wrong. There also are many administrative duties, such as the certifying of diagnoses, signing for hospital transfers, etc., which are of legal necessity in the hands of the medical officer. They cannot be executed by line officers, medical service corps officers, or hospital corps personnel.

In turn, the medical officer has the responsibility of recognizing special training and professional competence within the ancillary disciplines attached to psychiatry. He should accept the competence of the clinical psychologist within the field of diagnostic

psychological testing, fully utilize his contribution to the etiological and dynamic understanding of the patient, and allow him the authority of selecting test procedures and interpreting their results. He will accept the authority of the psychiatric social worker within the field of psychiatric case work. Successful administration in any organization rests solidly not only upon the acceptance of one's own responsibility but upon the recognition of the responsibilities of others.

The mature officer, be he medical or a member of one of the ancillary disciplines, will have no trouble in adjusting to the demands of both command and medical channels of responsibility. On the non-medical officer rests the responsibility of not proceeding independently beyond his areas of competence and authority. On the medical officer rests the responsibility of recognizing individual competence and special ability by delegating authority wherever possible and in the best interest of the service. On both rests the responsibility of recognizing the chain of military command.

The Case Evaluation

In examining the recruit the psychiatrist should keep firmly in mind that "unsuitability for service" with severance through an Aptitude Board is not based on the establishment of medical symptomatology *per se,* but on the establishment of lowered functional potential. Thus the psychiatrist is not faced with the common civilian task of establishing a diagnosis and reenforcing it by the delineation of the typical symptomatology, but rather with the evaluation of the individual's total personality and an assessment of his functioning as a military man. Discharge through an Aptitude Board is an administrative discharge, not a medical one, and before a man is recommended for such separation it must be clearly established that his total personality and consequent behavior are such as to result in an impairment of his functional potential that will render him a detriment to the efficiency of the military services. This shifts the stress in examination from symptomatology *per se* to the total evaluation of the individual's adjustment in the military setting. Dynamics become all important and interpersonal relations and performance of military duties must be assessed in the light of their contribution to the military effort. If the efficiency of the service will be lowered by the retention of the recruit, unsuitability for service can be regarded as established and the evidence is then presented to the Aptitude Board for action. In considering separation versus retention in the service the recruit's best interest must also be kept in mind, and the possibility of further aggravation of an existing condition must always be considered in making the final decision.

While such cases will form the main body of the work of the Psychiatric Unit, occasional cases of medical disability involving a Pulhes rating of 4 will be uncovered. Here there will be more attention to symptomatology. Such cases must be presented to boards of medical survey, not to the Aptitude Board. Such men receive a medical rather than an administrative discharge. It should also be remember that if the reason given for discharge is the possibility of an exacerbation of the recruit's condition by military service with a consequent threat to the recruit's health, or if the recruit's condition constitutes a threat to the health or safety of his service associates, medical survey rather than administrative discharge is necessary. The following section will deal more at length with the difference between "disability" and "unsuitability."

In working up a case, multiple opinions are a valuable check against error and the examining psychiatrist will often desire consultation with his colleagues. In addition to other psychiatric opinions, the case may require various laboratory tests, consultation with the other medical specialties, psychological testing, and social history material. Laboratory tests will be furnished by the Medical Department, but if a large number of recruits are being handled on the psychiatric ward the detailing of a full time internist to the ward may be advisable.

The Difference between "Unsuitability" and "Disability."

As we have implied above, confusion may arise in differentiating between "medical disability" and "unsuitability for service." Let us view a hypothetical case, Recruit A. During the psychiatric interview it is discovered that this recruit has a history of a previous psychotic episode during which he became acutely disturbed and assaultive. He was hospitalized for six weeks, at the end of which time he was discharged as recovered. Irrespective of how the examining psychiatrist may feel about such a history, it is not by itself reason for separation from the military services. Recruit A would have a Pulhes rating of 3 which is the minimal acceptable rating, but still not disqualifying according to present directives. If this history of a transient psychotic episode were the only dubious factor revealed by the examination, Recruit A would be sent to duty, although the psychiatrist might feel it wise to keep an eye on him and follow his progress during training.

Should the psychiatric examination, however, disclose evidence of a psychotic state existing at the time of the examination, the recruit would be considered ineligible for service. His Pulhes rating would be 4 which would disqualify him and demand his presentation before a board of medical survey on the grounds of "medical disability." Since

this psychotic condition must have existed previously but had been overlooked at the induction or recruiting examination, this is what is technically known as a revision of the Pulhes rating downward. Were the psychotic condition well advanced, wisdom would dictate his transfer to a Naval hospital with a medical survey being issued from there.

Should the psychiatrist be convinced that while no psychotic condition existed at the moment, there nevertheless was clear evidence that the recruit's adjustment was precarious and that military service would precipitate a recurrence of his psychosis, Recruit A might be recommended for medical survey on the grounds that military service would exacerbate his condition and constitute a threat to his health. If in view of the history of previous assaultive behavior the possibility of a physical attack on a shipmate definitely had to be considered, this would be further reason for survey on the grounds that his condition constituted a threat to the health and safety of his service associates.

If, as a result of the original examination or as a consequence of trial duty, definite evidence of emotional instability appeared which interfered with the recruit's adjustment to service although no psychotic condition were present at the moment, Recruit A might be adjudged "unsuitable for service." His Pulhes rating would remain 3 but owing to his difficulty in adjusting, his "functional potential" would be considered as lowered and he would be held to be contributing to inefficiency in the Naval service. Under such circumstances, however, he would not be considered medically disabled, but would be considered as "unsuitable for service" and would be presented to an Aptitude Board for an administrative discharge. Unsuitability for service will be the most common type of case encountered in selection practice and it is to be expected that most separations during training will be of this sort. In presenting Recruit A before an Aptitude Board the stress should be placed on the recruit's current difficulties and his failure to adjust to training. The history of a previous psychotic episode would become merely one further instance of an unstable personality which is preventing his adjustment in the service.

Let us take another hypothetical case whom we may call Recruit B. Recruit B suffers from enuresis. Bonafide, severe enuresis *per se* is considered a medical disability and necessitates a medical survey. We must remember, however, that enuresis is frequently symptomatic of basic personality maladjustment. It may indicate the presence of emotional instability, immaturity, or a neurotic syndrome. Occasionally bedwetting may be an accompaniment of nocturnal seizures. For this reason the enuretic recruit should be examined carefully for underlying personality difficulties. Thus on further investigation it might develop that Recruit B was not adjusting to the service, and that his emotional

instability was basic to the enuresis. He might be unable to benefit properly from his military training, might be causing disciplinary difficulty, and might be upsetting his shipmates by his inappropriate emotional behavior. If the psychiatrist decides that the maladjustment is severe enough to render Recruit B inefficient and ineffectual as a military man, his separation might be recommended through the Aptitude Board because of unsuitability for service rather than enuresis. The recommendation, however, would be based on the recruit's inability to perform efficiently, and to adjust to the demands of the military service, and not on his enuresis, although this latter might be instanced as further evidence of his basic instability.

Moreover, if the enuresis were frequent and severe, it might result in unfortunate social repercussions, thus Recruit B might find the extra duties of personal hygiene and the extra effort demanded in keeping his bedding washed interfering with his other duties. His shipmates might object to the odor in confined sleeping quarters. Recruit B might then become the butt of company jokes and minor aggressions resulting in an emotional upset which he could not handle. The consequent maladjustment might be severe enough to preclude his adjustment to military living. If so, Recruit B might properly be referred to an Aptitude Board for separation from the service. While the enuresis in these circumstances might be regarded as the cause of maladjustment, the reason for separation would be the recruit's failure to adjust, and not his bedwetting. In presenting such a case before an Aptitude Board the stress should be placed on Recruit B's inability to benefit from his training, his inefficient and maladaptive behavior, and his disruption of the orderly routine of his company.

In evaluating enuresis the examining psychiatrist should remember that isolated and sporadic incidents may occur in some individuals, particularly under emotional stress and excitement such as attends the change from a civilian to military environment. If an isolated bedwetting incident is uncovered which is not repeated and which does not precipitate disturbing social consequences for the recruit, and if his attitude toward the incident is healthy, no lowering of military potential need result. Such a recruit may be capable of valuable service to the military establishment.

The convulsive disorders (grand mal, petit mal, psychomotor attacks) are considered as medically disqualifying and a verified history of such is reason for separation from the service by way of medical survey. In diagnosing such cases, the electroencephalograph may be of great assistance. Since the convulsive disorders are medical disabilities, separation always should be accomplished through a board of medical survey rather than through an Aptitude Board.

The Psychologist

The duties of the civilian clinical psychologist are usually defined as including diagnosis, research, and therapy. His duties in the Naval service will parallel civilian practice, allowing for such special developments as are demanded by the problems peculiar to the military endeavor. One difference appears in the field of psychotherapy. Within the Naval service, the independent practice of psychotherapy is not permitted the psychologist. It remains the responsibility of the psychiatrist. If the clinical psychologist has been trained in this area, and if he demonstrates his competence as a therapist, the psychiatrist may delegate this responsibility to him, furnishing such supervision as may be indicated. The ultimate responsibility for the patient, however, remains with the psychiatrist. Actually this situation does not differ as greatly from civilian practice as may appear. In civilian life relatively few clinical psychologists practice psychotherapy independently. Most of those who have been trained in psychotherapy and do practice it, do so in a medical setting, either in the teamwork situation typical of institutional practice or within the framework of collaborative, group practice where consultation and supervision are available as needed.

Diagnostic testing is an area of special competence for the clinical psychologist. His testing techniques will furnish a valuable complement to the clinical skills of the psychiatrist. While some provision may be made for brief testing at the time of the original screening examination, the psychologist will be of particular value as a diagnostic consultant on the observation ward. His possession of various testing skills enables him to fulfill a function much like that of the pathologist in a modern hospital. He may be called upon for testing to answer questions of differential diagnosis or to confirm an established diagnosis when desirable. His tests will be invaluable in revealing personality dynamics and structure that will aid in understanding the patient's difficulties, in deciding the course of management on the ward, in the selection of therapy, and in ascertaining its progress.

In such cases the psychiatrist should refer the patient to the psychologist with a statement of the problem. The choice of the specific testing techniques to be used should be left to the psychologist. If the psychiatrist desires information from a specific test with which he is familiar, it is, of course, proper to request it; but the psychologist's diagnostic skill should not be hindered by limiting him to specific testing techniques. He will perform such tests as are necessary in his opinion to answer the diagnostic problems involved.

These tests will include the various intelligence scales such as the Wechsler-Bellevue,

and personality tests such as the Rorschach, Thematic Apperception Test, Blacky, etc., all designed to reveal the dynamics of the patient's personality. There are also numerous special tests designed to detect intellectual deterioration, organic brain damage, and performance deficit attributable to educational handicap. The psychologist usually is also skilled in interviewing and in the evaluation of case history materials, and he should employ these skills when desirable to supplement his test results in arriving at the final case evaluation. If desired in reporting his evaluation of the patient, the psychologist may include an enumeration of the specific test scores and findings, but in any event the report should summarize a picture of the patient's total personality and functioning potential as it issues from the complete psychological examination.

In cases involving intellectual and educational handicaps such as mental deficiency and illiteracy, the senior psychiatrist may wish to assign the primary responsibility for the case work-up to the psychologist. It should be stressed that adequate psychological testing remains our best basis for establishing the diagnosis of mental deficiency. As we have said before, such testing is just as important in saving a recruit from a false diagnosis of mental deficiency as it is in establishing a valid one. Intelligence testing is also of vital importance in such differential diagnostic problems as distinguishing mental deficiency from illiteracy or educational and cultural handicaps; distinguishing functional deficit from primary amentia; and distinguishing malingering from genuine intellectual defect. In interpreting such tests the psychologist should always remember that their statistical basis renders them susceptible to some error in predicting for the individual unique case, and should supplement the test findings by the critical application of his clinical experience before arriving at a final decision.

The field of research is another area in which the psychologist has had extensive specialized training. His skill and knowledge in experimental design and in the application of statistical techniques will be of great value. The senior psychiatrist may wish to recognize this by delegating to him the overall supervision of ongoing research.

The two competencies in the fields of testing and research will also enable the psychologist to play an important role in the use, interpretation, and further development of such psychiatric adjuncts and screening devices as the Standard Medical Screening Form A, Personal Questionnaire. He has been trained in the proper administration of group tests, and in the validational techniques such as item analysis, etc., which are necessary for their constant evaluation and improvement. More will be said about this and about the research functions of the Unit in the later chapter on "The Improvement of Present Techniques."

The psychologist can perform many other professional duties to help in the work of the Psychiatric Unit. If he is skilled in interviewing, he may assist in administering the original brief screening interview. His academic training may fit him for educational duties such as group lectures or for the use and development of special retraining techniques. One of the primary administrative functions of the senior psychiatrist is the delegation of responsibility where it will result in the best fulfillment of military and professional goals, and he will use his psychologists, like his other ancillary personnel, where and when the situation and his professional judgment may dictate. In so doing, however, he should remember that clinical psychology is a complement to psychiatry, and not a substitute for it.

The psychologist may also have further administrative and collateral duties in connection with the work of the Unit. They will include matters of personnel administration, various ward management functions, liaison with other departments, etc. Because of his particular background and training, the psychologist will play a peculiarly important role in liaison with the Classification Department and the Recruit Preparatory Training Command, since he will understand their problems and the techniques they use in meeting them. All these collateral duties will be assigned at the discretion of the Chief Psychiatrist to facilitate the most efficient functioning of the Unit.

In addition to the regular MSC clinical psychology officers ordered to duty with every Psychiatric Unit, billets have been provided with civilian psychologists in a Civil Service status. These civilian psychologists fill a dual purpose. They complement the meager billet allowance for military personnel and also provide a desirable element of continuity since they are not subject to the regular rotation provisions under which military personnel operate. As Civil Service employees they are subject to Civil Service regulations as well as Naval Command. Their hours of work are regulated by Civil Service directives but within these limits they must recognize and accede to the demands and requirements of the Naval service. If a military emergency necessitates weekend and holiday work, this can and must be met by staggering their five-day work week. The requirements of National Defense are primary in a military organization.

The Psychiatric Social Worker

The psychiatric social worker will perform many duties on the psychiatric ward which will contribute to the handling of the patients and to the efficient functioning of the ward. The intake interview following admission to the ward may be conducted by the social worker who explains the admission and its implications to the recruit and

aids him in understanding and adjusting to the situation. If desired, much of the general anamnestic material necessary can be gathered at this time and recorded in the case folder. Anamnestic interviews may also be done on out-patient referrals. During the recruit's stay on the ward he may meet with many problems of adjustment in which he can be assisted. There will be many situations in which the social worker can contribute directly or indirectly to the maintenance of morale on the observation ward.

Of particular importance will be the gathering of social history case materials from the recruit's home locality when such material is necessary for the accurate evaluation of the recruit's difficulties in the service. While it is proper to stress the request for information in certain specific areas, the professional contribution of the social worker should not be hindered by the limiting of information to these specific fields. Case histories will be obtained by the social worker through communication with community sources in the recruit's home locality. By Act of Congress the American National Red Cross is chartered to act "in accord with the military and naval authorities as a medium of communication between the people of the United States of America and their Army and Navy." The Navy has for many years relied almost entirely upon the more than 3,700 chapters of the American National Red Cross as a community resource in securing social histories. In order to make full use of this service which the Red Cross is pledged to give, the psychiatric social worker should confer with the Red Cross field director in the hospital or on the base requesting cooperation. It must be understood that such information is highly confidential and that its source and content will not be divulged to the patient, his relatives, or other unauthorized persons. It is to be used for the good of the patient in furthering the accurate evaluation of his difficulties. It must never be included in the patient's clinical record or in the proceedings of any evaluation board.

The social worker can make a vital contribution to the rehabilitation of those recruits who are separated from the service. Many of these men will need advice and assistance in readjusting to their home environment upon their return. It may be desirable to furnish some occupational guidance, to help the recruit in locating aid for some physical difficulty, or to give him guidance in family problems. This can be done through one or a series of terminal interviews at the time of separation, and by arranging contacts for him with those agencies in his home community that can help him with his problems. The social worker may also function in interpreting the recruit's condition to his family where this is necessary or desirable.

The psychiatric social worker functioning in a military context will find it different

from the usual civilian professional setting. The attitude of primary responsibility to the patient and to his welfare, while always a vital consideration, of necessity may have to be subordinated to the welfare of the service as a whole. The maintenance of combat efficiency is the ultimate goal of the Naval medical service, and national survival demands that individual good be sacrificed if necessary to the larger interest of the group. The administrative structure within the military service is more complex and more authoritative than in a civilian setting, and the social worker must adjust to its demands and learn to function efficiently and cooperatively within the formal chain of command necessitated by military responsibility. In using his case work skill, he may at first feel some environmental limitations owing to the complexity and rigidity of military regulations, but with experience he will find that resources provided for the assistance of the recruit in his adjustment to the services are as rich and as comprehensive as those available in civilian community agencies, and he will find that military organization will make it easier to insure that his recruit client will receive the benefit of these resources.

Volunteer Workers

If the war population is large, and recreational and social opportunities need encouragement and extension, an expansion of these may be obtained through the use of volunteer workers such as the Gray Ladies of the American Red Cross. The local headquarters of the Red Cross may be contacted to obtain these. If sufficient volunteeer workers are not available through the Red Cross itself, they can make contact with other civilian groups in order to obtain further workers from other sources. Such assistance by the Red Cross will be invaluable in establishing the proper community contact and insuring that the volunteers will have some preliminary screening and will be orientated toward their task on the observation ward.

The use of volunteer workers in the hospital setting is no longer a purely fortuitous matter of the charitable contribution of odd time by interested and well-meaning citizens in the community. Volunteer workers today are organized. They represent a carefully selected group, committed to the expenditure of sizable and regular hours of labor and trained for their duties. The responsible community organization furnishing them usually will not countenance their placement in an institution until a need for them has been demonstrated and an orderly plan for the utilization of their services has been worked out. This is a protection for the volunteer worker as well as for the patient. Where such programs are handled successfully, they can result in innumerable benefits

to the patient, genuine satisfaction for the worker, and an increase in community cooperation and good feeling. Where they are not handled intelligently they can result in no benefit (or even harm) to the patient, disillusionment and disappointment to the worker, and the resulting lack of interest or even hostility in the community. Because of this they should not be undertaken lightly by any Psychiatric Unit. The staff must be willing to assume responsibility for a well-planned program and willing to devote continuing time and energy to assuring its successful progress.

The possible uses of such volunteer workers are many. They can participate in social and recreational activities and in the planning and execution of parties and social gatherings. They can assist in letter writing and such other duties. Educational programs, library facilities, etc., all can be implemented and executed through them. They may contribute to an atmosphere of relaxation and normal social activity on the ward which will help lower the tension inherent in the situation and boost morale. They can be available on weekends when time is apt to hang heavily on the recruit's hands. With some encouragement of initiative on their part, new activities may be worked out that will contribute to maintaining good spirit during the recruit's day on the ward. Under favorable circumstances, and if it seems desirable, they may even form a spearhead for developing community interest in supplying such luxuries as games, radios, television, etc., that might otherwise be unobtainable. However, moderation in this direction is indicated. Under no circumstances should the observation ward acquire a reputation as a soft spot, a refuge, or a "rest home." Adequate care is a necessity, as is good morale, but the rewarding of behavior problems by environmental overindulgence would destroy the purpose of the program and render effective "screening in" almost impossible by encouraging the fixation of symptomatology and furnishing motivation toward maladjustment rather than toward acceptance of service conditions.

The use of volunteer workers entails definite responsibilities and is not to be undertaken lightly. Careful selection of the workers for such a program is a vital necessity. Preliminary screening can be accomplished through the Red Cross or other community agencies supplying the volunteers. Final selection must be made by the Unit, either by the psychiatric social worker or some other member of the staff. Preliminary training and indoctrination must also be supplied before the worker can assume duties on the ward. Supervision will be necessary and a staff member should be placed in charge in a supervisory function. The utilization of civilian personnel in a military setting is bound to raise some delicate problems of authority. These can be handled tactfully and successfully, however, if the supervisor will remember that in such situations leadership and

positive guidance are more successful in handling social friction than are a flat reliance on authority and command.

There are many benefits to be obtained and many problems to be encountered in the use of volunteer workers. Unless the need is great, many Psychiatric Units may not feel the benefits will justify the time and energy necessary in devising and supervising such a program under ordinary conditions. Under some circumstances, however, particularly if mobilization or the development of hostility suddenly expand the duties of the Psychiatric Unit, increase the number of recruits to be handled and proportionately deplete the number of staff available, the possibility of aid from such a source might well be kept in mind.

The Hospital Corpsman

The work of the hospital corpsman on the observation ward is of peculiar and particular importance. It is easy to conclude that since he is handling less severe, noncustodial cases his duties will be lighter than they might be on the psychiatric wards of a regular Naval hospital. This is by no means so. The broad range of the type of cases he must be prepared to care for, and the psychological problems of handling them within the facilities of the observation ward create many difficulties that necessitate corpsmen of superior training and ability. The corpsman may be presented with every sort of problem, from that of caring for the severely psychotic patient awaiting transfer to the hospital down to the superficially less threatening but by no means easy problem of controlling the behavior of the inadequate, the unstable, and the unsocial in the daily round of ward activities. He will face behavior ranging from the psychotic outburst and the epileptic furor state to the covert and subtle disobedience of the psychopath. He must recognize and handle the despondency of the endogenous depressions, the less serious depressions of the reactive states, and the simple unhappiness of the nostalgic boy away from home for the first time in his life. And he must handle these problems together, in the free atmosphere of an open observation ward without the formal and extensive facilities of a hospital. The utmost in tact, persuasion, perseverance, and human as well as professional understanding will be necessary. Ward management is a fascinating but demanding problem in group dynamics and social interaction that will require the utmost in ability, responsibility, and devotion to duty that the corpsman can bring to it. He will function as a psychiatric technician in the best and fullest sense of the term.

Modern mental hygiene with its understanding of the philosophy of "total push"

therapy, stresses the importance of all the patient's contacts in assisting his healthy adjustment to his problems. Under the concept of "attitude" therapy it stresses the importance of the patient's attiudes and the important part that the nursing and supervisory personnel play in establishing these. Correct nursing care and supervisory attention on the ward must facilitate and supplement the more formal therapeutic treatment provided by the psychiatrist. The corpsman will be a vital element in providing the proper morale and emotional environment on the ward. Moreover, he will be of value in observing the behavior of the recruit on the ward. His reports of a patient's habits, daily deportment during the normal ward routine, and peculiarities of both person and behavior will be of great assistance in many diagnostic problems. Because of this he must learn the habit of careful and accurate observation, and clear and unbiased reporting. They are an essential part of his duties on the ward.

The corpsman must be careful to avoid the dangers of counter transference. Inevitably the problems of the patient may arouse echoes within his own personality structure, and he may find himself reacting emotionally when he should be calm and impersonal. Empathy is desirable in understanding the recruit, but the corpsman must control his own dynamics and not become emotionally involved in the patient's problems. Too much sympathy, displaced aggression, irritation and exasperation, and even undue curiosity must all be held firmly in check. In all his contacts he must offer the recruit the same impersonal understanding that is required of the psychiatrist in charge of the case.

All the above stresses the need for superior and trained personnel if the ward is to run smoothly and efficiently. While many of the corpsmen will be trained in psychiatric duties, many will not. Under these circumstances it may be wise to provide further formal instruction and organized educational opportunities, both in general psychiatric nursing and management, and in the particular and peculiar problems typical of the work of the Psychiatric Unit.

Disposition of Cases

After the individual psychiatric staff member assigned to the case has completed the case work-up, it is excellent practice to have it reviewed by the senior psychiatrist. This insures a double check as a guard against error, and enables the senior psychiatrist to keep in constant contact with the work of his staff. Depending upon the final decision the recruit either will go to straight duty, be put in a trial duty status, be transferred to a Naval hospital if his condition warrants it, or be recommended for separa-

tion from the service. As stated above, cases of medical disability will be separated through a board of medical survey, while cases of unsuitability for service will be presented to an aptitude board. Transfer to a Naval hospital will take place only if the requirements for treatment demand it, or if custody is indicated for a recruit who is a menace to the public health or to the safety of his shipmates. In any event, once a decision has been reached concerning any recruit, disposition should follow immediately. Unnecessary time spent upon the ward once the recruit's suitability for service has been clarified is expensive, wasteful of medical facilities, wasteful of potential manpower, and not in the best interest of either the man or the service. It also adds unnecessarily to the duties and responsibilities of the staff.

Owing to the individual peculiarities of each case, to the varying necessity for and difficulty in obtaining case history material, consultative services, etc., no exact time limits can be set for any recruit's stay upon the ward. During the last war, under conditions of efficient organization and determined staff cooperation, it was possible for some Units to hold the stay of the recruit upon the ward down to an average of from three to five days. This is an average, it is not attainable in every case, and may not be attainable even as an average except under favorable conditions. The Unit should not neglect the importance of the problem, however, and should always strive to clear the recruit from the ward as soon as it is humanly possible within the dictates of good medicine and the best interests of the recruit and the Naval service.

Physical Facilities for the Psychiatric Unit

In closing this chapter on the functions of the observation ward something should be said about the provision of the necessary physical facilities for the work of the Psychiatric Unit. The importance of adequate physical facilities cannot be overestimated if the Unit is to function efficiently. The building provided for the Unit's activities must contain sufficient space to house all its varied activities and should be situated convenient to both the Medical Command and the Training Command in order to insure the efficient movement of both the staff personnel and recruits under observation. Such facilities should include adequate space for the living quarters of those recruits assigned to the Unit for observation and study. This should include also a recreation area and recreation rooms for the recruits. Experience has shown that day rooms, etc., should be attractively furnished with simple, but adequate fittings. The use of cast-off and surveyed furniture invites careless treatment, and encourages vandalism. Plain but becoming masculine furniture creates a pleasant atmosphere, helps morale, and de-

velops a pride in surroundings that discourages aimless destruction. Visiting rooms and space for social work services should also be provided. If messing facilities are not located conveniently to the building, provision for messing space also must be made. If Wave personnel will be treated by the Unit, space must be provided for women's quarters. No security rooms need be provided since questionable cases in need of such detention are to be transferred to a Naval hospital. In addition to the living quarters, office space must be provided for the Unit staff and for the necessary clerical workers. This includes facilities for storing and maintaining the records of the Unit. Such office space should be separated from the living quarters provided. Adjacent to the staff offices should be space for waiting rooms to accommodate trial duty recruits called in for re-interview, out-patient consultation and recruits called in for examination in connection with special programs. Finally, space must be provided for meetings of the Aptitude Board. This should be strategically located in order that the Board's deliberations may proceed without interruption and without attracting undue attention.

The particular facilities may be expected to vary from training center to training center and will reflect local resources and local need, but the basic requirements must be effectively met if the Unit is to function efficiently and to adequately discharge the vital responsibilities inherent in the whole neuropsychiatric selection program.

THE APTITUDE BOARD

The Aptitude Board is constituted of a minimum of two line officers, one of whom must be at least of the rank of Lieutenant Commander; one clinical psychologist; and three medical officers, at least one of whom must be an experienced medical officer of the regular Navy, and one qualified as a psychiatrist. If personnel is not available, the Board will consist of one line officer of the rank of Lieutenant Commander or higher, and two medical officers, one of whom shall be a psychiatrist.

Function of the Board

The Board's function is to consider cases of unsuitability for service presented before it and pass judgment on the recruit's retention in the service in the light of the evidence presented to it. While the presence of a psychiatrist and psychologist on the Board assures close communication between the Board and the Psychiatric Unit, the Board and the Unit are distinct entities and their respective duties should not be confused. The Psychiatric Unit is a professional advisory and consultative unit charged with the task of selecting cases of unsuitability and gathering the evidence to be presented before the Board. The duty of the Board is to sit in judgment on this evidence and to decide upon the actual disposition of the case. It is not the function of the Board to challenge the nature of the medical evidence presented to it, but rather to consider this evidence in relation to the recruit's total functional potential for the Naval service. The gathering and evaluation of medical evidence is a medical function; it is the administrative, line function of the Board to integrate the medical findings with the other evidence of the recruit's suitability for service and to make recommendations for his disposition.[1]

Scheduling and Housing of the Board

The provision of the proper physical facilities for the meetings of the Aptitude Board and the scheduling of these meetings are functions of the Psychiatric Unit. Space for the Board meetings should be provided in the building housing the Unit, with the meeting room handy to the staff offices and to the observation ward and yet sufficiently removed from the main flow of traffic in the Unit so that the deliberations of the Board will not be disturbed. Adequate space and furniture must be provided within the room and its arrangement should be orderly and impressive in keeping with the dignity and authority of the Board. Since membership on the Board will constitute only one of the

1 Aptitude Board Actions at Recruit Training Centers. United States Navy Medical Newsletter 1952, Vol. 20, July 25, 18-19.

many supplementary duties in the busy lives of its members, it is easy to forget the importance of the Board's deliberations and final decision to the recruit appearing before it. Appearance before the Board will be one of the most vital and determining events in the life of such a recruit. It is the responsibility of the Board to realize this and to conduct its procedures accordingly, and it is the responsibility of the Unit to see to it that the physical surroundings provided for the meeting enhance its dignity and impressiveness.

Individual patients should be scheduled in accordance with the completion of their work-up by the staff, and Board meetings should be scheduled according to the demands of the case load. Efficient scheduling will provide a uniform and rapid turnover, prevent undue delay in disposing of any case, and result in a saving of time and expense that will be in the best interest of both the recruit involved and the Naval service.

Disposition of Cases

The Board may recommend to the Commanding Officer that the recruit be discharged or it may recommend his return to duty. If doubt exists, it may recommend further trial duty or admission to the sick list for further study. If the decision is for discharge, the recommendation is then forwarded to the Commanding Officer. Upon receiving the Commanding Officer's concurring endorsement the discharge can become effective, and separation from the service should take place immediately.

If discharge is recommended, the recruit must appear in person before the Board and be informed of its decision. This personal appearance before the Board may have great significance to the recruit. The decision may be unwelcome to him. It may even be traumatic. Upon the tact, insight, and psychological skill with which the recruit is handled will depend in great part his acceptance of the decision, his future motivation toward the military effort, his attitude toward the service upon return to civilian life, and his personal adjustment to his future.

Once it is decided to recommend discharge of a recruit, everything should be done to execute the decision without delay. Every attempt should be made to minimize the time elapsing between the action of the Board and the recruit's actual leaving of the station. It may be helpful not only to rush the recommendations via the Senior Medical Officer to the Commanding Officer's desk immediately following Board action, but at the same time to forward a list of those recommended for discharge to the personnel officer in order that their records may be pulled and the separation unit alerted for rapid action following the Commanding Officer's endorsement.

Report of Aptitude Board

An Aptitude Board report must be prepared for each recruit presented before the Board. The preparation of such a report is undertaken by the Psychiatric Unit and it is presented for consideration by the Board at the meeting at which the recruit is being evaluated. The report must contain a succinct but clear statement of the evidence concerning the recruit's unsuitability. The statement must be accurate and convincing as these reports are forwarded to BuPers and permanently filed with the recruit's service record. It is even possible that the recruit may instigate some action for reconsideration at a later date, challenging the original findings of the Board. Because of this, the correct writing of the report is of the utmost importance.

The "Report of the Aptitude Board" form will be found in the basic letter included in the Appendix of this manual. We have already stressed the difference between "medical disability" involving a board of medical survey, and "unsuitability for service" which is the basis for the action of the Aptitude Board. The Aptitude Board does not make a medical diagnosis and its impressions are not entered in the health record of the recruit. Its recommendations are based upon an evaluation of the recruit's functional effectiveness in the military setting. The evidence adduced in the report may include symptoms, signs, social behavior, reaction to environment, significant developmental factors, etc., but they must add up to a current picture of poor military performance which threatens the efficient functioning of the military service.

Social service data obtained from the Red Cross may be considered by the Board in its deliberation, but may not be quoted or referred to in its report. Such material can, however, be used professionally as a guide for direct questioning of the recruit and any information then directly elicited from the recruit becomes a part of the clinical history and can be utilized in the Board's report.

Illustrative Cases

The preparation of a statement of unsuitability which is brief but nevertheless convincing is a difficult task at first, but the psychiatrist or psychologist writing it will soon learn the technique with practice. Here are a few examples of typical cases:

Recruit X is a youth whose intelligence is low enough to class him as mentally defective to a mild degree. As such, his Pulhes rating, while 3, would still qualify him as acceptable for military service. His social history establishes him as coming from a culturally impoverished rural area where he had no schooling whatever. He has never held a job and has been completely dependent upon his family. During his trip to the Train-

ing Center he was confused and bewildered. His difficulties were detected during the screening examination and he was placed on a trial duty status. In company he has been completely lost. He was unable to learn basic drill and could not adequately comprehend the instructions and orders of his Company Commander. As one result of his inadequacy he has been guilty of several minor disciplinary infractions. He is personally untidy and unclean and a constant source of difficulty in his company. A psychological examination revealed an intelligence quotient of 68 on the Wechsler-Bellevue test, and an inability to read and write. His Company Commander stated that he was unable to make any progress in instructing the recruit and called him "a liability to the service." The social history revealed a negative background as mentioned above. This recruit is presented before the Aptitude Board with the following impression:

"This 18-year-old seaman recruit presents a history of being raised in a rural, culturally impoverished area where his father is a tenant farmer. The family situation is typical of a large agrarian group surviving in hand-to-mouth fashion under difficult economic conditions. No formal education for the recruit was ever attempted, and his family was unable to offer him any educational encouragement or stimulation. He has never had any gainful occupation, and has been supported completely by his family.

"Motivation for enlistment is not clear. He is able to verbalize some vague desire to escape being drafted despite his inability to grasp the meaning of compulsory military service. During his trip to the Training Center he was confused by the rapid changes of environment during travel. His difficulties were obvious during the initial psychiatric screening examination and he was placed on trial duty status.

"After 3 weeks of recruit training his Company Commander noted that he was unable to understand rudimentary instructions, could not grasp and execute even routine orders, had failed all weekly tests, was personally untidy and unclean, and was a constant source of difficulty within the company structure owing to his inability to comprehend the military situation.

"Psychological examination revealed an intelligence quotient of 68 on the Wechsler-Bellevue Scale, plus an inability to read or write at the first grade level. Psychiatric findings indicate that this degree of mental deficiency and illiteracy is existing in an individual of such limited resources that his further retention in the Naval service is not warranted. This recruit meets the minimum induction standards as defined in AR40-115 and his retention would not jeopardize his health nor endanger that of his service associates. Therefore, he is not eligible for discharge by reason of physical or mental disability."

We have already stressed the difference between <u>medical disability,</u> which connotes a Pulhes rating of 4 and necessitates action by a medical survey board, and <u>unsuitability,</u> which connotes a Pulhes rating of 3 attended by a functional potential which is too low to allow efficient military performance and which necessitates action by an Aptitude Board. The last two sentences in the report above are necessary to establish clearly the authority of the Aptitude Board over the recruit in question. This makes it necessary to emphasize the recruit's inability to meet the requirements of military ser-

vice, a fact sharply brought out in paragraph 3. The rest of the report sketches in the historical background and current clinical findings to clinch the evidence of lowered functional potential. The result is a report which offers conclusive evidence for the Board's decision in favor of separating the recruit from the Naval service.

Recruit Y is a tense, unstable individual of 22 with a long history of emotional difficulties. He was separated from his wife after one year of marriage and returned to live with his mother and father. At the original screening examination he was given a Pulhes rating of 3 and sent to trial duty. During training his many anxieties and the inappropriate, rigid defenses with which he attempted to handle them resulted in a constant state of emotional upset and precluded any adjustment to military living. Supportive therapy was ineffective and he was presented before the Aptitude Board with the following report:

"This 22-year-old seaman recruit is the only child of overprotective, overindulgent parents who have encouraged him in the belief that his health is delicate and that he 'is different from other boys.' He has always been overly dependent upon his family, and had little outside social life during his school days. Following graduation from high school at the age of 18 he went to work as a clerk in his father's business where his father 'could keep an eye on him.' He married at 20, but his wife left him after one year saying, 'I couldn't stand him. He worries all the time.' Since then he has been living at home with his family, and for the past six months has been under treatment by the family doctor who has occasionally given him sedatives for his 'nerves.' He has a medical history of such treatment several other times in the past.

"Motivation for enlistment was in part a desire to escape from the feeling of failure stemming from his marital difficulties and to prove to himself that he 'could be a man.' His maladjustment was recognized at the initial screening examination and he was placed on trial duty status.

"While he seems to have made a genuine attempt to adjust to military living, his many anxieties and his rigid attitudes toward personal hygiene, eating, and the general conduct of his life have made it impossible for him to adjust in company. He is unable to use the head when others are present, sleeps poorly, is bothered by nightmares, and occasionally has periods of despondency when he bursts into tears. His shipmates regard him as a queer duck, and add to his difficulties by kidding him about his shortcomings. The Company Commander reports that he is emotionally disturbed, inadequate, and a detriment to his company.

"Psychiatric findings reveal a tense, unstable individual with a history of mild transient psychoneurotic reactions, who does not have sufficient personality assets and strengths to cope with living in a military environment. Psychological testing confirms this picture. His further retention in the service is not warranted. He meets the minimum induction standards as defined in AR40-115 and his retention would not jeopardize his health nor endanger that of his service associates. He therefore is not eligible for discharge by reason of physical or mental disability."

Recruit Z was a belligerent, aggressive individual with a long history of family rebellion and minor difficulties with the law. He was in constant difficulty during the trip to the Training Center, and his fundamentally asocial nature was immediately recognized

during the initial screening examination. As there were severe doubts about his ability to adapt to discipline and training he was referred immediately to the observation ward for further study. He continued bellicose and uncooperative on the ward and was referred to the Aptitude Board with the following report:

"This 19-year-old seaman recruit has a long history of asocial behavior. As a boy he ran away from home twice, spending considerable time on the road. He has been involved in several minor altercations with the law. One year ago he was expelled from high school for hitting a teacher. Since then he has held several jobs from all of which either he has been fired or has quit after arguments with his employers.

"His reason for enlistment was to seek adventure and to get a chance to fight. During the trip to the Training Center he was obstreperous, insubordinate, and at one point became engaged in a fist fight with a fellow recruit. His fundamentally asocial nature was recognized during the initial screening interview and he immediately was referred to the observation ward for further study. His behavior on the ward continued to be belligerent and uncooperative and his attitude toward the corpsmen was hostile and insubordinate. He was involved in several altercations, and kept the ward in a state of unrest and disturbance.

"Psychiatric findings reveal a psychopathic personality with strong asocial trends of a hostile and aggressive nature. Psychological testing on the Wechsler-Bellevue Scale revealed an intelligence quotient of 89. His explosive temper and basic hostility toward others is revealed clearly on the Rorschach and the Thematic Apperception Tests of personality. In view of his long history of asocial behavior and his belligerent, trouble-making behavior while under observation at the Training Center, it is felt that he will not be able to adjust to the service and that his further retention is unwarranted. He meets the minimum induction standards as defined in AR40-115 and his retention would not jeopardize his health nor endanger that of his service associates. Therefore he is not eligible for discharge by reason of physical or mental disability."

Let us suppose, however, that in this case the Aptitude Board did not agree with the findings of the Psychiatric Unit. One member disagreed vociferously with the recommendation for discharge saying, "A little Navy discipline will make a man out of him." After some discussion Recruit Z was then sent to trial duty. During trial duty, however, his difficulties continued unabated and he was finally given a Captain's Mast. In view of his history of retention on the observation ward, the Commanding Officer conferred with the senior psychiatrist before deciding upon the case. As a result it seemed wisest to separate the recruit from the service rather than involve the Navy in constant disciplinary difficulties with him. He was again admitted to the ward and re-presented to the Aptitude Board which then concurred unanimously in his discharge. The previous report would serve with the addition of the following lines at the end of paragraph two:

"Upon being sent to trial duty his troubles continued and he was a constant source of irritation and difficulty to both his superiors and his shipmates. His behavior is considered a detriment to the service."

It is, of course, impossible to anticipate every type of case that will arise, but three more illustrative reports follow as further examples:

"This 17-year-old seaman recruit is one of a family of 7 children. The father is an inadequate, unstable individual who has supported his family at a marginal level by doing odd jobs and day labor. The mother has had to supplement the family income by taking in laundry. Neither parent has exhibited any interest in the children and the home is lacking in discipline and intellectual stimulation. The recruit was enuretic until the age of 10, and has had a speech impediment as long as he can remember. He completed grammar school at 16 after failing 2 grades. Since then he has hung around home, making no attempt to contribute to the support of the family.

"Motivation for enlistment was one of simple opportunism. He states, 'I heard they feed you well and it's an easy life.' His speech impediment and unkempt appearance were noticed at the original screening examination but he was passed to duty [redacted] ing company he rapidly got into difficulty. He was so unclean as to be repulsive to others, shiftless, slow at comprehending orders, neglectful of his duties, and a source of lowered company morale. His Company Commander was unable to improve him and finally referred him to the Psychiatric Unit. While on the observation ward his problems were discussed with him, supportive therapy was attempted, and he was returned to duty in another company. After 3 weeks, however, there still was no improvement and his new Company Commander reported him a definite liability to the service.

"Psychological testing on the Wechsler-Bellevue Scale revealed an intelligence quotient of 75. Psychiatric findings show an inadequate individual of low intelligence further handicapped by a speech impediment. There are no personality strengths to compensate for his deficiencies and his further retention in the service is not warranted. This recruit meets the minimum standards for induction as defined in AR40-115 and his retention would not jeopardize his health nor endanger that of his service associates. Therefore he is not eligible for discharge by reason of physical or mental disability."

"This 20-year-old seaman recruit was raised as an only child in an unhappy family where both parents drank heavily and quarrelled frequently. During his grammar school career he was in frequent disciplinary difficulty and was suspended several times. At the age of 14 he ran away from home and went on the road for a period of 10 months. When he finally completed school at 16 he adopted a semi-nomadic life for several years, traveling with a carnival summers and spending winters at home. He has a history of several arrests for drunkenness and once on suspicion of robbery.

"His motivation for enlistment was to avoid the draft and to seek excitement and travel. Noticed during the screening examination, he was placed on trial duty. In company he was careless with money, and an inveterate gambler. He was a constant trouble maker, and reacted with hostility to any attemept to correct him. He was suspicious and hostile toward his shipmates. His Company Commander reported him 'Completely unreliable and a trouble maker. This man upsets the whole company. No good at all.'

"Psychological testing on the Wechsler-Bellevue Scale revealed an intelligence quotient of 85. Personality tests showed many aggressive, asocial traits. Psychiatric findings show an emotionally unstable youth of dull intelligence with strong aggressive, asocial trends. In view of his long history of asocial behavior and his failure to adjust in his training company, his further retention in the service is unwarranted. This recruit meets the minimum standards for induction as defined in AR40-115 and his retention would not jeopardize his health nor endanger that of his service associates. Therefore he is not eligible for discharge by reason of physical or mental disability."

"This 18-year-old seaman recruit was raised in a broken home. The father divorced the mother when the recruit was 3 years old. Since then his mother has supported him on alimony payments, devoting her entire life to him. He is an overprotected, sissified

individual who has never been away from home until his enlistment. He has never dated, has no friends, and relies completely on his mother for all social life.

"Motivation for enlistment was to avoid the draft. He says his mother preferred him to enter the Navy because it was a cleaner, more gentlemanly life. He was severely nostalgic on the trip to the Training Center and cried frequently. This resulted in his being referred to the Psychiatric Unit immediately upon arrival at the Training Center. He was held on the observation ward for several days until his nostalgia subsided, and then sent to duty. In company, he was a complete failure. He remained nostalgic, lachrymose, and completely lacking in motivation. He failed to understand and enter into his training duties, and was a detriment to his company. He was returned to the observation ward for several days, and then returned to duty. His failure to adjust continued and his Company Commander returned him to the Unit, reporting him a detriment to the service.

"The psychiatric findings reveal an immature, unstable individual with strong passive dependency. In view of his inadequate personality structure and his repeated failure to adjust his further retention in the service is unwarranted. This recruit meets the minimum induction standards as defined in AR40-115 and his retention would not jeopardize his health nor endanger that of his service associates. Therefore he is not eligible for discharge by reason of physical or mental disability."

SPECIAL DIAGNOSTIC PROBLEMS

A chapter on diagnostic problems may appear somewhat incongruous in a treatment of Naval psychiatric selection procedures since current Aptitude Board procedures prohibit the use of a diagnosis, per se. We are not dealing here, however, with the narrow administrative use of diagnostic labels as such. Our interest is not in diagnostic pigeon-holing as a means of administrative disposition, as it may occasionally be utilized in some civilian custodial or legal settings. Our interest is in diagnosis in a broader setting, in diagnosis as an orderly scientific process of identifying and classifying a phenomenon in order that an increased understanding of its nature and characteristics may be obtained. Just as taxonomy enables a biologist or a botanist to place an organism in its proper position in the animal or plant world, and thus to apply toward its further understanding all the accrued scientific knowledge concerning this class of organisms; so psychiatric diagnosis enables us to place a particular patient in a meaningful relation to all other patients, and to apply to the care and disposition of this patient all the information that psychiatry as a clinical science has gathered about other patients of this sort. It enables us to make hypotheses concerning further implied characteristics of the patient and to make predictions concerning his future behavior.

Thus to say that a recruit is a mental defective or that he is an asocial psychopath enables us to utilize in his treatment all the previous information that we have concerning these types of people. To say that he has a mental age of ten years means that his intellectual ability approximates that of a child of ten years and that we must take this into account in evaluating his serviceability to the Navy, in handling him either in company or on the ward, or in establishing rapport with him if supportive or other therapy be attempted. In this sense, diagnosis becomes crucial in understanding the recruit for dispositional or administrative purposes. It is also of great value from the research point of view, since diagnosis now becomes a matter of taxonomic convenience and brevity in handling scientific data in manageable fashion. Diagnosis and the etiology thereof thus are of basic concern to the Psychiatric Unit.

No single chapter in a guide such as this could hope to cover all the multitude of diagnostic problems raised in military neuropsychiatric selection. There are, however, a few broad diagnostic areas that merit special attention; not only because the problems they offer are complicated and difficult, but because, while common in the military service, they are relatively uncommon in civilian practice. Here differential diagnosis entails not only the ordinary niceties of descriptive psychiatry in recognizing overt

symptomatology, but also the more difficult problem of the dynamic evaluation of the complex psycho-social matrix in which the symptom arises; and the relative importance of any single symptom in the entire symptomatological complex the total behavior of the patient may exhibit. Thus the question may arise in malingering as to whether the malingering is simple and asymptomatic or whether it is a manifestation of basic, asocial personality trends, which in turn may be indicative of a psychopathic personality or of a schizophrenic process. Upon the decision rests not only the matter of suitability for service, but the administrative procedure demanded — disciplinary action, out-patient therapy, separation through the Aptitude Board or by medical survey, or custodial care in a hospital. The fields that we will discuss here — illiteracy, mental deficiency, nostalgia, malingering, and standards for Waves — all offer their own particular and complicated problems of diagnosis.

Illiteracy

The ability to read and write is of particular importance in the Navy, and the illiterate recruit is placed under a special handicap in the Naval service. The Navy world is a verbal world, and this must be recognized as it entails peculiar and pressing problems as far as literacy is concerned. Watch Quarter and Station bills are presented in written form and are constantly being changed. Unless the recruit can read these and keep up with their continuing revision, he will be in constant difficulty. In addition his advancement within the service will depend upon his ability to master printed manuals and to pass written examinations. Facility in reading and writing thus becomes of vital importance to him.

Illiteracy, as such, is of course not a medical diagnosis; nor is it in itself disqualifying for military service, since recruits who are unable to read or write are given special literacy training when qualified to benefit from it. Our psychiatric interest in illiteracy springs from two sources. In the first place, the inability to read and write may be symptomatic of basic difficulties such as mental deficiency or personality disorder. These are matters of medical interest. In the second place, illiteracy is a handicap and as such places limitations upon the individual's ability to adjust. Shame connected with his illiteracy, or the added difficulty his handicap poses for him in adapting to a literate world, may be the deciding factor in precipitating overt maladjustment in an unstable individual. In such cases, illiteracy as a handicap predisposing to or precipitating difficulties in adjustment must be evaluated dynamically in understanding the total personality picture.

The Psychiatric Unit staff member will encounter illiteracy in two situations — in the ordinary psychiatric interviewing of recruits, and in the examination of those illiterate recruits referred for special examination by the Classification Department. In the course of the ordinary psychiatric interview illiteracy may be concealed by the recruit or go unnoticed by the examiner. When it is revealed, the interviewer should consider its possible symptomatic significance, and assess its role in the potential adjustment of the recruit.

The main screen for illiteracy comes during the aptitude testing program conducted by the Classification Department. Here the recruit will receive tests designed to reveal his proficiency in reading. When illiteracy is uncovered during these testing procedures conducted by the Classification Department the recruit is referred to the Psychiatric Unit for further individual psychological testing and psychiatric examination to determine whether or not he is able to benefit from special training in reading and writing. If he is intelligent enough to learn, emotionally stable and well adjusted, and free from further complications which can be expected to block his educational progress, he is returned to Classification with the recommendation that he be given literacy training. If he is adjudged unable to learn either because of low intellect, psychiatric difficulty or character disorder, or because of any combination of these, he is held for separation from the service. This is achieved through the Aptitude Board by reason of unsuitability for service, unless his condition is such as to place him in a Pulhes 4 category and qualify him for separation through medical survey. We will return to this problem of referrals from Classification in the chapter on "Other Duties."

Our psychiatric interest springs from the relevance of illiteracy to the problem of understanding the recruit's basic personality difficulties, and his chances of making an adequate emotional adjustment to the demands of military service. The easiest approach to the significance of illiteracy is through an understanding of the reasons for the man's inability to read and write. Roughly speaking, there are three main sources of illiteracy - - the recruit either <u>has not had the opportunity</u> to learn, <u>can't</u> learn, or <u>won't</u> learn. This differentiation is basic to an understanding of the recruit's problems.[1]

One reason for illiteracy is the simple lack of educational training. Some men have not had the opportunity to learn. This lack of opportunity is rare in large urban areas where educational facilities are excellent, but is not uncommon in isolated rural areas where school terms may be short, teachers may be poorly trained, and at times school facilities may even be completely lacking or so inconvenient as to discourage

1 Hunt, W. A. and Wittson, C. L. The neuropsychiatric implications of illiteracy. Armed Forces Med. J., 1951, 2, 365-369.

their use. In such isolated areas the problem may be further complicated by the low cultural level of the surrounding population with an attendant lack of motivation to encourage the youth in gaining an education under great difficulty. Economic pressure may also be a factor in discouraging schooling under such conditions. Such men, however, can benefit from further education, and should be recommended for special literacy training.

Another cause of illiteracy is mental deficiency. Here are the men who can't learn. The low grade or severe mental defective cannot read and write because he has not sufficient intelligence to master the task. His inability is absolute, and he cannot benefit from training. Such men are obviously unfit for service, and would usually fall in the Pulhes 4 category. Their number will not be great under present induction procedures (one Training Center reports only 11 cases of incapacitating mental deficiency during the past two years), but in times of rapid mobilization or lowered induction standards their incidence may be expected to rise. The moderate mental defective may learn some of the rudiments of reading and writing with great difficulty, but the pressure of the learning situation added to his intellectual deficiency may produce a stress situation which his limited personality resources are unable to handle, with consequent maladjustment resulting. While the mild mental defective can learn to read and write at a simple level, his lack of intellect makes the matter so difficult that he can easily be prevented from learning by attendant emotional instability or by extraneous environmental handicaps that would not deter a more intellectually able individual. Here the question of functional potential for adjustment may arise. Such cases are not considered medically unfit, they are classified as Pulhes 3 rather than 4, and if unable to adjust to service demands are separated through the Aptitude Board by reason of unsuitability. The presence of illiteracy always raises the question of possible unsuitability for service and the illiterate recruit's intelligence and personality resources should always be carefully investigated.

We must stress, however, that while there is a strong relationship between illiteracy and mental deficiency, the relationship is by no means absolute and illiteracy per se should not be mistaken for mental deficiency. The question of differential diagnosis is of vital importance. As we have said before, many men cannot read and write because they never have had the opportunity to learn although they are capable if given the chance. To label such an educationally handicapped individual as feebleminded is unfair to the man and may deprive the Navy of usable manpower. Nevertheless, many such erroneous diagnoses were made during the last war. Occasionally in search-

ing through Naval medical records one finds a man separated from the service for mental deficiency, although his training center record showed that he was tested at the Psychiatric Unit while at the Training Center and found to be of low normal intelligence although suffering from a literacy handicap. Such erroneous diagnoses apparently were based on the assumption that illiteracy is always indicative of mental deficiency. Proper care can prevent such errors.

The best diagnosis of mental deficiency is made only after adequate psychological testing. Even here, however, great care must be taken if the man is illiterate because many of our intelligence tests are based upon verbal materials which are highly related to school experience. Since illiteracy is also apt to be correlated with low cultural environment and opportunity, and since this in turn also influences test performance, it may further handicap the illiterate in an intelligence examination. Such cases should always be referred to a psychologist if one is available. The psychologist will be aware of the problem and will have special testing materials designed to handle it. We will come back to this in the following section on "Mental Deficiency."

Finally, many individuals never learn to read and write because they will not make the effort. These are the illiterates who won't learn. They constitute the great majority of literacy cases with which the Psychiatric Unit will be concerned. Children with emotional difficulties, schizoid personalities, asocial trends, etc., may withdraw from the educational situation or aggressively resist it as an expression of their basic personality maladjustment. Many an illiterate is fundamentally an asocial psychopath, an inadequate personality, or a seriously disturbed individual whose inability to read and write is merely symptomatic of deeper personality problems. This must always be kept in mind in examining illiterates. Unfortunately, resistance to formal education also is one of the common defenses of the normal child in adjusting to his environment. This is true of children in grammar school, adolescents in high school, and youths in college. It is therefore necessary to carefully evaluate the extent of the resistance, its consequences to the individual, and the social disruption it entails before drawing the conclusion that it is pathognomonic.

The importance of careful psychiatric scrutiny of illiterates is further indicated by the fact that illiteracy, like any handicap, is a hazard to successful adjustment. It is one more barrier to normal social adjustment that the individual must overcome if he is to succeed in finding his place in society. When it occurs in an individual already handicapped by low intelligence or personality difficulty it may be the deciding factor in swinging the hard-pressed individual toward final maladjustment. Consequently, when

it occurs in an otherwise borderline individual, it must be considered seriously as an unfavorable factor predisposing toward unsuitability for service. Thus the study of Naval illiterates referenced in this chapter showed that illiterate recruits, carefully screened during their training center experience and subsequent literacy training period in a special program, nevertheless had a rate of psychiatric attrition during subsequent service that was double the normal Navy rate at the time. The authors of this study found that of all the illiterates discharged during literacy training about one-fourth were separated as being mentally deficient, another one-fourth were described as unable to learn, and for the remaining half there appeared to be a "mutually reinforcing reaction between personality difficulty and the educational handicap." These figures are confirmed by the recent experience of our Training Centers.

The illiterate therefore merits careful psychiatric scrutiny. While many illiterates are so because of a lack of educational opportunity, illiteracy may be symptomatic of mental deficiency or of basic personality disorder. It may also act as an exacerbating factor in cases of already poor adjustment. The Navy can neither afford to lose trainable personnel who can render adequate service, nor to carry the inefficient and inadequate on its rolls. Careful diagnosis is the answer.

Mental Deficiency

The problem of mental deficiency is highlighted by the current necessity for utilizing every available source of manpower. In selecting military recruits the armed services must go as far down the scale of intelligence as they possibly can without destroying the efficiency of the fighting forces. This means that it is now necessary to make some use of higher grade mental defectives who might not be considered suitable material for recruitment under ordinary peacetime conditions. On the other hand, there are lower limits beyond which recruiting cannot go without harming the efficiency of the services. The Navy certainly cannot use the severe mental defective who is unable to maintain himself successfully in a civilian environment. The matter is further complicated by the fact that in many marginal cases the only accurate answer to the question of the recruit's true functional potential must be found in actual trial duty in a training company. Many such men who can perform useful service would be lost to the Navy if they were arbitrarily excluded at the examining centers.

Not many cases will filter through whose intellectual handicap is so severe in and of itself as to preclude military service. Their recognition and diagnosis is relatively easy. The main problem here is one of differential diagnosis, of being certain that one

is dealing with a case of primary mental deficiency and not a secondary intellectual deficit which is symptomatological of an organic difficulty or a functional mental disorder. With cases of mild mental deficiency the intellectual handicap itself is rarely incapacitating. The diagnostic problem here is not the recognition and assessment of the degree of mental deficiency as an isolated factor, but the evaluation of the intellectual handicap as one of a complex of factors all interacting and in their total effect determining the individual's functional potential. We must consider intelligence as one element in the picture of total personality assets and liabilities which includes previous educational training, vocational experience, emotional stability, personality defenses, physical condition, etc.

Some cases of severe mental deficiency will occasionally be found among the incoming recruits. These are individuals who are unable to learn because they do not possess the necessary intellectual ability. Even with opportunity and the most favorable environment they cannot acquire the skills necessary for successful living in a complex military environment. We may feel sorry for them and wish them well, but they have no place in the service if they interfere with the efficiency of the organization. The Navy cannot carry men who are unable to make any useful contribution to its activities. In such cases the mental deficiency is considered as incapacitating and the individual is given a Pulhes 4 rating as a case of medical disability and is separated from the service through a medical survey board.

In most cases met with in training center practice, however, the problem will not be one of mental defect as an incapacitating condition per se. The problem will be one of relative defect, of an intellectual handicap not incapacitating by itself, but existing as a liability in the total personality picture. It must be considered in the light of other contributing factors such as education, cultural opportunity, vocational experience, motivation, emotional stability, maturity, concurrent psychopathosis, physical health, etc. As a liability it may sum with other liabilities to so lower the individual's functional potential that he will be unsuitable for service. While an intelligence quotient of 80 usually does not place a person in the mentally defective category, such dull intelligence in an immature, emotionally unstable youth might contribute the final handicap which would render his adjustment to the service impossible. In another recruit, an intelligence level equal to an intelligence quotient of 70, provided the individual were mature, stable, and well motivated might not per se preclude service; but might well if the individual were illiterate, since it might prevent him from assimilating the required material in the time allotted for literacy training.

On the other hand, while mental deficiency is a liability, it may be compensated for by other assets. Had the stable, mature recruit of IQ 70 mentioned about not been illiterate, had he had the previous benefit of as much schooling as he could assimilate and had he had the added advantage of valuable vocational experience he might well have adjusted to the service. There would be limits to the quality of his performance, and there are limits to the number of such men the services can use, but places for some of them can be found. Unfortunately the diagnostic decision in such cases is not an easy one and necessitates the best resources that modern dynamic interpretation can make available. When the final decisioptitude Board.
assets is not adequate to the demands of mn is that the total balance of the individual's for service and is separated through the Ailitary life, the recruit is adjudged unsuitable

We have already mentioned the problem of differential diagnosis, that what seems to be mental deficiency at first examination may later, after further investigation, prove to be something else. Many individuals may appear lacking in intelligence simply because they have not had a chance to learn the techniques and tools, such as reading, writing, arithmetic, etc., which most of us have absorbed almost insensibly in our educational system and through which our intelligence works in solving the problems of daily life. Or they may, because of a language handicap, some motor difficulty with speech, or perhaps a simple lack of verbal ease and facility, be unable to communicate their intelligence adequately to an examiner. Such cases would include the individual who has not had adequate educational training; and the alien who does not speak or understand our language, and who may in addition be completely lost in our culture — the dictates of which seem so clear to us but so confusing to him. They include the illiterate, those suffering from a sensory handicap like deafness, and those suffering from a motor handicap such as one in the speech area. Many a shy, inarticulate country boy from a rural area poor in educational facilities may give an erroneous impression of feeblemindedness on superficial examination. Such individuals may be quite able to acquire the tools and techniques of problem solving and communication if they are given adequate opportunity. It is here that careful examination, including psychological testing, may save many a potentially useful sailor for the service who might otherwise have been lost through casual classification as a mental defective.

It also is necessary to differentiate between amentia and dementia, between the primary lack of intellectual ability that we associate with "familial" or "idiopathic" mental deficiency and the secondary loss of intelligence that we call deterioration or intellectual deficit and that we associate with organic brain damage and with the func-

tional psychoses. In these last the loss is apt to be spotty and irregular and we speak of "scatter" in test performance, meaning that the subject may fail easier test items that we would expect him to pass, and may pass more difficult items that we might expect him to fail. The most common type of divergence or scatter in performance is that between vocabulary and reasoning. Often vocabulary, as an old and well-established habit system, will show relatively little loss when reasoning and problem solving are quite confused and inefficient. The objective tests of the psychologist are peculiarly well-adapted for demonstrating these cues, but the trained interviewer will find that with some experience he often can pick them up in the course of the interview. In addition the organic or functional case will exhibit other cues, such as the anxiety and hesitation or the symptoms of dysarthria that may appear in the response of the organic and the tangential circumlocutions of the schizophrenic.

As an illustration, here is the answer of a schizophrenic to a question from the Information sub-test of the Wechsler-Bellevue Intelligence Scale. The question is "Where is Egypt?" The correct answer of course is "Africa." The schizophrenic's answer was "In a manner of speaking it may be said to be an oasis, plenty surrounded by sand." This answer is incorrect, although the question should not be difficult for a normal individual who has been through grammar school geography. And yet the man obviously is not mentally defective. The word "oasis" is not common in the vocabulary of the mental defective, and the implied conception of the fertile Nile valley surrounded by desert shows a familiarity with geography as well as an ability to abstract and conceptualize that we would not expect in a person of low intelligence. In addition there are definitely schizophrenic qualities to the reply. It shows the schizophrenic tendency to think symbolically, and the tangential, circumlocutory nature of the opening phrase, "In a manner of speaking it may be said to be . . . , " is obvious. Unfortunately, not all schizophrenics will answer in such diagnostically appropriate fashion.

Finally, as we mentioned in discussing illiteracy, educational difficulties may be characteristic of the behavior disorders and may produce an artificial appearance of low intelligence in a recruit. The withdrawn, shy, schizoid individual may passively resist the educational process as part of his general withdrawal from the world. This leads to an educational handicap and apparent mental deficiency. It is sufficiently common in education to receive a label, "pseudo feeblemindedness." Sometimes the same thing results from an aggressive negativism in which the individual actually denies the demands of his environment rather than passively retreating from them. It is not uncommon to encounter asocial psychopaths, whom skillful testing will reveal to be of nor-

mal or at worst dull intelligence, who nevertheless were labeled as mentally retarded in school because they would not cooperate with the educational system. The apparent lack of intelligence in these cases may not only be attributable to educational difficulties, but may spring from an inability to handle the interpersonal relations of an interview situation. They can't or won't "give" to the examiner. Thus many an asocial psychopath, schizoid personality, mildly depressed or overly anxious person will not or cannot cooperate with the examiner in answering questions and hence gives a false impression of mental deficiency.

Psychological testing as an objective diagnostic procedure has been developed largely as the result of the pressure of just such problems as these and the psychologist will be equipped with testing techniques adequate to meet most needs. Because of this the referral of such cases to the psychologist is standard procedure. He will be equipped not only with valid and reliable techniques for the measurement of intelligence, but will have tests for reading ability and educational achievement, as well as non-verbal intelligence test materials for use when language handicap is present. Even relatively culture-free tests are available when the question of cultural background arises. Moreover, the tests are susceptible of differential analysis when organic or psychotic difficulties are suspected, and personality tests may also be introduced to supplement such analysis where psychopathosis is suspected. Modern psychological testing is a powerful and necessary clinical tool when differential diagnosis is difficult. Nevertheless, the psychologist should always be alert to the basic problems involved, and not let his clinical responsibilities end with the obtaining of his objective test results.

Throughout we have stressed mental deficiency as a defect that interacts with, and is influenced by, other aspects of the personality. It is a handicap to which the individual must accommodate himself and one that may hinder his problem of total adjustment. As in illiteracy, in mental deficiency we are faced with a mutually reinforcing reaction between any personality difficulty present and the intellectual handicap. Thus, one recent study showed that a group of mental defectives who rendered three years of successful Naval service terminating in honorable discharge nevertheless were a more severe medical and disciplinary problem than were a control group of normal recruits.[1]

In mental deficiency the psychiatrist in addition must always watch out for compensatory behavior and unhealthy personality mechanisms that may arise in answer to the pressures of adjustment, as the mental defective strives to live up to the demands of

1 Hunt, W. A., Wittson, C. L., and Hunt, E. B. Military performance of a group of marginal neuropsychiatric cases. Amer. J. Psychiat., 1952, 109, 168-171.

social living in a world where his associates are intellectually superior to him. Certain types of compensatory reaction are easily recognized among the feebleminded. One is over-compensation. This is illustrated by the recruit who strives to compensate for his lack of intelligence by continually attempting tasks that are beyond his ability. This results in frequent failure and consequent disruption of the efficient functioning of his unit. Another is an anxiety reaction. Here the recruit may recognize his inability and see it as a constant threat and source of ever-present insecurity with resulting overwhelming anxiety. Still another is a paranoid reaction. In this case the individual solves the problem of his failure by attributing the blame to his associates. This may develop in typical paranoid fashion into delusions of self reference and persecution.

In some cases these compensatory attitudes may yield to simple supportive therapy. The mental defective may be given insight into his limited abilities, may be encouraged to accept them, and may be supported in his attempts to find a level of performance within simple environmental demands where he can find a place satisfactory to himself and achieve sufficient acceptance by his associates to satisfy his desire to belong to and contribute to society. In other cases, these mechanisms may be so well established, so firmly entrenched, that they constitute handicaps too great to be overcome and necessitate separation from the service. Again the decision can only be made by the clinician after careful consideration of all the evidence.

Nostalgia

In civilian psychiatric practice the patient is usually seen in his "home" environment. Nostalgia is an unusual problem under such circumstances. It is fairly common in the military service, however, since most of the recruits seen are away from home for the first time. The separation usually is not one of a few miles but one of many miles, and the psychological separation may be even greater than the geographical one. Not only are family and friends missing, not only is there an absence of the comfortable and well-established routine of the home, but the contrast between the old and new environment is extreme. The new friends are not like the old, and the new routine is completely different from the familiar one at home. Every adolescent as part of his gradual socialization builds for himself a self-created world in which his needs may be satisfied and his tensions allayed. He has a "pal" or two with whom problems can be talked out, and from whom security and support can be obtained. There are established ways of relieving tension through rough-housing, informal sports, or walking to the drug store. An ice cream cone, a coke, or a raid on the ice box provide him with succorance and symbolic

reinforcement. Aggression can be ventilated in cursing, in practical jokes, in gang activities. He has established his own symbolic expressions when open rebellion seems necessary. He can wear old clothes, keep his hat on in the house, use derogatory nicknames for his teachers, or neglect his homework. When escape is necessary he can go to the movies, flee to a basement workshop, or retreat to his room with a book or his radio. Now all these are suddenly taken away from him, and he must find new ones. Most important of all these new ones must be created from new materials in a strange and completely novel environment.

Add to this the fact that leave is not permitted during the "quarantine" period extending through the first few weeks of training, and the threatening aspect of a rigidly structured and highly disciplined environment, and nostalgia (or homesickness) becomes understandable. At times, in new recruit companies, it may even have epidemic aspects which are somewhat dismaying when they occur but which remain benign under simple supportive and activity therapy. Idleness is fertile soil for nostalgia and keeping the recruit busy and distracted helps to counteract it. Distraction is not the only agent in this approach. The recruit is not only kept from thinking of home and friends by encouraging activity on his part; but through this activity he finds new interests, new friends, and through this experience and gradually acquired familiarity with his new surroundings he finds new identifications, new defenses, new sources of support and security in the previously threatening and strange military environment.

The problem seems to be more pressing during peacetime service than in wartime. This is probably attributable to the increased excitement, tension, and the higher motivation present when actual hostilities threaten the country. This bears direct relationship to the successful treatment of nostalgia by a mixture of supportive and activity therapy designed to distract the recruit from his memories of home and to furnish new interests and new sources for emotional satisfaction through which he can satisfy his previous personal needs, which are now deprived and threatened in the strangeness of his new setting.

A recruit with typical nostalgia presents the familiar signs of a person with a mild reactive depression. He is depressed and mildly retarded. There are well-marked overt signs of emotion which frequently include agitation and tearfulness. Insight is present and the recruit realizes that he is missing home and family, and frankly desires to return to them. This simple nostalgia is usually benign and open to the therapy mentioned above. The diagnosis is usually clear and self-manifest.

It is not this simple nostalgia, however, which we wish to stress here but rather

some related problems which pose questions of differential diagnosis. One of these confusing conditions is "cryptic nostalgia" — a condition which has been called a home fixation rather than homesickness. The usual depression, overt emotion, and insight typical of ordinary nostalgia is missing. Such a recruit has been described as "not agitated and depressed. He may appear somewhat apathetic and preoccupied but in general he gives the impression of accepting his environment and of not being displeased with it. There is no obvious affective disturbance. Finally, he has no insight into his condition and does not realize that something is wrong.

"On the positive side he can be described as a person who has not as yet severed his ties with home and still is completely immersed in thoughts of family and friends. He is literally a person with something on his mind and that something is present to the exclusion of everything else. This continual preoccupation with thoughts of home and friends causes an air of abstraction. The subject appears absent-minded and vague and is slow in responding. He has trouble in paying attention, finds it hard to concentrate on the task at hand and may fail to carry out his routine duties efficiently. He, himself, has no understanding of his difficulties and cannot comprehend the reason for his failure to measure up to the standard expected of him."[1]

This condition is easily confused with two more serious entities, mental deficiency and schizophrenia. The abstraction and failure of attention often results in apparently poor intellectual ability. This is manifested during training by poor learning, an inability to remember, errors in carrying out commands, and generally poor performance. In the interview situation and during psychological testing the picture is one that superficially resembles mental deficiency. The school history, however, usually is not consistent with the diagnosis of mental deficiency, scatter may be found in intelligence test scores, and there will be occasional glimpses of an intelligence well above the recruit's current standard of performance. A little care in establishing rapport, and persistence in arousing interest and motivation will result in obtaining a performance superior to that of the mental defective.

The air of abstraction present in cryptic nostalgia may also suggest schizophrenia. There is a similar lack of contact and volition, evidence of inertia, and apparent inability to concentrate. The accessibility however is more apparent than real and general probing will reveal an adequate and appropriate affective response to the environment. The history also will fail to confirm the suspicion of schizophrenia.

In treating cryptic nostalgia a single, skillful psychiatric interview is usually sufficient to give the recruit insight into his condition and to enable him to remedy the situation and to achieve a satisfactory adjustment.

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1 Wittson, C. L., Harris, H. I., and Hunt, W. A. Cryptic nostalgia. War Med., 1943, 3, 57-59.

Related to the problem of cryptic nostalgia and worthy of brief passing mention here is the problem of the cryptic depressions, a matter which recently has received some discussion in the psychiatric literature. In the cryptic depression, physiological components are emphasized and the emotional aspects are deceptively slight. These are mild depressions in which fatigue and gastro-intestinal difficulties are foremost in the symptomatic picture with melancholia not prominent. They may be differentiated from the true depression by a difference in content preoccupation as there is no self-abasement and guilt present. They differ in history from the schizophrenias and their intellectual production will separate them from mental deficiency. Content preoccupation, history, and intellectual production also will differentiate them from the cryptic nostalgias.

Malingering

Malingering, or the conscious and willful simulation of some psychopathic disturbance in order that an individual may obtain some personal goal otherwise unobtainable, is bound to occur in the military services where strong personal motivations are often frustrated by the necessity of substituting social goals for personal ones, and of enforcing this social orientation through detailed organization and rigorous discipline. The current publicity given the problem of mental disorders in the medical services and the erroneous impression on the part of many of the public that neuropsychiatric disorders are easily "faked" will direct much of this simulation into psychiatric channels when it occurs.

With some exceptions such as the amnesias, malingering involving the simulation of psychopathosis is relatively easy to detect. Its detection is based upon the fact that while the malingerer feels familiar enough with the simulated disorder to attempt a conscious reproduction of its typical manifestations, he actually is not sufficiently familiar with it, and hence is unable to reproduce the genuine and complete symptomatic picture characteristic of the disorder in question. To the trained observer there will always be atypical elements to arouse suspicion, and crucial discrepancies will be uncovered by further intensive examination. This is particularly true in the use of the objective, carefully standardized tests of the psychologist. While the public often is convinced of the ease of malingering on such tests, the opposite is true, as experience and careful experimentation have shown over and over again.[1] Even the trained and experienced clinician would have difficulty in faking an abnormal test picture when he is confronted

1 Hunt, W. A. and Older, H. J. Detection of malingering through psychometric tests. U.S. Nav. Med. Bull., Wash., 1943, 41, 1318-1323.

with the numerous and subtle items that compose the modern psychological test battery. For this reason, if the decision of malingering is difficult to render on the basis of a clinical examination, psychological testing often will add further vital information and clarify the picture.

For convenience we may separate malingering into two types — asymptomatic and symptomatic.[2] Asymptomatic malingering occurs in a normal person whose personality structure shows no evidence of basic psychopathosis. Symptomatic malingering occurs in basically unstable individuals and is symptomatic of some underlying psychopathosis. The first is the "pure" type, a willful and conscious attempt to circumvent some distasteful situation by subterfuge. In the second type, the malingering is not of primary significance in itself, but is important as a behavioral expression of some serious and fundamental maladjustment. While it also may be conscious and willful, it often grades over insensibly into the unconscious mechanisms of hysteria.

Asymptomatic malingering is not as common as is sometimes thought. More often one finds symptomatic malingering in which the psychopath is expressing his hostile, asocial motivations or the neurotic is seeking one more possible means of escaping from an anxiety arousing environment. Asymptomatic or pure malingering may be characterized as occurring in normal individuals, occurring only when encouraged by environmental circumstances, not inflexibly persevering and being carried to extremes which entail serious social consequences for the individual, and being easily treated by manipulating the motivation and dynamics of the malingerer. Such asymptomatic malingering often appears " . . . in a poorly motivated but psychologically healthy recruit when an externally created opportunity such as a periodic medical examination or regular sick call presents itself. Since the malingerer is in normal contact with his social environment, he is unwilling to press his simulation to the point where his actions involve him in serious consequences either of a disciplinary or medical nature. He can usually be brought into line by a few carefully chosen remarks from the medical examiner. As he has the normal person's accessibility to social pressure, group morale can be used in controlling him."[2]

As an illustration we might use Recruit X, an individual somewhat poorly motivated toward the national emergency and loathe to leave a well-paying civilian job and a comfortable home. During the neuropsychiatric interview at the Training Center he proceeded to build up an elaborate history of severe incapacitating headaches. Neither the work history, social history, nor his own description of his symptoms fitted the claim

2 Hunt, W. A. A further study of the detection of malingering. Nav. Med. Bull., Wash., 1946, 46, 249-254.

of incapacitation. Instead of accusing him of malingering the examiner mildly remarked that his headaches did not seem to be as bad as he thought they were and sent him on to trial duty. When reinterviewed at a later period, the recruit had no somatic complaints, was doing well in his recruit company, and remarked that the Navy was fine, and that his shipmates were "swell fellows." Another recruit gave a history of childhood injuries during the original examination. He was sent to duty, and a social history was obtained which was essentially negative. When called in automatically for reexamination at the end of three weeks of training, however, he gave a lengthy and impassioned history of nervous instability. The story was obviously false, and gentle probing by the examiner produced a confession and the statement that several letters from home had produced some dissatisfaction. The situation and his reactions were discussed with him and he was returned to duty. When seen again at a later date he was happy and stated "Nothing could get me to leave the Navy."

Because of the basic soundness of their personality structures, both of these recruits were able to recognize the demands of reality, to appreciate the necessity for military service and the fact that they must accept it, to reject the idea of simulation since the "cost" would be too great, and to find positive satisfaction for their needs within the military setting. Normal social empathy is present in such recruits, and when the psychiatrist uses this wisely and skillfully the malingering is quickly handled. In such cases formal discipline of a severe nature is not indicated, as it may encourage or confirm asocial feelings, psychologically isolate the individual from the group, and help to sever the normal social identifications which are available for use in correcting the recruit's behavior. A pleasant firmness is usually adequate to the situation.

Symptomatic malingering is more frequent and constitutes most of the serious behavior occurring under this category. It poses the usual problem of recognizing the basic underlying difficulty and of treating the recruit as a medical case. It may be characterized as occurring in the abnormal individual suffering from some basic psychopathosis, manifesting itself without encouragement from the social environment, being carried to extremes which often may involve serious medical or disciplinary consequences, and being treatable only by getting at the basic psychopathosis and working with that. Such symptomatic malingering is particularly characteristic of psychopaths, neurotics, and psychoneurotics. It may even occur sometimes as symptomatic of an early psychosis.

An example is the case of Recruit Y who was admitted to a Naval hospital with superficial slashes on both wrists. The recruit stated that he was despondent and had

attempted suicide. The superficiality of the wounds aroused suspicion, however, and among his effects was found a letter from his sister telling him that if he made a fake suicide attempt he would be let out of the service as a neuropsychiatric casualty. Charges were prepared against him and there was strong pressure for severe disciplinary action. The psychiatrist in the case demurred, saying that the recruit was unstable and gave evidence of schizophrenia in its early stages. After a lengthy and some at times acrimonious discussion, psychiatric opinion prevailed and the recruit was surveyed from the service. After a short period of hospitalization, he was returned to private life and remission. Three years later he developed a full blown schizophrenia and custodial care in a state hospital ensued.

Recruit Z appeared at sick call claiming severe incapacitating headaches. There was no previous history, and neither the pretended symptoms nor the circumstances surrounding their occurrence rang true. In response to the expressed doubt of the examiner, the recruit became hostile and cursed the service, claiming he was not getting adequate medical attention and threatening to write his congressman. Further examination revealed a long history of asocial behavior involving nomadism, truancy, a poor job history, and several arrests. The recruit was finally discharged as a psychopathic personality.

There is another curious and by no means rare type of attempted malingering that is used to call the doctor's attention to some other difficulty which the recruit cannot face openly. Many ill individuals are afraid of the threat of disease and cannot accept it and face it honestly. In such cases they may approach a doctor indirectly with some other presenting complaint much as the average middle age man who, fearing a cardiac disorder, doesn't mention it directly but approaches his physician with a request for a "general checkup." Thus many neurotics may not be able to face their anxiety openly. They may realize that they need help and yet try to avoid a direct opening up of their problems with the accompanying threat of overwhelming anxiety. Under such circumstances the neurotic may compromise and approach a psychiatrist indirectly with a trumped-up claim of headache, insomnia or dyspepsia, hoping against fear that the psychiatrist will see through his "symptoms," find the real cause of the difficulty, and force the patient to face it. This type of approach is often found in homosexuals who realize their difficulty and their need of assistance, and yet cannot come immediately, directly, and openly to the point of their problem when discussing it with a psychiatrist. It is obvious that here the mechanism of shamming and simulation is approaching closely the dynamics of the dissociated, hysteroid mechanism.

All such cases of symptomatic malingering must be handled as examples of whatever basic disorder is present. The psychiatrist must recognize the basic difficulty and work with this. The recruit in such cases must not be viewed as a malingerer, but as a sick person, and he must be handled as such. Disciplinary treatment is contraindicated, and like all symptomatic treatment is unavailing in establishing any permanent solution. While there is a human and understandable temptation to let the asocial psychopath pay penance for his malingering by going to the brig, such a solution is a waste of the Navy's time and money and an evasion of the psychiatrist's medical responsibility.

Standards for Waves

The problem of selection standards for Waves will not be of concern to all Psychiatric Units owing to the limited extent of the recruitment and training program for women. Nevertheless, some units may be called upon to evaluate Wave personnel, either in a regular Wave training program or as part of their out-patient clinical duties. If the unit is called upon to participate in a general training program its activities should follow the same basic pattern used with male recruits — participation in the original physical examination, trial duty referral services, and provision for an observation ward. Some minor adjustments and deviations from standard practice may be demanded, but those Training Centers that have cooperated in Wave training programs in the past have found that the standard neuropsychiatric selection practices for males worked quite well with females.

The official psychiatric standards and procedures for women in general seem to be the same as those for men, but AR40-115 is not very clear on this point. It does suggest that standards for officers will be utilized for female personnel where applicable and recognizes that sex differences in maladaptive behavior exist and must be taken into account in evaluating any specific case. Thus it states "due attention will be paid to differences in manifestations in psychiatric disorders in men and women." It does not expand upon these differences, however, and the psychiatrist is left to work out the problem in the light of what experience he has had.

The examiner working with Waves will do well to remember that there are cultural differences between the sexes. More emotional expression is permitted to females and society is more tolerant of an emotional outburst in the female than it is in the male. In many ways, such as physical fortitude, general sophistication, language, social responsibility, social behavior, etc., as well as in ethical behavior, there still exist remnants of a "double standard" within our society, and this difference in social climate toward the

sexes will produce differences in both the precipitating factors and the exhibiting symptomatology when a maladjustment does occur.

Some of the difficulties appearing in the male selection program will be absent. The pressure for womanpower is not as great and the original selection and recruiting standards are higher. This will minimize such problems as mental deficiency and illiteracy. The frank psychoses may occur less often. On the other hand, some problems of motivation and adjustment may be accentuated. The fact that there is no draft pressure on the women and that sole reliance is placed upon completely voluntary enlistment changes the motivational picture. Experience has shown that when dealing with Waves the Naval psychiatrist may expect more escape reactions, more individuals who are attempting, through enlistment, to escape from an unhappy home, social, or occupational situation.[3] There will be more cases of career disillusionment in private life. This will accentuate the unsettling factor of possible career disillusionment within the service itself, if the Wave does not find the occupational satisfaction that she is seeking through her enlistment. The problem of adjustment within the service is further exacerbated by the fact that there are no general duty billets available for women as there are for men. In general women seem more capable in civil life of masking psychopathosis behind an acceptable social facade, but in the military service their efforts are no longer successful and the difficulty becomes more recognizable.

Actual figures from one Naval Training Center indicate that among the pathological personality types, there may be fewer cases of inadequate personality and more cases of schizoid personality. Among the immaturity reactions passive dependency seems to be equally common, but passive aggressive reactions may be more common. Outright aggressive reactions and immaturity with eneuresis are rare. There will be many more cases of emotional instability. All the psychoneurotic disorders also seem to be more prevalent among Waves.

The disciplinary problem may be expected to aggravate the work of the Psychiatric Unit. There are fewer accepted measures of handling disciplinary problems among women, and the psychiatric staff unfortunately may be drawn into disciplinary problems as a last resort. Great tact and discretion is necessary here. Good cooperation with the training and administrative staffs may make it impossible for the Unit to overlook or deny certain referrals, but the staff psychiatrist must always remember that his responsibility is a medical and not a disciplinary one. Mental hygiene and preventive psy-

3 Eberhart, J., and Socerides, C. W. Psychiatric selection of women for Naval service, U. S. Armed Forces M. J. (In press.)

chiatry are his field, and not law enforcement.

Fortunately experience is acquired rapidly in the mass practice typical of military psychiatry and the examiner will soon learn to allow for sex differences in dealing with Waves. He will learn not to mistake nostalgia or a mild reactive depression, freely and overtly expressed, for a serious endogenous depression. He will learn to differentiate between normal unrepressed emotional lability and genuine emotional instability. He will learn the differences in value systems and the resulting differences in the tensions produced by the military service. When he has learned these lessons his confusion will disappear and underneath the surface differences in behavior he will recognize the same fundamental elements of conflict and the same fundamental mechanisms of adjustment that he has been encountering with male recruits.

EDUCATIONAL FUNCTIONS

The functions of the Unit as set forth in the preceding pages are many and diverse, with implications for most of the numerous activities of a Training Center. The Psychiatric Unit can do a job for every command at a Training Center. A basic principle for the activities of the Unit should be to give service whenever it is requested. Such service, however, cannot be forced upon the command; the request must come from the command itself. This demands a close and sympathetic cooperation with many other departments. Such cooperation will be obtained only when the departments concerned have a sympathetic understanding of the selection program and accept its potential contribution to the efficient functioning of the Training Center and the Naval service at large.

Informal Contacts

This understanding can be achieved only through a gradual and continuing program of education in the nature and possibilities of neuropsychiatric selection. Some of this can be accomplished through individual contacts. Each officer and man of the Psychiatric Unit should realize that he is not only acting in a professional capacity in the Medical Department, but that he also serves the program as an educational and diplomatic emissary to the other branches of the service. In writing reports upon referrals, as well as in personal conferences on cases, he should be clear, explicit, and courteous in making his decisions and in explaining their implications and consequences. He must seize opportunities for explaining the background and aims of the program and discussing its function with all those concerned with its execution. Key officers of other departments concerned may be invited to attend Aptitude Board meetings or to visit the Unit to inspect the ward and to see the records office in action. The efficient clinician also will comprehend and understand the viewpoint and problems of the Company Commanders, and of the interviewing and assignment personnel in Classification, and he will make his comprehension and understanding clear to those with whom he is in contact. At all times he must be ready to teach others and to learn from them in turn.

Formal Contacts

Such informal personal contacts will aid greatly in making the work of the Unit understood and accepted, but they are not all. In many cases they can be supplemented by formal educational activities such as films, lectures and orientation courses. The directives call explicitly for such activities to be undertaken with the Company Com-

manders, but they also will be desirable elsewhere with medical colleagues in other specialties, with the Classification Section of the Personnel Division and with the other departments of the Recruit Training Command.

The Role of the Company Commander

The Company Commander has always occupied a peculiarly important role in the Navy's neuropsychiatric selection program. On him rests the responsibility for suppiying the Psychiatric Unit with accurate Company Commander Reports on the behavior of trial duty recruits during training; reports that will play a great part in determining the wisdom and justice of psychiatric and Aptitude Board decisions. Much also depends upon his ability to recognize promptly and refer immediately for examination such cases of doubtful suitability for service as may have been missed during the original screening examination but become obvious later during the training period. It is also his wise and understanding handling of the new recruits, bewildered and confused as they may well be at the beginning of the training period, that will assure the ultimate successful adaptation of many a recruit whose original adjustment is shaky, and will help in establishing positive and healthy attitudes on the part of the entire Company.

Lectures to Company Commanders

Because of the important role played by the Company Commander in the selection process, every opportunity must be seized to educate him in the need for, and the working of, the selection program. Some of this education can be done by way of the many informal contacts that inevitably arise, but much of it must be accomplished in the formal lectures and discussions for which time is allotted during the regular training activities. Such formal periods should be neither rigid nor authoritarian. As orientation sessions they are best conducted in an atmosphere of give and take where the lecturer or discussion leader not only clarifies the role of the Psychiatric Unit and the Recruit Company Commander in the selection process, but invites criticism and suggestion in order that a mutual understanding may result. Only through such mutual understanding can the free and voluntary cooperation so vital to the program be obtained.

It should be remembered that the Company Commanders are a selected group. They are alert individuals, most of them with an extensive, non-technical understanding of the dynamics of personality. Many of them also have an excellent knowledge of personnel requirements aboard ship, in fact their knowledge of psychiatric job requirements in the fleet may exceed that of the lecturer. Thus the psychiatrist who has never

had see duty will do well to approach the indoctrination lectures with an attitude of mutual interchange and coordination of information, rather than an attitude of authoritarian dissemination of knowledge.

The particular details of these formal sessions will vary from installation to installation depending upon the time and personnel available, the scheduling difficulties, the number and extent of local problems, and the particular aptitude and motivation of the staff assigned to the work. In general a series of talks is desirable if time and scheduling permit. These may be formal lectures or informal discussions. The amount of structuring necessary and desirable will depend upon the size of the audience, with large groups indicating a more formal lecture approach and small groups indicating the possibility and desirability of informal discussion. Some staff members may be better in one than the other, and it should be remembered that the best teaching results when the teacher does not follow a rigid pattern but adapts his technique to his own personal abilities and assets. The selection of topics to be discussed and points to be stressed will vary with local problems. Above all, if the lecturer or discussion leader is to do a good job, he must be allowed a chance for initiative and for a creative individual approach to his task. To be good, teaching must be enjoyed by the teacher, and he must identify with, and feel personal pride in, his role.

There are certain general areas which need coverage. The Company Commander should be given some idea of the extent and importance of the neuropsychiatric problem in the military services, and the part that neuropsychiatric selection plays in alleviating it. This should be done in general terms in relation to the over-all manpower situation, the threat to the efficiency of the service when men break down, the damage to the man, and the resulting cost to the government which is shared by every taxpayer. It should then be tied down to particulars in terms of what it means to the individual man in the military service, its significance for his personal safety in combat, for the ease and efficient functioning of his particular unit during noncombat conditions, with the resulting benefits in personal comfort, enjoyment of his job, and pride of service.

The particular working of the Psychiatric Unit in the Training Center's activities should be carefully described. The Pulhes system should be explained, and the significance of "unsuitability for service" be clarified, particularly in relation to the concept of trial duty. The Company Commander should understand the importance of trial duty in giving every man a chance to show his stuff in order that every available manpower resource may be utilized. In this connection the key importance of the Company Commander in the trial duty process should be brought out and his responsibilities

should be dealt with in detail. He should understand thoroughly the necessity for writing clear and accurate Company Commander Reports on those recruits whose adjustment the Psychiatric Unit is observing. The significance of the recruit's performance in his daily training activities should be explained in relation to the concepts of "functioning potential" and "unsuitability for service," as well as the importance of the Company Commander's Report as a criterion which assists the psychiatrist in evaluating the recruit, and the Aptitude Board in making its ultimate decision as to the retention of the recruit in service.

It should be pointed out that errors occur in the original screening examination and that some "poor risks" elude the psychiatrist and slip through into training unsuspected. He should be aware of the possibility of such cases, recognize them when they arrive, and refer them promptly to the Psychiatric Unit. In such a situation the alert Company Commander plays the part of a secondary screen in the selection process.

Finally, he should understand the ordinary problems of adjustment that face every new recruit, and his role in assisting the new recruit toward adjustment. He should realize the problems that arise in connection with identification, in connection with dependency needs, etc., and his signal influence in establishing in the recruit in those first days of service positive attitudes that will determine the man's future success and happiness and pride in the Naval service. In doing this it should be stressed that the Psychiatric Unit is really there to serve the broadest and best interests of the Company Commander, and that cooperation with it is not a mere acquiescence to formal directives but a means of assuring his own best interests and the interests of the Navy as a whole.

It is particularly necessary to get across the idea that the Unit is there to "screen in" as well as to "screen out," to assist the recruit who is having trouble in adjusting as well as to eliminate those who cannot adjust. If the Company Commander is alive to the possibility of helping recruits who need it, if he understands his key function in the life of the recruit, and if he is willing to work closely and cooperatively with the Unit, many doubtful recruits can be salvaged who otherwise would be lost to the service.

The concept of the "self-created world" mentioned previously during our discussion of nostalgia in the chapter on Special Diagnostic Problems might well be developed in these lectures by pointing out that every individual has numerous well-established mechanisms through which he can allay anxiety and relieve tension, express hostility and aggression, receive succorance and support, and satisfy his emotional needs within the acceptable social boundaries of his every day milieu. These are such long accepted,

thoroughly ingrained habits that we are seldom aware of their dynamic significance for our adaptation to life, although they are the very bricks and mortar of which our lives are built.

Thus the busy staff psychiatrist, bogged down in administrative routine and behind in the preparation of his numerous case write-ups and reports, while painfully aware of the constant needs and demands of his recruit patients, may aggressively close his office door, refuse to see anyone for two hours and immerse himself in paper work as he tries to clear his desk. The closed door may give release to his hostility, express an aggressive assertion of individuality by shutting out the demands of the world, while the activity entailed in completing his reports works off tension, and is productively applied to one narrow area of his general problem where he can gain and see actual progress, thus helping to allay his anxiety. The worried Company Commander disturbed about the lack of progress in a poor company may take them on the field for extra drilling. He "punishes" the "bad" recruits for their part in arousing his anxiety, escapes into a situation where his insecurities and self-doubts are quieted by his dominant position, "forgets" his problems in the physical activity of the drill field, and makes a frontal assault on at least one aspect of his problem. The bewildered adolescent recruit trying to find new identifications in a very masculine military world, may go to ship's service, purchase a cigar, puff ostentatiously while making a worldly survey of the merchandise displayed for sale, and pass loud and "manly" comments to his fellow recruits. He is temporarily escaping from the demands of military training, quieting his insecurities by the vigorous playing of a masculine role, and achieving a little oral satisfaction from the cigar.

To the psychiatrist's colleagues in the Unit the closed door may seem asocial and unfriendly; to the recruits the Company Commander may seem harsh and punitive; to the Company Commander the cigar-smoking recruit may seem amusing or brash, "a boy trying to fill the shoes of a man"; but all of them must be sympathetically understood as attempts of human beings to satisfy their human needs in a rigorous, demanding environment. These may not be "good" solutions, but they are human solutions, and they must be evaluated in terms of the dynamic needs of the individuals adopting them.

We must remember that the recruit in joining the military services has been torn away from his customary, familiar civilian environment; and by this separation has been deprived of most of the habitual mechanisms that he has evolved for solving his emotional needs. It is this deprivation, this temporary lack of accepted outlets for his feelings and drives, that generates tension within the new recruit. This tension in itself,

however, is not an evil thing. It is a necessary concommitant of the learning process, and will be relieved as the recruit adjusts to his new environment and learns a new way of living to meet its demands. It is in understanding the problems of the new recruit, and in helping him to acquire healthy psychological habits in meeting these problems that the importance of "screening in" reveals itself.

It might also be pointed out that the attitude of the Company Commander toward the Psychiatric Unit is a crucial factor in setting the tone for the way in which recruits regard the Unit. Trial duty recruits may feel defensive and anxious about being sent to the Unit for re-examination. The Company Commander can alleviate this anxiety on the recruits' part by explaining the function of the Unit and by taking the proper attitude toward it himself.

Some time might also be spent in delineating typical clinical problems such as psychopathic personality, illiteracy, mental deficiency, nostalgia, reactive depression, etc. This should be done at a down-to-earth level with a liberal use of practical illustrative material. The goal here is not to institute a corps of "junior psychiatrists" but to enable the Company Commander to recognize these problems when they arise, to understand them, and to take the indicated desirable action. This will aid in preventing any attempt on the part of the Company Commander to handle the confirmed asocial individual through firm discipline, to shame the anxiety-ridden neurotic, to force the mentally defective beyond his limited abilities, to label the psychosomatic case as a gold-brick, or to berate the inadequate as lacking in guts. The stress should be on the understanding of the dynamics of behavior and it offers an excellent transition to the problems of normal adjustment and the mental hygiene of the average recruit. The significance of immaturity, dependency needs, aggression, identification, displacement, etc., can be brought out and the clever teacher can ultimately tie these down to the emotional problems of the audience, the Company Commanders themselves, in order that they may achieve further insight into their own emotional adjustment and realize its significance to the emotional milieu and successful performance of their Companies.

Unless the lectures provide for a genuine dynamic interplay between the lecturer and his audience, they will accomplish little. The material not only must be heard by the audience, but it must also be understood, and in being understood it will be empathically as well as logically assimilated. The Company Commander will achieve not only a better insight into the recruit's dynamics with a further comprehension of the resulting behavior, but he will also achieve a greater feeling for the role that he as a person plays in the recruit's life and the part the recruit as a person plays in his life.

This will encourage the Company Commander to explore his own dynamics and help him to a better self-understanding as well as a better understanding of others. Indeed it is even possible that the lecturer himself may benefit from the preparation of his lectures and from his efforts to communicate his thinking to his audience. From his labors he may gain a deeper comprehension of his own particular role in the total military setting and of the part his own personal dynamics play as he labors to fulfill his role in the selection process. It is not unknown that the physician may heal himself.

The lecturer should not, of course, expect to cover all of these suggested topics in one lecture. It is usually much more effective to present a few points at a time in a series of lectures, each followed by a period of discussion. The discussion period provides an opportunity for the Company Commanders to question the lecturer further about specific points he has not made clear, or on which there may be conflicting opinions or misunderstandings, or simply to express their views and relate their problems.

Illustrative Discussions

The following items are excerpts from recordings made of actual discussion sessions following lectures by Psychiatric Unit psychiatrists at two different Naval Training Centers. They are presented here for their possible value as discussion starters, as well as to show the type of problems on which Company Commanders feel they need help and clarification.

1. "Why does the Psychiatric Unit call over 'good' men for re-examination?"

   The Company Commander was referring here to the fact that some of his trial duty recruits turned out to be among those in the top 10% of the Company, and he questioned why they were ever put on trial duty in the first place. This presented an opportunity for the psychiatrist to explain in greater detail the concept of trial duty and the status of recruits so classified, to explain why the Unit feels the need of a follow-up on some men with no obvious difficulties, and to stress the point that this implies no stigma for recruits classified thus.

2. "How does it happen that the Psychiatric Unit may, after re-examination of a 'bad' recruit and in disregard of the unfavorable comments made in the Company Commander's Report, return him to Company?"

   The psychiatrist discussed the manpower shortage, and explained the necessity for each of the services to take their share of marginal men, and pointed out that the standards are of necessity lower now than they were several years ago. He also explained the function of the Aptitude Board and the basis on which it discharges a man from the service. He explained that in many cases such men are returned to Company because it is felt that, though they may not be eligible for sea duty, some niche can be found for them, and that every man who can be used at any job must be kept in.

3. "What is the most effective way to handle cliques within a Company?"

   A general discussion among the Company Commanders followed. The concensus of opinion was that cliques are frequently the result of a lack of positive leadership on the part of Company Commanders. The discussion then continued at some length as to what constitutes effective leadership.

4. One Chief objected that the Psychiatric Unit disclosed some of the contents of a Company Commander's Report to a recruit and complained that this sort of thing puts a Company Commander on the spot.

   The psychiatrist explained that this is not the usual procedure but that sometimes it is necessary to confront a recruit directly with his own shortcomings and problems. It is better to be forthright with the men than to hedge. Company Commanders should not feel defensive about this, he said; if they give a man a poor Report the man deserves it. On the other hand if a man fails, he has a right to know where and why, and being able to confront him with his mistakes and omissions provides a good starting point for discussion as to how these can be corrected. The psychiatrist emphasized, however, that the Unit never plays a recruit off against his Company Commander, and that this revealing of information is the exception rather than the rule, and is done only when it is therapeutically necessary or highly desirable.

5. "When you get a recruit in your Company who is a bed-wetter and you feel pretty sure that it is just a game to try to get out of the Navy, is it OK to try your own cure on him?"

   The psychiatrist suggested that all such cases be referred to the Psychiatric Unit, since, in the first place, even though the recruit is malingering as suspected, this in itself may be symptomatic of a more basic personality difficulty, and in the second place, if the recruit is actually an eneuretic, punitive measures might result in the disappearance of this symptom but would leave untouched the basic difficulty which caused it, so that another symptom would probably develop to take the place of the eneuresis.

6. One of the Company Commanders objected to the question on the Company Commander's Report, — "Do you wish this man to remain in your Company?", claiming that he usually felt that he didn't want to unload a problem recruit on to someone else, so would rather keep him than pass the buck.

   General discussion followed on the subject of Company Commander responsibility, on how far a Company Commander should go in "nursing" a backward recruit through training, on what preferential treatment of one recruit may do to the morale of the whole group, etc. A criterion was finally agreed upon: if one recruit disrupts a Company to the extent that the progress of the rest of the men is impaired or retarded, it is time to get rid of him. Always consider what is in the best interest of the majority of the Company.

If handled successfully, such discussions serve the purpose, at least in part, of group therapy sessions. They open the way for insightful discussion, for requests for personal assistance and information, with resultant clarification and change of unhealthy and un-

satisfactory attitudes which impede the success of the training situation.

Educational Films

The motion picture "Preventive Psychiatry in the Navy; the Role of the Recruit Company Commander," which was distributed in 1952 for use in connection with the educational activities of the Psychiatric Units, was designed especially with this last purpose in mind. While the film was prepared specifically for use with Company Commanders, it may be of value elsewhere with other groups. The film opens up the entire problem of social interaction between the Company Commander and his Recruit Command along with its implications for the successful adjustment and development of the Company as a unit during training. It offers a springboard for the discussion of questions of mental hygiene and preventive psychiatry at the vital moment when the new Company is formed, and it goes beyond that to the problem of the Company Commander's own personal adjustment and its implications for the leadership situation in which he is placed. The film opens with the processing of a group of new recruits and their assignment to Recruit Companies. The actions of different Company Commanders in taking over their new Companies are then depicted. A contrast is made between the ease and sureness of one Commander and the insecurity, tension and consequent instability of another Commander.

The film may be used as an independent unit or as one presentation in a series. If it is used as part of a series of talks or discussions, it may fit in easily at any of several points in the series. One lecturer may like to use it as an opening presentation to introduce, in an easy natural way, the problems of adjustment to Navy life and to immediately arouse the personal interest of the Company Commanders in the problems of mental hygiene by involving them in a discussion of their own dynamics. Another lecturer may wish to introduce it later after there has been some preliminary discussion of mental hygiene problems and their significance in the training situation. Flexilibity of treatment is desirable and any lecturer will learn with experience in what order he can get the most out of the material. The film itself is sufficiently independent and self-contained so that it may even be used as an educational film without accompanying comment.

Ideally, however, the film is perhaps best introduced as a focus for discussion in small groups of from twenty to thirty Recruit Company Commanders. It may be presented without any introduction or it may be prefaced with introductory remarks. These might deal with the tension and confusion of the newly arrived recruit as he

goes through processing. The factors of fatigue, apprehension over the unknown, feelings of insecurity in a strange situation, and the sense of loss stemming from the disappearance of the familiar home atmosphere might all be stressed, as well as a discussion of the compensatory emotional behaviors to be expected in this strange and threatening situation. This might be followed by some discussion of the emotional aspects of the situation as it appears to the new Company Commander. The threat of assuming command of a new and strange group of individuals, anxiety over the probable success of the Company in training, and the general tension connected with the myriad problems of getting the group started in its new life. The film can then be shown with general discussion to follow. If the lecturer feels it best not to break the ice with any prefatory remarks, the above points may be developed in the discussion that follows.

The staff member using the film for the first time will do well to familiarize himself with it beforehand. It may be well to have several trial runs with smaller groups of several people each to facilitate discussion, to familiarize the leader with the questions that may arise, and to give him a chance to try out various ways and means of promoting discussion and of directing it to significant areas. This will give the lecturer some preliminary preparation and result in greater ease and facility when he handles larger groups.

Easy and pertinent discussion may arise spontaneously and immediately, or it may be necessary to start it by leading questions such as, "Which Commander handled his Company best?"; "How does the Commander's behavior affect his recruits?"; "Should a Company Commander assume a stern attitude in taking over a new Company?" or, "What happened when you went through boot training?" Further questions such as, "Do you find your own moods influencing your actions toward the recruit?"; "What do you dislike about taking over new Companies?"; "What do you consider the major problems in taking over a new Company?"; "Do some recruits irritate you?", etc., all will help in furnishing a springboard for discussion. The discussion leader should guard against allowing any one member of the audience to dominate the discussion and should exercise skill and tact in keeping the discussion relevant and to the point. There always is a danger that the discussion may degenerate into a "gripe" session with a ventilation of extraneous complaints about general recruiting policies, the administrative details of the training program, and other points on which the Company Commanders feel strongly but which are irrelevant to the work of the Unit. Some catharsis must be allowed when this occurs, but it is up to the discussion leader to keep it within bounds, to turn it to some positive benefit, and to skillfully cut it off when it gets too far afield. If time permits and opportunity allows, it may even be possible to utilize some of the problems raised as a basis for further discussion sessions at a later date.

In all this the discussion leader should not assume an authoritarian, domineering

role. He should control and direct the discussion but should do so subtly and without seeming to. Insight can never be forced upon the listener; he must be personally involved, and must accept the insights as his own with a consequent feeling of personal discovery and resolution of problems through his own cerebration in order that he may accept the material offered and use it for his personal orientation. It is this cooperative understanding that is the finest fruit of the discussion method and that will result in the greatest benefit from the use of such educational films.

THE IMPROVEMENT OF PRESENT TECHNIQUES

Medicine is a science. Its diagnostic and therapeutic techniques must be subjected to scientific proof. The original directives establishing the neuropsychiatric selection program recognized the need for the constant development and improvement of existing selection techniques as well as for the discovery and standardization of new ones. Thus the original letter of the Surgeon General, dated 1 February 1941, defining the duties of the clinical psychologist, instructs him not only to administer objective tests of intelligence, ability and temperament, but also "to collect data on such scales which can later be studied in relation to the psychiatric findings and service records for purposes of establishing validity." The research intent of this statement is clear. The constant scientific reappraisal of accepted techniques and the experimental investigation of new ones, so typical of the development of the modern science of medicine, is particularly necessary in military neuropsychiatry where new and peculiar problems are constantly arising, and where speed, accuracy, and efficiency often have an even more vital function than in civilian medicine.

Moreover, the Naval service is justly proud of the quality of its medical personnel. It makes every attempt to encourage their professional and scholarly development. The history of Navy medicine contains many names who have made important contributions to the growth and improvement of basic clinical practice. This scientific interest is instanced not only by the development of a specific research branch with the Bureau of Medicine and Surgery, but by the constant facilitation of research and study by individual medical officers in the field. It is reflected in the publication of the U.S. Armed Forces Medical Journal and by the reports and abstracts contained in the U.S. Navy Medical Newsletter. Only by such constant investigation and improvement can military medicine be kept at the peak of efficiency demanded by the needs of a military organization. As one Naval officer informally has stated, "Research is not a matter involving long-haired college professors, but a necessary and practical matter of knowing where you are, how you got there, and where you are going next."

The problems of neuropsychiatric selection are forever changing, reflecting the constant changes in available manpower and in the mental hygiene of the nation from which such manpower is drawn. In addition, psychiatry and clinical psychology are relatively young sciences and many of their techniques are still in the developmental stage. Continual investigatory effort is necessary if constantly changing problems are to be met by a steadily developing science of psychiatry.

The Naval Medical Research Forms

In February 1952, the Neuropsychiatric Branch of the Bureau of Medicine and Surgery, recognizing that no neuropsychiatric unit can function efficiently without systematic provision for a continuing reappraisal of existing methods and procedures, and the constant development of new improvements, instituted the Naval Medical Research Forms 1 and 2. These Research Forms, the "Standard Medical Screening Form A" (Personal Information) and the "Standard Medical Evaluation Form A" (Company Commander's Report), are designed to provide for uniform and comprehensive collection of data on all incoming recruits. This information is then coded and put on IBM punch cards. The gathering of such data is essential. Just as the formal monthly reports of the activities of each Psychiatric Unit aid the Bureau in its planning for the neuropsychiatric processing of recruits, so the recording on punch cards of the data collected on the Research Forms will provide objective data in an immediately useful form which can be readily analyzed for the purpose of studying the factors which contribute to the incidence of neuropsychiatric casualties in the Navy. For example, a great wealth of information is available in the Bureau of Personnel and can be cross-validated with the medical data collected on the Research Forms. Likewise, neuropsychiatric incidence by individual case is recorded in the Statistical Division of the Bureau of Medicine and Surgery and lends itself to cross-validational studies. As will be immediately apparent, this is of great significance to the Bureau because it is already known that a majority of cases of neuropsychiatric incidence occur during the relatively early period of a man's service in the Navy.

One of the major purposes of the Medical Screening Form is to gather standard manpower data which will be helpful in policy and planning. The recruit's educational background, place of residence, etc., are all important matters for neuropsychiatric screening. As shifts occur in the characteristics of our recruit population, there will be concomitant shifts in our screening problems. If the educational level drops, there will be an increased stress on problems of mental deficiency and its differential diagnosis. There will also be an increasing number of cases of illiteracy with greater emphasis on literacy training programs. This will mean an increased individual intelligence testing burden for the clinical psychologist attached to the Psychiatric Unit, as it will be his duty to establish, through an individual test, whether or not the illiterate is intelligent enough to benefit from literacy training. Shifts in the average age level of the recruit population will emphasize or de-emphasize problems of immaturity and nostalgia. An increase

in the number of incoming married men may be reflected in an increase in cases of separation anxiety. To predict some of the psychiatric problems expected, it is necessary to have certain socio-economic data about the recruit population, and this Form will furnish it.

The information gathered here will also serve a basic research purpose. It will make it possible to study such things as the relationship between emotional adjustment and educational level, and will assist in answering such questions as whether or not seventeen-year-old recruits are more prone to develop emotional maladjustments in the service than are twenty-year-old recruits. Much of this data will also be useful in subsequent test validation, and for other purposes.

Standard Medical Screening Form A, Personal Information.

Psychiatric screening adjuncts, such as the Research Forms, have in addition a definite place in the clinical examination. They can and do make their own positive contribution. The psychiatrist in his interview is performing two functions. He is gathering information, and he is integrating and arranging his information as a basis for clinical judgment. The second function he, and he alone, can perform efficiently. The mere gathering of information, however, can be done in simpler fashion. While we have no objective devices for recognizing and registering such clinically significant behavior as "evasiveness," there are some things such as the patient's age, educational level, and marital status, etc., that can usually be obtained without the intervention of a trained clinician. In fact it may be a waste of the clinician's time to utilize him for obtaining such data. In the hospital or office situation, the simpler facts of the case history are usually gathered by a social service worker, a medical student, a nurse, or a secretary. If the recruit is literate, the use of the Standard Medical Screening Form does not demand even the assistance of the medical corpsman; the recruit himself can fill it out.

Since the Form will be filled out before the interview takes place, it will be available for the psychiatrist at that time, and he can obtain by quick visual inspection of the sheet much information that otherwise could be obtained only by laborious and time-consuming questioning. Both his time and his energy can be spared the obvious, and directed toward the subtle probing of more delicate and clinically profitable areas that are not suitable for investigation by the questionnaire method.

Standard Medical Screening Form A, Personal Questionnaire

The reverse side of the Standard Medical Screening Form contains some clinically significant questions of the type usually included in neuropsychiatric inventories or

"screen" tests. The purpose of these questions is not to supplant but to supplement the psychiatric interview. They are intended to be psychiatrically suggestive, but not traumatic in nature. Since this record also will be available to the psychiatrist at the time of the interview, the answers to these questions should suggest further lines of inquiry to be probed more deeply and at greater length in the face-to-face situation. Here, of course, the interview can be conducted more subtly and with greater control over the subject's reactions than is possible in the impersonal, paper and pencil testing situation. Through the interview, resistances may be overcome, undue anxiety may be avoided, defenses may be subtly penetrated, and in general the full possibilities of the dynamic social interaction of the interview situation may be exploited in whatever way seems best fitted for the achievement of the goals of the psychiatrist.

In using this Form a quick visual inspection might show the psychiatrist that the recruit had answered both that he had had a very unusual experience such as a "miracle," and that he preferred to go around by himself. This could suggest a schizoid tendency and lead to an actual investigation during the interview of the presence of early psychotic symptoms. The immediate purpose of these questions is to serve as a guide to the psychiatrist, to give him a starting point or jumping-off place for his interview. The answers are indicators of the possible direction the interview might take. It is to be expected that there will be individual differences in the extent to which various interviewers will utilize this Form and the manner in which it will be used. It should facilitate the interview and extend its potentialities, increasing its scope and flexibility rather than being allowed to limit it. It is an adjunct and an aid, and should be used as such.

Further examination of the questions will reveal that some of them are related to one another inasmuch as they refer to the same general aspect of adjustment. Thus questions involving headaches, gastric disturbances, back pain, etc., may be thought of as psychosomatic questions concerned with the way in which the individual expresses his difficulties through bodily symptoms. In this manner we can conceive of the questionnaire as covering certain broad areas of adjustment with several questions assigned to each area. In addition to the psychosomatic "area" we might think of an "area" of motivation. This would include those questions bearing directly upon the recruit's motivation for military service as revealed by his feeling that he did not have any personal stake in the country's emergency, that military service meant undue sacrifice for him, or that he could make a greater contribution in civilian life. Familial relationships might constitute another "area" by questions involving sibling rivalry, preference for

one or the other parent, parental indulgence, etc. An area of inter-personal relations might be represented by questions bearing upon the ease with which friendships were formed, on-the-job relations with fellow workers, and employers, etc. We might even think of a pathognomonic area including questions involving sudden fits of temper, experiences of depersonalization, unreasonable jealousy, and other pathological behavior. The concept of area is not introduced in any strict theoretical sense, but merely as a helpful tool in assisting the psychiatrist to organize the material on the questionnaire and to bring out inter-relationships between questions.

These questions have been drawn from many sources. Some of them come from the Cornell Selectee Index. Others have been taken from a research project conducted at the USNTC, Bainbridge, Maryland. Many of them have been suggested by Naval psychiatrists and psychologists currently engaged in screening recruits. Those bearing on motivation are the result of work on a Marine Corps Officers Selection Project conducted by the Neuropsychiatric Branch of the Bureau of Medicine and Surgery in conjunction with the Marine Corps. All of them are questions which were significant and useful in a psychiatrist evaluation situation. They will now be subjected to further experimental validation.

Later, after careful experimental study of their potentialities, it is hoped that these questions may develop into a "screen" test, as well as continuing to serve as a screening adjunct. In the further experimental development of the questionnaire as a screening test, the information offered on the Personal Information sheet and on the Company Commander's report will offer important criterion material against which the questions on the questionnaire can be validated. Since the Company Commander's report is usually available after the recruit has had three or four weeks training, actual performance criteria are thus available for validational use almost immediately. If certain significant patterns are found in the responses to the questions it should be possible to work out a scoring system which would allow the test to act as a rough screen separating the well-adjusted recruits from those men giving some indication of maladjustment. Such a "screen" test should be used merely as an indicator for further psychiatric interview with the final clinical decision coming from the trained psychiatric staff member.

A careful, experimental, statistical evaluation against objective criterion data will be one of the bases for the revision of the Personal Questionnaire. It will also be revised in the light of its successful clinical use as an adjunct to the interview. The ex-

perience of the clinicians using it under actual field conditions will be of great importance in estimating its value as a clinical adjunct and its role in the total clinical situation. From this personal experience of it in the actual selection situation will come many insights and suggestions for its improvement that will complement the statistical material as a basis for its further development.

Standard Medical Evaluation Form A, Company Commander's Report

This Form is a Company Commander's report to be filled out by the Chief Petty Officer in charge of a recruit training company. These reports are not asked on all recruits but only on those "suspect" cases who are on a trial duty status. As pointed out in the directives governing the selection process and discussed earlier in these pages, while it is recognized that in some cases of severe neuropsychiatric disability military service is flatly out of the question, there are many marginal cases that may be able to make an adjustment. Some individuals with an intellectual defect, if they are emotionally stable and have benefited educationally to the limit of their intellectual ability, might be able to render, under full mobilization conditions, acceptable service in some line of work. Many individuals with neurotic symptomatology may be able to adjust satisfactorily to the service. Some emotional problems may even disappear under the special conditions of Naval service. Frequently dependency needs unsatisfied in civilian life may be satisfied in the Navy or Marine Corps, and the relegation of the Command function to superiors may alleviate deep-seated personal anxieties. To separate arbitrarily these cases from the service would deprive the Navy of a pool of usable manpower. On the other hand, to accept them arbitrarily without a careful delineation of their assets and considered placement in accordance with these assets will not only damage the efficiency of the Navy but do irreparable harm to the individual. The answer lies in trial duty in a training company.

The training period reproduces the Navy situation in miniature. It gives us a chance to study the actual performance of the recruit under service conditions. Technically, the Company Commander's report serves as a "work-sample" test. It records for psychiatric consideration the recruit's behavior in a service situation and makes possible an evaluation of the actual extent to which the recruit is realizing his true functioning potential. It should be invaluable in making a final psychiatric decision as to the serviceability of the marginal recruit. The Standard Medical Evaluation Form furnishes the psychiatrist with the Company Commander's evaluation of the recruit's performance in training. Through it he is able to supplement his clinical appraisal in the

re-interview situation with data on the recruit's progress and adjustment as seen through the eyes of his Company Commander. The psychiatrist cannot be present to observe the recruit in his daily training activities so he must rely upon the observations of some other person who can. No one is better fitted for this function than the Petty Officer directly in charge of such activities, and the Standard Medical Evaluation Form has been designed for his specific use in reporting such observations. This report form also will be of assistance to the Company Commander by calling his attention to special areas of difficulty, and by helping him to crystallize his opinions of the recruit. The psychiatrist must reserve for himself the final evaluation of the clinical significance of the recruit's behavior, but he must rely on the Company Commander for reporting the behavior upon which this evaluation is based.

The format of the report form derives from many sources. It embodies the experience of the several Training Centers during World War II and subsequently, plus the results of research conducted at Great Lakes and Bainbridge Naval Training Centers. It has had much critical revision and amendment, and, finally, has been given a preliminary trial in the field under actual working conditions. Moreover, other, further revisions will be made as accumulating data and increasing practical experience with the form make this possible. Our selection techniques should not be viewed as static. They will develop constantly as our constantly increasing knowledge provides a basis for improvement.

The report form has another significant aspect that should be mentioned here. Not only is it a valuable aid to the whole selection process, offering as it does direct evidence of the recruit's functioning in a genuine military situation, but it has the potentiality of becoming a powerful research instrument as well. Since the close of hostilities in World War II, the Neuropsychiatric Branch of the Professional Division of the Bureau of Medicine and Surgery has been engaged in an extensive research investigation of the efficacy of neuropsychiatric selection, as well as the evaluation and refinement of the specific techniques involved, such as the psychiatric interview, personality inventories, intelligence test, etc. In all of these studies it is necessary to find some criterion measure by which the technique being investigated can be evaluated. Thus, a study has been made of the efficiency of the psychiatric interview by having a psychiatrist, on the basis of a brief interview, make predictions on the probable future serviceability of selected groups of recruits, and then evaluating the subsequent service performance of these recruits to see whether or not it agrees with the original psy-

chiatric prediction. In the past such criteria as number of hospitalizations, number and kind of disciplinary infractions, separation from the Navy for neuropsychiatric reasons, etc., have been used to evaluate military performance. This is a slow process since, if one selects a period of one year as desirable for study, it means that more than one year must elapse before the criterion data can be collected and made available for study. The very collection of such records from various sources also is a difficult and laborious process. While such studies are valuable, the final answer often comes long after the original question was raised. In planning operations it may thus be necessary to make arbitrary administrative decisions months or years before it is possible to obtain the objective data on which it would have been desirable to have had the planning based had the data been currently available at that time. This time lag necessitates the post hoc assessment of previous practices, rather than the more desirable use of current experimental data as a basis for refining present programs and developing new ones for the future.

The Company Commander's report will offer us a current criterion. It will give us a means of evaluating performance during training so that the assessing of the efficiency of selection techniques can begin as soon as three or four weeks after their actual administration. In addition, such criteria can be so phrased that it is directly applicable to the problem at hand, and can be easily gathered and assembled. In this way the Company Commander's report will have a research significance and value well beyond its intrinsic importance as an aid in the selection process itself.

The data furnished by the report also will be useful in discovering and defining areas of adjustmental difficulty during training which may then be corrected or alleviated by the application of pertinent mental hygiene measures, such as brief out-patient therapy with the recruit, indoctrination lectures and discussions with training personnel, etc. It will help in fulfilling the positive goal of "screening in," or helping marginal personnel adjust to service conditions, as well as in "screening out," or separating from the service those who are demonstrably unfit.

Cautions on the Clinical Use of the Screening Forms

Since the Screening Forms have a clinical as well as a research function we may digress a moment at this point to state certain dangers in their clinical use. With both the Personal Information sheet and the Personal Questionnaire available for the psychiatrist's use during the interview, he will find them useful adjuncts for guiding the di-

rection of his questioning. Caution is necessary, however, particularly in using the questionnaire. One basic problem that needs stressing is the constant temptation for the interviewer to rely too strongly on such an adjunct to the interview. The anxieties that beset the examiner in the interview situation are many and the tensions great. He may be sorely tempted to transfer his clinical responsibility to the questionnaire and to let it do his work for him. He may follow the questions literally, assume that it is unnecessary to go beyond the material covered by them, and accept the data offered as diagnostic in itself without further interpretation or investigation on his part. If he does this, he defeats the purpose of the interview; loses the breadth, flexibility, and range that is its very essence; and surrenders the exercise of his clinical insight and initiative to an automatic testing device. If used in this fashion, the Form becomes just another questionnaire, open to all the demonstrable errors and limitations of such techniques.

Moreover, the recruit's answers themselves cannot be accepted literally. Herein lies one of the demonstrable limitations of the paper and pencil questionnaire as a completely objective technique. The response the recruit makes on the test must be accepted literally and scored as such, without further investigation. We should keep in mind the case of the recruit who checked "yes" in response to the printed questionnaire item, "Do you use dope?" When questioned further by the psychiatrist as to when and how he used it, he replied, "You know, when you don't like a guy, when he's dumb, you call him a dope." Such mistakes are neither farfetched nor uncommon. Similarly, answers to the questions concerning motivation must be interpreted further. It is quite possible that some recruits might have been making a more important contribution to the country's defense in their civilian occupations. They may have valid reason for answering that they feel that military service means undue sacrifice for them. In fact, in some cases the failure to check this item might indicate strongly masochistic trends with pathological significance. Checking a question like, "Do others often talk about you behind your back?" may be indicative of paranoid schizophrenic trends, or it may merely stem from adolescent insecurity.

The answers in any one area will achieve greater significance when they are integrated with the responses in other areas. Thus, the anxiety revealed on the questions further defines itself when accompanied by positive answers to the psychosomatically oriented questions, indicating that the recruit's anxiety is being converted into bodily symptoms. Positive answers to questions in the familial area may indicate the source of the anxiety or insecurity revealed elsewhere, and may even suggest the direction in

which some brief therapy might proceed. Such integration must be accomplished by the clinician. It cannot be done by the questionnaire itself.

The danger of relying too heavily upon the questionnaire material will be greater in the inexperienced interviewer. As he gains more background, becomes familiar with the interviewing routine and gains mastery over its techniques, he will find it easier to relegate the questionnaire to its proper role, and let his clinical judgment assert itself as it should. Familiarity with the format of the questions will also result in his finally being able to detect the patterns of response immediately, without refreshing himself as to the specific content of each question.

The discerning clinician will realize that the questionnaire also has other possible values beyond the specific information it offers. The administration of this Form gives the recruit a "face saving" rationale for the subsequent personal interview. By the time he reaches his medical examination he is used to filling out forms; and what could be a strange, threatening situation arousing the question, "Why is he going to talk to me?", may become an understandable situation in which, "He wants to talk about my answers on the paper." In time the psychiatrist will find many ways which he can work the questionnaire into the interview, and by its skillful manipulation, utilize it as one working instrument in a complex, dynamic situation.

The Organization of Research

Such research need not interfere with the daily work of the Unit. it does make the keeping of accurate records doubly important. If careful, complete, and accurate records of the work of the Unit are kept, a check upon the efficiency of the examination and treatment procedures in use is relatively easy. This is facilitated by the IBM machines provided, and by the provision of personnel to run them. With the great numbers of recruits flowing daily through each training center, the validation and standardization of new procedures is accomplished with a rapidity not possible in civilian professional practice. Such investigation should be considered an integral part of the duties of the neuropsychiatric staff.

The possibilities opened for research are enormous. The four major difficulties of research in the field of personality dynamics — availability of subjects, the collection of the basic information necessary for proper sampling or selection of subjects, the control of experimental conditions, and the availability of criterion data against which to evaluate results — are all obviated in the Naval setting. The subjects are there in vast

numbers. Sampling information can be collected from the Standard Medical Screening Form A, Personal Information, supplemented by data collected in the psychiatric interview and on the Standard Medical Screening Form A, Personal Questionnaire. This can be further supplemented by test scores from the Classification Department. The authoritative and highly structured nature of the training situation makes the control of experimental conditions much easier than in a civilian setting. Excellent criterion data are supplied by the Standard Medical Evaluation Form A, Company Commander's Report, and this can easily be supplemented by such data as sick bay attendance, disciplinary record, demerits in company, and success in completing training, all of which can be obtained through the cooperation of the Medical and Training Commands.

The psychologist interested in developing new diagnostic testing procedures or in further standardizing and validating older ones can collect evaluative criterion data from the sources above within a few weeks. The psychiatrist or psychologist interested in the relative importance of various personality factors can study the importance of such things as immaturity, anxiety, etc., in relation to adjustment to military living, the significance of various family constellations to adjustment, or the diagnostic significance of such symptomatic behaviors as enuresis, insomnia, headaches, job history, or court record. The psychiatrist interested in therapy can study the effect of introducing supportive therapy during the original interview or at some later interview. The potentiality for research is enormous and the possible variations in experimental design are innumerable. The research-minded clinician will find in the selection procedures of the Psychiatric Unit infinite opportunity to contribute to the basic knowledge of psychiatry and psychology, to expand his own professional horizons, and, best of all, to contribute to the efficiency of the Navel service through the improvement of its selection procedures. And all this can be done with minimal disruption of the daily work of the Unit.

OTHER ANCILLARY DUTIES

The psychiatrist attached to a Training Center Psychiatric Unit will find himself with many duties beyond those of the basic selection program per se. In part, this is attributable to a natural extension of neuropsychiatric selection into other fields beside that of basic training. This will include screening examinations for various special services such as underwater demolition, etc. In part, these extra duties are ramifications of the "screening in" aspect of selection with its stress on the total mental hygiene program aimed at helping the neuropsychiatrically marginal man to adjust. In many cases, for instances, this will involve out-patient therapy of a supportive sort as well as the educational functions previously mentioned. In part his duties will arise from the fact that despite his specific attachment to the Psychiatric Unit he also must carry on any psychiatric duties that might devolve upon him as a member of the Training Center Medical Department. Thus he may be called on for expert opinion in disciplinary cases, consultation and treatment involving station personnel, etc. As a military man he is always available for such extra duties as may be assigned him through the Senior Medical Officer by the Commanding Officer.

Out-Patient Referrals

The Psychiatric Unit will receive many referrals for examination and evaluation from other departments of the Training Center. As the work of the Unit becomes integrated in the daily routine of the Center these referrals will increase and will constitute an important professional function. They will involve not only recruits in training but ship's company as well. Referrals may come directly from the Medical Department when psychosomatic problems are involved, questions of neurological disorder arise, and mental deficiency or personality disorder is present as a complicating factor in diagnosis and treatment. The Classification Department may ask for personality and psychiatric evaluations in questions of billet assignment. The Training Command, Chaplain's Department, etc., all may call for assistance when emotional and personality problems present themselves among their personnel. Such duties are not only a necessary part of the Unit's activities but their successful execution will do much in establishing the Unit as a vital part of the Training Center and the resulting understanding and appreciation of the potential contributions of neuropsychiatry will greatly facilitate the basic activities of the selection program.

Out-Patient Therapy

Many of these out-patient examinations of ship's company will not be limited to questions of disposition or of psychiatric advice with a particular problem, but will entail limited out-patient therapy if the difficulty is not severe enough to warrant the use of a Naval hospital. Many cases of nostalgia, separation anxiety, generalized insecurity, behavior problems, etc., can be helped by mild insight or supportive therapy. Such treatment will pay off in preserving vital manpower for the service and in the increased efficiency of its military performance. This therapy may be time consuming, necessitate trained personnel and be limited by the pressure of other duties, but it should be encouraged wherever possible. Moreover, it is a necessary aspect of "screening in" in connection with the recruits in basic training. The concept of trial duty is not a matter of "sink or swim." Those recruits who will benefit from supportive therapy and from counseling and advice should receive every assistance possible and advisable in making their adjustment to the service.

Disciplinary Cases

A particularly important additional function arises in connection with the examination of disciplinary cases. At some installations it has been the regular practice to have all personnel involved in serious disciplinary infractions necessitating an appearance at Captain's Mast or other trial receive a psychiatric examination. At other installations such an examination is requested only for special cases where mental deficiency, psychotic condition, or severe personality or behavioral disorders appear definite. In this way the psychiatrist can serve an important advisory function in the facilitation of individual justice and in increasing the efficient performance of the military organization. He furnishes expert opinion much as he might be called upon for by the court in a civilian setting.

The problems that arise go far beyond the mere question of legal responsibility in individuals who are feeble-minded or psychotic. They go beyond the question of extenuating circumstances in a neurotic or emotionally unstable person. Often the offender may be an alcoholic or a psychopathic personality whose continuing disciplinary difficulties are a reflection of his basic instability. In many such cases the best interests of the Navy are served by separating the individual from the service on a medical survey based upon his psychiatric condition, rather than allowing him to continue his erratic military career and to tie up military personnel on courts and boards as well as in custodial functions when they could be used more profitably elsewhere. As an

illustration we might use the case of the steward's mate who was taken in custody after attempting to attack a shipmate with a knife. Psychiatric examination showed him to be a typical asocial psychopath who in two years of Naval service had had a general court martial, several summary courts, and innumerable Captain's Masts. After consultation with the psychiatrist the Commanding Officer dropped the disciplinary charges and referred the man to the Medical Department where he received a medical survey because of his psychopathic personality. The Navy thus relieved itself of a pointless disciplinary burden.

At some training centers a psychiatrist may be attached directly to the brig as Brig Psychiatrist. His duties have been summarized in a recent article[1] as being "to determine which men are capable of adjusting to the military service reasonably well so that their tour of duty will be marked by generally sustained, useful, productive work and which men, because of their psychologically pathologic structure, will be incapable of this and will be chronic psychiatric and/or disciplinary problems requiring special attention without any long-term benefit from it.

"The brig psychiatrist can be helpful by advising not only as to the mental competency of the offender but also as to his ability to benefit from disciplinary and rehabilitative action. When justified, the offender's psychologic problem should be considered not only when deciding disposition before sentence (as in the case of the psychotic), but also when imposing sentence (should psychologic problems be relevant), and when conferring status on completion of sentence."

The handling of disciplinary problems involves not only professional competence but social discretion and the exercise of tact in public relations as well. The psychiatrist must hold his own sympathies and aggressions firmly in check and evaluate each problem impersonally in the light of its psychiatric implications, both for the individual concerned and above all for the best interests of the Naval service. Often the psychiatrist may be drawn into a disciplinary problem as a last resort. Cooperation with the administrative command demands that he accept all requests for assistance but he must always remember that his responsibility is a medical and not a disciplinary one. Mental hygiene and preventive psychiatry are his field, and not law enforcement. It is most important that he maintain a realistic, overall perspective of the total problem so that psychiatry does not become the scapegoat for offenders and thus lose its value for the Naval judicial system.

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1 Tolpin, Paul H. Psychiatric evaluation of military prisoners. U. S. Armed Forces M. J., 1953, 4, 883-887.

Special Examinations

Some of the special services within the Navy, such as the submarine service, underwater demolition, etc., have more severe requirements in terms of emotional stability and personality characteristics than do the more general types of duty. Recruits applying for such duty following basic training must be evaluated psychiatrically before being selected for the special service involved. Such examinations will in general resemble the screening interview with such adaptations as are necessary to meet the special demands of the specific service. The standards are set by the services involved although some interpretation and execution is usually demanded of the examining psychiatrist. In every case the psychiatrist should do his best to adapt his techniques and final judgment to the demands and requirements of the special service concerned, familiarizing himself as best as is possible with its needs and not imposing his own personally determined, and consequently egocentric, biases and opinions on the situation. This is a difficult task for the psychiatrist without a broad background of Naval duty but a necessary one if the proper results are to be obtained.

The Examination of Illiterates

At one time in the Navy's history the problem of illiteracy was easily handled. The chaplain aboard ship was directed to instruct the illiterate sailor during his spare time if the sailor also was free. With the technological progress of the modern Navy and its consequent demands for education and literacy and with current manpower needs necessitating the use of illiterates in large numbers, a more formal program is necessary. The number of illiterates will vary with manpower demands. In peacetime with recruitment needs small and educational standards high it is no problem. With general mobilization or outright war and in the current emergency large numbers of illiterates must be taken into the military services. The services accordingly have set up special training programs to assist illiterates in gaining the necessary minimal skills in reading and writing. Before a man is accepted for such training, however, the Navy must assure itself that the illiterate recruit is trainable, that he actually can benefit from the educational opportunity to be provided him, and it is to assist in establishing the fact that he can benefit from training that the Psychiatric Unit is called in to examine him.

Under "Special Diagnostic Problems" we have discussed the principal factors that contribute to illiteracy and its neuropsychiatric implications. These have been classed as education deprivation, mental deficiency, and personality defects. With

the constantly increasing educational opportunities in this country and with their rapid penetration into previously backward areas, educational handicap is not the problem it once was. Mental deficiency, however, is a constant factor in causing illiteracy. A man cannot learn to read and write unless he possesses a certain minimal intelligence level. It is difficult to set an arbitrary standard for this. Probably a mental age of at least 6 or 7 years is necessary even at the lowest primary levels of reading. It is exceedingly doubtful that low-grade morons or high-grade imbeciles can acquire the ability satisfactorily within any reasonable time limit. With the present selection standards mental deficiency is not a serious cause of illiteracy in the Naval service. Occasional illiterate mental defectives are found, but currently their numbers are few. With general mobilization however, or with the lowering of present educational and intellectual standards, their numbers would increase. Most of our current illiterates owe their difficulty to concurrent psychopathosis or personality and motivational defect. These are the people who can't learn because they won't learn. Figures from all our training centers currently indicate that the most important factor influencing the ability to benefit from literacy training at present is some form of underlying psychopathosis. It is in order to screen out such individuals (and the occasional mental defective) who are unable to benefit from training that the Psychiatric Unit is called upon to give a psychiatric examination to all recruits selected for literacy training. Here again in marginal cases modern mental hygiene methods may also be called upon to assist the recruit in adjusting to and benefiting from such training.

It is impractical to set an absolute test criterion for the determination of illiteracy as test criteria shift with shifting standards, change with changing tests. As part of the battery of tests given each new recruit by the Classification Department, tests for literacy, as well as a nonverbal classification test, are administered. Recruits falling below a certain score are then referred to the Psychiatric Unit for an evaluation of their potentiality for training. If they are adjudged trainable, they are assigned to a special literacy training program. If not, they are separated through the Aptitude Board by reason of unsuitability, unless their condition is such as to necessitate a medical survey.

The psychologist will be particularly useful in examining such cases because of his background and training in the testing procedures which should form an important part of the examination. These should include an individual intelligence test, a nonlanguage test, and some test of oral reading. A test of school achievement will also be helpful. One Training Center Psychiatric Unit uses a battery composed of the Wechsler-Bellevue Scale, the revised Army Beta Scale, the Gray Oral Reading Test, and the Stan-

ford Achievement Test.

We have already discussed the problems involved in making a decision on the ability to benefit from literacy training in the section on "Illiteracy" in the chapter on "Special Diagnostic Problems." After a decision is reached a report is made back to the Classification Department. Two such actual reports follow by way of illustration.

"This recruit was originally placed in a trial duty status at the time of his initial screening examination. At that time he appeared tense, tremulous, and there was an apparent family conflict. He was again given a psychiatric interview two weeks later. No pertinent findings were elicited. The Company Commander's report considered him as fair and improving. Although completing seven grades of school the Stanford Achievement Test indicated a total average grade achievement of only three grades. Performance in all of the school subjects was consistently poor. The full scale Wechsler-Bellevue IQ of 81 would indicate a dull normal level of functioning. However the performance IQ of 104 is well within average range. A noted discrepancy between the verbal and performance scale occurs. The lower performance on the verbal scale seems to be a function of specific difficulty in handling language concepts. This recruit is considered as meeting the minimal standards of AR40-115. He should be assigned to a special training program in an effort to improve his limited school achievement."

"This recruit has a full scale Wechsler-Bellevue intelligence quotient of 62. On the Gray Oral Reading Test he qualifies at the eighth grade level. The recruit is not an illiterate as indicated by his ability to read at a good eighth grade level. The psychological deficit as presented in his low score on the classification test as well as the intelligence examination is the result of his emotional instability and other psychiatric factors in his personality adjustment. His civilian adjustment prior to his enlistment in the service was marginal. He is lethargic, preoccupied, and shows poor judgment. His academic work has been poor. It is highly doubtful that he could maintain an adequate adjustment to the service. Accordingly he is to be presented before the Aptitude Board with a recommendation that he be discharged from the service by reason of unsuitability."

In handling such ancillary duties as well as any others that may arise it is well for the psychiatrist to remember the principle of rendering service where service is requested. The function of the Psychiatric Unit is to improve the operating efficiency of the Navy. Wherever it can assist in doing so it should, in order that its efforts may play an important part in the common cause and basic purpose of recruit training.

ORGANIZATION

Basic to any organizational plan for the Psychiatric Unit are the two lines of authority, military command and medical responsibility. The Unit must function not only within the framework of accepted professional medical practice, but within the framework of standard military practice as well. There is no necessary antithesis here, and good psychiatry can be accomplished within a military setting just as well as within a civilian one.

While the overall responsibility for the Unit, both militarily and medically, remains in the hands of the Senior Psychiatrist, he will share his duties and responsibilities through delegation. The work of the Unit is complex, including, as it does, the maintenance of the observation ward with all its examining and treatment facilities, the screening of new recruits, the interviewing of trial duty cases, outpatient referrals, special examinations, educational activities, research, etc. If the staff is small and the work load not overwhelming, the plan of organization may be simple, with general participation of all the staff in all the duties, and with each man immediately responsible to the Senior Psychiatrist himself.

If the staff is large and the various duties heavy, delegation of responsibility may be necessary. Thus the Senior Psychiatrist may appoint a member of the medical staff as officer in charge of the observation ward. If there are several psychologists aboard they may be constituted as an informal department under a Chief Psychologist who reports to the Senior Psychiatrist. Individual staff members in turn may be appointed responsible under the Senior Psychiatrist for such special functions as the original screening examination, trial duty interviews, special interviews, etc. In such a case some specialization of duties may arise among the members of the staff with one man concentrating much of his time on screening and evaluative interviewing, another on therapeutic interviews, another on educational functions, etc. Such specialization is proper if it contributes to the efficiency of the Unit. It takes account of individual differences in professional ability and in work preferences, and may make for a better and more contented working Unit. Some rotation among the various duties, however, is desirable at times in order that each staff member may fully comprehend and understand the entire working of the Unit. Such rotation fulfills a training as well as an operational function, and tends to alleviate operational fatigue.

In any case no set pattern of organization can be proposed here. The final details of any organizational pattern will always depend on the particular situation in the

specific Training Center involved. Of necessity it must be a function of the staff available, their particular abilities, the press of general duties, and the special priorities of particular local problems.

Observation Ward

The organization of the observation ward will in general be governed by those special provisions which are necessitated by the ambulatory status of the occupants and by the special programs provided for them. Trained psychiatric technicians are desirable for ward personnel as the activities of the ward are demanding and require great skill and facility in understanding and controlling psychiatric patients if the corpsmen are to contribute the proper assistance and support to the work of the medical staff. The ward is an "observation ward" and its full value will not be realized unless the corpsmen are capable of making accurate behavorial reports upon the patients. Moreover they will be called upon for skill and initiative in averting difficult situations, i.e., quieting panic reactions, recognizing impending psychotic states, including suicidal tendencies, and contending with both individual and group "acting out" of a disruptive nature. They will also play an important role therapeutically and much will depend upon the atmosphere that they create upon the ward.

When one is available it may be desirable to have a psychiatric nurse in charge of the ward; if one is not available, a Chief Pharmacist's Mate should be provided. The Chief MAA billet is a particularly difficult position owing to the "duty" status of the recruits on the ward. Experience has demonstrated that maximum efficiency is attained only with nonmedical personnel functioning in this capacity. If the Chief Psychiatrist finds it helpful, he may designate a medical staff officer as First Lieutenant, to be responsible under him for the activities of the ward.

If psychiatric technicians are not available, and reliance must be placed upon psychiatrically untrained corpsmen, it will be well to provide formal instruction for them. Such instruction should cover basic psychopathology; practical psychodynamics with special reference to the phenomena of transference, counter-transference, and "acting out"; and the recognition and handling of common neuropsychiatric emergencies. The ward personnel provide the basic tone for ward morale and unless the atmosphere is healthy and proper the activities of the ward cannot take place at full efficiency and with the proper results in first rate patient care.

Office Organization

The organization of the clerical office of the Psychiatric Unit is of particular im-

portance. The work of any Neuropsychiatric Unit demands an adequate and efficient office staff of clerical workers. Patients admitted to the ward must be recorded and routed correctly through the necessary schedule of ward examinations. Aptitude Board reports must be prepared promptly, and the separation of men from the service must be completed with all facility. Trial duty candidates must be followed during training, Company Commanders' reports obtained, and social histories written for when necessary. Referrals and outpatient cases must be routed for examination and treatment. Moreover, on the effective operation of the record office will depend the accumulation of the vital research data so necessary in keeping the psychiatric program geared to meet the changing needs of Naval selection. The importance and wide ramifications of the entire neuropsychiatric selection program are reflected in the tremendous amount of "paper work" necessitated by the activities of the Unit. Again the specific delegation of duties and the organizational plan for the clerical staff must remain an individual matter for each Unit depending upon the volume of work, the relative local importance of the various duties of the Unit, and the personnel available.

The office should be in the charge of a Chief Pharmacist's Mate, and he must have available a trained and adequate clerical staff. The majority of these should be mature and dependable civilian employees, but some Navy personnel is always desirable for matters involving military security, for the facilitation of communication and cooperation with other military departments of the Training Center, to provide military control in times of emergency, and to provide personnel for the odd duty hours not covered under civil service regulations. The provision for civil service clerical workers also has its particular advantages. It will make for a larger billet complement and be desirable if there is a shortage of available military personnel. Most important of all, it will make for continuity and added efficiency in the work of the office since these workers will not be subject to military rotation and change of duty. This need may become even more apparent in times of military emergency. At such times civilian workers also serve the further function of releasing military personnel for active duty elsewhere.

Generally speaking, in order to maintain the basic military orientation of the Unit, civilian personnel should not be assigned duties where they have direct contact with the recruit population. The corpsmen assigned to the Unit should be responsible for logging men in for trial duty interviews and filling out the necessary forms involved in admitting recruits to the ward.

Owing to the limited personnel available and the large number of duties to be accomplished, a flexible office structure is necessary with at least two persons able to

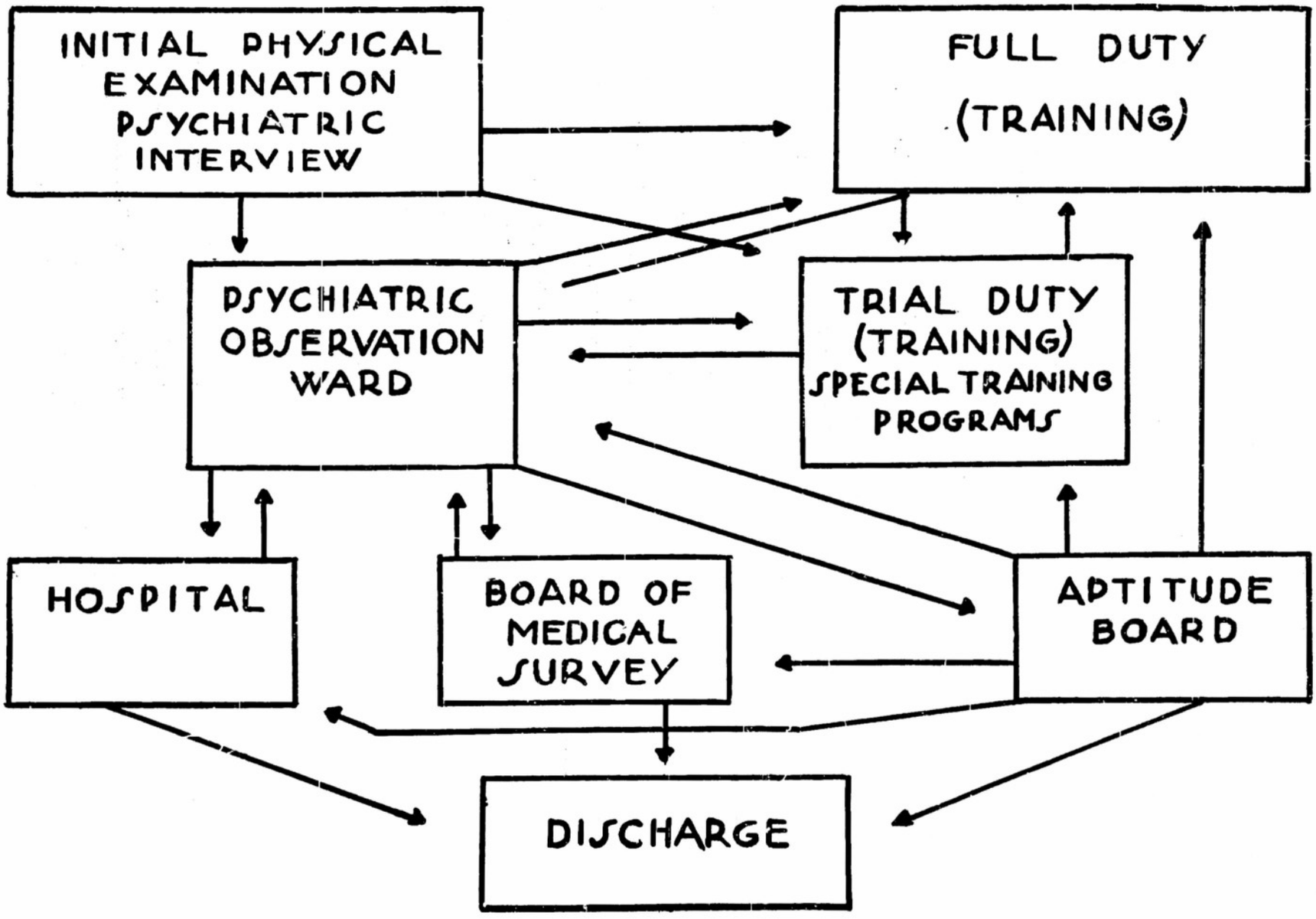
perform each job. The details of each and every task should be outlined and incorporated in a Record Office Procedures Manual which also should include such details as the departmental telephone numbers of those outside departments cooperating with the Unit and the names and titles of relevant personnel who are to be contacted.

It has been found that some clerical tasks may be handled appropriately by the night corpsmen if so desired, thus relieving some of the pressure on the day crew. By way of illustration, the daily sick list can be prepared after midnight, and trial duty records can be pulled and prepared for the following day's interviews.

One of the more important bookkeeping duties of the Psychiatric Unit is the preparation of the Quarterly Report submitted to the Bureau of Medicine and Surgery. Instructions for preparing this report are included in the Appendix. This is the report through which the Bureau of Medicine and Surgery keeps in contact with the work in the field and by which it guides its planning for the neuropsychiatric selection program. Its accurate preparation is essential for the integration and development at the Bureau level of the entire selection program.

Paper work is demanding and laborious, but it must be done accurately and with dispatch if the work of the Unit is to proceed efficiently. It is basic to the current activity of the Unit and essential for accurate planning for the future, as well as being a necessary prerequisite of any research function. It may be regarded with distaste or with humorous contempt, but it merits neither. Its efficient execution is vital to the Unit, and demands a careful organization of the office staff involved.

FLOW CHART OF NEUROPSYCHIATRIC SELECTION



BIBLIOGRAPHY

The following very brief bibliography is not intended to be comprehensive and is highly selective. The staff member who wishes to read more widely in the field will find further references in the selections below. The grouping is somewhat arbitrary and introduced merely for convenience.

General Background

Braceland, Francis J. Psychiatric lessons from World War II. Amer. J. Psychiat., 1947, 103, 587-593.

Ebaugh, Franklin G., Solomon, Harry C., & Bamford, Thomas, E., Jr. (eds.) Military neuropsychiatry. (Res. Publ. Ass. nerv. ment. Dis.) Baltimore, Md.: Williams and Wilkins, 1946.

Gregg, Alan. Lessons to learn; psychiatry in World War II. Amer. J. Psychiat, 1947, 104, 217-220.

Menninger, Karl A. A manual for psychiatric case study. New York: Grune & Stratton, 1952.

Menninger, William C. Psychiatry In A Troubled World: Yesterday's War and Today's Challenge. New York: The Macmillan Company, 1948.

Menninger, William C. The future role of psychiatry in the Army. Milit. Surg., 1947, 100, 108-113.

Raines, G. N. Current problems in naval psychiatry. Milit. Surg., 1947, 100, 119.

Solomon, H. C., & Yakovlev, P. I. The manual of military psychiatry. Philadelphia: Saunders, 1944.

Neuropsychiatric Selection

Carmichael, Leonard & Mead, Leonard C. (Eds.), The selection of military manpower — a symposium. National Academy of Sciences, National Research Council. Publication 209. 1951.

James, Arthur A. The transition of the citizen into the wartime armed forces. U. S. Armed Forces med. J., 1950, 1, 938-944.

McDaniel, F. L. Selection and placement of the naval recruit. Milit. Surg., 1948, 102, 114-116.

Poliak, P. P. Some observations on induction center and training station psychiatry. J. nerv. ment. Dis., 1944, 99, 799-807.

Vernon, Philip E., and Parry, John B. Personnel Selection in the British Forces. London: University of London Press. 1949.

Wittson, C. L., & Hunt, W. A. Three years of naval selection: a retrospect. War Med., 1945, 7, 218-221.

Zubin, Joseph. Recent advances in screening the emotionally maladjusted. J. clin Psychol., 1948, 1, 56-63.

Research on Neuropsychiatric Selection

Aita, John A. Efficacy of the brief clinical interview method in predicting adjustments; five-year follow-up study of three hundred and four army inductees. Arch. Neurol. Psychiat., 1949, 61, 170-176.

Brill, Norman Q., & Beebe, Gilbert W. Follow-up study of psychoneuroses: preliminary report. Amer. J. Psychiat., 1951, 108, 417-425.

Brill, N. Q. & Beebe, G. W. Psychoneuroses, military applications of a follow-up study. U.S. Armed Forces med. J., 1952, 2, 15.

Brill, N. Q. & Beebe, G. W. Some applications of a follow-up study to psychiatric standards for mobilization. Amer. J. Psychiat., 1952, 109, 401-410.

Hunt, W. A. An investigation of naval neuropsychiatric screening procedures. Groups, Leadership, and Men. In Guetzkow, H. (Ed.), Pittsburgh, Pa.: Carnegie Press, 1951. 245-256.

Hunt, W. A. & Wittson, C. L. Some sources of error in the neuropsychiatric statistics of World War II. J. clin. Psychol., 1949, 5, 350-358.

Hunt, W. A., Wittson, C. L., & Burton, H. W. A validation study of naval neuropsychiatric screening. J. consult. Psychol., 1950, 14, 35-39.

Hunt, W. A., Wittson, C. L., & Burton, H. W. A further validation of naval neuropsychiatric screening. J. consult. Psychol., 1950, 14, 485-488.

Hunt, W. A., Wittson, C. L., & Hunt, E. B. Military performance of a group of marginal neuropsychiatric cases. Amer. J. Psychiat., 1952, 109, 168-171.

Jacques, E. L. The role of psychiatry in personnel selection in the Canadian Army. Bull. Canad. Psychol. Ass. 1943, 3, 16-17.

Sharp, William L. Fate of 395 mild neuropsychiatric cases salvaged from training period and taken into combat. Amer. J. Psychiat., 1950, 106, 801-807.

Wittson, C. L., Hunt, W. A., & Stevenson, I. A follow-up study of neuropsychiatric screening. J. abnorm. soc. Psychol., 1946, 41, 79-82.

The Psychiatric Interview

Berdie, R. F. Psychological processes in the interview. J. soc. Psychol., 1943, 18, 3-31.
Closson, J. H., & Hildreth, H. M. Experiment in psychotherapy during selection examining. Nav. med. Bull., 1944, 43, 39-43.
Deemer, W. L., Jr., & Rafferty, J. A. Experimental evaluation of the psychiatric interview for prediction of success in pilot training. J. Aviat. Med., 1949, 20, 238-250.
Hildreth, H. M., & Hill, J. M. A neuropsychiatric questionnaire for group examining. Nav. med. Bull., 1945, 45, 895-902.
Hunt, W. A., Wittson, C. L., & Hunt, E. A theoretical and practical analysis of the diagnostic process. Current Problems in Psychiatric Diagnosis. In Hoch and Zubin (Eds.) New York: Grune & Stratton. 1953.
Masserman, Jules H. Psychiatric supplementation of the medical history and physical examination. Dis. Nerv. Syst., 13, 1-8, 1952.
Newman, S. H., Bobbitt, J. M., & Cameron, D. C. The reliability of the interview method in an officer candidate evaluation program. Amer. Psychologist, 1946, 1, 103-109.
Oldfield, R. C. The psychology of the interview. (4th Ed.) London: Methuen, 1941.
Sullivan, Harry Stack. The psychiatric interview. Psychiatry, 1951, 14, 361-373.
Sullivan, Harry Stack. The psychiatric interview: II. Psychiatry, 1952, 15, 127-141.
Whitehorn, J. C. Guide to interviewing and clinical personality study. Arch. Neurol. Psychiat., 1944, 52, 197-216.
Wittson, C. L., & Hunt, W. A. The predictive value of the brief psychiatric interview. Amer. J. Psychiat., 1951, 107, 582-585 .

Psychological Testing

Altus, William D., & Bell, Hugh M. The validity of a general information test for certain groups of Army illiterates. J. consult. Psychol., 1947, 11, 120-132.
Colmen, J. G. A rapid determination of intellectual adequacy for the naval service. Nav. med. Bull., 1944, 42, 1093-1095.
Ellis, Albert, & Conrad, Herbert S. The validity of personality inventories in military practice. Psychol. Bull., 1948, 45, 385-426.
Goosen, Carl V. The Goosen Hidden Intelligence Test. Publ. Opin. Quart., 1950, 14, 759-766.
Gough, Harrison G. & Peterson, Donald R. The identification and measurement of predispositional factors in crime and delinquency. J. consult. Psychol., 1952, 16, 207-212.
Hilden, Arnold H., Taylor, James W., & DuBois, Philip H. Empirical evaluation of short W-B scales. J. clin. Psychol., 1952, 8, 323-331.
Hildreth, H. M. Single-item tests for psychometric screening. J. appl. Psychol., 1945, 29, 262-267.
Hildreth, H. M., Wheeler, J. A., Jr., & Williams, S. B. A psychometric procedure for screening mental defectives. Nav. med. Bull., 1944, 43, 316-320.
Hunt, W. A. & French, E. G. The CVS Abbreviated Individual Intelligence Scale. J. consult. Psychol., 1952, 16, 181-186.
Hunt, W. A., & Stevenson, Iris. Psychological testing in military clinical psychology: I. Intelligence testing. Psychol. Rev., 1946, 53, 25-35.
Hunt, W. A., & Stevenson, I. Psychological testing in military clinical psychology: II. Personality testing. Psychol. Rev., 1946, 53, 107-115.
Keller, Margaret, Child, Irvin L., & Redlich, Frederick C. Preliminary test of intelligence; a brief test of adult intelligence designed for psychiatric examiners. Amer. J. Psychiat., 1947, 103, 785-792.
Lyon, Blanchard, Molish, Herman B. & Briggs, Dennie. The Cornell Index: A comparison of a matched sample of psychiatric "suspects" and nonsuspects. U. S. Armed Forces med. J., 1953, 4, 977-985.
Saslow, George, Counts, Robert M., & DuBois, Philip H. Evaluation of a new psychiatric screening test. Psychosom. Med., 1951, 13, 242-253.
Shipley, W. C., & others. The personal inventory, short form (format CO: derivation and preliminary psychiatric validation. (OSRD, 1944; Publ. Bd., No 34781.) Washington, D.C.: U.S. Dep. Commerce, 1946, Pp13. $1.00, microfilm; $1.00 photostat.
Stevenson, Iris. A bibliography of Naval clinical psychology. Psychol. Bull., 1945, 42, 390-392.

Profiling (Pulhes)

Germain, George L., Browne, C. G., & Bellows, Roger M. Measuring men and jobs: physical profiling systems. Occupations, 1952, 30, 579-583.
Germain, George L., Browne, C. G., and Bellows, Rogers M. Criteria for physical analysis forms. Pers. Guid. J., 1953, January, 245-249.

Jacobs, Eugene C. Pulhes: the physical profile serial system. U. S. Armed Forces med. J., 1953, 4, 235-241.
Karpinos, Bernard D. Evaluation of the physical fitness of present-day inductees. U. S. Armed Forces med. J., 1953, 4, 415-430.

Psychiatric Social Work

Buckley, Irene G., & Valk, Margaret A. Selected bibliography on psychiatric social work. Publications Committee, American Association of Psychiatric Social Workers. 1948.
Maas, Henry S. (Ed.) Adventure in Mental Health: Psychiatric social work with the armed forces in World War II. New York: Columbia University Press, 1951.
WHY VOLUNTEERS? In Illinois State Mental Hospitals. 40 pp. Published 1953 by the Illinois Department of Public Welfare, distributed without cost by the Illinois Board of Public Welfare Commissioners, Room 1525, 160 N. LaSalle Street, Chicago.

Special Problems

Davidson, Henry A. Malingered psychoses. Bull. Menninger Clin., 1950, 14, 157-163.
Dayhaw, Lawrence T. Malingering: a review of the literature during the decade 1933-1943. Rev. Univ. Ottawa, 1949, 19, 201-248.
Hunt, W. A. The detection of malingering; a further study. Nav. med. Bull., 1946, 46, 249-254.
Hunt, W. A. & Older, H. J. Detection of malingering through psychometric tests, Nav. med. Bull., 1943, 41, 1318-1323.
Hunt, W. A. & Wittson, C. L. The neuropsychiatric implications of illiteracy. U.S. Armed Forces med. J., 1951, 2, 365-369.
Kanner, Leo, Feeblemindedness: absolute, relative, and apparent. Nerv. Child., 1948, 7, 365-397.
Ranson, Stephen W. Military medicolegal problems in field psychiatry. Bull. U. S. Army med. Dep., 1949, (Suppl. No. 9) 181-188.
Sarason, Seymour B. Psychological problems in mental deficiency. New York: Harper, 1949.
Segal, Henry A. Iatrogenic disease in soldiers. U. S. Armed Forces med. J., 1953, 4, 49-59.
Wittson, C. L., Harris, H. I., & Hunt, W. A. Cryptic nostalgia. War Med., 1943, 3, 57-59.

DEPARTMENT OF THE NAVY
Bureau of Medicine and Surgery
Bureau of Naval Personnel
Headquarters, United States Marine Corps
Washington 25, D.C.

BUMED 1910.1
BUMED:33:RAB:hgm
27 April 1953

BUMED INSTRUCTION 1910.1

From: Chief, Bureau of Medicine and Surgery
Chief of Naval Personnel
Commandant of the Marine Corps

To: Commanders, All Naval Training Centers; Commanding Generals, U.S. Marine Corps Recruit Depots, Parris Island, S.C., and San Diego, Calif.

Subj: Aptitude boards; functions of

Ref: (a) Art. 18-3, MMD
(b) Art. 18-2, MMD
(c) Art. 18-1, MMD
(d) Physical Standards and Physical Profiling for Enlishment and Induction, AR 40-115
(e) Art. 18-5, MMD
(f) BuPers ltr Pers-B222-MK, P19-1, of 9 Nov 1951
(g) Art. C-10310, BUPERS Manual
(h) Art. 10275, MARCORPS Manual

Encl: (1) Sample form for reports of aptitude boards

1. Purpose. It is the purpose of this instruction to present the functions of aptitude boards and to authorize action on the reports of such boards.

2. Cancellation. BUMED Circular Letter 49-19 of 24 February 1949, issued as a joint BUPERS-BUMED-MARCORPS letter, and approved by the Secretary of the Navy, is hereby cancelled and superseded.

3. The Aptitude Board.

a. An aptitude board shall be permanently convened by the commander or commanding general of each of the addressed activities.

b. The aptitude board shall consist of two line officers, one clinical psychologist, and three medical officers; or, in the event sufficient personnel are not available, it may consist of one line officer and two medical officers. In either case, the board shall include a line officer of the rank of lieutenant commander or major, or higher, at Navy or Marine Corps activities, respectively; one experienced medical officer of the Regular Navy; and one medical officer who is qualified as a psychiatrist. For the processing of members of the reserve components, the board, with due regard to the availability of qualified numbers and the categories regular and reserve which may be considered, shall include in the membership to the fullest practicable extent fair and adequate representation from the reserve components.

c. It is the function of the aptitude board to consider the cases of recruits referred to it by the psychiatric unit or the medical officer of the station, with a view to discharge for unsuitability if indicated, and to make appropriate recommendations in the premises to the commander or commanding general in accordance with reference (a). No person shall be recommended by the aptitude board for discharge from the service until he has appeared in person before the aptitude board and been informed of the proposed action.

4. Evaluation of Recruits.

a. The term "recruits" applies to all newly enlisted, newly inducted members, or reserve members ordered to active duty, who are undergoing and have not completed recruit training.

b. Evaluation of each recruit's fitness and suitability for service is a function of addressees. This evaluation should be conducted with a view to separating members from service when it is determined that they are unsuitable for service because they cannot be expected to perform useful duty. In this connection, reasonable effort should be made to detect those recruits who present defects or tendencies which were concealed or not detected at the time of enlistment or induction.

c. A guide for determining the physical and military fitness of recruits for service is outlined in reference (b).

d. The preliminary evaluation of each recruit's physical fitness shall be conducted by the Medical Department representatives at the station and the evaluation of each recruit's neuropsychiatric fitness and suitability for service shall be performed by the psychiatric unit, as outlined in reference (c), as part of the initial physical examination.

e. A recruit with obvious and serious neuropsychiatric handicaps shall be sent to the Psychiatric Observation Ward for further observation. Recruits with less obvious or serious handicaps or about whose fitness for service there is doubt, should be returned to a trial of duty and observed under drill and training conditions in a regular recruit company, with the understanding that the psychiatrist shall have opportunity for further examination of the recruit if he deems it necessary.

f. A recruit may be referred to the psychiatric unit for examination and observation at any time during the training period at the station. During this period of observation, he should be admitted to the sick list if patient status is desirable.

g. Company commanders and other cognizant authorities shall be apprised of the importance of referring recruits, not adjusting well to training conditions, for medical attention.

5. Referral of Recruits Regarded as Unfit or Unsuitable for Service.

a. If, in the opinion of the medical officer of the station, after due consideration of the applicable standards in references (b) and (d), a recruit is not fit for duty (incapacitated) by reason of physical disability, or if, in the opinion of the psychiatric unit, a recruit is not fit for duty (incapacitated) by reason of mental disability, his case may be disposed of as follows:

(1) If treatment or protective custody is required or if the classification is "4" in any column of the PULHES chart, the recruit shall be admitted to the sick list for disposition by a board of medical officers.

(2) If the medical officer of the psychiatric unit considers that a recruit is unsuitable for service but the recruit does not present an incapacitating physical or mental disability below the current minimum standards for induction as stated in references (c) and (d), certification shall be made to that effect and the recruit shall be referred to an aptitude board for disposition.

b. In summarization, if a recruit is found to present physical or mental defects which, of themselves, render him physically unfit for service under existing standards, he may be discharged for medical reasons (physical disability); but if he presents physical or mental defects which are not, of themselves, disqualifying for useful duty, even in a limited capacity, his discharge, if effected, must be for unsuitability rather than by reason of physical disability. Thus it is necessary to distinguish between defects which impair functional usefulness, thereby warranting discharge for reasons other than disability, and defects which incapacitate, thereby warranting discharge for medical reasons.

6. Action to be Taken on Reports of Aptitude Boards.

a. Addressees of this letter are hereby authorized and directed to take final action on reports of aptitude boards in the cases of all enlisted and inducted recruits, subject only to the restrictions noted below.

b. Commanders, naval training centers, are authorized to take final action only in the cases of Navy recruits.

c. Commanding generals of addressed Marine Corps activities are authorized to take final action only in the cases of Marine Corps recruits.

d. Reports of aptitude boards shall be reviewed by the commander or commanding general. If he approves a recommendation for discharge, the recruit concerned shall be discharged and the action shall be final.

e. If the commander or commanding general disapproves a recommendation for discharge, he shall so indicate by endorsement and shall forward the report via BUMED to BUPERS or MARCORPS, as appropriate, for final action.

f. In case the commander or commanding general considers a recruit's special qualifications sufficiently valuable to warrant his retention despite the aptitude board's recommendation for discharge, he may submit the report via BUMED to BUPERS or MARCORPS, as appropriate, for consideration of the desirability of retaining the recruit in service.

g. If the commander or commanding general approves the report of the aptitude board recommending discharge of the recruit from service, the report (original only) shall be forwarded to BUMED, together with the terminated health record.

h. In all cases, regardless of recommended action or disposition, a copy of the report of the aptitude board shall be placed in the recruit's service record.

7. Disposition of Recruit Recommended for Discharge. The recruit to be discharged upon approved recommendation of an aptitude board shall be discharged by reason of unsuitability and shall be issued a general discharge certificate, on which reference shall be made to this instruction and reference (g) or (h), as appropriate, as authority for discharge. The reason and authority for discharge shall be entered on the recruit's service record.

8. Reports.

a. Report of Aptitude Board. The enclosed form headed "REPORT OF APTITUDE BOARD" is a sample of that to be used in reporting the finding and action taken by the aptitude board. The Board shall not make medical diagnoses, and no statement of its impressions is to be entered in the health record or on the aptitude board's report. Sufficient pertinent data will be recorded to support the board's conclusions and recommendation. This may be in the nature of symptoms, signs, social behavior, reaction to environment and so on. The information derived from Red Cross social service data may be considered by the board in determining appropriate disposition. However, such reports are confidential, and the information shall not be quoted or referred to in the board's report. The information secured by the Red Cross is for the individual's benefit through its value in determining proper management of his case. These reports can be used professionally as a guide for direct questioning of the recruit and the information elicited then becomes a part of the clinical history which can be included in the board's report. (See reference (e)).

b. Report of Discharges. A separate report of the action taken in each case resulting in discharge shall be made. The report involving a Marine Corps recruit, specifying the date of discharge, shall be made immediately to the Commandant of the Marine Corps. Reports regarding Navy personnel shall be submitted in accordance with reference (f).

c. Effect of Discharge. Discharges effected pursuant to the authority contained herein shall not only serve to terminate the current enlistment contract but also any additional service obligation which may have been incurred.

H. L. PUGH
BUMED

BUPERS
MARCORPS

Approved: 22 Apr. 53
C. S. THOMAS
Under Secretary Navy

Copy to:
COMDTsNDs&RCs
INSPNAVMEDACTs
COMSEAFRONTs
DMCc&RCMOs
NNMC
CINCLANTFLT
CINCPACFLT

Enclosure (1)

REPORT OF APTITUDE BOARD

Place ..... Date .....

From: Aptitude Board

To: Commander (or Commanding General)

Subj: Report of aptitude for the Naval Service of:

.....

(Name in Full, Service No., Rate) Class (USN, USNR, USN-I, USMC-V, USMC, USMCR, USMC-I)

Born: Place ..... Date .....

Enlisted or

Inducted: Place ..... Date .....

Total Service: Navy .....Marine Corps .....

Army .....Air Force .....

CLINICAL SUMMARY:

(To conclude with the specific statement, "This recruit meets the minimum induction standards as defined in AR 40-115 and his retention would not jeopardize his health nor endanger that of his service associates. Therefore, he is not eligible for discharge by reason of physical or mental disability.")

Board's Conclusions and Recommendations: (Use whichever alternative is appropriate.)

(a) The general qualifications of ..... warrant his retention in service. It is recommended that he be returned to duty.

(b) The general qualifications of ..... do not warrant his retention in service. He is not in need of hospitalization. His condition existed prior to entry into Naval Service and has not been aggravated by service. If discharged he will not be a menace to self or to others. It is recommended that he be discharged from service by reason of "unsuitability." Statement was (not) submitted in rebuttal.

(c) The findings in the case of ..... are inconclusive for determination of his fitness and suitability for service. It is recommended he be admitted to the sick list for further study.

(Signed by members)

....

....

....

*FIRST ENDORSEMENT

From: Commander (or Commanding General)

To: Chief, Bureau of Medicine and Surgery

1. Forwarded, recommendation of Board approved.

2. Subject man has been discharged from the U.S. Naval Service this date by reason of "unsuitability" and has been issued a general discharge certificate.

(Signed)..... .....*Note: This endorsement to be used only when discharge is effected.

D61712

DEPARTMENT OF THE NAVY
Bureau of Medicine and Surgery
Bureau of Naval Personnel
Headquarters, United States Marine Corps

BUMED 1910.2
BUMED:33:RAB:hgm
21 May 1953

BUMED INSTRUCTION 1910.2

From: Chief, Bureau of Medicine and Surgery
Chief of Naval Personnel
Commandant of the Marine Corps

To: COMs all NAVTRACENs; COs all NAVHOSPs, CLUSA; COs all NAVRECSTAs CLUSA; CGs and COs, all MARCORPS Activities, CLUSA

Subj: Disposition of enlisted and inducted members by reason of physical disability or military unfitness; standards and procedures for

Ref: (a) SecDef Memorandum of 2 Aug 1948
(b) Physical Standards and Physical Profiling for Enlistment and Induction, Army Regulation No. 40-115 of 20 Aug 1948, as amended
(c) Chapter IX, NS, MCM, 1951
(d) Title IV of the Career Compensation Act of 1949 (37 USC 271-285)
(e) Chapter 18, MMD

Encl: (1) Certificate relative to full and fair hearing before Physical Evaluation Board

1. Purpose. To promulgate standards and procedures for the separation of subject members from the Naval Service who have become functionally incapable of performing useful service.

2. Cancellation. BUMED Circular Letters numbered 50-15, 51-34, and 51-106, issued as BUPERS-BUMED-MARCORPS Joint Letters dated 3 February 1950, 19 February 1951, and 13 July 1951, respectively, and approved by the Secretary of the Navy, are hereby cancelled and superseded.

3. General. Members of the Naval Service may be found unfit for military service by reason of physical disability due to disease and also injury or because of inherent pre-existing defects which constitute military unfitness as distinguished from physical disability.

4. Standards for Discharge by Reason of Physical Disability

a. In accordance with reference (a), no list of specific injuries, diseases, or other medical conditions will be established "as cause for discharge for physical disability" and the medical evaluation of the member's physical capacity will be determining for discharge in the same manner as for induction. In general, a member shall be separated from the active list for physical disability only when:

(1) In the judgment and opinion of competent medical personnel, he has become functionally incapable of performing useful duty during the remainder of his service, with due consideration given to whether his scaled-down physical profile serial is consistent with any assignment wherein he could perform useful duty within the military department in which he is serving; or

(2) He has a physical disability of such nature that, in the opinion of competent medical personnel, to retain him for further active duty would aggravate such condition to the detriment of his future health and well-being; or

(3) His retention would, in the opinion of competent medical personnel, jeopardize the health or safety of his service associates.

b. Subject to the foregoing statement of policy, no male member whether enlisted or inducted shall be separated from the active list for physical disability prior to completion of obligated service under the Universal Military Training and Service Act, as amended, if his re-classified profile serial is at the minimum or higher than the minimum profile serial acceptable for induction under AR 40-115, reference (b).

5. Disposition by Reason of Physical Disability

a. Disposition of Members When Physical Evaluation Board Action is Indicated. Reference (c) established medical boards and assigned to such boards the duty of reporting upon the state of health of members of the service who are obviously incapacitated for the performance of duty or in whose cases there may be reasonable doubt as to fitness to perform duty when such unfitness results from physical disability. It provides that individual cases shall be referred to a medical board in such manner as the convening authority directs and that requests for such referral may be made to such authority when it is necessary to determine the physical fitness of an individual in the Naval Service. The determination of physical fitness in this manner is indicated when discharge, separation, or retirement of physically disabled personnel by means of physical evaluation board action is under consideration.

(1) Disciplinary Cases. When a medical board submits a clinical report in the case of an enlisted or inducted member whose physical disability renders him unfit for service and court martial proceedings or investigative proceedings which might lead to court martial are pending, indicated, or have been completed, and in cases of uncompleted sentences of courts martial involving confinement or discharge, the clinical report, together with all pertinent facts relative to the disciplinary aspects of the case, shall be forwarded by the convening authority to the Bureau of Naval Personnel or Headquarters, Marine Corps, as appropriate, via the Bureau of Medicine and Surgery, for such administrative action as is deemed warranted. No orders directing or authorizing the appearance of the member before a physical evaluation board shall be issued by the convening authority. The collection of pertinent facts relating to the disciplinary features of such cases is not the function of the medical board but shall be accomplished by the convening authority. If, after a member has appeared before a physical evaluation board in accordance with reference (d), he becomes subject to disciplinary action, BUPERS or MARCORPS, as appropriate, shall be notified by dispatch. (See paragraph 9b below for details.)

(2) Temporary Dispositions. After an enlisted or inducted person who is a patient in a naval hospital is ordered to appear before a physical evaluation board, the commanding officer of the naval hospital may, when he considers that the member does not require retention in the hospital, release him from the sick list and transfer him to an appropriate duty station to await action on the case. This is equally applicable in the event of subsequent readmission to the sick list.

(a) Navy personnel released from the sick list under the above conditions should be transferred to a naval activity near the naval establishment in which the physical evaluation board before which the member is to appear is convened. Marine Corps personnel shall be returned to the Marine Corps activity upon whose rolls they are carried.

(b) In the above cases, the commanding officer of the naval hospital shall indicate, on copies of the orders, the temporary disposition so effected citing this instruction as authority. One copy each of the orders bearing the indicated disposition data shall be forwarded to BUMED, BUPERS or MARCORPS as appropriate, and the commanding officer of the station of transfer.

(c) At the discretion of the commanding officer of the station of transfer, with the advice of the medical officer of such station in each case, these men may be assigned such specific duties as are compatible with and will not aggravate their physical condition, while awaiting action by the Secretary of the Navy. In this connection, attention is invited to current instructions relative to the disposition of personnel awaiting final action of disability retirement or discharge proceedings.

b. Discharge of Members by Board of Medical Survey Action for Physical Disability Not Incurred in or Aggravated by Service

(1) Authority to Discharge. Commanders naval training centers, commanding officers receiving stations CLUSA, and commanding officers naval hospitals CLUSA are hereby authorized to discharge enlisted or inducted members, including female enlisted members, of the Navy and Naval Reserve, on active duty, by reason of physical disability; and commanding generals and commanding officers Marine Corps activities CLUSA are hereby authorized to discharge enlisted or inducted members, including female enlisted members, of the Marine Corps and Marine Corps Reserve, on active duty, by reason of physical disability; provided:

(a) The member has appeared before a board of medical survey and such board (which shall consist, to the fullest practicable extent, of fair and adequate representation of members from the reserve components, with due regard to availability of qualified reservists, and categories, regular and reserve, which may be considered by the board) has expressed affirmatively and specifically the opinion that the member does not meet the minimum standards for enlistment or induction as set forth in reference (b); that the member is unfit for further naval service by reason of physical disability; and that the physical disability was neither incurred in, nor aggravated by, a period of active military service.

(b) The convening authority of the board of medical survey concurs in the above opinions of the board.

(c) The member has been fully advised, by the convening authority of the board of medical survey, of his right to demand a full and fair hearing by a physical evaluation board prior to discharge.

(d) The member, after having been advised of his right to a full and fair hearing, certifies in writing, in the form prescribed in paragraph 9a below and enclosure (1), that he does not demand such a hearing prior to discharge.

(e) There is no disciplinary action pending.

(2) Hospitalization not Necessary in Some Cases. In order to avoid unnacassary hospitalization, tha report of medical survay may be submitted by any activity authorized to convene a boerd of medical survay in accordance with referance (e). Whenever practicable, and particularly when hospitalization is not required for treatment, all indicated special studies should be obtained on a consultation basis.

(3 Procedure and Reports

(a) In the case of Naval personnel, whera tha convening authority of the board of medical survey is othar than a naval addressee, the mamber shall be transferred and the report of madical survay, togather with the executed certificate, shall be forwarded for appropriate action, to the naarest naval receiving station.

(b) In the case of Marine Corps personnal, whare the convening authority of the board of medical survay is othar than a Marine Corps addressee, the member concerned shall be transferred and the original and four legible copias of the report of medical survey, together with tha axecutad certificate, shall be forwarded for appropriate action to the Marine Corps activity upon whose rolls the individual is carried.

(c) In all cases, the discharging activity shall forward the original and one copy of the report of medical survay and two signed copies of tha enclosure to the Chiaf of Naval Personnel or the Commandant of tha Marine Corps (Code DMB), as appropriate, via tha Chiaf, Bureau of Medicine and Surgary, with andorsements thereon showing the action takan by the addressea; and when the commanding officer of a Marine Corps activity takes final action one copy shall be returned to the commanding officer of tha naval hospital from which received showing by endorsement thereon the action taken and the specific authority therefor. Whan practicabla, the backs of survey forms shall be used for action and forwarding endorsements, striking out inapplicable printed matter as necessary.

(d) When discharge is effected pursuant to this authority, thare shall be entered on the reverse side of the discharge certificate abreast the antry "Authority": (a) for Navy personnel, article C-10305, BUPERS Manual 1948, and this instruction; or (b) for Marine Corps personnal, paragraph 10268, Marina Corps Manual, and this instruction. The raason and authority for discharge shall be antered in the service record.

(a) Haaring Demanded before PEB. In the evant the mamber demands a haaring before a physical evaluation board, or, if the convaning authority of tha board of medical survey does not concur in all of tha opinions of the board raquired by paragraph 5b(1)(a) abova, tha original of the raport of medical survay shall be forwarded to a physical avaluation board in liau of a clinical report, and a copy sent to the Chief, Bureau of Medicine and Surgary. This action shall be shown by endorsement on tha raport of medical survey.

(f) Discharga for Reasons other than Physical Disability Indicated. When an addressea is of tha opinion that a mamber qualified for discharge by reason of physical disability, in accordance with this paragraph, should be dischargad by reason of unsuitability, unsatisfactory record, misconduct, or for other reasons, tha report of medical survey shall be forwarded via BUMED to BUPERS or MARCORPS, as appropriata, for final action.

(g) Tamporary Disposition. When the report of madical survay is submittad via BUMED to BUPERS or MARCORPS for final action and the member is a patient in a naval hospital, the commanding officer of tha naval hospital, whenaver he considers the mamber does not requira ratention, may relaase him from the sick list and transfar him in a duty status to an appropriate duty station to await Navy Department action. Navy personnel should ba transferred from the hospital to the nearest naval raceiving station. Marine Corps parsonnal should be returnad to the organization on whose rolls they are carried. Tha commanding officer of the naval hospital shall indicata in his andorsement on the report of madical survay the tamporary disposition effected; and shall furnish an extra copy of the report to the new duty station. At tha discretion of the commanding officer of tha naw duty station, with the advice of the station medical officer, these members may ba assigned such specific duties as are compatibla with and will not aggravata their physical conditions while awaiting action of BUPERS or MARCORPS.

6. Administrativa Discharge of Mambers Not Suitable for Military Service Because of Medical Conditions Not Constituting Physical Disability.

a. Boards of medical survey shall submit reports on those members on the sick list who are unfit for service by reason of one of the below listed conditions, except when medical board action is indicated as noted in the next subparagraph.

Addiction (drug)
Aggressive reaction
Alcoholism
Antisocial personality
Asocial (amoral) personality
Cyclothymic personality
Maladjustment, situational, acute
Mental deficiency, primary
Motion sickness
Paranoid personality
Passive-aggressive reaction
Passive-dependency reaction
Emotional instability reaction
Inadequate personality
Immaturity with symptomatic habit reaction
Primary childhood behavior reaction
Schizoid personality
Specific learning defect
Sexual deviate

The composition of boards of medical survey shall, with due regard to availability of qualified reservists, and the categories, regular and reserve, which may be considered by the board, provide in the membership of the board, to the fullest practicable extent, fair and adequate representation of members from the reserve components.

b. The above conditions constitute inherent preexisting defects or the results thereof and warrant discharge for administrative reasons when functional usefulness is impaired thereby to such extent as to cause military unfitness. Such conditions are to be distinguished from those which cause physical disability which is ratable under reference (d) and thereby incapacitate an individual so as to warrant retirement or separation for physical disability. When any of these defects represents an inherent condition, rather than the secondary result of disease or injury, it is to be reported upon by a board of medical survey; whereas, when any such defect represents the secondary effect of disease or injury, it shall be reported upon by a medical board.

c. Authority to Discharge. Commanders naval training centers, commanding officers naval receiving stations CLUSA, and commanding officers naval hospitals CLUSA are hereby authorized to discharge enlisted or inducted members, other than female members, of the Navy and Naval Reserve, on active duty, when discharge for one of the conditions listed in paragraph 6a is recommended; and commanding generals and commanding officers Marine Corps activities CLUSA are hereby authorized to discharge enlisted or inducted members, other than female members, of the Marine Corps or Marine Corps Reserve, on active duty, when discharge for one of the conditions listed in paragraph 6a is recommended; provided:

(1) The member concerned does not have a diagnosis of Addiction (drug), Alcoholism, Asocial (amoral) Personality, or Sexual Deviate;

(2) The member concerned has less than eight years' active service; and

(3) The member concerned indicates in writing that he has been informed of the findings and does not desire to submit a statement in rebuttal.

d. Procedure and Reports

(1) In those cases involving Navy personnel at Marine Corps activities and Marine Corps personnel at Navy activities, transfers shall be effected for discharge and reports submitted, as in subparagraphs 5b(3)(a), (b), (c) and (g) above, except that statements of members as required by paragraph 6c(3) above, declining to submit a statement in rebuttal, shall be forwarded instead of certificates relative to a full and fair hearing which have no application in the absence of a physical disability.

(2) Reports of medical survey wherein discharge is recommended and the individual surveyed is a female member or any of the following eventualities occur shall be forwarded via BUMED to BUPERS or MARCORPS, as appropriate, for final action:

(a) The member submits a statement in rebuttal.

(b) The member has completed eight or more years of active service.

(c) The member has a diagnosis of Addiction (drug), Alcoholism, Asocial (amoral) Personality, or Sexual deviate.

(d) The addressee having authority to take final action considers that the member should be discharged by reason other than convenience of the government, or otherwise considers it preferable to forward the report via BUMED to BUPERS or MARCORPS, as appropriate, for action.

Cases in this category would be those where the record shows commission of serious offenses, the conduct marks are generally unsatisfactory, or addressee has other good and sufficient reasons. In submitting recommendations for discharge by reason of unsuitability, unfitness, misconduct or for other reasons, in these exceptional cases, the procedures prescribed as applicable articles in BUPERS and MARCORPS manuals shall be followed.

(3) Normaliy, the reason for discharge in the inherent-pre-existing-defect-type cases shall be convenience of the government. There shall be entered on the reverse side of the discharge certificate abreast the entry "Authority": (a) for Navy personnel, article C-10306(g) BUPERS Manual 1948, and this instruction; or (b) for Marine Corps personnel, paragraph 10271, Marine Corps Manual, and this instruction. The reason and authority for discharge shall be entered in the service record.

7. Authority to Make Other Dispositions

a. Commanders naval training centers, commanding officers receiving stations CLUSA, and commanding officers naval hospitals CLUSA are hereby authorized to take final action on medical survey reports in the case of enlisted or inducted members, including female enlisted members, of the Navy and Naval Reserve, on active duty, and commanding generals and commanding officers Marine Corps activities CLUSA are hereby authorized to take final action in the case of enlisted or inducted members, including female enlisted members, of the Marine Corps Reserve, on active duty, as follows:

(1) When the recommendation of the board is "return to duty."
(2) When the recommendation of the board is "retention for further treatment."

b. When final action is taken in accordance with this paragraph, the original and one copy of the report shall be forwarded via BUMED to BUPERS or MARCORPS, as appropriate, indicating by endorsement thereon the action taken.

8. Effect of Discharge. Discharges effected pursuant to the authority contained herein will not only serve to terminate the current enlistment contract but also any additional service obligation which may have been incurred.

9. Forms and Reports

a. Certificate Relative to Full and Fair Hearing. When an enlisted or inducted member having a physical disability which was not incurred in or aggravated by service certifies that he does not demand a full and fair hearing in accordance with paragraph 5b(1)(c) and (d) above, such certificate shall be in the form prescribed in enclosure (1).

b. Dispatch Report in Disciplinary Cases. If, subsequent to appearance before a physical evaluation board, a member becomes subject to disciplinary action, a dispatch report, with information copy to the naval hospital which began the processing, shall be submitted to BUPERS or MARCORPS, as appropriate, in accordance with paragraph 5a(1) above, stating action taken or contemplated.

J. L. HOLLOWAY, JR.
BUPERS
H. L. PUGH
BUMED

G. C. THOMAS
ACTING, MARCORPS
Approved: 19 May 1953

JOHN F. FLOBERG
Assistant Secretary of the Navy for Air

CERTIFICATE RELATIVE TO A FULL AND FAIR HEARING

.....
(date)

I hereby certify that it has been fully explained to me that the Board of Medical Survey before which I appeared has found that I am suffering from a physical disability, namely (Diagnosis), which was not incurred in, or aggravated by, a period of active service after 1 October 1949.

I further certify that it has been fully explained to me that under section 413 of the Career Compensation Act of 1949 and the regulations prescribed by the Secretary of the Navy of the administration of Title IV of the Career Compensation Act of 1949 I am entitled, as a matter of right, to a full and fair hearing before a Physical Evaluation Board if I demand such hearing.

I further certify that it has been fully explained to me that unless I demand a hearing before a Physical Evaluation Board I shall be discharged from the Naval Service in the near future without further hearing and without disability retirement pay or severance pay and without any compensation whatsoever.

With full knowledge of the findings of the Board of Medical Survey convened in my case and with full knowledge of my rights in this matter, I hereby certify that I do not demand a hearing before a Physical Evaluation Board and request that I be administratively discharged from the Naval Service as soon as possible.

Witnessed by:

....
(Signature)

.....

.....

Subscribed and sworn to before me this ..... day of ....., 19....., I having the authority to administer oaths.

.....
(Signature)

.....
(Rank)

DEPARTMENT OF THE NAVY
Bureau of Medicine and Surgery
Washington 25, D.C.

BUMED 5700.1
BUMED-31-LHM
29 December 1952

BUMED INSTRUCTION 5700.1

From: Chief, Bureau of Medicine and Surgery
To: Naval Hospitals, Hospital Ships, and Stations Having Medical Officers Attached
Subj: Red Cross activities in the Naval Medical Department
Ref: (a) Art. 3-37, ManMedDept (The American National Red Cross)
(b) Art. 21-25, ManMedDept (Representatives of the American Red Cross — medical care)
(c) Ch. 23, Sec. VIII, ManMedDept (Release of Information From Records)
(d) Art. 25-11, ManMedDept (Donations)
(e) Appendix A, ManMedDept (Treaties and Conventions)

1. Purpose. To provide information and consolidate directives, in addition to those contained in references (a) through (e), concerning the American National Red Cross and the Naval Medical Department.

2. Cancellations. This letter supersedas and cancels BUMED Circular Letters 51-143 and 52-31.

Section I. RED CROSS PROGRAM OF SERVICES

3. Approval of Program. Tha Secratary of Defansa and the President of the American National Red Cross have approved the following summary of the program of services rendered by the Amarican Rad Cross to patients in medical facilities of the Armed Forces.

4. Needs Based on. The Red Cross program of services to tha Armed Forces is based upon clearly damonstrated needs recognized by the military astablishmant, and the measures taken by tha Red Cross to meet such naeds have received official militery sanction.

5. Cooperation With Military. Acting through its local chapters and through a national organization staff assigned to military installations within continental United States and to occupation araas and thaaters of operation throughout the world, tha Red Cross cooperates closely with the military authorities, supplementing and assisting in tha activities of tha military astablishmant with respect to the health, welfara, and morala of military personnel.

6. Volunteers and Others. In addition to its full time staff with the Armed Forces and in many chapters, all Red Cross activities for the benefit of mambers of the Armed Forces and their families are sustained by Red Cross volunteers serving in mora than 3,700 chapters, in naarly 5,000 branches of chapters, and in military installations. Tha voluntary affort of the representatives of many othar agancias and groups is channeled and coordinated through Red Cross chapters and through Red Cross Camp and Hospital Councils representing many chapters and local agencias in the vicinity of military installations.

7. When Furnished. The Red Cross program functions in periods of peace as wall as in periods of war. In time of war or whan war is threatened, the program is extandad to include activities and services not ordinarily required in time of paace.

8. For Whom. The Red Cross serves the man and his family as a unit. Its program has baen designed, on tha one hand, to help men and women serving in the Armed Forces, whether on duty or in military hospitals, and, on the other hand, to help the familias and dependants of those in military services resident in communities throughout the United States.

9. Services Furnished. Subject to such administrative regulations governing military welfare and recreation as may be prescribed, tha Red Cross, acting in close cooperation with commanding officers, conducts a program consisting of the following servicas. These servicas will not duplicate nor parallel any Governmantal provisions, although with the approval of tha proper authorities they may supplement such provisions.

a. Walfare Sarvices For Patients, Families, Depandents. In order to meet Red Cross responsibilities certain activities ara nacessary in bahalf of servicemen and thair families in paace or war. These may become necessary because of tha saparation of tha man from his family, tha interruption of his usual way of life or bacausa of tha hazards and casualties causad by war. These services are offarad to maintain or improve morale by keeping servicaman informad of home conditions and families informed concerning the welfara of the sarvicemen and by supplamenting the social resources when nacessary. Assistance may be given to the serviceman and to the military through the sacuring of information which may aid in medical and military decisions. The following services may be given:

(1) Counseling. Counseling with servicemen on personal and family problems.

(a) For patients:

1. Securing from chapters assistence to the serviceman and his family with personal and family problems that may affect morale.

2. Counseling with servicemen about to be discharged regarding plans for reentry to civilian life.

(b) For families and dependents:

1. Counseling with families of patients in personal and family problems.

(2) Financial Assistance.

(a) For patients:

1. With the approval of commanding officers, financial assistance by loan or grant to patients without sufficient funds to return home if practicable, because of sickness, death, or other major emergencies in the immediate family.

2. Upon recommendation of medical officers, financial assistance to enable patients in military hospitals to take advantage of leave for the purpose of recuperating from illness, when local Red Cross chapters report that home conditions are favorable to convalescence.

(b) For families and dependents:

1. Providing, by the use of Red Cross funds or by referral to other resources, financial assistance needed by dependents of servicemen in emergencies.

(3) Reporting and Communications.

(a) For patients:

1. Assisting with communications between patients and their families and with inquiries concerning location and welfare.

2. Transmitting or requesting information through Red Cross channels when direct communication fails or will not meet the need.

3. Obtaining reports of home conditions at the request of commanding officers to secure confidential information required for the adequate consideration of matters pertaining to discharge or leave of absence.

4. Obtaining, upon the request of appropriate officers, social, medical, or other specified data, to be used as an aid in dealing with the problems of military personnel in disciplinary status.
29 December 1952

5. Provide a channel of communications for obtaining, upon request of medical officers, social, medical, or other data to be used as an aid in determining diagnosis, treatment, and other military disposition of patients in military hospitals.

(b) For families and dependents of patients:

1. Guidance concerning direct communication between the family and the serviceman.

2. Transmitting or requesting information through Red Cross channels when direct communication will not meet the needs.

3. Reporting to the families of seriously or critically ill patients in military hospitals, following the official notification sent by hospital authorities, giving such additional information concerning the patient's condition and personal situation as may be desired by the hospital authorities.

4. Reporting to the families of servicemen who die in military hospitals, following the official notification, giving such additional information as may be advisable in the opinion of medical officers.

(4) Information.

(a) For patients:

1. Provide information to patients concerning federal and state benefits available to them or their dependents while in service or after discharge, and assistence in applying for such benefits. Also providing information regarding various community resources available for specific services.

2. Inform servicemen about to be discharged regarding the Government's provisions and regulations for benefits to which they may be entitled.

(b) For families and dependents:

1. Informing the families of servicemen regarding Government provisions for their benefit and assisting them, where necessary, in the preparation of application forms and other necessary papers.

(5) Referral.

(a) For patients:

1. Referring service personnel to appropriate specialized agencies to obtain services and benefits that are available to them. These include legal aid services, personnel services by the military, post discharge employment, and the like.

(b) For families and dependents:

1. Informing families of specialized agencies and assisting them in obtaining services that are available to them covering such matters as employment, medical care, child welfare provisions, and legal aid.

(6) Assistance to Relatives Visiting Military Installations.

(a) For patients:

1. Providing for the comfort and care of relatives who visit patients, particularly those who are summoned to hospitals because of serious illness, and assistance in emergencies to relatives visiting able-bodied personnel.

(7) Comfort Supplies. Providing comfort and chapter-produced articles for military patients temporarily without funds or to whom such articles are not accessible, the articles having been approved through understandings with the military authorities. Similar articles may be furnished also to active duty personnel in emergencies.

b. Recreation Service to Patients. The Secretary of Defense and the President of the American National Red Cross have approved the following summary of the Recreation Service in the American National Red Cross Program in Military Hospitals.

(1) Recreation service to military patients is based upon the conviction that recreation is helpful in sustaining and cultivating morale favorable to treatment and in developing human capacities. Many patients have a considerable amount of leisure time in the hospital. Failure to provide for constructive use of this time can result in its being a demoralizing factor, whereas, the provision of opportunities to participate in recreational activities suited to the mental, emotional, physical, and social capabilities of the individual assists in producing a healthy and optimistic outlook. Although some patients in military hospitals have personal recreation resources, the majority need leadership and guidance in finding activities that provide a recreational outlet for them.

(2) The conduct and coordination of suitable recreation activities for patients is a part of the total program of service to the military provided by the Red Cross acting in its capacity as liaison between the community and the serviceman. The program is conducted with military medical approval and in conformity with military regulations. Recreation service is implemented through both nationally employed and chapter personnel of the Red Cross. National funds are allocated for staff personnel and for basic supplies and equipment. Chapters provide volunteer workers and whatever supplemental equipment and materials they can. Since the Red Cross serves as a channel for the participation of the entire American public in providing recreation service to patients, its program includes the coordination of suitable activities offered by non-Red Cross groups and individuals. The chapters encourage community groups or individuals to provide service and material assistance.

(3) The American Red Cross hospital executive, when requested by the commanding officer to represent him, guided by his policies, accepts and coordinates in the recreation program the suitable services and materials offered by non-Red Cross groups and individuals.

(4) Included in the program content are:

(a) To provide during the leisure time of patients, recreational opportunities that meet the interests of patients, are adapted to their medical limitations, and contribute to their adjustment to hospitalization and medical treatment.

(b) To assist patients in the redirection of their recreational interests and pursuits when such redirection is indicated by medical limitations during and/or following hospitalization.

(c) To assist patients who lack recreational interests to acquire and pursue them.

(d) To assist patients to have fully enjoyable recreation experiences both in social groups and individually.

(e) To encourage the broadest possible voluntary participation in recreation that is consistent with the medical treatment program.

c. Health and Safety Services. Extension to military installations of instruction in water safety, first aid, home nursing and nutrition. Classes in such instruction are organized, as appropriate and as approved by responsible military authority for servicemen and their families. Many commanding officers have recognized the remedial value of aquatics in reconditioning servicemen. Families of servicemen benefit greatly through training in home nursing and nutrition.

d. National Blood Program. Cooperating with the military in obtaining donations of blood through the Red Cross regional and other blood centers and providing whole blood and blood derivatives to military hospitals when requested.

e. Volunteer Services. The assistance of chapter volunteers is extensively used in carrying out the foregoing responsibilities and also those that follow. Red Cross volunteers serve in activities such as canteen service, entertainment and instruction service, motor corps, social welfare and production, all of which are vitally important to the functioning of the Red Cross with the Armed Forces.

f. Additional Red Cross Services in Time of War. In time of war or when war is imminent, when requested by the military, the Red Cross will, in addition to the foregoing services, undertake responsibility for the following:

(1) Amplify its social welfare, recreation, and moral activities for patients with the approval of the Department of Defense, as may be necessary to meet existing conditions.

(2) Provide additional trained personnel to assist with recreation for patients and with the coordination and utilization of volunteers in connection therewith.

(3) In theatres of war, cooperate with the military. The Red Cross will also enroll local volunteers. The program may include recreational facilities and activities including dances, motion picture shows, reading and recreation rooms, information booths, tours to places of interest, etc. Snack bar services and refreshments at parties, dances, and special events may be included.

(4) Provide supplemental recreation supplies and equipment, recognizing that the Government has the primary responsibility. The Red Cross will undertake to meet temporary needs due to unforseen situations, such as the temporary unavailability of regular Government supplies.

(5) Provide all of the foregoing services that are applicable to mobile hospital units, hospital ships, hospital trains, ambulances, planes and rest homes.

(6) Provide the following services not applicable to medical facilities of the Armed Forces.

(a) Assistance to Prisoners of War.

1. Handling inquiries as to welfare through the International Red Cross Committee after appropriate clearance with Department of Defense.

2. Obtaining, through the Department of Defense, names of prisoners of war so that Red Cross services may be available to their dependents, if necessary.

3. Providing supplementary food packages, clothing, medicine, comfort articles, and other supplies, distributing them to prisoners of war through the International Committee of the Red Cross.

Section II. RELATIONSHIP OF RED CROSS PERSONNEL TO COMMAND

10. Status. Personnel employed by the Red Cross and assigned to facilities of the Medical Department of the Navy have the status of members of the staff of the facility. They provide the services of the foregoing program for both patients and personnel of the staff. As members of the staff they must conform to the routine of the establishment and must comply with the instructions of the commanding officer.

11. Cooperation. They should confer with medical officers regarding patients for whom Red Cross services are requested and may be granted access to the medical records of such patients. They must have free access to the wards in order effectively to render services to patients.

12. Title and Responsibilities. The senior Red Cross representative assigned to a Medical Department facility carries the Red Cross title, Field Director. She is responsible to the commanding officer for conducting the Red Cross program in that facility and will represent the Red Cross in all relationships with him. In the Red Cross organization the Field Director is administratively responsible directly to the appropriate Red Cross area office. The Field Director provides technical supervision and coordinates the work of Civil Service personnel carrying on medical, or psychiatric social work in naval hospitals. Upon the request of the commanding officer, the Field Director will take steps to recruit volunteers to be trained with the assistance of the staff of the hospital, to augment the paid Red Cross staff. Trained volunteers serve under the direction of the Field Director, and may be assigned to activities of the Red Cross program or to other activities of the establishment. The Field Director may represent the commanding officer, upon his request, in coordinating the efforts of individuals and groups in the community who desire to serve the hospital.

Section III. SPACE, SUPPLIES, AND MAINTENANCE

13. Providing for. The commanding officer shall provide Red Cross personnel with adequate space which will be readily accessible to the medical staff and patients and will afford privacy for interviews. Office supplies and equipment may be provided, when available, from Government sources. Maintenance, including cleaning supplies and services, of spaces assigned for Red Cross activities, will be provided at no charge to the Red Cross.

Section IV. MOTION PICTURES

14. Program. The Red Cross is authorized to conduct a program of 16 m.m. motion pictures in the wards of activities under the management control of the Bureau.

15. Ward Movie Operators. Enlisted men may be detailed as projectionists in addition to their regular duties. They should be instructed in operation of the projectors and correct handling of films, in order that every precaution will be taken to prevent careless handling and damage to the film. Men so detailed will receive extra compensation from the Field Director at a fixed rate per show.

Section V. CONFIDENTIAL STATUS OF REPORTS

16. Obtaining and Handling. The collection of social data is an important phase of Red Cross activity in naval hospitals. Such social case histories are usually obtained by local chapters and cooperating civilian agencies and individuals with the understanding that the information will be held and treated as confidential. Case reports obtained from or through the Red Cross shall be held as strictly confidential and provision shall be made to prevent the reports falling into the hands of unauthorized persons. Under no circumstances shall information as to the contents of a Red Cross report be communicated to the patient, his relative, friends, or other unauthorized persons. Such reports shall not be included in clinical records of patients, nor in the records of proceedings of physical evaluation boards. Information contained in social service reports may be embodied in the clinical records by abstracting the information and incorporating it as part of the case history without identification of its source, in a manner similar to that employed in entering case material obtained from sources other than the physician's history; verbatim copying shall not be employed.

17. Requests To Be Specific. In order that this service may function effectively and to reduce the compiling of irrelevant material to a minimum, requests for social data should plainly outline the scope and kind of information desired in each case and should be made as early as possible.

Copy to:
COMDTsNDs&KCs

H. L. PUGH

DEPARTMENT OF THE NAVY
BUREAU OF NAVAL PERSONNEL
WASHINGTON 25, D. C.

In reply refer to
Pers-B22-jw
3 December 1951

From: Chief of Naval Personnel

To: Commanding Officers, All Recruit Training Commands

Subj: Procedure for Physical Profiling of Enlisted and Inducted Male Recruits

Ref: (a) BuPers C/L 65-51, NDB 30 April 1951, folio 51-297
(b) Army Regulations 40-115
(c) BuPers-BuMed-MarCorps Joint Letter Pers-B222-JMS P19-1 BUMED-33-RAB P3-1/P19-1 C/L 51-34, MARCORPS DM-1577-j1 dated 19 February 1951
(d) BuPers-BuMed-MarCorps Joint Letter Pers-77-JMS P3-5 BUMED-3352-FGS P3-1/P19-1 C/L 49-19, MARCORPS 1500-10 dated 24 February 1949
(e) BuPers-BuMed-MarCorps Joint Letter Pers-B22-MK P3-1/P19-1 BUMED-33 P3-1/P19-1 C/L 51-106, MARCORPS DM-1577-j1 dated 13 July 1951
(f) BuPers-BuMed-MarCorps Joint Letter Pers-66-CED P3-5 BUMED C/L 50-15, MARCORPS DM 1577 dated 3 February 1950
(g) Recruiting Service Manual of the U.S., Instructions 232.2
(h) Article C-5210, BuPers Manual

1. GENERAL INTRODUCTION

Reference (c) provides that the physical standards required of all male applicants for enlistment or induction shall be those prescribed in reference (b), effective 1 May 1951. Reference (g) provides for the establishment and recording of the physical profile in the case of all members enlisted or inducted. Reference (c) provides that no person (with certain exceptions) enlisted or inducted shall be discharged for medical reasons or recommended for retirement for physical disability if his physical profile serial is at the minimum or higher than the minimum profile serial acceptable for induction under the standards established in reference (b). It is necessary to properly identify all personnel who are not fit for full duty (sea duty) in order to assign them to duties commensurate with their physical capabilities. It is the intent of this letter to: (a) require the verification of physical profile of all trainees after a period of observation, in accordance with the PULHES system, (b) direct the assignment of appropriate limited duty designators as provided for in reference (h) to standards and are considered capable of performing useful service, (c) establish procedures for assignment and accounting for personnel found not fit for full duty.

2. PROFILING:

A. Initial Profiling . . . The initial profiling of enlistees or inductees is accomplished at the recruiting station, armed forces examining station, or induction station at the time of enlistment or induction. This is done by the medical examiner on the basis of physical facts alone. By separate instructions, all recruiting stations have been directed to enter the enlistee's physical profile and physical category on the reverse side of the original, duplicate, and Part 2 of the Enlistment Contract. The duplicate thereof is filed in the individual's service record.

B. Verification of Initial Profile — The initial profile assigned at time of enlistment or induction will be verified by physical profile boards at the recruit training commands. (See following paragraph for description of these boards.)

3. PHYSICAL PROFILE BOARD

Commanding Officers, Recruit Training Commands, are directed to establish physical profile boards for the purpose of verifying the physical profiles of recruits under their cognizance. These boards shall be composed of a minimum of three officers, two of whom shall be line officers and one a medical officer. At least one of the line officers shall have experience in duties afloat and one shall be experienced in the field of personnel classification. These boards will verify or change the initial profile of each recruit based upon observed performance of duty as well as physical examination (if required). This verification may revise the profile either upwards or downwards. In addition to verifying the physical profile serial assigned, the physical profile board shall determine if the recruit is physically qualified for full duty (sea duty). A limited duty classification designator shall be assigned in accordance with reference (a) in addition to the physically qualified for full duty (sea duty), (b) but meet the physical standards for enlistment or induction, and (c) do not fall within one of the three exceptions listed in reference (c). Full duty (sea duty) as used in this directive includes persons assigned either designator L-2 or L-3.

4. DISPOSITION

A. Recruits shall be reported available for assignment provided their verified physical profile serial is at the minimum or higher than the minimum for enlistment or induction and provided the member does not fall within any of the exceptions listed in reference (c).

B. Recruits whose verified physical profile serial is below the minimum standard for enlistment or induction and who are not physically qualified for full duty (sea duty) and recruits who fall within one of the three exceptions listed in reference (c) shall not be reported as available for assignment but shall be processed for discharge or retirement in accordance with current directives.

5. REPORTS

Separate instructions will be issued for reporting recruits available for assignment according to limited duty designations.

6. RECORDING

A. The verified Physical profile (complete), and the L designator if appropriate and when assigned, will be entered on page 13 of the individual's service record in accordance with the following examples:

Example #1: .....
Date

P U L H E S
1 1 2 1 2 1

Verified profile: "B." Qualified for full duty.

.....
Signature

Example #2: ....
Date

P U L H E S
1 1 1 1 1 1x

Verified profile: "A." Assigned limited duty designator L-5*

*This type case should occur very infrequently.

.....
Signature

Example #3: .....
Date

P U L H E S
2 3x3 1 3 1

Verified profile: "C." Assigned limited duty designator L-4.

.....
Signature

Example #4: .....
Date

P U L H E S
1 3 2 3 1 1

Verified profile: "C." Qualified for full duty.

.....
Signature

NOTE:

Suffix "x" should follow the appropriate grade (serial) as illustrated, and indicate that the individual is not fit for full duty (sea duty) in Example #2 because of a defect in the "S" factor and in Example #3 because of a defect in the "U" factor. This suffix shall be used in all similar cases, where appropriate, in addition to those serials authorized under paragraph 7 of reference (b).

B. The L designator will also be entered in parentheses as a standard part of each such person's identification in accordance with paragraphs 2 and 3 of reference (h) and the example set forth therein.

7. Attention is invited to the fact that authority herein, granted to assign L designators to recruits and recruits only is an authorized exception to the provisions of paragraph 2 of refernce (h).

8. This directive is effective upon receipt.

/s/ L. T. DUBOSE

Copy to:
Comdts, All Naval Districts and River Commands, CLUSA
CinCPac
CinCLant
ComSerPac
ComSerLant
ComEastFron
ComWestFron

NavMed Res Form 1
5-20-52

STANDARD MEDICAL SCREENING FORM A [_____]

PERSONAL INFORMATION

..... Billet or Process No. .....
(Recruit Training Facility) Platoon Number (Marine Corps Only).....

1. Name..... Today's date.....
Last First Middle

2. Age..... Where were you born?..... Date of birth.....
City State Mo. Day Year

3. Rank or Rate..... Circle one: USMC USMCR USNR-SS USMC-SS USN USNR USNR-SV USMC-SV Service Number.....

4. Permanent home address.....
Street or RFD City State

5. Where is your permanent home located? On a farm..... In a small town..... In a city.....

6. Where did you get your last medical exam for the service?.....

7. Check branch of service you really wanted: Air Force..... Navy..... Marine Corps..... Army..... Other.....

8. Are you now (check one): Single..... Married..... Widowed..... Divorced..... Separated.....

9. Do you have any children? Yes..... No..... How many living?..... How many dead?.....

10. Circle highest grade completed at school: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

11. Draw a line under any of the above numerals to show school grades you failed or repeated.

12. How old were you when you quit school?..... Your race? Caucasian..... Negroid..... Other.....

13. What is your religion?..... How often do you attend church? regularly ..... often ..... seldom ..... never .....

14. Where was your father born?..... How far did he go in school?.....

15. Where was your mother born?..... How far did she go in school?.....

16. Check if any of the following applies to your parents:

	Your age when this happened:
Mother dead	.....
Father dead	.....
Parents separated	.....
Parents divorced	.....
I was adopted	.....

17. How many brothers do you have?..... How many brothers older than you?.....

How many sisters do you have?..... How many sisters older than you?.....

18. Did you ever play on an athletic team? Yes..... No..... Were you ever captain? Yes..... No.....

19. What sports have you taken an active part in?.....

20. What previous military service do you have?..... How long?.....
(This includes National Guard or any Reserve time)

21. How many jobs have you had since you left school?.....

22. What was the longest you ever worked at any **ONE** full-time job?..... Years..... Months. What was it?.....

23. How did each of your parents (or guardian) feel about your enlistment? Check space below which shows their attitude.

	Refused to give permission	Recommended against it	Left it up to you	Liked the idea	Recommended it strongly
Father:	.....	.....	.....	.....	.....
Mother:	.....	.....	.....	.....	.....
Guardian (if you had one):	.....	.....	.....	.....	.....

24. What was the longest time you ever spent away from home? Years..... Months..... Days.....

25. If you weren't drafted, why did you enlist?.....

.....

1 2 3 4 Initial Rating..... .....MD *(DO NOT TURN THIS PAGE UNTIL TOLD TO DO SO)*
Examiner

1 2 3 4 Final Rating.....MD
Examiner

If your answer to a question is "Yes," place an "X" in the box to the left of the number.
If your answer to a question is "No," leave the box blank.

- ☐ 1. Do you feel that you will have trouble making good in the service?
- ☐ 2. Are you often worried or upset?
- ☐ 3. Have you ever been fired or asked to resign from a job?
- ☐ 4. Could you do more for your country in a civilian job than in the service?
- ☐ 5. Do you have any particular physical or health problem?
- ☐ 6. Did you parents bring you up more strictly than other kids?
- ☐ 7. Do you sometimes get violently angry without too good reason?
- ☐ 8. Are you ever troubled by a sick headache?
- ☐ 9. Are you deliberate about deciding on a course of action?
- ☐ 10. Are you very good in standing up for your rights?
- ☐ 11. Are you often ill at ease around your friends?
- ☐ 12. Do you ever feel you have more than your share of bad luck?
- ☐ 13. Did you ever go steady with one girl before you were 15?
- ☐ 14. Did you dislike going to school as a kid?
- ☐ 15. Are you bothered often by having an upset stomach?
- ☐ 16. As a kid did you feel you were often punished unfairly?
- ☐ 17. Did you ever have a very unusual experience such as a "miracle"?
- ☐ 18. Do you ever have pains in the heart or chest?
- ☐ 19. Do you feel dissatisfied unless you are among the best?
- ☐ 20. Insofar as you know, were you considered a very healthy child?
- ☐ 21. Do you resent others trying to advise you?
- ☐ 22. Do you prefer to go around by yourself?
- ☐ 23. Do you have dates less often than most fellows your own age?
- ☐ 24. Have you had to make undue sacrifices by coming into the service?
- ☐ 25. Have you ever been bothered by having nightmares or frightening dreams?
- ☐ 26. When you were punished, was it usually more severe than other kids got?
- ☐ 27. Did you ever look in a mirror and think you might be someone else?
- ☐ 28. Does your skin break out easily?
- ☐ 29. Would you prefer to go steady with a girl instead of playing the field?
- ☐ 30. Do you feel that petting without being engaged is wrong?
- ☐ 31. Do you feel that your life has been unsuccessful up to now?
- ☐ 32. Are you ever bothered with nervousness?
- ☐ 33. Do you have trouble making friends?
- ☐ 34. Do you feel that others have more of a personal stake in the emergency than you?
- ☐ 35. Have you ever had dizzy spells or fainting spells?
- ☐ 36. Did you feel unable to ask your parents about very personal problems?
- ☐ 37. Have you ever smoked reefers or taken dope?
- ☐ 38. Have you ever been troubled by cold sweats?
- ☐ 39. As a kid did you have trouble with stuttering or stammering?
- ☐ 40. Do you consider your friends to be your equals?
- ☐ 41. Does the thought of ever going into combat frighten you very much?
- ☐ 42. Do people usually misunderstand you?
- ☐ 43. Have you ever been in trouble for drinking?
- ☐ 44. Do you feel that the privileges you now enjoy are not worth fighting for?
- ☐ 45. Do you often have trouble in getting to sleep?
- ☐ 46. Do you think you were loved more by one parent than the other?
- ☐ 47. Do you sometimes feel electric currents in your head?
- ☐ 48. Did you bite your fingernails often as a kid?
- ☐ 49. Have you wet the bed since you were 8 or 9?
- ☐ 50. Did you get into fights often as a kid?
- ☐ 51. Do people you know frequently dislike you?
- ☐ 52. Do you really like to fight?
- ☐ 53. Have you ever kept house for your father or some other man?
- ☐ 54. Do you feel that obligations of the military service are unfair?
- ☐ 55. Do your hands ever tremble enough to bother you?
- ☐ 56. Has anyone in your family ever had a nervous breakdown or been treated for their nerves?
- ☐ 57. Do you frequently drink just to get drunk?
- ☐ 58. Are you ever bothered by your hands sweating so they feel damp and clammy?
- ☐ 59. Did you ever have trouble with bed-wetting?
- ☐ 60. Do you get tight or drunk easily?
- ☐ 61. Do others often talk about you behind your back?
- ☐ 62. Do you often get down in the dumps?
- ☐ 63. Do you enjoy being with boy friends more than with girl friends?
- ☐ 64. Will your time in the service keep you from achieving your personal goals?
- ☐ 65. Are you frequently bothered by back pains?
- ☐ 66. Were either of your parents often mean or unkind to you?
- ☐ 67. Do you often get unreasonably jealous of your friends?
- ☐ 68. Do you bite your fingernails now?
- ☐ 69. Do you feel that it was unfair for you to be called into the Service at this time?
- ☐ 70. Do you suffer from asthma or hay fever?

NavMed Res Form 2
5-20-52

STANDARD MEDICAL EVALUATION FORM A

Date .....

From: ..... Number ..... Company or Platoon

To: OFFICER-IN-CHARGE, NEUROPSYCHIATRIC UNIT

Subject: (Recruit's Name) ..... Last First Middle Recruit's Service Number

AFQT Score ..... Navy Literacy Test Grade ..... Navy Non Verbal Test Grade .....
GCT Score ..... Weekly Test Marks .....

1. Subject named man has been under my observation .....days (or) .....weeks, and has completed .....days (or) .....weeks of recruit training.

2. It is my opinion that his aptitude for the Navy or Marine Corps is (circle one):
   Poor Average Good Outstanding
   a. His progress in training is (circle one): Downhill No Change Improving

3. The following has been noted with regard to this man's reactions to training and to his buddies:
   a. In the company or platoon as a group (check one):
      ..... He is often arguing and picking fights.
      ..... He does not let others push him around, but does not look for trouble.
      ..... He lets others take advantage of him.
   b. With regard to his ability to learn and use what he knows (check one):
      ..... He is unable to understand or carry out simple orders and instructions.
      ..... He is slow in learning but eventually gets it.
      ..... He seems to understand instructions but can't carry them out.
      ..... He has no difficulty learning or carrying out instructions.
   c. He responds to orders and instructions (check one):
      ..... Poorly and with resentment.
      ..... Accepting without comment.
      ..... With initiative and in a military manner.
   d. During free periods (check one):
      ..... He stays off to himself.
      ..... He is usually a part of the group.
      ..... He is a leader of group activity.
   e. With regard to himself and his clothes (check one):
      ..... He is objectionably dirty and untidy.
      ..... He is up to par with his shipmates.
      ..... He is unusually neat and clean.
   f. His interest in the Navy or Marine Corps (check one):
      ..... Is poor - sorry he joined.
      ..... Goes no farther than the fact it's a job.
      ..... Good. He's proud to be a bluejacket or a Marine.

4. During the time this recruit has been in my company or platoon, I have noted the following (Indicate "yes" or "no" for each):

Wet the bed	Unreliable	Sad and depressed .....
Walk in his sleep	Overboisterous	Tries to run outfit .....
Faint or have fits	Wrestling	Disobediant .....
Requests to go to sick call frequently		Wise Guy .....

5. I would like to keep this man in my outfit (check one): Yes ..... No .....

6. What other comments or remarks can you make about this man?: .....

.....

.....

Signature _____ Rank or Rate _____ Date _____
Company Commander or Drill Instructor

23 June 1952
NUMBER 1145.1

DEPARTMENT OF DEFENSE DIRECTIVE

SUBJECT Qualitative Distribution of Military Manpower — Modification

Effective 1 July 1952, pursuant to the provisions of the Secretary of Defense Directive of 2 April 1951, the following mental group designators, raw and percentile score ranges, and percentage quotas are established:

Mental Group	Raw Score Limits	Percentile Score Limits	Percentage Quota
I	81-90	93-100	9
II	65-80	65-92	28
III	47-64	31-64	36
IV	27-46	10-30	27

Percentile scores and mental level categories will be used in recording the results obtained on AFQT 1 — 2.

The minimum score for acceptance will continue to be AFQT percentile score 10.

This directive supersedes Department of Defense Directive Number 1145.1, dated 26 November 1951.

FOR THE SECRETARY OF DEFENSE:

MARSHALL S. CARTER
Brigadier General, U.S.A.
Director, Executive Office of the Secretary

30 June 1951
NUMBER 100.03-1

DEPARTMENT OF DEFENSE, United States of America

Department of Defense Directive, Washington 25, D.C.

TITLE 100 MANPOWER

SUBTITLE 03 MILITARY MANPOWER

NUMBER 100.03-1
Qualitative Distribution of Military Manpower — Modification

Pursuant to the provisions of the Universal Military Training and Service Act, Secretary of Defense Directive of 2 April 1951, Subject: Qualitative Distribution of Military Manpower, is amended to provide that the minimum score for acceptance will be AFQT converted score 10 (GCT 65 equivalent).

The following revised mental group percentage limits are effective 1 July 1951:

Mental Group	AFQT Percentile	Percentage Quota
I	93-100	8
II	65-92	31
III	31-64	38
IV	10-30	23

Secretary of Defense

The Secretary of Defense

Washington

2 April 1951

MEMORANDUM FOR THE SECRETARY OF THE ARMY
THE SECRETARY OF THE NAVY
THE SECRETARY OF THE THE AIR FORCE
THE JOINT CHIEFS OF STAFF

SUBJECT: Qualitative Distribution of Military Manpower

1. The following policies are hereby promulgated to provide for the qualitative division of military manpower accessions among the Services on an equitable basis. These policies are applicable to the procurement of personnel through induction or by voluntary recruitment. They will be implemented 1 May 1951 by the Army, Navy, Marine Corps and Air Force.

2. Policies of a general nature

a. Each service may continue voluntary enlistment programs, subject to necessary limitations imposed by this and any other pertinent directives.

b. The same minimum physical standards for acceptance will obtain for each service. These acceptance standards will be identical for enlistment and induction of males except for officer candidates and aviation cadets.

c. Qualitative distribution of personnel enlisted and inducted under common physical standards will be accomplished by quota control of accessions to each of the services in each of the four major mental groupings.

3. Male acquisitions (with the exceptions cited below), whether obtained by induction or enlistment, will be charged against the qualitative and quantitative allocations of the respective services.

Exceptions

a. Officer candidates and aviation cadets.

b. Individuals exempt (as distinguished from deferred) from induction as set forth in Section 6 of the Selective Service Act of 1948 as amended or other applicable legislation.

4. a. These policies will be administered under procedures prescribed by the Office of the Assistant Secretary of Defense, Manpower and Personnel.

b. When special requirements support such action, a service may request of the Secretary of Defense specific exceptions to proportionate qualitative distribution.

5. Detailed policies are outlined in inclosure 1.

G. C. MARSHALL

Enclosure — 1

POLICIES FOR QUALITATIVE DISTRIBUTION OF MILITARY MANPOWER ACCESSIONS AMONG THE SERVICES

1. In order to equalize the qualitative distribution of male personnel among the Armed Forces the following policies for distributing, processing and reporting personnel accessions, enlisted and inducted, on and after 1 May 1951 are established for the Army, Navy, Marine Corps and Air Force.

2. a. The basis for determining mental qualifications and standards of acceptance for enlistment will be the Armed Forces Qualification Test, expressed in terms of the Army-Air Force table of converted scores. Mental groups will be as follows:

Mental Groups	AFQT Percentile Score
I	93-100
II	65-92
III	31-64
IV	13-30
V	12-and below

The minimum score for acceptance will be AFQT converted score 13(AGCT 70).

b. The minimum for physical acceptance will be that established in AR 40-115 "Physical Standards and Physical Profile for Enlistment and Induction," as amended.

c. Accessions to each service will be statistically controlled by each Service in accordance with percentage quotas for each mental group to be prescribed from time to time by the Secretary of Defense. These percentages will be adjusted to maintain an essential balance among the services in accordance with the intent of this directive. Effective 1 May 1951 the following percentage quotas for enlistment by mental groups are established:

Mental Groups	Percentage Quota
I	8.0
II	32.0
III	39.0
IV	21.0

(1) The services will accept for enlistment, within each mental group established above, and in order of application so far as vacancies in any group exist, the normal distribution of AFQT individual scores and will not attempt to select from any arbitrary range of scores within each group.

(2) A shortage of enlistments in any one mental group may be filled by a corresponding average in lower categories. For example, a shortage of 5% in group II may be filled by adding 5% in group III; the 5% average in group III will be charged against the group II allocation. However, acquisition of personnel in a higher category in excess of the established percentages will not be permitted.

(3) Should any service fail in any two months to obtain by voluntary enlistment the specified number of accessions in any mental group, if not filled as in (2) above, such shortage will be filled in a subsequent month from among Selective Service registrants forwarded for induction. Thus, assuming a 10,000 objective for a given two months, recruiting effort should strive to produce the following:

I — 800, II — 3200, III — 3900, IV — 2100

However, assuming only 1600 are procured in group IV, and all other groups are filled, the required 500 will be procured in a subsequent month from among Selective Service registrants forwarded for induction in mental group IV. A shortage in Groups I, II or III would be similarly filled by inductions in the same or lower groups.

(4) Enlistments in excess of the percentages prescribed above will not be contracted in any one month for application against the percentage quota for any future month. Accepted enlistees will be applied against the percentage quota for the month in which they are accepted for service, and such enlistees must actually enter the service within that month, except as may be otherwise specifically authorized.

(5) The designated supervisory agency will submit to the Department of Defense and to each Service a monthly report of enlistments and inductions by mental groups and by mental-physical categories in accordance with procedures to be specified, using the prescribed standard reporting forms.

3. Effective 1 July 1951, mental and physical examinations of all chargeable accessions will be conducted at the main recruiting and induction stations now operated jointly by the Army and Air Force or by the Navy or Marine Corps. An agreed number of these will, on that date, be redesignated Armed Forces Examining Stations. Operating personnel at these stations will be augmented by Navy or Marine Corps or Army and Air Force personnel as required and agreed among the Services. In the interim period, Navy and Marine Corps accessions may continue to be examined in accordance with standards listed in paras. 2a and b at currently established Navy or Marine Corps examining stations.

SOCIAL HISTORY GUIDE—B
(Revised March 1946)

I. IDENTIFYING INFORMATION: Name of man, marital status, composition of family, where man makes his home, race, nationality, and religion.

II. SOURCES OF INFORMATION: List informants, their relationship to man, length of time they knew him. Describe what appears to be their present attitude toward him. Attitude toward the interview? What is their attitude toward serviceman's possible return home? Records consulted (Social Service Exchange, school, hospital, juvenile or other court records, and the like)?

III. DEVELOPMENTAL HISTORY: Give date and place of birth and any unusual factors connected with the birth. Was there a birth injury? Did he walk and talk at an unusually early or late age? Note anything unusual in development, such as feeding difficulties, stuttering, nail biting, fainting spells or convulsions, nightmares, sleepwalking, bed wetting longer than usual, special fears, temper tantrums.

IV. HEALTH AND MEDICAL HISTORY: General health record throughout life. Was man ever hospitalized for either medical or mental conditions? When? Reason? Any accidents or injuries, particularly head injuries? Severity and age when occurred? Secure details and a report from the doctor whenever possible. Usual reaction of man to illness of himself? Of a member of his family?

V. FAMILY HISTORY: What appear to be the general relationship and attitudes of the family group? How many brothers and sisters? How did he get along with brothers and sisters? His relationship to parents? How much responsibility did he take for parents before entering service? Are parents divorced? Are they foreign born? Is this a source of conflict? Religion? What has been the occupation of the father or head of the family? General financial status of family through the years? If either parent is dead, what age was the man at the time of the death and how did he react to it? Were methods of child training oversevere or overindulgent? How was he punished? Was there an extreme attachment of the man to any member of the family? Any unusual facts regarding the health history of family? Is there any history of mental illness, suicide, epilepsy, criminalism, drug addiction, alcoholism, and the like, in the immediate family?

VI. PERSONALITY: In general, what kind of person is he? Did he play alone or with groups? Was he a leader, or was he shy and always the follower? Timid, overly modest, or a show-off? Did he have a sense of duty? Calm or high strung? What were his interests and hobbies? How did he usually spend his leisure time? Did he have pets? Was he cruel to animals? If so, at what age? Was he happy-go-lucky or responsible? Were there any marked changes in habits, interests, and attitudes at the time of adolescence? Did he have girl friends? Older or younger? Approved or disapproved socially? Did he have any strong attachments to boys? Describe any unusual interest in religion. What were his ambitions? Did he ever run away from home or show nomadic tendencies? What was his reaction to authority? Did he get into fights? Was he afraid of fighting? Were there any outstanding behavior problems?

VII. PERSONAL HABITS: Sexual adjustment of man, particularly if irregular in any way? If married, at what age? What has been his adjustment to marriage? Does the wife feel that they have been happy together? Any separations? Describe the wife, something of her interests and the amount of responsibility she takes in the home. What has been the attitude of the man toward his children? His relationship with them? Alcoholism or drug addiction?

VIII. EDUCATION: How far did he go in school? Regularity of attendance, and failure or promotions? Reasons for leaving and age? How well did he do in studies? Did he have any special interests or outstanding difficulties in school subjects? Were there any particular problems of behavior or of adjustment to teachers and fellow students? Include here reports of any psychological tests given by schools, clinics, or institutions.

IX. EMPLOYMENT: What was serviceman's main former occupation? Longest job held? What did his employers think of his performance? Did he advance? What other kinds of work has he done? Length of time? How did he get along with his fellow workers?

X. MILITARY:
a. What was his attitude on enlisting or being inducted? Did he fear coming into Navy, or did he want to? Did he feel that his family would miss his financial support?
b. What was family's reactions when he first entered service? Have they tried to help him make an adjustment? How?
c. If he was AWOL or deserted from the Navy, did he stay with his family?
d. If AWOL or in desertion, did he work and help support his family? What did he do?

AR 40-115

Section XXII

PSYCHOSES, PSYCHONEUROSES, AND PERSONALITY DISORDERS

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79. General considerations. The object of the psychiatric examination is to procure men who are without psychiatric disorders of such a degree of severity as to make impossible their rendering effective military service. To be effective, a man must have had the capacity, as demonstrated in civilian life, to function and adapt effectively.

80. Routine procedure. The diagnosis of psychiatric disorders depends on whether an individual possesses qualities or patterns of behavior of such a nature and severity as to have seriously handicapped him in the conduct of his private life and affairs and/or in his interpersonal relationships. The evaluation of such factors in a man is accomplished by psychiatric examination and a knowledge of his past history. The latter may be gathered together from various sources; the man himself, his physician, the medical survey forms provided by the Selective Service System, hospital and court records, and other social service or welfare agencies. Attention will be given not only to unfavorable or negative data in the history, but also to the favorable or positive data, since a history of good adjustment in the past may be reasonably accepted as favoring a good adjustment in the military service as well.

81. Minimum psychiatric examination. a. Mental and personality difficulties are most clearly revealed in the subject's behavior toward those with whom he feels relatively at ease. The most successful approach is often one of the straightforward professional inquiry coupled with real respect for the individual's personality and due consideration for his feelings, which does not mean diffidence. The routine or habitual use of questions that are emotionally charged, psychologically shocking, in bad taste, and are not customarily used in comparable civilian examination and practice, will be avoided.

b. The psychiatric examination will be made (at the end of the medical investigation) outside of easy hearing of other men. Matter of diagnostic significance is often concealed when the individual feels that he must be impersonal and give replies that will not impress listeners with his peculiarity.

c. Questioning will begin with something that is obviously relevant to the immediate situation. Information is elicited as to whether the individual suffers any symptoms of a psychiatric nature, and as to whether he has been well or poorly adjusted in the past and at present. The examiner pays close attention to content and implication of everything said and to any other clues and, in a matter-of-fact manner, follows up whatever is not self-evidently commonplace.

d. Despite the handicap of time limitations, the neuropsychiatrist will carefully avoid unscientific methods which give inadequate or inaccurate data. Thus, a neuropsychiatric examination consisting of a few leading and suggestion questions, such as "Do you worry?" "Are you nervous?" or "Do you have headaches or stomach trouble?" is inadequate, and positive answers to such questions are not in themselves justifiable cause for rejection. Isolated signs, such as nail biting, slight tremor, or vasomotor symptoms, are not disqualifying.

e. The probable presence of some types of psychiatric disorders, in particular the major psychoses and marked degrees of feeble-mindedness, may often be suspected by alert observation of the individual's behavior if the examiner knows what to look for and what to regard as significant. In other cases, one would not be able to suspect the presence of any morbid condition without some knowledge of the individual's history.

82. Acceptable. a. Personalities usually classed as normal, attributes of which are —

(1) Evidence of ability to get along with family, friends, casual acquaintances, authorities in school or society, employers, and fellow workers.

(2) Conventional attitude toward sexual problems.

(3) Acceptable minimum mental requirements as indicated in profile serial chart, section II will be based upon levels of intelligence which have permitted a satisfactory adjustment in civilian life. Moderate degrees of mental deficiency in an emotionally stable individual are usually not incapacitating for military service.

(4) Sufficient stability and ability to obtain and keep, or at least to seek a job.

b. Stuttering or stammering of a degree which hes not prevented the man from successfully following a useful vocation in civil life.

c. Psychoneurosis of any degree will be acceptable if it has not incapacitated in civil life.

d. History of transient psychotic reactions in an individual of otnerwise clearly demonstrated stebility are acceptable.

83. Nonacceptable. Individuals who are found to have any serious psychietric disorders such as—

a. Emotional instability of a degree which has incapacitated for civil life. Mental deficiency es an incapacitative disability will be determined in accordance with profile serial chart, section II.

b. Psychosis or authenticated recent history of psychosis.

c. Pethological personality types of e degree to have incapacitated for adjustment in civil life.

84. Diegnostic criterie. a. Mental deficiency. See paragraphs 85 to 87.

b. Psychosis. Schizophrenic reection (dementia praecox). This mental disorder is manifested by obscurely metivated peculiarities of behavior and thought. Of these, the so-called hebephrenic type is the most obvious. More difficult to identify is the simple type. These are the numerous shiftless, untidy, perhaps morose, sometimes nomadic individuals who have had what was regarded es a normel childhood. Somewhere between the ages of 12 end 25 they underwent a change, acute or insidious, with dilapidation of their social interests and the habits in which they had been trained. They may or may not have received treatment in hospitals for mental disease. The peranoid type is another large division. These persons cling to fantastic beliefs in their overwhelming importance, end often feel that people are persecuting them or otherwise interfering with their career or well-being. Some of them believe that they are in communion with supernatural beings. Others believe that they are victims of plots, secret organizations, spy rings, or religious or fraternal groups. They are often plausible in supporting these delusions by clever misinterpretation of facts. Some of them are very evasive and skillful at concealing the pattern of their disorder. A morbid suspiciousness of anyone who takes an interest in them is frequent. They may become tense and hateful when interrogated. An attitude of unusual cautiousness of suspiciousness toward the examining physician or toward fellow individuals should suggest the possibility that the individual may be paranoic. The catatonic states present great difficulty in diagnosis. Perhaps the only sign of these conditions is the impression of queerness which the person makes on anyone who seeks to get acquainted with him. The actual oddities of behavior or thought may be subtle; it may be difficult, in retrospect, to point to any particular instances of the unusual. The most striking signs of these conditions may in fact come out in connection with the physical examination. The physician, at some state of the physical examination, may observe a peculiar reaction which upon questioning may awaken a suspicion of a prepsychotic state. These individuals frequently entertain unfounded convictions as to bodily peculiarities or disorders which they attribute to excessive sexual acts of one sort or another. These beliefs, sometimes hard to elicit, are often medically incredible and bizarre. Questioning them on intimate personal matters often leads to great embarassment, confused speech, or actual blocking of thought, so that they do not know what to say. Get history of family life and of school, vocational, and personal career.

c. Psychoneurosis.

(1) Evaluating the degree of severity. In evaluating the degree of severity of psychoneurosis, the following factors will be considered:

(a) Type, severity, and duration of the symptoms existing at the time of the examination and/or in the past.

(b) Amount of external precipitating stress.

(c) Predisposition as determined by the basic personality make-up, intelligence, performance, and the history of past psychiatric disorders.

(d) Impairment of functional capacity in civil life.

(2) Types of reactions. The accepted types of neurotic reactions are as follows:

(a) Anxiety reaction. In this type of reaction the anxiety is diffuse and not restricted to definite situations or objects, as in the case of the phobias. In such reactions, both the psychological and physiological aspects of the anxiety are being felt by the patient, but only the physiological aspects are observable by the physician.

(b) Dissociative reaction. This may occur in well-integrated personalities, the repressed impulse giving rise to anxiety, may be either discharged or deflected into verious symptomatic expressions such as fugue, amnesia, etc. Often this may occur with little or no participation on the part of the conscious personality. The diagnosis should specify the symptomatic manifestations of the reaction, such as depersonalization, dissociated personality, stupor, fugue, amnesia, dream state, somnambulism.

(c) Phobic reaction. By an automatic mental mechanism, the anxiety in these cases becomes detached from some specific idea or situation in the dail,' life behavior and is displaced to some symbolic object or situation in the form of a specific neurotic fear. In civilian life, the commonly observed forms of phobic reaction include fear of syphilis, dirt, closed places, high places, open places, some animals, etc.; in military life, other specific fears have been observed, such as fear of specific weapons, combat noise, airplanes, etc. The patient can control his anxiety if he avoids the phobic object or situation.

(d) Conversion reaction. This term is synonymous with "conversion hysteria." Instead of being experienced consciously (either diffusely or displaced as in phobias), the impulse causing the anxiety in conversion reaction is "converted" into functional symptoms or parts of the body, mainly under voluntary control.

(e) Somatization reaction. The anxiety is relieved in such reactions by channeling the originating impulses through the automatic nervous system into visceral organ symptoms and complaints. These reactions represent the visceral expression of the anxiety which is thereby largely prevented from being conscious. The symptom is due to a chronic and exaggerated state of the normal physiology of the emotion, with the feeling or subjective part repressed. Long continued visceral dysfunction may eventuate in structural changes. This group includes the so-called organ neuroses. It also includes certain of the cases formerly classified under a wide variety of diagnostic terms such as "conversion hysteria," "anxiety state," "cardiac neurosis," 'gastric neurosis," etc.

1. Psychogenic gastrointestinal reaction. This subcategory may include some instances of such specified types of gastrointestinal disorders as peptic ulcer-like reaction, chronic gastritis, mucuous colitis, constipation, "heart burn," hyperacidity, pylorospasm, "irritable colon." etc.

2. Psychogenic cardiovascular reaction. This subcategory includes most cases of such established types of cardiovascular disorders as paroxysmal tachycardia, pseudoangina pectoris, neurocirculatory asthenia, and some types of hypertension.

3. Psychogenic genito-urinary reaction. This subcategory includes some types of menstrual disturbances, impotence, frigidity, dysuria, etc.

4. Psychogenic allergic reaction. Occasional instances of apparent allergic responses, including some cases of hives and angioneurotic edema, have a major emotional element in their production.

5. Psychogenic skin reaction. This subcategory includes the so-called neurodermatoses, dermographia, and other related disorders when involving major emotional factors.

6. Psychogenic asthenic reaction. General fatigue is the predominating complaint of such reactions. It may be associated with visceral complaints, but it may also include "mixed" visceral organ symptoms and complaints. Present weakness and fatigue may indicate a physiological neuroendocrine residue of a previous anxiety and not necessarily an active psychological conflict. The term includes cases previously termed "neurasthenia."

(f) Obsessive-compulsive reaction. In this reaction, the anxiety may be observable in connection with obsessional fear of uncontrollable impulses. The patient himself may regard his ideas and behavior unreasonable and even silly, but nevertheless is compelled to carry out his rituals. The symptomatic expressions include such reactions as touching, counting, ceremonials, hand washing, recurring thoughts accompanied often by compulsion to repetitive action. They may include food, dirt, or germ phobias, or inflexible rituals of behavior.

(g) Hypochondriacal reaction. Characterized by obsessive concern of the individual about his state of health or the condition of his organs. It is often accompanied by a multiplicity of complaints about different organs or body symptoms. Some of such reactions may become excessively and persistently obsessional and develop associated compulsions. Such cases may be classified more accurately as "obsessive-compulsive reactions."

(h) Neurotic depressive reaction. A nonpsychotic response precipitated by a current situation — frequently some loss sustained by the patient — although dynamically the depression is usually related to a repressed (unconscious) aggression. The degree of the reaction in such cases is dependent upon the intensity of the patient's ambivalent feeling towards his loss (love, possessions, etc.), as well as upon the realistic circumstances of the loss. This reaction must be differentiated from the corresponding psychotic response.

d. Pathological personality types. Such disorders are characterized by pathological trends in the personality structure with minimal subjective anxiety, and little or no sense of distress. In most instances, the disorder is manifested by a life-long pattern of action or behavior ("acting out"), rather than by mental or emotional symptoms. The maladjustment of many individuals is evidenced by life-long behavior patterns. Such individuals are frequently described as personality types. In the evolution of psychoneuroses or psychoses, these types may be likened to abortive stages. They do not usually progress to the stage of psychosis. Nor do they justify a diagnosis of any type of neurosis or psychosis, although they may show some of the characteristics of both. They represent border-line adjustment states. The following types of pathological personality types will be differentiated:

(1) Schizoid personality. Such individuals react with unsociability, seclusiveness, nomadism, and often with eccentricity.

(2) Paranoid personality. Such individuals are characterized by many traits of the schizoid personality, coupled with a conspicuous trend to utilize a projection mechanism, expressed by suspiciousness, envy, extrema jealousy, and stubbornness.

(3) Cyclothymic personality. Such individuals are characterized by frequently alternating moods of elation and sadness, stimulated apparently by internal factors rather than by external events. The patient may occasionally be either persistently euphoric or depressed, without falsification or distortion of reality.

(4) Inadequate personality. Such individuals are characterized by inadequate response to intellectual, emotional, social, and physical demands. They are neither physically nor mentally grossly deficient on examination, but they do show inadaptability, ineptness, poor judgment, and social incompatibility.

(5) Antisocial personality. This term refers to chronically antisocial individuals who, despite a normal background, are always in trouble, profiting neither from experience nor punishment, and maintaining no real loyalties to any person, group, or code. Ordinarily an individual of this type is not the calculating criminal, but one who is on the verge of criminal conduct and may eventually become involved in such conduct. This term includes most cases formerly classified as "constitutional psychopathic state" and "psychopathic personality," but as defined here, the term is more limited as well as more specific in its application.

(6) Asocial personality. This term applies to individuals who manifest their disregard for social codes and often come in conflict with them by becoming gangsters, vagabonds, racketeers, prostitutes, and generally environmental ("normal") criminals. Many such individuals are to be regarded as the normal product of a life-long abnormal environment. This term includes most cases formerly designated as "psychopathic personality, with asocial and amoral trends."

(7) Sexual deviate. These conditions are often a symptom complex, seen in more extensive syndromes as schizophrenic and obsessional reaction. The term includes most of the cases formerly classed as "psychopathic personality, with pathologic sexuality." State whether overt or latent, and specify the specific type of the pathologic behavior, such as homosexuality, transvestitism, pedophilia, fetishism, and sexual sadism (including rape, sexual assault, mutilation).

e. Chronic addiction.

(1) Addiction to alcohol. An individual will be regarded as a chronic alcoholic if he habitually uses alcohol to the point of social or physical disablement, as evidenced by loss of job, repeated arrests, or hospital treatment because of alcoholism. Such a history, if obtained, should be verified. Many chronic alcoholics exhibit the following signs and symptoms: suffused eyes, prominent superficial blood vessels of nose and cheek, flabby, bloated face, red or pale purplish discoloration of mucuous membrane of pharnyx and palate; muscular tremor in the protruded tongue and extended fingers, tremulous handwriting, emotionalism, prevarication, suspicion, auditory or visual hallucinations and persecutory ideas.

(2) Addiction to drugs. The habitual use (or authentic history thereof) of narcotics is cause for rejection. If narcotics have been taken by hypodermic injection, there will be scars, usually on the skin of the forearms. Constricted pupils should be viewed with suspicion, and the possibility of the use of narcotics investigated.

f. Behavior disorders. These may or may not be cause for rejection depending upon their severity. They are cause for rejection if it is considered that the symptom itself has prevented adjustment and has been incapacitating in civil life. These disorders fall into the following groups:

(1) Emotional immaturity. Certain individuals in rare instances are too inexperienced or too dependent on family ties to function effectively in the armed forces.

(2) Stammering and stuttering. Cause for rejection if of such a degree that registrant is normally unable to express himself clearly or to repeat commands.

g. Not suited for military service. Information and time are often times inadequate to establish accurate diagnoses. In many instances the symptomatology and/or behavior may make disqualification of the registrant necessary, although not sufficiently well-crystallized to warrant the diagnosis of a clinical disease entity. To label a registrant with a diagnostic term in so brief an examination without adequate data available, is unscientific and unfair to the individual. Each clinical diagnosis will be based upon adequate historical and examinational evidence. In those instances where insufficient data are available to arrive at a diagnosis and where it is the neuropsychiatrist's considered opinion that the registrant is not acceptable, he will indicate that the individual is disqualified as "not suited for military service." The above clause, "not suited for military service," will be amplified by one of the following qualifications:

(1) Because of severe antisocial tendencies. This will refer to instances of repeated conflicts with the law, severe truancy, a history of repeated stealing, check forging, combativeness, and other similar antisocial tendencies.

(2) Because of severe neurotic symptoms. This will refer to long-standing psychosomatic complaints, persistent phobias or obsessions, frequent and long-continued medical and/or neuropsychiatric treatment, and recent or self-damaging somnambulism.

(3) Because of severe emotional instability. This will refer to extreme fluctuations or excessive emotional states, mental hospital treatment.

(4) Because of severe schizoid tendencies. This will refer to extreme seclusiveness, pronounced mannerisms, and queer or eccentric behavior.

(5) Because of mental deficiency.

(6) Other. Other specific qualifying phrases may be utilized, such as "sexual deviate," or other pertinent phrases.

Section XXIII
INTELLIGENCE

	Paragraph
General considerations	85
Acceptable	86
Nonacceptable	87

85. General considerations. Minimum intelligence requirements for military service are prescribed to insure that only men capable of absorbing training within reasonable limits of time will be inducted. Factors of intelligence measured by prescribed Army tests are not necessarily those measured by other tests of intelligence; therefore, intelligence tests other than authorized Army tests will be used. Concepts such as mental age and intelligence quotient are not applicable to results achieved on Army tests, and will not be used to describe the mental level of individuals being tested. Further, since intelligence rather than education is the criterion used to determine the trainability of an individual, references to the educational level attained by an individual are irrelevant when used to describe the level of intelligence.

86. Acceptable. A man achieving the critical score or a higher score on one or more of the authorized tests is acceptable for induction. Examiners will use extreme care and judgment in reporting their findings on individuals' records. Such terms as "imbecile" and "moron" will not be used. A diagnosis of mental deficiency will be based on the results of objective tests interpreted in the light of the above considerations. Illiteracy per se is not to be classified as mental deficiency.

87. Nonacceptable. Individuals whose intelligence level places them in profile 4, as shown in profile serial chart, section II, are not acceptable.

S

Profile Serial	Neuropsychiatric
1	No psychiatric disorder.
2	Mild transient psychoneurotic reaction. Mild character and behavior disorders. Borderline mental deficiency.
3	Mild chronic psychoneuroses. Moderate transient psychoneurotic reaction. Mental deficiency, mild degree. History of transient psychotic reaction.
4	Psychosis. Moderate or severe chronic psychoneuroses. Severe transient psychoneuroses (situational). Marked degrees of character and behavior disorders. Marked mental deficiency.
Factors to be considered	Type, severity, and duration of the psychiatric symptoms or disorder existing at the time the profile is determined. Amount of external precipitating stress. Predisposition as determined by the basic personality makeup, intelligence, performance, and history of past psychiatric disorders. Impairment of functional capacity.

REPORT OF APTITUDE BOARD

U.S. Naval Training Center, Bainbridge, Maryland (Date).....

From: The Aptitude Board

To: The Commander

Subj: Report of aptitude for the Naval Service of:

.....

(Name in full, Service No., Rate) Class (USN, USNEV, USNR USN-T)

Born: Place ..... Date .....

Enlisted or Inducted: Place ..... Date .....

Total Service: Navy ..... Marine Corps .....

Army ..... Air Force .....

.....

Summary:

Board's Conclusions and Recommendations: (Use whichever alternative is appropriate)

(a) The general qualifications of ..... warrant his retention in service. It is recommended that he be returned to duty.

(b) The general qualifications of ..... do not warrant his retention in service. He is not in need of hospitalization. His condition existed prior to entry into Naval Service and has not been aggravated by service. If discharged he will not be a menace to self or the others. It is recommended that he be discharged from service by reason of "unsuitability." Statement was (not) submitted in rebuttal.

(c) The findings in the case of ..... are inconclusive for determination of his fitness and suitability for service. It is recommended that he be returned to a further period of trial duty and re-evaluated by this board at the termination of this period.

(Signed by members)

.....

.....

.....

.....

.....

.....

FIRST ENDORSEMENT*

From: The Commander

To: The Bureau of Medicine and Surgery

Subj: Report of aptitude for the Naval Service in the case of:

.....

1. Forwarded, recommendation of Board approved.

2. Subject man has been discharged from the U.S. Naval Service this date by reason of "unsuitability" and has been issued a General Discharge certificate.

(signed)

*Note: This endorsement to be used only when discharge is effected.

INSTRUCTIONS FOR PREPARATION OF PSYCHIATRIC UNIT REPORT — NAVMED 1317

PART I

This section covers the initial psychiatric screening load and the followup psychiatric studies of recruits suspected of neuropsychiatric handicap both in the initial physical examination and later referred from other sources during the period by the report.

A. Enter the total number of incoming recruits.

B. Enter only the total number of recruits actually screened as a part of the incoming physical examination.

C. Enter the total number of recruits who were suspected of neuropsychiatric handicap whether placed immediately on the psychiatric ward or sent to trial duty while awaiting further scheduled psychiatric study.

D. Enter the total number of recruits who were not screened at the incoming physical examination or were not suspected in the initial psychiatric screening examination but were later referred irrespective of source.

E. Enter the total number of recruits still in process of psychiatric study. This figure should be the same as that entered in Part II, E, of the previous report.

F. Self-explanatory. This figure indicates the total psychiatric screening and evaluation work-load for the period covered by the report.

G. Self-explanatory. Sub-items No. 1, 2, and 3, indicate the location of recruits still undergoing psychiatric study. The total of these sub-items should be the same as the total entered in Part II, E, this report.

PART II

This section covers the dispositions effected on recruits received and/or studied during the period covered by the report including those remaining from previous reports. (Part I, E.)

A. Enter the total number of recruits psychiatrically screened as part of the initial physical examination (Part I, B) who were not suspected of neuropsychiatric handicap and were sent to full duty.

B. Enter the total number of recruits who underwent psychiatric screening other than during the initial physical examination and all others who underwent neuropsychiatric evaluation but were returned to full duty during the period of this report. CORRECTION: ON FORM NAVMED 1317: (Part I, G, in section Part II, B should read Part I, F.)

C. Enter the total number of recruits who have been determined to possess definite neuropsychiatric handicap where both psychiatric and psychological work-up have been completed for Aptitude Board presentation.

D. Self-explanatory.

E. Enter the total number of recruits for whom final disposition has not been determined. This includes those still on trial duty, on the psychiatric observation ward, or elsewhere such as the brig, or a special company. This figure entered here should be the same as the total in Part I, G, this report.

F. Self-explanatory. This figure less total in Part II E, (this report) represents the actual work-load during the period of this report.

Additional Information on Parts I and II

Checks: As indicated in the foregoing, total figure in Part I, G, should be the same as total figure in Part II, E. Also total figure in Part I, F, should be equal to totals Part II, F plus Part I, C, plus Part I, D.

Loads and Rates: Actual disposition, current status, NP suspect rate per 1000, Aptitude Board recommendation rate, Aptitude Board discharge rate, and actual disposition rate (all per 1000 recruits) will be computed as per instructions below and these figures entered in space provided as additional information.
Part II, F minus Part II, E, equals actual dispositions
Part II, F minus Part I, F, equals current status

Part I, C plus Part I, D divided by Part I, B, multiplied by 1000 equals NP suspect rate per 1000.

Part II, C, divided by Part I, A, multiplied by 1000 equals Aptitude Board Rate.

Part III, column One divided by Part II, C, equals percentage of concurrence.

Part III, total of columns 1 and 3, divided by Part I, A, multiplied by 1000 equals Discharge Rate per 1000.

Part III, A

This section provides for the names of all recruits who have not been cleared for full duty whether by reason of inaptitude discharge, survey, or other reasons such as disciplinary, etc. Complete psychiatric and psychological reports must be provided. Individual reports for recruits by name are forwarded via BuMed and BuPers to the field Recruiting Station who enlisted each man. Further, legal aspects of disposition are checked against provisions and requirements of Circular Letter BuMed 49-19 and/or Circular Letter BuMed 50-41a.

COMMENTS:

This section provides for additional information of a statistical nature not covered in preceding sections such as submarine or Naval Academy psychiatric examinations. There will be included also brief statements concerning such professional activities as the following:

A. Personality information and professional assistance given to Company Commanders with respect to clinical information which might contribute to an objective level of personality effectiveness for those recruits "selected in;" e.g., recruits exhibiting leadership potential.

B. Personality information and psychiatric professional assistance to Classification officers which might assist them in basing the assignment of naval recruits on his personality resources as well as his pattern of aptitudes and skills.

C. Professional psychiatric efforts with respect to determining the group dynamics operative in training station situations involving recruits:

(1) Activities which helped to eliminate psychiatric stress.

(2) Activities which helped to capitalize upon positive group resources.

D. Operational psychiatric research in progress.

E. Psychiatric Staff Personnel aboard and required.

9ND—6-28-46-MD-E30-6M

P NP

CLINICAL RECORD, N. P. OBSERVATION WARD

(N. P. UNIT, U. S. N. T. C., GREAT LAKES, ILL.)

Deck No. ..... Intvr. .....

Case No. .....

Name ..... Date Admitted .....

Co. No. ..... Rate ..... Pay No. .....

Service No. ..... Date Inducted, ... At .....

Age ..... Birthdate ..... Birthplace .....

Place of Residence ..... (Street or R. F. D. No. / City / County / State)

Admitted From Recruit Line..... Recruit Training ..... Other Source .....

Remarks:

I have read and I understand the NP standing orders, ...

EXAMINATION:

1st. Exam.....

2nd. Exam.....

3rd. Exam.....

4th. Exam.....

5th. Exam.....

RED CROSS:

SSR Requested.....

Medical Rx.....

Psychiatric Rx.....

Occupational.....

.....

DISPOSITION:

Trial Duty.....

Duty.....

SOD Recommended.....

Inaptitude Rec.....

Transferred to.....

Diagnosis.....

.....

Recheck.....

Written.....

Board.....

Reported.....

Discharged.....

.....

Criminal Record. Yes..... No.....

FAMILY HISTORY:

Father.....
Name | Street or R. F. D. | County | State

Mother.....
Name | Street or R. F. D. | County | State

Wife.....
Name | Street or R. F. D. | County | State

Brothers (Names, ages)

Sisters (Names, ages)

Children (Names, ages)

SCHOOL HISTORY:

Age at completion .....

Highest grade completed .....

Reason for leaving school:

Disciplinary or truancy record:

CRIMINAL RECORD:

ATTITUDE TOWARDS MILITARY SERVICE:

PREVIOUS MILITARY SERVICE:

WORK RECORD:

DISEASES OR INJURIES

(1. Head injuries, 2. Headaches, 3. Dizziness or fits, 4. Somnambulism, 5. Enuresis, 6. Alcohol, 7. Significant family history of disease, 8. Hospitalizations.)

SOCIAL ADJUSTMENT:

Interview by Dr..... Date.....

NAME .....

ABBREVIATED PSYCHOLOGICAL MEASURES[1]

Ivan N. Mensh, Washington University Medical School, and
William A. Hunt, Northwestern University

INTRODUCTION

The present military emergency once again has introduced pressing problems of manpower mobilization, among them the selection of personnel. World War II first high-lighted the use of abbreviated psychological tests in military selection procedures, although test abbreviation dates back to the pre-World War I period (57) and to Doll's pioneer work (17) 35 years ago. Indeed, the psychological "test," first devised by Galton, was introduced as "an experimental method of measurement . . . characterized by its brevity," but not until World War II was there any large scale development and application (65) of abbreviated psychological measures. In the past decade, one of the authors and his co-workers (40) recognizing the utility of abbreviated techniques for many situations, particularly during periods of rapid mobilization when inadequate numbers of trained personnel are available for screening military recruits, have developed and evaluated many series of brief tests.

Beginning with Doll's report in 1917 and in the more than 20 years prior to 1940, there had been published (65) but 36 articles on abbreviated techniques of psychological measurement. During the recent war years and in the immediate post-war period about 150 articles in this area appeared, and at present there are available nearly double that number of reports. These have increased our fund of information about abbreviated tests, and also have helped to sharpen our focus on the problems arising from their use. The need for brief or abbreviated measures is seen (65, 112) in many situations, civilian and military, ranging from application in the neuropsychiatric screening of military recruits to use in brief-contact clinics and in the screening practices of medical centers where heavy case loads and few personnel demand rapid survey methods for neurological, psychosomatic, and other forms of neuropsychiatric illness. Schools, courts, business and industry, penal and mental institutions, public opinion polls, all have recognized the need for rapid devices of psychological measurement. Doll (17) early pointed out the importance of economy of time in psychological study; Hunt et al (45) have emphasized the economic factors of "mechanics, manpower, and time;" and Bobbitt, Wechsler, and others (65) also have reported the need for abbreviated methods of psychological measurement.

Officers of the Navy also have been long concerned with the need for abbreviated psychological tests, as noted in Louttit's (57) historical review of psychological examining in the Navy. A symposium on intelligence tests reported in the U. S. N. Medical Bulletin of 1915 (47, 83, 86, 94) summarized adaptations of the Binet scale which had been tried out since 1912 by several Navy medical officers. They reported the advantages and limitations of the modified tests, and one of the writers, G. E. Thomas, presented requirements for tests which read like a 1952 study rather than one nearly 40 years old. After a year and a half of the adaptation and trial of the Binet scale at Portsmouth naval prison, Thomas wrote:

> There has been much discussion by psychologists outside the Navy and by some of the medical officers in the service, of the value of the Binet system as a means to determine the mentality of the recruit . . . If a mental test is to be applied in the Navy it should be devised for the recruiting officer and it should answer the following requirements: 1. It should be fair in its requirements, and a definite minimum passing mark established. 2. It should be sufficiently varied to make evident the intelligence, education, and training. 3. It should be so devised that but slight, if any, variations are possible in the results of the different examiners. 4. It should not consume much time. (94)

The qualities of "cutting score," range, objectivity, and economy of time are described here, and to them Jenkins, another of the symposium participants, added (47) the requirement: "It can be applied by any intelligent person after a little training."

RATIONALE AND PROBLEMS

In 1946, Hunt and Stevenson (44) summarized important considerations underlying the rationale of abbreviated tests in noting that " . . . changes in efficiency must be evaluated in the light of the

[1] This study is part of a larger project subsidized by the Office of Naval Research and conducted at Northwestern University under ONR contract 70NR-45011, NR 154 091. Thanks is due Edna B. Hunt for assistance with the bibliography. The opinions expressed are those of the individual authors and do not represent the opinions or policy of the Naval Service.

demands of each separate screening situation, and an increase in brevity is often worth the slight decrease in test efficiency that it entails. In military testing, the value of any test cannot be determined by fixed and absolute standards. Value is a relative matter determined by the economic factors involved." In the development of new brief methods of psychological examination or in the abbreviation of previous, longer forms, not only must the criteria specific to short forms be satisfied but also those for the usual-length test (65). For example, reliability and validity are just as real problems in abbreviated tests as in longer ones. Moreover, because of fewer items and shorter forms, reliability may decrease as pointed out by Symonds (91), Cattell (10), Wallen (100), and others. However, there are studies such as that of Brokaw (8) in which the reliability of a battery of 6 tests for classifying Air Force personnel for technical training changed only from .95 to .90 when abbreviated by 50 per cent, and the validity of the battery changed only from .57 to .56 after abbreviation.

The general problem of test criteria recently has been reexamined and reported (3) by the American Psychological Association's Committee on Test Standards. Standards of professional judgment in selecting and interpreting tests are presented, stressing the need for "sufficient information about a test so that users will know what reliance can be safely placed on it." Particularly relevant is the Committee's statement that "somewhat different standards should be stressed for different types of tests and not all types of information are equally crucial." This professional group judgment coincides with Hunt and Stevenson's earlier comment on the rationale of abbreviated tests (vide supra). Further, the Committee's definition of the scope of the standards presented in their report — "The present standards apply to tests which are distributed for use as a basis for practical judgments rather than solely for research" — applies directly to situations obtaining in military and naval screening procedures where practical judgments must be made continually on the acceptance, acceptance with qualification, or rejection of recruits. In the committee report, standards are given in terms of desired level of information about interpretation of tests (purposes and applications for which the test is recommended, professional qualifications required to administer and interpret the test, data to be taken into account other than test scores), validity (type of validity — predictive, status, content, congruent — and statistical analysis; validational groups comparable to samples for whom test is designed; criterion adequacy), reliability (coefficients of internal consistency, equivalence, and stability), administration and scoring, and scales and norms (percentiles and standard scores, appropriateness of norms, definition of normative samples).

These standards apply equally well for abbreviated tests. Already noted is the problem of reliability based on internal consistency when a parent test is shortened. In a statistical sense, the method of abbreviation operates to lower reliability, but reliability coefficients of equivalence and of stability may be computed as alternate forms of an abbreviated test are developed and applied, either by repeated samplings, by use of the test-retest situation, or in cross-validational studies with samples other than the normative groups on which the test was originally evaluated. The other criteria of test use — interpretation, validity, scales and norms — have the same significance for the abbreviated test as do they for the parent test. In general then, standards of test construction and use are equally the province of parent and of abbreviated psychological measures.

Against this background of test development and use there appear several principal problems in abbreviated testing. Mensh (65) has reviewed these in summarizing studies of the effects of practice, whether termed "experiential factor," "warm-up," transfer or "functional transfer," fatigue, or work decrement; effects of "filler material" or "dead wood" items in long tests; effects of contextual changes; rapport and motivation in abbreviated testing; examiner differences; and order of item difficulty and of administration of the abbreviated test within a battery of tests. Practice effects have long been the concern of psychologists and have been shown to be a function of various factors; "dead wood" items argue for shorter tests but Hunt, Conrad and others have cautioned that a priori guesses about efficiency must be replaced by actual trial of items; contextual, set, and motivational factors have been studied by Conrad (12), Cronbach (16), Horst (36), McCall (26), Mensh (64), and Sears (84) among others; and specific, restricted goals in abbreviated testing have been suggested by Brigham and by Doll (7, 17) early in the history of mental testing, and more recently by Cotzin and Gallagher (14, 15), Hunt and Stevenson (44), Kent (49, 50, 51), Terman and Oden (93), Vernon (98), Wonderlic and Hovland (110), and Zubin (112). Typical of the caution of these investigators is this comment: " . . . a highly serviceable measure . . . Its success with defectives should not be assumed for other clinical groups without further investigation." (15)

The method of specific goals and successive testing proved its efficiency in the military and naval services where thousands of men were screened by brief examinations (25, 65, 112) designed for the specific purpose of discriminating a defined sample (principally two groups — mental deficiency, or personality disturbance serious enough to interfere with adjustment to the armed services) of the population under test.

Most of them were relatively rough. They stood up well in terms of the number of the desired

population identified (mental defectives, the emotionally unstable, etc.) but falsely identified many normal individuals as undesirable. The pick-up or correct identification rates of these tests ranged roughly from 60 to 90 per cent of the population to be identified. The false positive rates, or number of desirables incorrectly identified as undesirable, however, ranged roughly from 5 to 25 per cent of those tested. The final decision as to the use of the test always depended not only upon the efficiency of performance in these terms; but upon such economic factors as time and manpower required, whether or not a better technique were available, and the purpose for which the test were used.

Thus a military screening unit that had neither time nor personnel available for carefully interviewing and examining all the incoming recruits might use as a rough preliminary sieve a test which had a pick-up rate of 85% and a false positive rate of 25% and hold for further examination all men "failing" the test. In such a case, out of 1,000 men to be examined the test might select 300 for further examination. This group of 300 (containing 85% of the unsuitables it was desired to identify) would then be subjected to a psychiatric interview and further testing when desirable in order to separate the undesirables from the false positives. Such a procedure would result in a time and manpower saving of 60 to 70 per cent and still maintain an acceptable screening performance.

The consideration of such economic factors and the acceptance of limited and specific goals for test performance, however, operate against other aspects of test efficiency; and extreme caution must be used in both the clinical and practical inferences drawn from such testing. This caution is present in Doll's earlier insights. After indicating the advantages of abbreviated scales of intelligence, he objectively balanced them against limitations:

> . . . It may be advisable to emphasize some of the limitations of the brief scale as well as its advantages. Equivalence in mental age rating must not be misconstrued as meaning complete psychological or clinical equivalence. Neither may one forget that a mental age rating does not in itself alone furnish a sufficient means of mental diagnosis or determinations of feeblemindedness. The more complete measuring scales of intelligence furnish a much greater variety of standard situations in which the subject may be caused to display his mental abilities to the trained observer. Moreover, the results of the more extended examination are more satisfactory by reason of the more elaborate consideration of more phases of the subject's intelligence and rule out the possibility of invalidation due to exceptional circumstances of environment or education. (17)

Brigham referred (7) to Binet's explanation of the reason for having a series of test to measure intelligence, rather than a single test. This argues against abbreviated testing but must be considered against the background of the hypothesis suggested by Brigham and successfully put to test by Doll — that an efficient, brief scale could be developed from a longer one by using those items and tests which discriminate against some sample of the population, in Doll's case, the mentally defective. Binet's reasoning is consistent with the reasoning of a number of experimenters with abbreviated testing, e.g., Wonderlic and Hovland, whose brief form of the Otis Self-Administering Test (110) included a number of items distributed uniformly over the range of difficulty. In only one instance have single-item tests been devised (34) and these were for a specific purpose with a defined population sample.

The inherent nature of abbreviated tests places a limitation on the level of reliability of the measures. Among factors affecting reliability is the significant one of number of items. In general, tests are more reliable if the number of items is large (91), and Cattell has framed the question specifically: "Is it possible to cut down a test much below one hour and still get a measure of sufficient consistency (reliability) — not to mention validity — to be used as a basis for decisions affecting the individual's whole career?" (10). Lorge, too, has decried (56) the "tendency to use short tests with out adequate consideration of reliability or of consistency . . . " Yet Doll's study of the Binet-Simon Scale showed that the item intercorrelations were so high that more than half (3 of 5 at each age level) of the tests could be omitted without affecting reliability of the mental ages obtained (17). Also, Lawshe and Mayer (54) found that brief tests of 20, 40, 60, 80, and 100 items could be selected from among 300 items with reliability as high or higher than the long form. And, with respect to validity, in a study of 800 Army inductees and 625 Army prisoners Altus (2) concluded that "the validity of a test is not entirely a function of its length . . . it is possible by careful item selection to reduce a test to as few as 13 questions and still retain a fairly good approximate measure of verbal intelligence . . ." However, Altus cautioned that such approximation should be used only where there is a time premium permitting only one or two minutes.

Other limitations have been recognized by Hunt and Stevenson in their statement of "three common arguments against the use of shorter forms. First, they do not offer the fineness of discriminatory measure that the long tests do. Second, they do not offer the same richness of diagnostic possibilities, i.e., in the analysis of scatter. Third, their use demands more clinical background and skill on the part of the examiner. There is truth in all these arguments, but they are not as conclusive as they

seem" (44). We already have seen that brief tests can be efficient when designed for a specific discriminatory function, and that screening procedures imply that selection is a sifting process (44, 112). Also, recent studies of Hunt and his co-workers (37-43, 52, 63, 73) have demonstrated the clinical diagnostic possibilities of abbreviated tests.

In a comparison of various Wechsler-Bellevue abbreviations, Patterson examined critically the limitations of short tests of intelligence and personality. He recognized the necessity for developing and using brief tests, used and evaluated various measures himself, but pointed out certain dangers and was concerned with "'undue emphasis in clinical psychology" on the trend toward shorter tests.

> . . . Indeed, the need is for more good comprehensive tests, rather than shorter forms. For clinical use, it would appear that an hour or more is not too exorbitant a time for determining the patterning of intellectual functioning, for example. Less than this amount of time decreases the reliability of the sample of the subject's behavior, and reduces the aspects of functioning that can be observed and tested. As a result, a short test not only gives an incomplete picture of the subject's abilities, but often an unreliable picture. Moreover, the limitation of testing to one or a very few functions or aspects of behavior prohibits the comparison of the subject's functioning in various areas . . . (72)

In summary then, economy in both subject and examiner time, in equipment, and in personnel dominates the motivation behind abbreviated measures. Economy in these areas, however, does not permit the criteria of good test construction to be overlooked. Thus the vital problems of reliability and validity are as central to abbreviated techniques as to longer forms of psychological tests. Other problems also must be considered — practice, "warm-up," transfer, "experiential" effects in brief testing as well as in standard-length tests; how can "dead wood" and "filler material" be best localized and eliminated to produce efficient brief measures; the specific goals and functions of abbreviated techniques; the role of examiner differences in the use of short tests; and the significance of set, motivational, and contextual factors which may change as a function of test abbreviation. The limitations of abbreviated testing are reflected in these many factors. As Hunt, Conrad, and others have pointed out, only experimentation can hold the answer to these problems. Some of the answers now are available through recent experimental studies. These show the promise of brief psychological measures which have served a useful function in meeting the need for psychological evaluation.

AVAILABLE ABBREVIATED PSYCHOLOGICAL TECHNIQUES

The experimentation within the recent war and post-war periods has produced a number of abbreviated psychological techniques, some of which are sub-test selections, e.g., vocabulary and other measures (17, 20, 40, 95, 96) from the parent test; others are item selections, as from the Minnesota Multiphasic Personality Test (25, 92); still others are inspection methods as Munroe's technique (68-70) with the Rorschach test; screening devices of which the Saslow symptom index (22, 82) is a sample; and specially devised techniques such as the Kent E-G-Y series (49-51).

Abbreviated psychological measures span the entire range of test materials and methods. There are brief tests for adjustment (1, 2, 76), alcoholic addiction (62), anxiety (25, 32, 92, 105), aphasia (27, 46), controlled association (61), feeling and attitude (35), food aversions (101, 102), memory function (21, 89, 104), mental deficiency (40, 48, 90), myokinetic and autokinetic response (85, 87, 99), neuroticism (19), optimism-pessimism (11), psychiatric prognosis (59), psychosomatic disturbance (67, 106, 107, 109), public opinion (79-81), reaction time (77), time appreciation (9), visual-motor function (4, 5, 6, 23, 24, 55, 58, 111), and vocabulary (13, 95, 96), among others. Samples studied range from childhood through old age, and from "normal" throughout the spectrum of behavior pathology.

Intelligence measures. The extensive use of the Wechsler-Bellevue Intelligence Scale has served as stimulus for use of this test as a parent form from which many abbreviated tests have been selected. Recently there has been a review of research with the W-B Test for the years 1945-50 by Rabin and Guertin (75) in which shorter forms are discussed. Prior to this review are those of Rabin in 1945 (74), and Watson in 1946 (103). In these three reviews nearly 200 studies are summarized, of which about one-fifth are with abbreviated forms. There also have been about 40 studies which report performance of abbreviated forms of the Stanford-Binet Intelligence Scale. Together, these two tests have served as parent forms in nearly 90 studies, more than a third of the reports on test abbreviation published in the psychological literature to date. A third test, the Kent Oral Emergency Test (49-51), different from the W-B and S-B tests in that it was devised as a brief test, has stimulated about 30 studies, serving either as criterion or as experimental test.

A comprehensive study of the clinical usefulness of abbreviated intelligence tests (37-43) has been carried out by the authors and their colleagues. Shortly after the close of World War II, a brief test battery was developed, consisting of the Comprehension and Similarities sub-tests from the Wechs-

ler-Bellevue Intelligence Scale, Form I, and Thorndike's 15-word vocabulary scale (95) taken from the Stanford-Binet vocabulary test. Known as the CVS Individual Intelligence Scale, it was selected for extensive investigation both because of its correlation with external criteria of intelligence and for its diagnostic potentiality. With a sample of 1,649 Naval recruits (40) a correlation of .80 was obtained between CVS and the Navy General Classification Test (GCT). Reliability has been largely inferred on the basis of consistent validity ... the testing of separate samples, but a retesting of 116 mental defectives (40) after an interval of one year gave a reliability coefficient of .81. In view of the limited range of intelligence in the sample this can be considered satisfactory. A series of studies of the CVS Scale (40) with large numbers of naval recruits, and with repeated samples of clinical populations has demonstrated the clinical usefulness of this brief battery. The psychological literature now includes CVS data on samples of normal (38, 40, 52), mentally defective (39, 52), brain-damaged (39, 63), and psychotic (39, 52) subjects. The CVS Scale represents a brief verbal scale which can be memorized by the clinician, does not involve test equipment other than a record form of a single page, correlates significantly with external criteria of intelligence, and has potentialities as a rough diagnostic screen for indicating possible psychological disturbance. For situations where non-verbal material is indicated, there are several brief, individual intelligence scales which have been evaluated (38, 39) by Hunt and French. All combine vocabulary with nonverbal materials, correlate significantly (.69-.83) with both GCT and CVS, and have differentiated clinical samples of schizophrenics and mental defectives from normals. The goal of satisfactory diagnostic differentiation demands cross-validation with further samples and a more extended list of clinical disorders.

Personality inventories. The history of the personality inventory as a rapid screening method illustrates how the basic pattern of this technique, laid down 35 years ago, has remained unchanged. Zubin reports a personal communication from Woodworth in which there is the history of the first screening device to be used by the military (112). Woodworth had been appointed by the American Psychological Association in April of 1917 to chair a Committee on Emotional Fitness for Warfare.

> Woodworth and Poffenberger worked assiduously on this problem at Columbia and after trying out various tests "hit upon the idea of assembling minor neurotic symptoms, as found by psychiatrists in the case histories of individuals who later developed neuroses or psychoses, and tallying up the score of positive answers . . . intended as a screening device with primary use of the quantitative score, but also with attention to certain 'starred questions' which the psychiatrists . . . believed would be of significance quite apart from the total score."

A comprehensive review by Ellis and Conrad (18) of the military applications of personality inventories, many of them brief methods, has yielded a number of conclusions about factors responsible for the favorable results in military practice and the disappointing findings in civilian practice. After examining studies of military personnel by inventories making use of a psychiatric criterion (prognosis or diagnosis of neuropsychiatric unfitness for military duty), the authors concluded that certain factors appear to have played a part in the results obtained. These factors were criterion contamination and overlap, use of extreme or atypical groups, differential motivation, inadequate statistical treatment of data, lenient evaluation of "false-positive" results and neglect of "false-negative" cases, sample heterogeneity, lower intelligence or greater naivete of military subjects with "less distortion" of responses than among civilians, specialized redign and validation, and application "for screening only, and not for elaborate personality analysis."

In studies making use of a performance criterion, as success in a training course, prediction was much less effective than with a psychiatric criterion. Ellis and Conrad attribute the difference to prior elimination of abnormals in selection for training courses, lack of reliability or validity of the performance measures, differences in aptitude and previous training rather than differences in emotional adjustment, and shift of criterion from validation in terms of the psychiartic criterion in the original standardization, to validation in terms of performance measures. They state:

> 1. Personality questionnaires should be especially designed for the group to whom they are applied, and should be validated against dependable external criteria. Criterion-contamination should be guarded against; and criterion-overlap, if it occurs, should be taken into account in evaluating the findings.
>
> 2. Special attention should be given to persuading or inducing respondents to answer the inventory items as truthfully as they can.
>
> 3. Personality inventories may possibly be more effective when used with relatively uneducated and less intelligent groups, than with groups that are more sophisticated.
>
> 4. The users of personality inventories should realize that only limited and specialized demands may be made on the inventory technique; and that broad and incisive personality diagnosis is still the specialty of the trained clinician employing subtler and more compre-

hensive psychological techniques. (18)

At the 1947 Maryland Conference on Military Psychology, Wexler summarized the Navy's experience with psychiatric screening tests in the following terms:

> Perhaps the best way to summarize our experience would be to suggest, as a potentially valuable research instrument, an inventory with several broadly diagnostic scales, having items in paired-choice form, with a "self-idealization" scale as a possible corrective for scores on the units directed toward the measurement of maladjustment, and finally, with a separate inquiry, perhaps biographical or attitudinal, into defensive or integrating elements which might serve to counterbalance and negate the total picture of disturbance. (108)

Projective techniques. During the past 15 years there has been great emphasis upon projective methods, as distinguished from structured intelligence and other diagnostic devices, and personality inventories whose data are treated in traditional psychometric fashion. It would be expected therefore, that demands for abbreviated psychological measures also would include the projective techniques. As with the other two principal types of psychological methods there are now available in the projective field both abbreviated forms of parent tests and brief tests specifically designed for rapid evaluation.

The most widely used method, the Rorschach technique, has been modified by group administration, multiple-choice selection of responses, decrease in the standard number of stimulus cards presented, and rapid methods of scoring and interpretation. During World War II, Hertz (33) streamlined the 8-10 hours of administration, scoring, and interpretation with the standard methods, to 50 minutes of administration time using summary sheets and check lists to speed interpretation. However, problems of reliability and validity of the briefer methods are as major [65] as they are in use of the standard techniques. These difficulties also are found in the Harrower-Erickson screening modification (29-31) in which multiple-choice responses are introduced rather than free association, thus sharply limiting the range of response. Zuckerman (113) suggested further modification for large-scale Rorschach testing, with three exposures for each of the ten stimulus slides — 20, 15, and 15-second exposures, respectively — and ten multiple-choice items per exposure to be responded to on IBM answer sheets and scored by stencil. Munroe (70) has reported an experiment with group administration, three minutes per card, and scoring and tabulation in a 20-minute period by means of her Inspection Rorschach Check List. This latter device (68-70) represents still another avenue for the abbreviation of tests, with concentration on shortening significantly the time required for scoring and tabulating Rorschach data. Munroe (71) supports the use of projective methods in group testing in her comment that "the projective method offers a complex specimen of spontaneous action even when administered to groups . . . where current individual methods are adapted to group use, the group tester for the first time can approach the problem of evaluation with something of the resourcefulness and knowledge available to the clinican working with similar individual methods."

Another principal projective technique, often used in conjunction with the Rorschach method, is the Thematic Apperception Test and this also has been modified in both administration and scoring in order to reduce the time factor. The use of slides and a reduced number of stimulus cards have been experimented with as methods of economy in administration. Harrison and Rotter (28) used 5 slides in 30-second exposures with 7½ minutes allowed for each response period; and Smith, Brown, and Thrower (88) used 8 cards of the TAT series as an aid in history-taking, diagnosis, and treatment situations in the neuropsychiatric clinic of a general hospital.

In addition to the Rorschach and Thematic Apperception Test abbreviations there are a number of other projective techniques which require relatively brief periods of administration. These include among others Mira's myokinetic psychodiagnosis (87), Bender's visual motor gestalt test (4), the Geosign Test (76), the graphomotor projective technique (53), van Lennep's Four-Picture Test (97), Machover's Draw A Person Test (60), and word association and sentence completion (78) techniques.

SUMMARY

The history of abbreviated psychological measurement extends back over the past 40 years, beginning with the efforts of medical officers of the U.S. Navy to adapt the Binet Scale for measuring intelligence to selection of recruits. Criteria for such brief techniques were formulated at that time which still hold for present-day testing, covering the requirements of "cutting" scores, adequate range, objectivity, economy of time, and simplicity of administration and scoring. These pioneers in brief psychological measurement also were aware of the limitations of the methods. Continuing concern arising from experimental evidence has indicated caution in their use.

World War II gave the major impetus to abbreviated tests and the present emergency and manpower mobilization problems again have stimulated interest in the development and validation of

rapid, objective methods for neuropsychiatric screening. There now are available in the psychologic and psychiatric literature about 300 reports on abbreviated or brief psychological tests. These cover the range of intelligence and other diagnostic measures, personality inventories, and projective techniques; and sample populations of normal, neurotic, psychotic, and brain-damaged individuals. These many studies have attempted to meet the demands for brief psychological methods by the military and naval services, hospitals, clinics, schools, and business and industry.

Advantages of abbreviated measures lie in their economy of time both in subject and examiner time, in elimination of "deadwood" and "filler" items, in equipment, and in trained personnel. These have been demonstrated in studies of verbal and nonverbal test materials where their diagnostic usefulness has been proven. The limitations of brief measures must be examined in terms of their specific goals, and the significance of set, motivational, and contextual factors which may change as a function of test abbreviation. In conclusion we may repeat our previous quotation: " . . . changes in efficiency must be evaluated in the light of the demands of each separate screening situation, and an increase in brevity is often worth the slight decrease in test efficiency that it entails. In military testing, the value of any test cannot be determined by fixed and absolute standards. Value is a relative matter determined by the economic factors involved." (40)

1. Altus, W. D. The adjustment of Army illiterates. Psychol. Bull., 1945, 42, 461-476.
2. Altus, W. D. The validity of an abbreviated information test used in the Army. J. consult. Psychol., 1948, 12, 270-275.
3. American Psychological Association Committee on Test Standards. Technical recommendations for psychological tests and diagnostic techniques: Preliminary proposal. Amer. Psychol., 1952, 7, 461-475.
4. Bender, L. A Visual Motor Gestalt Test and its clinical use. New York: Amer. Orthopsychiat. Assoc., 1938.
5. Benton, A. L. A visual retention test for clinical use. Arch. Neurol. Psychiat., 1945, 54, 212-216.
6. Benton, A. L. A multiple choice type of the visual retention test. ibid., 1950, 64, 699-707.
7. Brigham, C. C. Two studies in mental tests. Psychol. Monogr., 1917, 24, No. 1.
8. Brokaw, L. D. Comparative validities of "short" versus "long" tests. J. appl. Psychol., 1951, 35, 325-330.
9. Buck, J. N. The Time Appreciation Test. J. appl. Psychol., 1946, 388-398.
10. Cattell, R. B. The measurement of adult intelligence. Psychol. Bull., 11943, 40, 153-193.
11. Chant, S. N. F., & Myers, C. R. An approach to the measurement of mental health. Amer. J. Orthopsychiat., 1936, 6, 134-140.
12. Conrad, H. S. Characteristics and uses of item-analysis data. OSRD Report No. 4034, 1944.
13. Corsini, R. J. The immediate test. J. clin. Psychol., 1951, 7, 127-130.
14. Cotzin, M., & Gallagher, J. J. Validity of short forms of the Wechlser-Bellevue Scale for mental defectives. J. consult. Psychol., 1949, 13, 357-365.
15. Cotzin, M., & Gallagher, J. J. The Southbury Scale: A valid abbreviated Wechsler-Bellevue for mental defectives. ibid., 1950, 14, 358-364.
16. Cronbach, L. J. Response sets and test validity. Educ. psychol. Measmt., 1946, 6, 475-494.
17. Doll, E. A. A brief Binet-Simon scale. Psychol. Clin., 1917, 11, 197-211, 254-261.
18. Ellis, A., & Conrad, H. S. The validity of personality inventories in military practice. Psychol. Bull., 1948, 45, 385-426.
19. Eysenck, H. J. A comparative study of four screening tests for neurotics. Psychol. Bull., 1945, 42, 659-662.
20. Finkelstein, M., Gerboth, R., & Westerhold, R. Standardization of a short form of the Wechsler Vocabulary subtest. J. clin. Psychol., 1952, 8, 133-135.
21. Freeman, E., & Josey, W. E. Quantitative visual index to memory impairment. Arch. Neurol. Psychiat., 1949, 62, 794-797.
22. Gleser, G., & Ulett, G. The Saslow screening test as a measure of anxiety-proneness. J. clin. Psychol., 1952, 8, 279-283.
23. Graham, F. K., & Kendall, B. S. Performance of brain-damaged cases on a Memory-for-Designs Test. J. abnorm. soc. Psychol., 1946, 41, 303-314.
24. Graham, F. K., & Kendall, B. S. Further standardization of the Memory-for-Designs Test on children and adults. J. consult. Psychol., 1948, 12, 349-354.
25. Grant, H. A rapid personality evaluation: Based on the MMPI and Cornell Selectee Index. Amer. J. Psychiat., 1946, 103, 33-41.
26. Guilford, J. P. Psychometric methods. New York: McGraw-Hill, 1936.
27. Halstead, W. C., & Wepman, J. M. The Halstead-Wepman aphasia screening test. J. Sp. Hear. Dis., 1949, 14, 9-15.

28. Harrison, R., & Rotter, J. A note on the reliability of the Thematic Apperception Test. J. abnorm. soc. Psychol., 1945, 40, 97-99.
29. Harrower-Erickson, M. R. A multiple choice test for screening purposes. Psychosomat. Med., 1943, 5, 331-341.
30. Harrower-Erickson, M. R. Modification of the Rorschach method for large scale investigations. Assoc. Res. Nerv. Ment. Dis., 1946, 25, 340-344.
31. Harrower-Erickson, M. R., & Steiner, M. Modification of the Rorschach method for use as a group test. J. genet. Psychol., 1943, 62, 119-133.
32. Hartogs, R. The clinical investigation and differential measurement of anxiety. Amer. J. Psychiat., 1950, 106, 929-934.
33. Hertz, M. R. Modification of the Rorschach Ink Blot Test for large scale application. Amer. J. Orthopsychiat., 1943, 13, 191-211.
34. Hildreth, H. M. Single-item tests for psychometric screening. J. appl. Psychol., 1945, 29, 262-267.
35. Hildreth, H. M. A battery of feeling and attitude scales for clinical use. J. clin. Psychol., 1946, 2, 214-220.
36. Horst, P. Item analysis by the method of successive residuals. J. exp. Educ., 1934, 2, 254-263.
37. Hunt, W. A., & French, E. G. A second fifteen-word vocabulary test for use with abbreviated intelligence scales. J. consult. Psychol., 1949, 13, 124-126.
38. Hunt, W. A., & French, E. G. Some abbreviated individual intelligence scales containing nonverbal items. J. consult. Psychol., 1949, 13, 119-123.
39. Hunt, W. A., & French, E. G. The Navy-Northwestern Matrices Test. J. clin. Psychol., 1952, 8, 65-74.
40. Hunt, W. A., & French, E. G. The CVS abbreviated individual intelligence scale. J. consult. Psychol., 1952, 16, 181-186.
41. Hunt, W. A., French, E. G., Klebanoff, S. G., Mensh, I. N., & Williams, M. The validity of some abbreviated individual intelligence scales. J. consult. Psychol., 1948, 12, 48-52.
42. Hunt, W. A., French, E. G., Klebanoff, S. G., Mensh, I. N., & Williams, M. The clinical possibilities of an abbreviated individual intelligence test. ibid., 171-173.
43. Hunt, W. A., French, E. G., Klebanoff, S. G., Mensh, I. N., & Williams, M. Further standardization of the CVS individual intelligence scale. ibid., 333-359.
44. Hunt, W. A., & Stevenson, I. Psychological testing in military clinical psychology: I. Intelligence testing. II. Personality testing. Psychol. Rev., 1946, 53, 25-35, 107-115.
45. Hunt, W. A., Wittson, C. L., & Harris, H. I. The screen test in military selection. Psychol. Rev., 1944, 51, 37-46.
46. Jacobson, J. R. A method of psychobiologic evaluation. Amer. J. Psychiat., 1944, 101, 343-348.
47. Jenkins, H. E. Mental defectives at Naval Disciplinary Barracks, Port Royal, S.C. U.S. Nav. Med. Bull., Wash., 1915, 9, 211-221.
48. Keller, M., Child, I. L., & Redlich, F. C. Preliminary test of intelligence. A brief test of adult intelligence designed for psychiatric examiners. Amer. J. Psychiat., 1947, 103, 785-792.
49. Kent, G. H. Oral test for emergency use in clinics. Ment. meas. Monogr., 1932, No. 9.
50. Kent, G. H. Emergency battery of one-minute tests. J. Psychol., 1942, 13, 141-164.
51. Kent, G. H. Series of emergency scales. New York: Psychol. Corp., 1946.
52. Klehr, H. Clinical intuition and test scores as a basis for diagnosis. J. consult. Psychol., 1949, 13, 34-38.
53. Kutash, S. B. Recent developments in the field of projective techniques. Ror. Res. Exch., 1949, 13, 74-86.
54. Lawshe, C. H., Jr., and Mayer, J. S. Studies in item analysis: I. The effect of two methods of item validation on test reliability. J. appl. Psychol., 1947, 31, 271-277.
55. Lord, E., & Wood, L. Diagnostic values in a visuo-motor test. Amer. J. Orthopsychiat., 1942, 12, 414-428.
56. Lorge, I. Intellectual changes during maturity and old age. Rev. educ. Res., 1944, 14, 438-445.
57. Louttit, C. M. Psychological examining in the United States Navy: An historical summary. Psychol. Bull., 1942, 39, 227-239.
58. Louttit, C. M. The Mirror Tracing Test as a diagnostic aid for emotional instability. Psychol. Rec., 1943, 5, 279-286.
59. Low, A. A., Singer, H. D., & McCorry, C. L. Life situation tests as aids in psychiatric prognosis. Amer. J. Psychiat., 1939, 96, 147-164.
60. Machover, K. Personality projection in the drawing of the human figure. Springfield, Ill.: Chas. C. Thomes, 1948.

61. Melamud, D. I. Value of the Maller Controlled Association Test as a screening device. J. Psychol., 1946, 21, 37-43.
62. Manson, M. P. A psychometric determination of alcoholic addiction. Amer. J. Psychiat., 1949, 106, 199-205. Also, J. clin. Psychol., 1949, 5, 77-83.
63. Matarazzo, J. D. A study of the diagnostic possibilities of the CVS with a group of organic cases. J. clin. Psychol., 1950, 6, 337-343.
64. Mensh, I. N. The effects of test abbreviation upon responses to the individual items. J. clin. Psychol., 1949, 5, 22-36.
65. Mensh, I. N. Brief psychological measures. Nerv. Child, 1949, 8, 349-359.
66. Mensh, I. N. Statistical techniques in present-day psychodiagnostics. Psychol. Bull., 1950, 47, 475-492.
67. Moore, R. C. Psychiatric screening tests at a precommissioning center. U. S. Nav. med. Bull., 1947, 47, 676-682.
68. Munroe, R. L. Inspection technique: A modification of the Rorschach method of personality diagnosis for large scale application. Ror. Res. Exch., 1941, 5, 166-191.
69. Munroe, R. L. The inspection technique: A method of rapid evaluation of the Rorschach protocol. Ror. Res. Exch., 1944, 8, 46-70.
70. Munroe, R. L. An experiment with a self-administering form of the Rorschach and group administration by examiners without Rorschach training. Ror. Res. Exch., 1946, 10, 49-59.
71. Munroe, R. L. The use of projective methods in group testing. J. consult. Psychol., 1948, 12, 8-15.
72. Patterson, C. H. A comparison of various "short forms" of the Wechsler-Bellevue Scale. J. consult. Psychol., 1946, 10, 260-267.
73. Pollaczek, P. P. A study of malingering on the CVS abbrevieted individual intelligence scale. J. clin. Psychol., 1952, 8, 75-81.
74. Rabin, A. I. The use of the Wechsler-Bellevue Scales with normal and abnormal persons. Psychol. Bull., 1945, 42, 410-422.
75. Rabin, A. I., & Guertin, W. H. Research with the Wechsler-Bellevue Test: 1945-1950. Psychol. Bull., 1951, 48, 211-248.
76. Reichenberg-Hackett, W. The Geosign Test: A semistructured drawing situation utilized as a screening test for adjustment. Amer. J. Orthopsychiat., 1950, 20, 578-594.
77. Rodnick, E. H., & Shakow, D. Set in the schizophrenic as measured by a composite reaction time index. Amer. J. Psychiat., 1940, 97, 214-225.
78. Rotter, J. B. Word association and sentence completion methods. In Anderson, H. H., & Anderson, G. L. An introduction to projective techniques. New York: Prentice-Hall, 1951.
79. Sanford, F. H. The use of a projective device in attitude surveying. Publ. Opin. Quart., 1950, 14, 697-709.
80. Sanford, F. H., & Older, H. J. A short Authoriterian-Equalitarian Scale. Phila.: Inst. Res. Human Relations, June, 1950.
81. Sanford, F. T., & Rosenstock, I. M. Projective techniques on the doorstep. J. abnorm. soc. Psychol., 1952, 47, 3-16.
82. Saslow, G., Counts, R. M., & DuBois, P. H. Evaluation of a new psychiatric screening test. Psychosomat. Med., 1951, 13, 242-253.
83. Schier, A. R. Review and possibilities of mental tests in the examination of applicants for enlistment. U. S. Nav. med. Bull., Wash., 1915, 9, 222-226.
84. Sears, R. Motivational factors in aptitude testing. Amer. J. Orthopsychiat., 1943, 13, 468-493.
85. Sexton, M. C. The autokinetic test: Its value in psychiatric diagnosis and prognosis. Amer. J. Psychiat., 1945, 102, 399-402.
86. Sheehan, R. Service use of intelligence tests. U. S. Nav. med. Bull., Wash., 1915, 9, 194-200.
87. Simon, J. L. The myokinetic psychodiagnosis of Dr. Emilio Mira. Amer. J. Psychiat., 1943, 100, 334-341.
88. Smith, J. A., Brown, W. T., & Thrower, F. L. The use of a modified TAT in a neuropsychiatric clinic in a general hospital. Amer. J. Psychiat., 1951, 107, 498-500.
89. Stone, C. P., Girdner, J., & Albrecht, R. An alternate form of the Wechsler Memory Scale. J. Psychol., 1946, 22, 199-206.
90. Strauss, A. A., & Kephart, N. C. Behavior differences in mentally retarded children measured by a new behavior rating scale. Amer. J. Psychiat., 1940, 96, 1117-1124.
91. Symonds, P. M. Factors influencing test reliability. J. educ. Psychol., 1928, 19, 73-87.
92. Taylor, J. A. The relationship of anxiety to the conditioned eyelid response. J. exp. Psychol., 1951, 41, 81-92.
93. Terman, L. M., & Oden, M. H. The gifted child grows up. Stanford: Stanford Univ. Press, 1947.

94. Thomas, G. E. The value of the mental test and its value to the service. U. S. Nav. med. Bull., Wash., 1915, 9, 200-211.
95. Thorndike, R. L. Two screening tests of verbal intelligence. J. appl. Psychol., 1942, 26, 128-135.
96. Thorndike, R. L., & Gallup, G. H. Verbal intelligence of the American adult. J. gen. Psychol., 1944, 30, 75-85.
97. Van Lennep, D. J. The Four-Picture Test. In Anderson, H. H., & Anderson, G. L. An introduction to projective techniques. New York: Prentice-Hall, 1951.
98. Vernon, P. E. Short tests of low-grade intelligence. Occup. Psychol., Lond., 1941, 15, 107-111.
99. Voth, A. C. An experimental study of mental patients through the autokinetic phenomenon. Amer. J. Psychiat., 1947, 103, 793-805.
100. Wallen, R. Some testing needs in military clinical psychology. Psychol. Bull., 1944, 41, 539-542.
101. Wallen, R. Food aversions of normal and neurotic males. J. abnorm. soc. Psychol., 1945, 40, 77-81.
102. Wallen, R. Food aversions in behavior disorders. J. consult. Psychol., 1948, 12, 310-312.
103. Watson, R. I. The use of the Wechsler-Bellevue Scales: A supplement. Psychol. Bull., 1946, 43, 61-68.
104. Wechsler, D. A standardized memory scale for clinical use. J. Psychol., 1945, 19, 87-95.
105. Wechsler, D., & Hartogs, R. The clinical measurement of anxiety. Psychiat. Quart., 1945, 19, 618.
106. Weider, A., Brodman, K., Mittelman, B., Wechsler, D., & Wolff, H. G. The Cornell Index: A method for quickly assaying personality and psychomatic disturbances, to be used as an adjunct to interview. Psychosomat. Med., 1946, 8, 411-413.
107. Weider, A., Mittelman, B., Wechsler, D., & Wolff, H. G. The Cornell Service Index: A method for quick testing of selectees for the armed forces. J. A. M. A., 1944, 124, 224-228.
108. Wexler, M., Owens, W. A., & Porter, R. B. Psychiatric screening of naval personnel. In Kelly, G. A. (ed.) New methods in applied psychology. College Park: Univ. Maryland, 1947. p. 60-66.
109. Wolff, H. G., Weider, A., Mittelman, B., & Wechsler, D. The Selectee Index: A method for quick testing of selectees for the armed forces. Trans. Amer. Neurol. Assoc., 1943, 43, 126-129.
110. Wonderlic, E. F., & Hovland, C. I. The personnel test: A restandardized abridgment of the Otis S-A Test for business and industrial use. J. appl. Psychol., 1939, 23, 685-702.
111. Wood, L., & Shulman, E. The Ellis Visual Designs Test. J. educ. Psychol., 1940, 31, 591-602.
112. Zubin, J. Recent advances in screening the emotionally maladjusted. J. clin. Psychol., 1948, 4, 56-62.
113. Zuckerman, S. B. A research suggestion in large-scale Rorschach. J. consult. Psychol., 1948, 12, 300-302.