

A History of the Organizational Development of Psychiatry in the U.S. Army: Colonial Period to World War II

Dominic Brendan Mammola

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In memory of

Stefano Mammola, Italian Royal Army, World War I

Dominic C. Mammola, U.S. Army, World War II

Jack Burkhardt, U.S. Army, World War II

Ernest Augustine, U.S. Navy, World War II

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About the Author

Dominic Mammola is a native of Harrisburg, Pennsylvania, and is a U.S. Army Veteran (1968-1974). He graduated from the U.S. Army Medical Field Service School, Department of Neuropsychiatry, Brook Army Medical Center and designated as a Social Work/Psychology Procedures Specialist. He is a recipient of the 3rd Armored Division Certificate of Achievement for Meritorious Service. He studied at Bishop's University (B.A), McGill University (M.A.), and also at the British Institute of Psychiatry (University of London) receiving a post graduate medical degree in Neuroscience. Dominic has worked for approximately forty years in the field of civilian psychiatry. He was deployed twice to New York City as a member of a police peer team to provide consultation and debriefing services to the officers of the New York City Police Department following the attacks of 9/11. He is a member of the American Legion, the Association of the United States Army, and the Society for Military History. Dominic, at present, lives with his wife, Barbara Burkhardt, in Callander, Ontario, Canada.

Contents

Introduction.....	1
Chapter 1: Prelude to U.S. Army Psychiatry: Colonial Period to American Civil War	2
Chapter 2: U.S. Army Psychiatry: American Civil War to World War I	12
Chapter 3: The State of U.S. Army Psychiatry, WWI, 1917-1918.....	16
Chapter 4: U.S. Army Psychiatry 1918-1942	23
Chapter 5: Phantom Freddy and U.S. Army Psychiatry in World War II	35
Chapter 6: Bibliographical Essay on Literature Pertinent for Further Study in Military Psychiatry.....	87

Introduction

This monograph's intent is to present a series of essays on the history of U.S. Army psychiatry up until World War II. There isn't anything in these essays that can not be found in the published literature. Literature surrounding this topic is quite voluminous, and one would be hard pressed to organize and store it. These introductory essays are designed for those persons having an interest in U.S. Army psychiatry, but lack the time, funds, or means to secure a multitude of published source material. This monograph is not mean to be encyclopedic in scope or the final word. Instead, it introduces the subject matter, provides references for each essay, and assists the reader in navigating through selected topics the author has chosen, trusting they are of similar interest to the reader. The reader needs to keep in mind that the essays pertain exclusively to U.S. Army ground troops. Thus, other military services such as the Navy, Marines, and Army Air Force are not included as each deserves separate attention and monographs of their own. Neither is class, gender, and race as lenses for historical analysis discussed in these essays as each one also deserves a monograph on its own. There is no pretense of systematic or comprehensive narration in the essays. Thus, there is no attempt to break new ground or to provide new perspectives or insights. Rather, the essays are designed to stir interest in U.S. Army psychiatry with a view for the reader to pursue a more comprehensive study in U.S. Army medical history, and to thereby learn to appreciate its heritage. Finally, these essays may be of particular interest to university students pursuing a research paper or project in U.S. Army medical history and to U.S. Army Medical Officers who are interested in a quick introduction to their service's history of psychiatry up until the World War II era.

Chapter 1: Prelude to U.S. Army Psychiatry: Colonial Period to American Civil War

Introduction

This essay serves as a historical introduction to how psychiatry developed in the United States and serves as a foundation for understanding military psychiatry in the following essays. This essay will make use of the Pennsylvania Hospital as an example of how psychiatry took shape organizationally in the United States. Additionally, it serves to provide historical antecedence to military psychiatry as employed in the U.S. Army. Above all, this essay is not designed as a critique of the psychiatric profession nor its theories or treatment, but more so is a developmental history as the profession of American psychiatry grew, and as a result, became slowly incorporated into the U.S. Army Medical Service over many years. Developments in military psychiatry only occurred as a result of developments in civilian psychiatry. For this reason, some recounting of historical developments in civil psychiatry are seen as helpful for understanding how military psychiatry evolved in the U.S. Army.

Prelude to U.S. Army Psychiatry: Colonial Period to American Civil War

During the colonial period, American villages were not of a sufficient size to supply almshouses for the care of the mentally ill. However, it was surmised that the village authorities would assume care of the poor as well as those believed insane. Moreover, those deemed to be capable of violent behaviour were kept by families at home for protection, but families viewed mental illness as shameful. Mentally ill persons were known to wander from their homes, and it was not unknown for them to be run out of villages.¹

Once colonial villages grew in size to a couple thousand inhabitants, they mirrored the English course of action by constructing a jail or an almshouse to house mentally ill persons. The almshouse was essentially a type of penal institution as well as a “work-house”. Even though the almshouse may have had a medical component of care, it was a “primitive hospital”. One almshouse was organized in Philadelphia in 1732 and another in New York City in 1736. Both

¹ The American Psychiatric Association, *One Hundred Years of American Psychiatry* (New York, NY: Columbia University Press, 1944), 7.

jails and almshouses offered very little in terms of care for the mentally ill, other than placing these persons under custodial supervision.²

As villages grew into more urban centers, the recognition of a need for hospitals was realized. This recognition can be traced historically to the establishment of the Pennsylvania Hospital founded in 1751 by Doctor Thomas Bond and Benjamin Franklin. One of the reasons for setting up this hospital was to provide care to those who were sick and poor, as well as those judged to be insane and aimlessly walking throughout the city of Philadelphia. Bond, while continuing his medical education in England, visited the Hôtel-Dieu Hospital in Paris, France. He was influenced by the purpose of this hospital, and this gave him the idea to have such a hospital in Philadelphia to provide care and treatment for those in need of medical and psychiatric care. The role of Benjamin Franklin and the building of the Pennsylvania Hospital was that he prepared a petition for the Pennsylvania Assembly on January 20th, 1751. The petition indicated that a hospital was needed beyond what the Pennsylvania Assembly had provided for dealing with society's underprivileged in need of either medical or psychiatric care. In addition, Franklin raised money to get the hospital project off the ground. The bill to establish the hospital was enacted into law on May 1st, 1751, and the first patients were admitted February 11th, 1753; six of these patients were psychiatric in nature.³

The next development of significance in the growth of colonial psychiatry was the arrival, thirty years after the founding of this hospital, of Benjamin Rush (1746-1813).⁴

Rush was a physician by training and a native to Philadelphia in the then British province of Pennsylvania. He is viewed as the “Father of American Psychiatry”, and saw mental illness as a disorder of the mind not predicated by explanations based upon demonology. The relationship of Rush to the development of American psychiatry has its antecedence during the American Revolutionary period of history. He is described as a “radical spirit” who supported independence from Great Britain. It is believed that his pleading for independence was transferred to his advocacy for medical and societal changes, enacted by his teaching of medicine at the University of Pennsylvania. He is credited with putting forth new concepts and ways of

² Ibid., 8.

³ Penn Medicine, “The Story of the Creation of the Nation’s First Hospital” 2017, <https://www.uphs.upenn.edu/paharc/features/creation.html> , (accessed August 17, 2019).

⁴ Ibid.

practising general medicine as well as his emphasis in giving psychiatry prominence in his teaching and published works that included topics on military medicine.⁵

Rush had also established the American anti-slavers society in keeping with his adherence for the need to promote changes in society as a strong defender of the “social rights of freedom.” In addition, he is known for having authored the very first American textbook on chemistry. Besides his teaching of medical students and being a signatory of the Declaration of Independence, he served as a surgeon of the Pennsylvania Navy, followed by the position of Surgeon General of the Middle Department of the Continental Army.⁶

Rush published *The Diseases of the Mind* that was used as part of his course teaching on the practise of medicine at the University of Pennsylvania. Rush considered this publication a highly important topic in medicine. He emphasised the psychosomatic aspects of physical illness and was a proponent of physical exercise to promote health. He also promoted the value of occupational therapy in addition to meaningful work, reading, music, and recreation. Moreover, he advocated for physicians to treat patients with dignity, respect, and sympathy as well as being sincere and truthful in dealing with them.⁷

According to Howard Sudak, a psychiatrist, Rush was a firm believer in the use of bloodletting and purging. Sudak states that “although by today’s standards the care provided was horrific and at times ineffective, Rush and his colleagues truly believed they were providing the most humane treatment possible.”⁸ One of Rush’s important acts was to stop the Pennsylvania Hospital from placing very insane patients in chains in cells without heat. He is also credited with putting an end to people in the community visiting the hospital to observe the mentally ill as a type of amusement. It is believed that due to Rush’s measures and the treatment the hospital gave to patients, that “the number of insane patients in the hospital was far greater than the physically ill.”⁹ Rush’s writing of his observations and inquiries in *The Diseases of the Mind* was released in 1812 and was the first published textbook on psychiatry in the United States.¹⁰

⁵ Clifford B. Farr, “Benjamin Rush and American Psychiatry,” *The American Journal of Psychiatry* 100, no.6 (1944), 2-15.

⁶ Ibid.

⁷ Ibid.

⁸ H. Sudak, “Pennsylvania Hospital’s Influence on the Field of Psychiatry” Penn Medicine, 2017, <https://www.uphs.upenn.edu/paharc/features/psych.html>, (accessed August 2019).

⁹ Ibid.

¹⁰ Ibid.

In the 1800's, the Pennsylvania Hospital's wards, housing psychiatric patients, were not sufficient for the population as more space was needed. Physicians in charge of the psychiatric population assumed that their patients needed to be in a confined environment, and also thought that curing them was not a possibility. Due to the increased need to deal with medical cases of all sorts, the Pennsylvania Hospital for Psychiatric Patients was established and started operations in 1841. This hospital for the insane was to become the Institute of Pennsylvania Hospital. This institute was under the direction of Thomas Story Kirkbride, who was a practising Quaker. Kirkbride instituted "moral treatment" with the underlying assumption that it was possible to cure mental illness. To this end, he organized the institute to have facilities for occupational therapy together with libraries and swimming pools that provided patients with both recreational and educational outlets to facilitate cures.¹¹ Kirkbride originated the asylum model of hospital construction copied throughout the United States, as well as being a spokesman to advocate for how the mentally ill were to be treated.¹²

In 1844, Kirkbride organized a gathering of 13 superintendents of the hospitals "also known as asylums" for the mentally ill in Philadelphia. The Pennsylvania Hospital was one of a number of hospital facilities in the United States at that time. This meeting of superintendents established the *Association of Medical Superintendents of American Institutions for the Insane* (AMSAI). The AMSAI in 1893 changed its name to *The American Medical-Psychological Association*, and again changing its name in 1921 to *The American Psychiatric Association*.¹³ The AMSAI was focused predominately on how hospitals should be administered and organized rather than upon psychiatric research.¹⁴

Dorothea Dix

An important figure in the story of the development of American Psychiatry is Dorothea Dix (1802-1887). A native of the state of Maine, she was an untiring advocate and champion for the rights, humane treatment, and care of the mentally ill. Her advocacy was not only within the United States, but extended internationally as she visited and inspected facilities for the mentally ill. It was in 1845 that Ms. Dix came up with the notion of federal assistance for hospitals serving

¹¹ Ibid.

¹² *One Hundred Years of American Psychiatry*, 51-53.

¹³ Ibid., 46.

¹⁴ Ibid., 47.

the mentally ill. She lobbied for this idea for a decade, and a bill was approved by both houses of the United States Congress in 1854. Unfortunately, the bill was vetoed by President Pierce on the premise that it was not constitutional, i.e., not within federal jurisdiction. Tireless in her continuing lobbying, she eventually succeeded in securing land to be purchased by the federal government at a discounted price. The land was secured and became the building site for St. Elizabeth's Hospital in southeast Washington, D.C. in January, 1853. This became the first federally operated hospital in the United States, and was originally named "The U.S Government Hospital for the Insane."¹⁵ It is discussed below how St. Elizabeth's Hospital played a role in looking after Civil War psychiatric cases.

American Civil War

Hans Binneveld, a social historian, has stressed the observation that during the nineteenth century, psychiatry essentially existed in asylums. In addition, this served to relegate the mentally ill to the "spatial and social periphery of society."¹⁶ This situation means that psychiatry in America existed totally detached from society and its institutions, including military ones. In Binneveld's analysis, it is little wonder that American psychiatry exercised no influence at all upon the American Civil War.¹⁷

Binneveld cites a number of contributing factors that account for the absence of a psychiatric service delivery system in the military. They are: 1) state of the art psychiatry in the 1860's possessed neither the know how or sense of social duty to provide assistance for the psychological casualties of war; 2) epidemics of illnesses as well as desertion needed to be addressed; 3) medical services were organized on a last minute crisis basis; 4) manpower losses resulting from all sorts of illnesses are calculated to be five times the losses due to combat action.¹⁸ Notwithstanding these factors, psychological problems were not unknown amongst Civil War soldiers. Binneveld asserts that Northerners found it necessary to withdraw from combat operations no less than five to seven thousand men per year who were afflicted with *Nostalgia*. Even though the Surgeon General of the Union Army, William Hammond, was

¹⁵ Clarence O. Cheney, "Dorthea Lynde Dix", *The American Journal of Psychiatry* 100, no.6 (1944), 60-68.

¹⁶ Hans Binneveld, *From Shell Shock to Combat Stress: A Comparative History of Military Psychiatry* (Amsterdam, Amsterdam University Press, 1997), 78.

¹⁷ Ibid.

¹⁸ Ibid., 61.

concerned with this type of soldier showing *Nostalgia*, a psychiatric treatment service was not organized.¹⁹ This is explained more below.

Civil War Years

Albert Deutsch, a social historian of American psychiatry, ascribes the absence of military psychiatric services to the fact that “organized psychiatry at the time was still confined to a small group of asylum administrative heads, more or less isolated from their mainstream community life.”²⁰ This resulted in neurology, rather than psychiatry, growing as a prominent medical speciality in the United States as a result of the Civil War.²¹ Nevertheless, Deutsch asserts that the Civil War generated a number of facts about mental illness in the military that should have been considered valuable in future armed conflicts but were quickly overlooked and needed to be eventually relearned in both WWI and WWII.²² As an example, medical officers in the Civil War, despite there being no organized delivery of care and treatment for psychiatric cases, made a good number of observations regarding mental health issues amongst soldiers. Surgeon General Hammond of the Union Army in his yearly report of June 30th 1862, addressed the issue of young recruits who showed signs of mental illness, and thought the rigors of military life were simply too much for men of 18 years of age to handle. Hammond believed the recruitment age should be 20 years of age to address this issue of breakdowns in young men.²³

Hammond’s concerns found support in an article published in the *American Medical Times* (dated February 14, 1863) under the title “The Evils of Youthful Enlistment and Nostalgia”, written by his Assistant Surgeon General, Dewitt C. Peters. Peters also criticized in this article the inadequate procedures of medical screening in the selective service system. Deutsch quotes Peters who stated “It is by a lack of discipline, confidence, and respect that many a young soldier has become discouraged and made to feel the bitter pangs of homesickness, which is usually the precursor of more serious ailments”.²⁴ Peters is here describing “*Nostalgia*” as a “species of melancholy, or mild type of insanity, caused by disappointment, and a continuous longing for the home. It is frequently aggravated by derangement of the stomach and

¹⁹ Ibid.

²⁰ *One Hundred Years of American Psychiatry*, 367-384.

²¹ Ibid.

²² Ibid.

²³ Ibid.

²⁴ Ibid.

bowels, and is daily met with, in its worst form, in our military hospitals and prisons, and is especially marked in young subjects.”²⁵

Another Union Army Medical Officer, J. Thomas Calhoun, the Second Division Chief Surgeon, U.S. Army 3rd Corps, ventured his clinical opinion on the topic of nostalgia. He criticized the way that men were recruited as a “principal cause” responsible for nostalgia amongst soldiers. Deutsch explains how Calhoun supported, as a treatment for nostalgia, a “generous furlough system” as a way of dealing with critical home sickness. Calhoun provided the example of General Hooker instituting a generous furlough system as recompense to change a low morale group of soldiers to a high morale one.²⁶

Calhoun, as noted by Deutsch, also recognized that in the midst of field operations, it may not be possible to offer furloughs, and instead, advocated that the nostalgic soldier be engaged in work throughout the day, which would thereby improve his appetite and sleep and provide little time to wonder of home.²⁷ This can be viewed as a prescribed type of occupational therapy to alleviate stress associated with military service. It is instructive to note that the *Medical and Surgical History of the War of the Rebellion 1861-1865* provided 5,213 instances of nostalgia in white soldiers of the Union Army for the year 1861.²⁸

For the most part, psychiatric problems were largely ignored in military medical published reports during the Civil War period. Deutsch indicates that just a couple of pages are noted in the published six volume medical and surgical history of the Civil War. In addition, Deutsch has pointed out the significant omission of anything psychiatric in the publication *Military, Medical, and Surgical Essays* dated 1846 and published on behalf of the U.S. Sanitary Commission. This publication was edited by Surgeon General William A. Hammond. As well, the topic of psychiatry does not appear in Captain Lewis Duncan’s published work *The Medical Department of the United States Army in the Civil War*, printed in 1911. Deutsch continues with the criticisms saying that not one paper on military psychiatry was published in the *American Journal of Insanity* (1844-1921), during the entire period of the Civil War.²⁹

²⁵ Ibid.

²⁶ Ibid.

²⁷ Ibid.

²⁸ Ibid.

²⁹ Ibid.

It is noteworthy to mention that in May 1864, the Association of Medical Superintendents of American Institutions for the Insane (AMSII) did make an offer to Surgeon General Joseph K. Barnes (the successor to Hammond) “to tender the services of the members of the association to assist in the care of the sick and wounded now at Fredericksburg.” Surgeon General Barnes declined the offer, indicating that it was not needed at that time given that there was no “urgent necessity.”³⁰

At the same AMSII meeting in 1864, members of the Association were informed of the dismal circumstances regarding the discharge of soldiers with psychiatric illness “without any provision for their safe return home or subsequent care and treatment.”³¹ This occurred in spite of the War Department General Order No. 69, issued in 1863, forbidding the discharge of psychiatrically ill soldiers. The issue was brought to Surgeon General Barnes’ attention, and he informed the AMSII that arrangements would be made for psychiatrically ill Union soldiers to be looked after at the U.S. Government Hospital for the Insane (St. Elizabeth’s) in Washington D.C.³²

St. Elizabeth’s hospital did claim recovery rates; however, what constituted recovery is not at all defined in Deutsch’s historical account.³³ Nevertheless, it is apparent from the history provided by Deutsch that hardly any interest in psychiatry applied to the military was exercised by the practitioners of medicine in the United States. The explanation for the absence of any attention by the profession of American psychiatry has been articulated by David Marlowe, a military psychiatry researcher. Marlowe has explained that the lack of a psychiatric service in the Union Army was predicated by the cultural attitudes of the 1860’s. Men in combat were either heroic or cowardly. This had to do with the make-up of a man’s character, which decided whether he behaved heroically or cowardly in battle.³⁴ Nevertheless, the Civil War provided only

³⁰ Ibid.

³¹ Ibid.

³² Ibid.

³³ Ibid.

³⁴ Ibid.; David H. Marlowe, *Psychological and Psychosocial Consequences of Combat and Deployment with Special Emphasis on the Gulf War*. (2000) Retrieved from https://gulflink.health.mil/library/randrep/marlowe_paper/index.html. (Accessed February 8, 2006).

A fuller discussion of the construct of heroic manly behaviour can be found in H. Van Wees, “War and Society”, in P. Sabin, H. van Wees, M. Whitby (eds), in *The Cambridge History of Greek and Roman Warfare. Vol.1*, Cambridge University Press, Cambridge, U.K., 2007, 293.

two possibilities to exit combat due to overwhelming stress. One was by desertion. The other was by a serious debilitating wound, which as Marlowe explains, was “itself a problematic path given what medicine knew about infection.”³⁵ Even so, reports during the Civil War demonstrated that “stress induced disorders” occurred, as already noted above by Deutsch. However, both medical and the cultural prejudices in the 1860’s blocked any development of a diagnostic system for their explication, and therefore prevented any medically organized care and treatment. Nevertheless, the term *Soldier’s Heart* was applied for particular symptoms such as a prolonged, increased heart rate, in conjunction with extreme fatigue.³⁶

The how and why of psychiatric casualties occurring in the Civil War is addressed by Lawrence Ingraham and Frederick Manning (both military medical researchers). They assert that the American Civil War shows the first example of combat stress reactions in soldiers as a military dilemma, which was not the case in previous historical periods. This is due to what they describe as the “ecology of premodern battle” and the “structure of battle itself.” They relay that short “battles fought in closed formations with weapons sufficiently inaccurate to generate many casualties therefore protected premodern armies from what we now know as battle stress reactions.”³⁷ They further explain that the primary psychological issue of premodern armies was dependant upon “group psychology: mass panic, not individual breakdown.”³⁸ This is not to say that psychiatric casualties were unknown in premodern warfare, but these individuals are not believed to have presented to the military as an important issue demanding attention. They were simply compelled to leave the military and were left to their own wits, an existence that was “nasty, brutal, and short.”³⁹

Adding to Deutsch’s account above, Lawrence Ingraham and Frederick Manning report that Civil War Army Surgeons recognized cases of soldiers showing a depressed mental state, lethargy, and a longing for home. This was described as *Nostalgia*, which was discussed earlier in the essay. These cases were predominately individuals who had not seen combat, and were posted in training encampments, engaged in “close ordered drill and the tedium of garrison life”.

³⁵ Ibid.; Marlowe, *Psychological and Psychosocial Consequences*.

³⁶ Marlowe, *Psychological and Psychosocial Consequences*.

³⁷ Lawrence Ingraham and Frederick Manning. “American Military Psychiatry.” In *Military Psychiatry: A Comparative Perspective*, ed. Richard A. Gabriel (Westport, CT: Greenwood Press, Inc., 1986), 26-27.

³⁸ Ibid., 27.

³⁹ Ibid.

They continue to explain that there was not much reporting on cases of nostalgia and that the primary military medical concern was dealing with surgical issues concomitant with infection. However, it was nonetheless noteworthy that once a drafted Army stayed in place due to there being no necessity for persistent foraging, soldiers demonstrated symptoms of psychological difficulty. For those soldiers unable to cope with Army life, routine training and marches, they were simply separated from the Army and were often “penniless, naked, and deranged.”⁴⁰ These men were obviously in need of care and protection. The sight of such men in American society, as explained by Deutsch, prompted civilians to demand the federal government to be obligated to care for those soldiers and St. Elizabeth’s Hospital in Washington D.C. was enlisted to this end. It may not be going too far to suggest that this is an early attempt of civilians sensing a need to exercise, through demands, oversight of the military to assume responsibility for men under their command.

⁴⁰ Ibid.

Chapter 2: U.S. Army Psychiatry: American Civil War to World War I

Colonel Albert Glass (1908-1983) a career U.S. Army psychiatrist, has pointed out that no systematised or organized psychiatric service existed in the United States Army prior to World War I. Even though the Army was alerted to, and did give consideration to mental problems in U.S. Army soldiers during and after the Civil War, there existed no organized psychiatric service because any sort of evolution in psychiatry, as pertaining to the Army, was contingent upon the development of civilian psychiatry, both in the United States and in Europe. This also explains the lack of reference to psychiatric issues in soldiers during the Revolutionary War and the War of 1812 that can be explained historically due to the late evolution of psychiatry in the United States. As well, medical records were not made during these wars of the medically sick, wounded, and physically incapacitated. As well, records were not made during the Mexican War (1846-1848), and therefore do not indicate any instance of mental incapacity among soldiers. This means that the development of Army psychiatry was inexplicably linked, as noted beforehand, upon developments in the civilian sector.⁴¹ Given this situation, the Army necessarily focussed upon the numerous infectious diseases that had to be dealt with medically and which were predictive of deaths, in addition to dealing with sanitation and hygiene programs to prevent disease among troops, i.e., preventive medicine.⁴²

By an order of the Secretary of War, the Army Medical School was inaugurated in 1893. The purpose of this five-month, post-graduate medical training was to ensure that all newly appointed medical officers could perform their duties to a high standard. The training involved seven areas of medicine, ranging from surgery to pathology, as well as four classes in mental illness, given at the U.S. Government Hospital for the Insane. Although mental illness was addressed in this curriculum, the primary drive of Army medicine in the years following the Civil War was to establish competency in preventive medicine and surgery.⁴³

Glass indicates that only “meager information” on mental illness in the Army can be located in the annual Reports of the U.S. Army Surgeon General or in military medical literature

⁴¹ Albert J. Glass, “Army Psychiatry in the Post Civil War Era 1866-1914”, in *Psychiatry in the U.S. Army: Lessons for Community Psychiatry* (Bethesda, MD: Uniformed Services University of the Health Sciences, F. Edward Herbert School of Medicine, 2005) <http://www.dtic.mil/dtic/tr/fulltext/u2/a434841.pdf>

⁴² Ibid., 9.

⁴³ Ibid., 10-11.

in the decades following the Civil War.⁴⁴ Glass conveys further that in these annual reports, the occurrence of mental illness is mentioned solely between 1882 and 1885. During these years, the incidence of mental illnesses is reported as 1-3/1,000 year. This rate is similar to that found in the Civil War, and to that of psychosis in the U.S. Army for the 20th century. However, no written accounts or noted debates are recorded dealing with either referral or treatment. It is surmised that in the years following the civil war, that cases of mental illness occurring in soldiers, were dealt with by admission to the U.S. Government Hospital for the Insane.⁴⁵ Unlike insanity, alcoholism is one topic that received consideration and discussion among medical officers as noted in one annual report of the Army Surgeon General. However, there was no effort to link alcoholism to mental illness either as a sequelae or cause of psychiatric disturbance. Rather, alcoholism was characterized as a negative habitual behaviour and understood as “wasteful of time and military effectiveness,” necessitating “exhortation and admonition” and, if not effective, required discharge from military service. However, it does need to be noted that besides exhortation and admonition, that some Army medical officers administered apomorphine to induce vomiting related to alcohol abuse with a view to producing a negative reaction to its consumption.⁴⁶

Headache and neuralgia continued to be reported in Army personnel and were categorized as disorders of the central nervous system. These disorders did not stimulate any discussion as to whether they could be associated with mental disturbance or emotional conflict.⁴⁷

During the Spanish-American War era (1898-1899), military medicine was predominately focussed on combatting infectious diseases in deployed Army personnel. This coincided with the new medical discipline of bacteriology and hygiene being established alongside radiology and diphtheria antitoxin being employed in medical practise. Infectious disease had become so serious by the 4th of August 1898, that Army medical officials recommended to the War Department that the Army should be removed from Cuba as soon as

⁴⁴ Ibid., 12.

⁴⁵ Ibid., 13.

⁴⁶ Ibid., 13.

⁴⁷ Ibid., 14.

possible or nothing would be left of it in terms of manpower. Since an armistice with Spain was enacted on the 12th of August 1898, it facilitated the removal of Army personnel from Cuba.⁴⁸

Mental Disorder:

As in the Civil War, insanity rates increased in 1898 and 1899 due to the speed of recruiting. The report of the U.S. Army Surgeon General of 1900 indicated that a physical examination does not screen out those who are mentally disturbed, and that such cases appear within the first two years of military service. The Surgeon General ascribed the incidence of insanity to the fact that the enlistment age was lowered to 18. This report, in retrospect, is essentially impressionistic and unsupported by evidence, in addition to being apparently blind to the fact that combat could be a causal factor in producing psychiatric problems. Glass, having the latter in mind, surmises that it is peculiar how “little or no comment was made in the later wars of the U.S. regarding the probability of increased rates of insanity or psychosis under war time conditions.” Nevertheless, for the years of 1898 and 1899, a good number of soldiers with mental illness were removed from the Philippines and interestingly are reported to have recuperated upon the voyage to the United States or recovered when admitted to the Presidio General Hospital of San Francisco, California. As a result, there was no need for them to be sent to St. Elizabeth’s in Washington D.C. Other cases that did not recover were sent to St. Elizabeth’s, where recovery rates were reported to be fairly good with a couple months of treatment. Glass surmises from these cases that it appeared the Army medical service had initially inaugurated a system of identification of mental illness together with an examination capacity for some, followed by treatment. However, alcoholism among soldiers was not viewed as a mental illness, in spite of its sequelae, i.e., delirium, tremors, brain damage, and death. Hospitalization for alcoholism is noted to have occurred more often in the peacetime Army than in times of war.⁴⁹

Training in Psychiatry:

Training for medical officers in psychiatry received greater attention in the early 20th century. This was facilitated by increasing the four training classes in psychiatric disorders, offered originally by the Army Medical School in 1893, to 24hrs of instruction, plus exposure to clinical cases. A good portion of these lectures were delivered by William Alanson White, M.D.,

⁴⁸ Ibid., 16.

⁴⁹ Ibid., 18-19.

the Superintendent of the U.S. Government Hospital for the Insane. Starting in 1909, it became a practise to assign one medical officer from the Army and one other from the Navy to St. Elizabeth's for a two-year period of instruction in psychiatric illness. This set into motion the initial development of career-trained medical officers in the field of psychiatry. This helped to promote the capacity of the Army Medical Service to provide some measure of psychiatric service delivery as well as consultation.⁵⁰

⁵⁰ Ibid., 20.

Chapter 3: The State of U.S. Army Psychiatry, WWI, 1917-1918

According to William Menninger, since the American Civil War, only a small number of physicians demonstrated any desire to study why some individuals became psychiatrically ill. Most of those physicians who did have an interest in psychiatric illness were employed in isolated insane asylums. As the 20th century unfolded, a number of physicians with an avid interest in psychiatry became recognized in university medical departments. In addition, interest in psychiatry was reinforced by the investigations of Sigmund Freud into the human mind and promoted in the United States by individuals such as A. A. Brill, James J. Putman, William Alanson White and others.⁵¹ Thus, it was the civilian medical sector which ended up leading the way for the U.S. Army Medical Service to pay heed to the neuropsychiatric problems of warfare in WW1. To this end, the National Committee for Mental Hygiene, in conjunction with the Rockefeller Foundation, produced a commission that believed it necessary to gain knowledge of the neuropsychiatric casualties and the services needed for treatment by meeting and consulting with the Allies. Two prominent civilian physicians emerged from this exclusively civilian organization to guide and advise the United States Army Medical Service.⁵² One was Pierce Bailey, a physician with specialization in both psychiatry and neurology, and an Associate Professor of Psychiatry at Columbia University, who was appointed to carry out the position of ‘Consultant in Psychiatry’ in the Office of the U.S Army Surgeon General. He was commissioned at the rank of Colonel.⁵³

One of the fruits of the National Committee for Mental Hygiene and the Rockefeller Foundation was the U.S. Army using psychiatric screening at induction centers with a view toward reducing the incidents of psychiatric cases in the military. Screening was viewed as “a principle of such significance, that whenever it is neglected, payment inevitably will be exacted from many postwar generations, not only in terms of huge economic burdens, but even more distressingly in terms of disrupted morale in human unhappiness and personal and social woe.”⁵⁴

⁵¹ William Menninger, *Psychiatry in a Troubled World* (New York, NY: Macmillan, 1948), 3.

⁵² Edward A. Strecker, “Military Psychiatry: World War I, 1917-1918,” in *One Hundred Years of American Psychiatry*, ed. Gregory Zilboorg (New York, NY: Columbia University Press, 1944) 385.

⁵³ Menninger, *Psychiatry in a Troubled World*, 3

⁵⁴ Strecker, *One Hundred Years of American Psychiatry*, 385; “Pearce Bailey”, in Gilman, D. C.; Peck, H. T.; Colby, F. M., eds. (1905). *New International Encyclopedia* (1st ed.). New York: Dodd, Mead.

The screening program was largely due to the efforts of Bailey, as consultant to the Office of the U.S. Army Surgeon General.⁵⁵

The other civilian was Thomas W. Salmon, a general practitioner by training, but with a career long interest in psychiatry and a strong advocate for the care and treatment of the mentally ill. Salmon was appointed as the Chief Consultant in Psychiatry with the American Expeditionary Forces, obtaining the rank of Colonel. Prior to the U.S. entry into WWI, Salmon went on a tour of England, being sponsored by the Rockefeller Foundation, to find out what the British had learned through their experiences pertaining to psychiatric casualties in their Expeditionary Forces. Salmon's observations of the British experience played a significant role in shaping U.S. Army psychiatry in WW1. In 1917, he published a monograph.⁵⁶ This publication set forth a number of recommendations which the U.S. Army adopted into an organized system for dealing with the care and treatment of psychiatric cases in both the Expeditionary Forces and non-expeditionary U.S. Army. The recommendations were published in time to coincide with the U.S. entry into WW1. The most important recommendation Salmon advocated for was that of screening of men for mental instability to exclude the "insane, feeble minded, psychopathic, and neuropathic individuals from entering the Army." The reason behind this recommendation, based upon his consultations with the Allies, was that the mentally unstable did not in all likelihood possess the necessary adjustment potential to cope with "terrific stress of modern war."⁵⁷ Salmon believed that the modern warfare exhibited in WW1 created conditions productive of psychiatric casualties, especially under conditions of continuous artillery shell fire.⁵⁸ At the time of Salmon's writing, it can be assumed that he was aware of the hundreds of thousands of casualties from the Battles of the Somme and Verdun.

Salmon also held the belief, and not unwarranted, that psychiatric casualties in war service resulted from a soldier's desire to escape an unforgiving environment characterized by the fear and horror of combat.⁵⁹ According to Salmon, it was not unknown for normal men to

⁵⁵ "Pearce Bailey", in Gilman, D. C.; Peck, H. T.; Colby, F. M., eds. (1905). *New International Encyclopedia* (1st ed.). New York: Dodd, Mead.

⁵⁶ Thomas W. Salmon, *The Care and Treatment of Mental Diseases and war Neuroses ("Shell Shock") in the British Army* (New York, NY: New York, Mental Hygiene War Work Committee of the National Committee for Mental Hygiene, 1917).

⁵⁷ Salmon, *The Care and Treatment of Mental Diseases and war Neuroses*, 20, 47-48.

⁵⁸ *Ibid.*, 27.

⁵⁹ *Ibid.*, 30.

succumb to psychiatric disturbance given such conditions.⁶⁰ Moreover, Salmon viewed the factor of fatigue in combat soldiers as a leading cause of psychiatric casualties.⁶¹

The other recommendation Salmon advised, and the U.S. Army instituted, was that of setting up facilities with trained personnel for the care and treatment of psychiatric cases, which included therapeutic programs for rehabilitation. These facilities are referred to as Base Hospitals, and were to be organized for deployment to France for the Expeditionary Forces. As well, facilities were set up in the continental United States for those psychiatric cases whose psychiatric condition was of such a nature that they were returned to the United States for continued care and treatment with a rehabilitation focus.⁶²

Considerable efforts were made to secure qualified personnel to staff these facilities once the recommendation to organize these facilities were willingly received by the War Department. The director of the National Committee for National Hygiene made herculean efforts to recruit the necessary personnel. The medical personnel recruited were given training in either U.S. Hospitals or those in England for training in the field of neuropsychiatry and then assigned for duty. Enlisted personnel and nurses were also trained for duty. The most prominent facility was Base Hospital #117 at La Fauche, France for the care and treatment of psychiatric casualties in the American Expeditionary Forces. Salmon recommended that this Base Hospital be positioned “in the advance section of the line of communications, providing nearby access from the front.”⁶³ Salmon’s reasoning for this was to instill in psychiatric cases the belief that their condition is short-lived and treatable. As well, the patient was impressed with the fact that his condition conveyed no sense of permanent disability with the expectation of returning to the United States.⁶⁴ This became the foundation for the theoretical construction of what becomes “forward psychiatry” in the AEF. Forward psychiatry is described in most all published literature in military psychiatry by the principles conveyed in the acronym PIE (Proximity, Immediacy, Expectancy). Regarding these principles, Salmon learned from the experience of the Allied medical officers, that treatment close to the front facilitated significantly more satisfactory

⁶⁰ Pearce Bailey, Frankwood E. Williams, and Paul O. Komora, *The Medical Department of the United States Army in the World War: Neuropsychiatry*, vol.X (Washington, DC: U.S. Government Printing Office, 1929), 431.

⁶¹ *Ibid.*, 341-373.

⁶² Salmon, *The Care and Treatment of Mental Diseases and war Neuroses*, 48-49.

⁶³ Bailey, Williams, and Komora, *Neuropsychiatry*, vol.X, 354-357.

⁶⁴ *Ibid.*, 357.

treatment results then treatment provided far from the front. Closer to the front meant that the “spirit of Army discipline played a positive role in recovery.” In addition, immediacy as a principle of forward psychiatry meant that the sooner the treatment, the less time away a psychiatric casualty spent from his unit, and therefore maintained bonding with it. The less immediate the treatment and more rearward, permitted time for symptoms to become fixated which in turn promoted justification for the soldier’s symptoms.⁶⁵

Franklin Jones, a career U.S. Army psychiatrist, neatly summarizes forward psychiatry by saying that “expectancy is created as the central principle from which the others derive. A soldier near his unit in space (proximity) or time (immediacy) can expect to return to it. Distance in space or time decreases this expectancy.”⁶⁶

Added to PIE, is another principle, ‘simplicity’ of treatment to create PIES. An example of simplicity is provided by Salmon and Fenton in “Rules for Psychoneurosis Wards”, which simply consisted of hot meals, rest, sleep, exercise, and instilling a sense of hope in recovery through selective therapeutic activities geared to returning the soldier to duty. The maintenance of a military atmosphere is believed to contribute to providing motivation for a return to duty.⁶⁷

Forward psychiatric treatment was bolstered by the assignment of psychiatrists to tactical divisions in the AEF. The chief surgeon of the AEF, Major General M.W. Ireland, circulated to all division surgeons, a memorandum dated September 8th, 1918. In this communication, Ireland noted that experience in the AEF indicated that if psychiatrists had been assigned to divisions, that many (some 4,000 cases) soldiers with “slight war neurosis” would not have been sent to base hospitals in the rear if they were examined and treated at division level. He further outlines, in some detail, the duties of psychiatrists, emphasizing that their work is to maintain fighting strength “at the highest possible point, and to bring about the prompt elimination, from the division, of those unfit for duty.” He also highlighted their duties when the division is in training or rest, and when in combat.⁶⁸ In actuality, the intentions of Major General Ireland’s

⁶⁵ Salmon, *The Care and Treatment of Mental Diseases and war Neuroses*, 36; Thomas Salmon and Norman Fenton, “The Medical Department of the United States Army in the World War”: In *The American Expeditionary Forces*, Vol.X (Washington, DC: U.S. Government Printing Office, 1929), 360-361.

⁶⁶ Franklin Jones and Albert Glass, “Overview,” in *Psychiatry in the U.S. Army: Lessons for Community Psychiatry*, Albert J. Glass and Franklin D. Jones, (Bethesda, MD: Uniformed Services university of the Health Sciences, F. Edward Herbert School of Medicine, 2005) 3

⁶⁷ Salmon and Fenton, *In the American Expeditionary Forces*, vol.X, 313.

⁶⁸ *Ibid.*, 307-309.

memorandum were realized in just one American division in the AEF. The reason for this, as explained by Ingraham and Manning, was that less psychiatric cases occurred than anticipated due to the combat moving away from the trenches and into more open offensive warfare. Furthermore, the war concluded before the “central lessons of triage and treatment” were fully realized and could be put into practise across the AEF.⁶⁹ One individual who served as a divisional psychiatrist in the AEF was Edward A. Strecker (1886-1959). He provides an account of his psychiatric work when his division was stateside, examining personnel psychiatrically unfit for duty at the point of embarkation. He relays that the psychiatric exclusion of soldiers for overseas duty did not prevent many soldiers undergoing psychological decompensation and becoming psychiatric casualties in France. In terms of assignment of psychiatrists in the AEF, he states that they were all posted in the vicinity of combat, but that their work took place in field hospitals where psychiatric casualties were treated for anywhere from 3-10 days. Those requiring more in-depth treatment were channeled to other facilities in the rear. He emphasizes that treatment occurred within earshot of artillery fire.⁷⁰ Strecker subscribed to the view that the patient should be told that his condition was not a permanent one. As Strecker states “the basic idea was an attempt to impress upon the patient’s conscious mind that his ailment was not serious, and on his subconscious mind that the situation that he now found himself in probably offered no greater advantages over the one he recently left.”⁷¹ The undercurrent to this is that since the ailment was not permanent, that neither would secondary gain be useful. Strecker stresses that this way of dealing with casualties prevented the soldier from negating the “duties and responsibilities” of being a soldier.⁷² This can be construed as advancing and promoting the conservation of fighting strength in the AEF as well as reinforcing that the soldier assumes a need to return to duty.

It can be hypothesized that forward psychiatry in the AEF, unlike civilian psychiatric practise, works on the premise that the individual soldier has a social contract with his group. Also, forward psychiatry defines its own parameters for ascertaining what is normal compared to

⁶⁹ Ingraham and Manning, *Military Psychiatry*, 33.

⁷⁰ Strecker, *One Hundred Years of American Psychiatry*, 390-391.

⁷¹ *Ibid.*, 400.

⁷² *Ibid.*

an abnormal reaction to war service, in addition to helping the soldier to move forward toward recovery and return to duty and not backward into chronicity and disability.

An issue arising from the military practise of psychiatry in the AEF was that of diagnostic nomenclature. Salmon describes the then diagnostic system in use as “defective nomenclature.” He points to the fact that confusion exists as to what constitutes a particular diagnosis. For instance, the same diagnosis could be ascribed to different psychiatric conditions due to there being no agreed upon criteria for signs and symptoms. An example was the diagnosis of “shell shock” which was used indiscriminately for varying psychiatric conditions having nothing to do with the effect of artillery shell fire. Salmon provides an example of a soldier receiving a diagnosis of shell shock, who was performing his war service satisfactorily until receiving word from his wife that she had taken with another man.⁷³ This meant that psychiatrists were not in agreement among themselves as to how to apply a particular diagnosis consistently as universally agreed upon criteria did not exist at the time. This situation persisted into the WWII era. It is with the publication of the War Department Technical Bulletin, Medical 203 in 1946 by the Office of the Surgeon General, Army Service Forces, that the U.S. Army had a considerably more uniform system for ascribing diagnosis of a psychiatric nature. This medical bulletin eventually formed the basis for the creation of the American Psychiatric Association’s first diagnostic and statistical manual in 1952. This provided psychiatric clinicians a uniform nomenclature with criteria for formulating diagnosis with more exactitude within a psychodynamic, theoretical framework. Underpinning this framework was the premise that stress can cause psychiatric symptoms in normal individuals.⁷⁴

Finally, the publication of Volume X, *Neuropsychiatry in the Great War*, provided extensive detailed information on the organization and administrative structure, of psychiatric service delivery, the staffing of both medical and allied medical disciplines, equipment and physical facilities, and the training of personnel to provide psychiatric care and treatment services. As well, abundant information is found on the clinical observation, analysis, and

⁷³ Salmon, *The Care and Treatment of Mental Diseases and war Neuroses*, 31-32.; For a short discussion about shell shock having no precise definition, see Edgar Jones and Simon Wessely, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War*, (New York, NY: Psychology Press, 2009), 238.

⁷⁴ “Nomenclature of Psychiatric Disorders and Reactions. Office of the Surgeon General, Army Service Forces, War Department Technical Bulletin Medical 203.” *Journal of Clinical Psychology* vol. 58, no. 7 (2000): 925-934.; Arthur C. Houts. “Fifty Years of Psychiatric Nomenclature: Reflections on the 1943 War Department Technical Bulletin, Medical 203.” *Journal of Clinical Psychology* 56, no. 7 (2000): 935–967.

diagnosis of psychiatric casualty case material underlined by the issue of diagnostic precision. The principles of forward psychiatry are articulated to serve as a template for future armed conflict with respect to psychiatric care and treatment of soldiers. All of this formed the historical memory of the U.S. Army Medical Service as pertaining to the military application of psychiatry. However, Volume X was not extensively promoted. According to the late Colonel John Boyd Coates, Jr., it “remained on the library shelves and ignored, and had to be learnt all over again” in WWII.⁷⁵ The neglect of this volume can be accounted for by the fact that the primary maxim extracted from the WWI experience was for more stringent selection of Army inductees to eliminate from military service those considered prone to psychiatric breakdown, and thus eliminate the need for provision of psychiatric services.⁷⁶

⁷⁵ John Boyd Coates, Jr. “The History of the U. S. Army Medical Department in World War II.” *Bulletin of the Medical Library Association* 47, no. 3 (July 1959), 264-273.

⁷⁶ Ingraham and Manning, *Military Psychiatry*, 33.

Chapter 4: U.S. Army Psychiatry 1918-1942

Introduction

This essay is essentially a reiteration of the late Colonel Albert J. Glass's (1908-1983) historical and in-depth chronological narrative of the position of the U.S. Army psychiatry in the period between WWI and the start of WWII. Glass's account is chosen due to its being concise and clear, as well as his breadth of comprehensive coverage. As a result, this essay is predominantly a long footnote to Glass. This is seen as fitting, given his reputation during a military career as the most prominent spokesman for Army psychiatry in the post WWII era.

Following WWI, the U.S. Army's observation and knowledge of the practice of psychiatry during war time conditions had a steadfast influence on the psychiatric care and treatment of soldiers. After the War, Army medical services preserved the physical psychiatric facilities organized for WWI in the United States and this played a large part in the maintenance of military psychiatric practice. The facilities comprised a system of open and closed wards, the providing of consultation services, and outpatient functions. These psychiatric services were supplied by the medical departments of various Army medical hospitals, such as Walter Reed General Hospital (Washington D.C.), Lettermen General Hospital (San Francisco, California), and the Station Hospital (Fort Sam Houston, Texas). An overseas facility was also charged with the delivery of psychiatric services, the Sternberg General Hospital (Manila, Philippines).⁷⁷

As was the case prior to WWI, the Army continued its practise of choosing two medical officers pursuing a career in the Army to attend a two-year program of training in psychiatry at St. Elizabeth's Hospital. In addition, in the ten-year period following WWI and less so thereafter, the psychiatric departments of Army hospitals provided admission and treatment for veterans having less than chronic psychiatric illness.⁷⁸

The incidence of mental disorders among Army soldiers in the period 1920-1930 is calculated to be 11 to 12 per 1,000 men each year. The range of psychiatric diagnosis encountered included dementia praecox, manic depressive psychosis, general paresis, alcoholic

⁷⁷ Albert J. Glass "Army Psychiatry Before WWII", in *Neuropsychiatry in World War II: Zone of the Interior*, ed. Albert J. Glass and Robert J. Bernucci, (Washington, 1966), Pg 8-9.

⁷⁸ *Ibid.*, 9.

and other assorted psychoses with an organic basis, constitutional psychopathic disorders, hypochondriasis, and a variety of neurotic disorders. In addition to the aforementioned psychiatric disorders were those not considered psychiatric in nature, such as: neurological disorders, addiction to drugs and persistent alcohol dependence.⁷⁹

The rate of hospital admissions between 1920 and 1930 was 7 to 8 per 1,000 each year. This is noted to be less than that of the period 1907-1916 when the incidence rate is about 16 per 1,000 each year. This was prior to the U.S. Government legislating the Nation Prohibition Act.

The significance of mental disorders in the Army and their establishing them as a pressing medical issue in the post WWI era is highlighted by the following observations:

1. Suicide was the primary agent of death in the Army, the rate being 0.5 per 1,000 strength each year.
2. Psychiatric disorders as a category were the biggest reasons for granting a medical discharge with an incidence of 6 to 7 per 1,000 strength each year. This demonstrated that over one half of admissions resulted in a medical discharge from the Army.
3. The primary leading diagnosis eventuating discharge was dementia praecox with a rate of 2 to 3 per 1,000 strength each year.
4. Leaving aside drug addiction and alcoholism, mental illness is listed as the leading reason for discharge, but the fifth or sixth as grounds for hospitalization, and third or fourth causal agent, resulting in reduction of a soldier's performance for his military job.
5. Mental illness was the primary reason for removal from overseas assignment.⁸⁰

Army medical staff were cognizant that psychiatric issues among personnel consumed a fair amount of their duty assignment. As well, the annual reports of the Surgeon General in the years 1924 and 1926 noted the weighty extent that psychiatric illness exacted on the loss of soldiers required to perform their duties. Blame for the situation was directed towards faulty recruitment of soldiers. The annual report of the Surgeon General for the year 1924 reported that each case of psychiatric illness was responsible for 71.8 days of lost duty time. The report goes on to ascribe the selection of mentally unfit recruits to the fact that what was learnt in WWI was not being applied to recruitment. The Surgeon General points to the assurance that weeding out

⁷⁹ Ibid.

⁸⁰ Ibid.

those with psychiatric problems at induction or recruitment points would prevent the Army from having to deal with the unfit. There is little commentary to indicate the potential difficulty in detecting psychiatric problems at the recruitment stage, especially those not displaying obvious florid symptomatology. It was not until June 1931 that Army Regulation 600-750 was modified to oblige recruitment personnel to make a more concerted effort to not accept applicants mentally unfit for service. This regulation stayed in effect till April 1939. It is not clear if this regulation achieved its desired effect.⁸¹

The application of military psychiatry at Army hospitals in the years between 1920 to 1930 was comparable to that in the civilian sector as pertaining to diagnosis and treatment. As an example, Letterman General Hospital reported in 1922 that virtually all psychiatric patients were managed by medical officers trained in psychiatry. As well, the William Beaumont General Hospital indicated that they had experienced favourable results in treatment of psychiatric disorders of a psychoneurotic nature showing hysterical symptomatology. Selected treatments noted as effective are the utilization of hydrotherapy, recreation treatment activities, and physiotherapy interventions. The Letterman General Hospital in 1923 took pride in reporting their hydrotherapy program, adding that the treatments were provided by trained, enlisted personnel. In 1927, Walter Reed General Hospital provided an account of how their facility was enhanced by separate “open and closed” neurological wards. They also reported the use of malarial treatment for cerebrospinal syphilis and general paresis in 19 patients. They also reported that the use of either chemical or mechanical measures to control patients were used in the least possible manner. Walter Reed General Hospital relayed their problem of having nothing established for care and treatment of psychiatrically ill females. Overall, during the period of 1920-1930, complaints were prevalent of there being not enough staff in the commissioned and enlisted ranks to deal with the considerably high caseloads in both the psychiatric and neurological areas of care and treatment.⁸²

The year 1921 saw the start of the School of Aviation Medicine at Mitchell Field, New York, which relocated to Texas. At the start of this school, a neuropsychiatry faculty was set up and was involved with the application of psychiatry to aviation medicine. This involved

⁸¹ Ibid., 10-11.

⁸² Ibid., 11-12.

conducting personality studies to be applied in choosing appropriate applicants for pilot training. Teaching was provided in psychiatry with a special emphasis upon how to conduct a good enough psychiatric evaluation of aviation applicants. By 1928, the neuropsychiatric faculty of the school relayed that research was to be conducted dealing with more desirable techniques for administering the neuropsychiatric component of the aviation test, as well as the assessment of flying skills. This research's focus was underscored by the need to identify those character attributes that would make an effective and competent pilot.⁸³

Alongside the development of Aviation Psychiatry, the Army continued to provide teaching in psychiatry at the Army Medical School in Washington, D.C. This comprised of a number of lectures that focused upon the detection and removal of psychiatrically unwell candidates for service in the Army. In addition, the methods for the identification and categorizing of psychiatric cases arising in members of the military was studied.⁸⁴

In the ten-year period (1930-1939) prior to WWII, both societal and marketplace transitions, plus the gathering clouds of a possible war made an impact on the occurrence and makeup of the Army's difficulty in facing psychiatric issues. As an example, starting in 1930, serious physical disablement from auto mishaps outstripped suicide as the primary agent of death in the Army. This new development happened in the face of a build-up of suicide incidence for 1930-1939. The suicide incidence after WWI showed a uniform rise that reached a point above 0.5 per 1,000 strength during the hardest years of 1931 to 1934 of the Depression. After 1935, the incidence of suicide decreased with the year 1939 showing a rate of 0.29 per 1,000 strength. Alcohol abuse, both chronic and acute, as well as psychotic disorders, declined from 7.2 per 1,000 strength in the year 1930 to 3.3 in 1939. A number of reasons are provided for the decrease in alcohol related admissions such as: 1) a higher caliber of recruit entering the Army; 2) modifying procedures that advised against inpatient care of alcoholics not having coextensive medical conditions, which previously were a large pool for generating alcohol related hospitalization; 3) much improved refinement in diagnostic classification, which made it easier to identify neurosis and character disorders, as well as various psychotic conditions. This

⁸³ Ibid., 12.

⁸⁴ Ibid.

development led to the understanding that the factor of alcohol abuse revealed the presence of an underlying psychiatric disturbance.⁸⁵

Statistical studies in the Army demonstrated that hospitalization for psychiatric disorders during the early part of the Depression were less than those for the period 1920-1930, the difference being 7-9 per 1,000 strength in 1930-1939, in contrast to 11-12 per 1,000 strength for the years 1920-1929. It is assumed that what accounts for this decrease was the prevailing market depression that provided more higher caliber newcomers to military service than in the prior decade. Better recruitment material was observed in 1931 as higher scores were required on intelligence test measures. One other reason cited for the lowered numbers of admissions for psychiatric disorders was the smaller number of individuals arriving to the military. It was noted that the latter was associated with the fact that medical discharges happened in men during their initial term of enlistment. This decrease in the incidence of psychiatric disorders requiring hospitalization came to an end in the years 1934 to 1939 due to the Army expanding coextensive with an increase in new entrants to the Army. This resulted in psychiatric admissions to go to 8.5-9 per 1,000 strength per year. What is surmised from this, from a psychiatric standpoint, was that mobilization during any time period, with many men entering the military, that it is to be expected that increases in the occurrence of psychiatric illness occurs.⁸⁶

During the interwar period, the subject of psychiatric screening received more attention as it was known through medical experience that psychiatric illness continued to be a major cause of military ineffectiveness. In addition, after WWI, psychiatric illness resulted in 44% of the entire number of all releases from military service in the white enlisted men's ranks posted within the United States. The Army's thinking about this was that the statistics for discharges, due to psychiatric illness, was not due to any proliferation of psychiatric disturbances in American society, but rather to inadequate methods of physical examination of recruits for military service and to poor diagnostic precision. This rather dominating theme of selection during the interwar years was not balanced by sufficient attention to the stresses that might be inherent in military service alone. However, an Army medical board, following a four-year investigation, surmised that two years of assignment to the Philippines was sufficient to

⁸⁵ Ibid.,13.

⁸⁶ Ibid., 14.

compromise both the mental and physical effectiveness of commissioned officers, and advised a two-year limited posting.⁸⁷

The exercise of psychiatry in the Army in the early part of the 1930's changed little from the 1920s. However, there was a fair amount of discussion about there not being sufficient numbers of personnel in psychiatry. The Veterans Administration in late 1932 started to remove psychiatric patients from its hospitals and by 1933 veteran patients of various dispositions had seen their numbers cut from 2,000 to 457 and predominately left to the care of the civilian sector. Coextensive with this in 1933, the Roosevelt administration inaugurated the Civilian Conservation Corps and this required Army hospital facilities to provide for any medical treatment and care.⁸⁸

Just prior to the establishment of the Civilian Conservation Corps, Walter Reed General Hospital put into operation new physical facilities for both open and closed ward care and treatment of psychiatric cases that could contain a 200-bed patient load. The new facilities, at the time, were considered innovative with such amenities as modern baths, push button toilets, and showers designed to prevent a patient from hanging himself. The new facilities provided the needed bed capacity to treat more patients. Although Water Reed General Hospital continued utilizing malarial agents to treat general paresis and syphilis affecting the central nervous system, as well as dementia praecox, the treatment was evaluated to be relatively ineffective.⁸⁹

For the most part during the interwar period, central nervous system diseases were the primary reasons for discharge with dementia praecox as the most prominent reason for incapacitation. Dementia praecox placed 8th as a reason for hospitalization. This diagnosis was the leading cause for medical removal from overseas duty. In 1938 the term "dementia praecox" was replaced by that of schizophrenia in keeping with civilian sector psychiatric nomenclature.⁹⁰

Beginning in 1939, as events in Europe unfolded, the probability for war became a distinct reality. Although medical and surgical issues associated with mobilization for the increasing size of the Army were addressed by the Surgeon General in conjunction with the War Department, no parallel planning was the case for military psychiatry. The neglect of psychiatry

⁸⁷ Ibid., 14-15.

⁸⁸ Ibid., 15.

⁸⁹ Ibid., 15-16.

⁹⁰ Ibid. 16.

was unusual given the Army's post WWI familiarity with the incidence of psychiatric illness among its personnel, in addition to this having been noted numerous times in the Surgeon General's annual reports since 1920. This neglect is all the more difficult to understand given the available knowledge that bringing in a great number of men into the Army was going to generate a higher occurrence of the presence of psychiatric illness. Most of all, abundant historical data existed from WWI and other wars that demonstrated that combat was responsible for generating a sizable number of psychiatric casualties. WWI had shown a ratio of 4 medical casualties for every 1 psychiatric casualty. Yet, even though this knowledge existed and was accessible to the Army, it was somehow ignored by its leaders. This led to the Army placing no effort into the use of psychiatry in WWII. This was alongside the fact that the Army possessed no standards or methodology for the bringing in of a great number of men for military service. In addition, the organizational structures for looking after cases of psychiatric illness were hardly adequate, even for the slender size of the Army while the nation was still at peace. Added to this, the importance of having a psychiatrist attached to a division, as was the case in WWI, was discontinued in 1941. This was only reversed in November 1943.⁹¹

Psychiatry in the Army was neglected due to the fact that there were few medical officers trained as specialists in psychiatry. In the year 1940 of the 35 medical officers in the Army that had psychiatric assignments, just 4 were actually qualified to practice psychiatry as a specialty by the American Board of Psychiatry and Neurology. The remaining medical officers had no proper training. Furthermore, at this time, psychiatry as a discipline within the Army was relegated to a subdivision under medical departments in Army hospital facilities. It exercised hardly any sway with the Office of the Surgeon General. Nonetheless, most of the psychiatrists in the regular Army were shifted to assignments of command and administration. This resulted in the utilization of psychiatry in the WWII Army to be carried out by physicians entering the Army with a minimal military background. Thus, as was the case in WWI, the practice of psychiatry in WWII was carried out primarily by the civilian sector.⁹²

The civilian sector of professional psychiatry made its voice known to the Army as war loomed on the horizon. This involved leaders in civilian psychiatric practice and various

⁹¹ Ibid., 17-18.

⁹² Ibid., 18.

psychiatric institutions drawing attention to the need for psychiatry to be included in war preparation. To this end, a Dr. William C. Sandy, head of the American Psychiatric Association, set up a panel in June 1939 focused on planning for a sudden state of exigencies and to consult with the other military services as to psychiatric requirements and accessibility of trained persons. This panel appeared before staff personnel of the Surgeon Generals of both the Army and Navy on the 16th of October, 1939. An outcome of this meeting was to determine by soliciting information from civilian sector psychiatrists as to how many of them may be accessible to the military. The panel also held a meeting on the topic of military psychiatry in May 1940 at the annual gathering of the American Psychiatric Association (APA). In addition, the panel conducted an observation tour of the Canadian Army, and took part in meetings with officials from the Selective Service. Some narrators of this period of time have examined the endeavours of the APA and considered their efforts to be rather pedestrian, and that Army officials were less than enthusiastic in their reception. Another comment on the APA was that they were simply satisfied to make proposals and resigned themselves to be invited to help. In other words, they were not proactive enough to exercise influence with the Army.⁹³

Another development within the APA occurred in May 1942, whereby a criticism was made that both the Army and Navy were not using psychiatric resources (facilities and personnel) to their desired effect, given the knowledge gained from WWI. A formal APA directive was agreed upon to approve the assignment of a panel with authority to undertake an aggressive response to the Army and Navy not maximizing their psychiatric resources. Three psychiatrists were delegated to serve on this panel and sometime thereafter received appointments to serve as consultants to the Surgeon General. However, it was two years later, in 1944, that the neuropsychiatry consultant's division of the Surgeon Generals office, sought advice from these panel members.⁹⁴

In October 1939, one other psychiatric organization that promoted the marshalling of psychiatry in the event of war was the William Alanson White Psychiatric Foundation, headquartered in Washington, D.C. The head of this foundation was Dr. Harry Stack Sullivan. His energetic drive was productive of various published papers, including formal public

⁹³ Ibid., 19.

⁹⁴ Ibid.

addresses, all of which aggressively emphasized more involvement of psychiatry in arrangements for mobilization. The advice ensuing from Sullivan's efforts was for the proper psychiatric evaluation of those to be conscripted into military service.⁹⁵

In addition to the efforts of both the APA and the William Alanson White Psychiatric Foundation, the Federal Board of Hospitalization emphasized the need for psychiatric screening and planning for mobilization. This body espoused a formal intention on the 16th of July 1940 pertaining to securing more psychiatric beds in hospitals that might be needed in the event of war. Underlining this intention was the insistence upon a thorough physical examination of inductees to screen out those demonstrating any physical or mental incapacity. Underscoring this was the need to prevent any financial compensation claims against the Federal government. Reinforcing the need to prevent claims was the superintendent of St. Elizabeth's Hospital, Dr. Winfred Overholser, who relayed that the issue of increasing psychiatric bed capacity could be alleviated by vigorous psychiatric examination of inductees before they were accepted into the military service for training. The statement by Dr. Overholser was greeted favourably by President Roosevelt on the 17th of September, 1940, and he passed it along to the chairman of the National Advisory Committee on Selective Service, a Frederick H. Osborn, who was quite taken with the whole idea of psychiatric screening. He passed along his indorsement of this to the medical division of the National Headquarters of the Selective Service.

The chorus for screening took hold on the 24th of October, 1940 when Dr. Clarence A. Dykstra, the Director of the Selective Service, met with deputies from different sections of the War Department, including Dr. Overholser, Dr. Sullivan, and Dr. Francis C. Steckel. At this meeting, arrangements were actualized for putting a psychiatrist into each medical advisory board, numbering 660. The advisory boards were stacked with civilian physicians from different medical specialties. The medical examiner of the district draft board could consult these specialists when needed for cases requiring clarification of physical or mental status. The inauguration of the draft in November 1940 thusly provided for needed psychiatric consultation when required, and was a component of the physical status assessment. Those passing through the first phase of the selective service process and deemed suitable for military service then went through the Army Induction Center for a decisive appraisal of both physical and mental

⁹⁵ Ibid., 20.

suitability for military training and service. In order to place this into action, Dr. Harry Stack Sullivan was delegated to serve as the consultant in psychiatry to the Selective Service. Besides this development, The William Alanson White Psychiatric Foundation provided a method for psychiatrically evaluating registrants for the draft. Due to Dr. Sullivan's persuasion, the method devised evolved into the *Selective Service Systems Medical Circular* No.1, circulated on the 7th of November 1940. The intent of the circular (given the title "Minimum Psychiatric Inspection") was to assist examining physicians working in 6,403 of the nations draft boards in uncovering mental impairments and characterological pathology in draftees. Dr. Sullivan, with the assistance of notable civilian and military psychiatrists provided two-day teaching courses in a number of major cities, from January to July 1941 to aid psychiatrists working in medical advisory boards as well as in Army Induction Centers. As mobilization for war accelerated, the medical director of the Selective Service and Major General Louis B. Hershey, as Selective Service Director, expressed serious unease with the discovery that notwithstanding psychiatric evaluation to weed out those with signs and symptoms of psychological maladjustment, that this did not prevent large numbers of men being released from military service due to psychiatric disturbance. Following the attack on Pearl Harbour, and with the increased speed of drafting men for war service, in January 1942 the initial draft board psychiatric evaluation was discontinued in preference for a unitary psychiatric evaluation process at Army Induction Centers under formal Army oversight. This modification came under considerable opposition, and eventually led to Dr. Sullivan giving up his position as the Chief Civilian Psychiatric Advisor to the Selective Service.⁹⁶

The other civilian body bearing upon the need for organizing psychiatric services in case of war was the National Research Council (NRC). October 1940 saw it forming a council to provide guidance to the Surgeon General regarding neuropsychiatric matters associated with the defence of the nation. The council created separate task groups to address personnel and training, neurology, psychiatry, and neurosis. The task group on personnel enumerated the civilian psychiatry and neurology pools of personnel capable of being utilized for national defence, and the Surgeons General were appraised of this for their consideration. In June 1941, the NRC proposed that the U.S. Army Office of the Surgeon General consider setting up a division of

⁹⁶ Ibid., 20-22.

psychiatry, and that a consultant psychiatrist be posted to each corps district. However, these proposals were dismissed by the Army because they somehow didn't conform with Army policy at the time. As well, in June 1941 the NRC proposal that the Army give consideration to incorporate psychologists as members of the Army medical department to collaborate with psychiatrists, but this was not to happen until considerably late in WWII. The National Research Council on February 1941 proposed a program for inductees to be observed for up to 5 days in induction centers for psychiatric screening if judged to be necessary, but this was not actually acted upon. In 1942, the NRC advanced an idea for planning civilian sector teaching in psychiatry to aid with mobilization; however, the Surgeon General's Office declined this, thinking it not worth while at that point in the war. This teaching became actualized, though in 1944.⁹⁷

The role of the civilian body of professional psychiatrists during the period of mobilization leading up to WWII has been judged to have been much less influential than their predecessors in WWI. One reason noted is that, unlike WWI, WWII did not awaken a patriotic fervor for engaging in war, at least not until the Pearl Harbour attack. Another reason that can be surmised is that the group of professionals brought together under Dr. Salmon were received more positively by the Army in WWI probably due to providing the Army with the blueprint of psychiatric services required. One further explanation has been articulated. It is that the combination of influential civilian and military psychiatrists oversold screening at induction. This is probably the most likely explanation, and is inline with the foremost lesson coming out of WWI, emphasizing very stringent methods of personnel selection. This pretty well relieved the Army of the need to make resources available for delivery of programs of psychiatric services pertaining to both prevention and treatment. The overemphasis on selection made the Army neglect the fact that psychiatric cases are expected to happen as individuals come into the military and encounter the multitude of tensions associated with training, overseas duty assignments, and combat violence.⁹⁸

It is hypothesized that transcending all of the above explanations for the Army's proclivity to pursue selection to solve the problem of the presence of psychiatric disturbance in

⁹⁷ Ibid., 22-23.

⁹⁸ Ibid.,23.

its personnel, was its institutional amnesia of its own medical history, viz., Volume 10, *Neuropsychiatry in the Great War*, published in 1929. Even though Volume 10 underscored in their authors opinion the importance of selection, they also, and perhaps more importantly, provided crucial data and numerous relevant clinical observations pertaining to the need for psychiatric service organization and delivery. Even a cursory perusal of this volume easily attests to the fact that psychiatric casualties in war service are inevitable, regardless of personality predisposition. The volume also emphasized the need for “forward psychiatric” treatment to be organized and delivered in a combat zone by competent, trained professionals aided by enlisted personnel. A theme encountered in this volume is that it is not unusual for normal men to break down psychologically in combat conditions with fatigue often a precipitating factor. Thus, there was sufficient historical information in this volume to have alerted the Army to the need to plan and organize psychiatric prevention and treatment services for its personnel. The neglect of this volume by Army medical authorities is difficult to understand without invoking the notion of institutional amnesia of its own medical history.

A voice from the American Civil War, that of Surgeon Woodward, said “a history becomes one of the most important duties of the medical department of the Army; a duty the evasion of which could be a grave crime against the Army of the United States, and against every citizen who, in future wars, volunteers in the defence of his country.”⁹⁹ It took a Colonel Frederick. R. Hanson to revive the psychiatric lessons from WWI, such as forward psychiatric treatment, to reverse the Army’s neglect of incorporating psychiatry as a necessary component of military operations during wartime conditions. This is the subject matter of the next essay.

⁹⁹ This is quoted in John Boyd Coates, Jr. Colonel, MC, USA. “The History of the US Medical Department in WWII.” Cited in Bulletin of the Medical Library Association, 1959 July; 47(3), 264-273.

Chapter 5: Phantom Freddy and U.S. Army Psychiatry in World War

II

Abstract

This essay is part U.S. Army organizational medical history and part historical biography, both of which converge to describe the evolution of combat psychiatry in the Mediterranean Theater of Operations during World War II. The organizational medical history tells the story of where U.S. Army psychiatry stood at the beginning and during military operations in the Mediterranean campaign. The biographical history portrays the professional activities of Colonel Frederick. R. Hanson, working as a U.S. Army Medical Corps psychiatrist and shaping the Army's medical organization to provide necessary psychiatric intervention and treatment, predominantly centered on his reintroduction of WWI forward psychiatry principles, and their place in a three-echelon system of psychiatric care and treatment. Colonel Hanson has not been the subject of any single published essay to date. This paper addresses this omission, and presents Colonel Hanson as the pivotal figure for understanding the development of Army psychiatry in World War II in the context of U.S. Army organizational and institutional obstacles that needed to be surmounted. This essay repeats the tenets of forward psychiatry noted in Chapter 3. This is seen as necessary so as to situate it in the historical context of Colonel Hanson's military psychiatric practice during World War II. This will also assist with consolidating learning.

Introduction

The United States Army's first major combat engagement against Nazi Germany in World War II (WWII) was Operation Torch on November 8, 1942 with the Anglo-American landings on the North West coast of Africa.¹⁰⁰ Provision for the care and treatment of psychiatric casualties was far from adequate with respect to planning and organization, which this essay

¹⁰⁰ For accounts of Operation Torch and other campaigns in the Mediterranean Theater see: Vincent O'Hare, *Torch: North Africa and the Allied Path to Victory* (Annapolis, Maryland: Naval Institute Press, 2015); James Holland, *Together We Stand: America, Britain, and the Forging of an Alliance* (New York, New York: Miramax Books, Hyperion, 2005); Carlo D'Este, *Bitter Victory: The Battle for Sicily, 1943* (New York, New York: Harper Perennial Books, 1988); Rick Atkinson *The Day of Battle: The War in Sicily and Italy, 1943-1944*, vol.2 (New York, New York: Henry Holt and Company, 2007); Carlo D'Este, *Fatal Decision: Anzio and the Battle for Rome* (New York, New York: Harper Perennial Books, 1992).

explains. Nonetheless, this situation was remedied by Colonel Fredrick R. Hanson, a British trained psychiatrist, American by birth, who served with the Royal Canadian Army Medical Corps (RCAMC) before transferring to the United States Army. Colonel Hanson proves pivotal in understanding how combat psychiatry evolved in the U.S. Army of WWII. This essay begins with a biographical sketch of Colonel Hanson from a number of historical sources with emphasis on his British training in the Canadian Army. This is followed by a presentation of forward psychiatry, which Colonel Hanson re-established in the United States Army. This is incorporated into Hanson's professional activities as a psychiatrist and later as Theater Consultant in the North African and Mediterranean Theaters of Operation. Also, the essay highlights the relevance of a memorandum he wrote which is pertinent to understanding both combat and non-combat factors contributing to the incidence of psychiatric cases. Research during and after World War II lends support to the memorandum and is discussed. Hanson's activities will be seen as driving the medical organizational structure as related to the delivery of psychiatric services in the face of institutional obstacles. Hanson's contribution to supervising the making of a combat psychiatry textbook, his teaching of military psychiatry, a G-1 (Personnel and Administration) assignment as well as his post WWII professional activities, will complete the essay, which concludes with the legacy he leaves for U.S. Army medical history and the example he set as a soldier-psychiatrist.

Professional Education, Training, and Formative Experiences

Colonel Frederick R. Hanson (1909-1964) was a native of Nebraska who was born to Swedish and Irish immigrant parents.¹⁰¹ He attended the University of Nebraska Medical School and graduated in 1936. He interned from 1936-1938 at the Royal Victoria Hospital in Montreal, Quebec. This was followed by residency training in neurology at the Montreal Neurological Institute (1938) under Dr. Wilder Penfield, and another year, presumably in neurology, at the Royal Victoria Hospital. His military service begins in 1939 as a Captain in the Royal Canadian Army Medical Corps (RCAMC) until 1942, at which time he transfers to the U.S. Army.¹⁰² This transfer was facilitated by the then Brigadier General (later Major General) Paul R. Hawley,

¹⁰¹ 1930 United States Federal Census, Ancestry, <https://www.ancestry.com/search/collections/1930usfedcen/>

¹⁰² Biographical Listing of Frederick Randolph Hanson In, *Biographical Directory of the American Psychiatric Association* (New York, New York: R. R. Bowker Co, 1958).

Chief Surgeon for the European Theater of Operations, United States Army (ETOUSA).¹⁰³ What may have motivated Hanson to enlist in the Royal Canadian Army is suggested by Ben Shephard, who reasons that Hanson may have possessed a need in his character to jump into “the drama of war.”¹⁰⁴ While in the RCAMC, Hanson was posted to England in March, 1940.¹⁰⁵ He was assigned to serve in a Canadian Army Psychiatric Hospital that was established under Dr. Wilder Penfield’s direction. This hospital was known as the No.1 Neurological Hospital, and was referred to simply as “Basingstoke.”¹⁰⁶ At this time (1940), Hanson is considered a neurologically trained medical officer, rather than one specializing in psychiatry. Nevertheless, Hanson’s development as a psychiatrist coincides with his assignment to the No. 1 Neurological Hospital. According to Albert E. Cowdrey, Hanson “studied and learned from the experience of the allies.”¹⁰⁷ Thus, at the No. 1 Neurological Hospital, Hanson gained exposure to various specialists in both psychiatry and neurology which played a part in his intellectual and professional development as a neuropsychiatrist. Terry Copp and Bill McAndrew advance the notion that Hanson was not particularly impressed by either psychoanalytic or psychodynamic conceptualizations regarding breakdowns in soldiers following exposure to combat conditions.¹⁰⁸ Part of the British currency of psychiatric thought in 1940 (following the British Expeditionary Force evacuation from Dunkirk) was expressed by British psychiatrists William Sargant and Elliot Slater, who co-authored *Acute Cases of Neurosis*.¹⁰⁹ They comment on the “acute cases of war neurosis from France,” which showed that men of reasonably sound personality may break down if the strain is severe enough.¹¹⁰ Hanson’s own conception of why some soldiers breakdown in combat closely parallels Sargant and Slater. It will be shown below that Hanson

¹⁰³ Albert J. Glass, *Neuropsychiatry in World War II, vol.II, Overseas Theaters*, ed. Hal B. Jennings and Albert J. Glass (Washington, DC: Office of the Surgeon General, Department of the Army, 1973), 8.

¹⁰⁴ Ben Shephard, *War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge, MA: Harvard University Press, 2001), 224.

¹⁰⁵ *Ibid.*, 216.

¹⁰⁶ Glass, *Neuropsychiatry*, 2:3. See also Terry Copp and Bill McAndrew *Battle Exhaustion: Soldiers and Psychiatrists in the Canadian Army, 1939-1945* (Montreal & Kingston: McGill-Queen’s University Press, 1990), 16.

¹⁰⁷ Albert E. Cowdrey, *Fighting for Life: American Military Medicine in World War II* (New York, NY: The Free Press, 1994), 140.

¹⁰⁸ Terry Copp and Bill McAndrew, *Battle Exhaustion: Soldiers and Psychiatrists in the Canadian Army, 1939-1945* (Montreal & Kingston: McGill-Queen’s University Press, 1990), 18.

¹⁰⁹ William Sargant and Eliot Slater, “Acute War Neuroses,” *The Lancet* 236, no.6097 (1940): [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(01\)02672-1/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(01)02672-1/fulltext)

¹¹⁰ Copp and McAndrew, *Battle Exhaustion*, 18.

held the view that many factors played a role in soldier breakdown that were extrinsic to the soldier's personality.

Calvin Drayer and Albert Glass, in their official history of U.S. Army Neuropsychiatry in WWII, argue for the British influences impacting Hanson in his educational development as a specialist in military psychiatry. They point out that Hanson's contacts in the Canadian Army and then in the British 8th Army provided him with knowledge "of combat experiences such as those at Tobruk, Libya," where forward psychiatry was practised by the British 8th Army.¹¹¹ Supplementing these British influences upon Hanson's psychiatric education, Copp and McAndrew indicate that Hanson attended lectures at Sutton Emergency Hospital in 1941 and 1942 and was made aware of a "standardized notion of forward treatment of battle neurosis."¹¹²

After Hanson's transfer to the U.S. Army in May 1942, he secures a leave of absence in order to accompany the Canadian Army on the Dieppe Raid (August 1942) to "observe the stress of actual combat."¹¹³ Cowdrey asserts that this experience provided Hanson "a first-rate opportunity to study the reactions of men under fire."¹¹⁴ In addition, he remarkably participated in a "few torpedo boat excursions to France."¹¹⁵ It is unclear whether he did these torpedo boat runs while in the American Army or previously in the Canadian Army. Nevertheless, such daring actions lead Drayer and Glass to affirm that "by personally placing himself in difficult combat situations, he impressed both line and medical superiors with his realistic understanding of battle-induced psychiatric casualties and a need for their early and active treatment."¹¹⁶ Shepard adds to this dashing behaviour of Hanson by describing him as "clever, energetic, handsome, a slim figure in dark glasses and well-cut uniform."¹¹⁷

There is little doubt that Hanson's training and experiences, made him very valuable to the U.S. Army Medical Service. In addition, he appears to be perhaps the only American medical

¹¹¹ Glass, *Neuropsychiatry*, 2:3.

¹¹² Copp and McAndrew, *Battle Exhaustion*, 25. For an explanation of forward psychiatry treatment principals, see: Franklin D. Jones et al., ed., *War Psychiatry* (Washington, DC: Office of the Surgeon General at TMM Publications, Borden Institute, Walter Reed Army Medical Center, 1995), 9-11. The original classic articulation of forward treatment is: Pearce Bailey, Frankwood E. Williams, and Paul O. Komora, *Neuropsychiatry*, Vol.X, *The Medical Department of the United States Army in the World War* (Washington, DC: U.S. Government Printing Office, 1929), 283, 303, 309, 313, 314, 316, 317, 332; Ingraham and Manning, *Military Psychiatry*, 28-32.

¹¹³ Glass, *Neuropsychiatry*, 2:3.

¹¹⁴ Cowdrey, *Fighting for Life*, 140.

¹¹⁵ Shephard, *War of Nerves*, 216.

¹¹⁶ Glass, *Neuropsychiatry*, 2:1.

¹¹⁷ Shephard, *War of Nerves*, 217.

officer familiar with forward psychiatry, and thusly positioned himself exceptionally well for its reintroduction into the U.S. Army Medical Service. Reinforcing this is the fact that the Army's School of Neuropsychiatry's curriculum did not teach forward psychiatry, and neither did civilian medical schools providing training for army medical officers.¹¹⁸

Conceptualization of Forward Psychiatry

The historical antecedents of forward psychiatry are found in the medical practice of the Russian Army during the Russo-Japanese War (1904-1906),¹¹⁹ and in both the French and British Armies of World War I.¹²⁰ Pertinent to this discussion are the lessons the British learned from their French medical allies in World War I. The French implemented a system of forward treatment centres close to the front lines, which were adopted by the British.¹²¹ Both British and French medical officers had discovered that "patients with war neurosis, improved more rapidly when treated in permanent hospitals near the frontline than at the base, better in casualty clearing stations than even at advanced base hospitals and better still when encouragement, rest, persuasion and suggestion could be given in a combat organization itself."¹²² The lesson extracted from the French and British is that the longer a soldier is separated from his squad or platoon members, the more likelihood there is for his allegiance to them to deteriorate. This sets into motion the passage of time "for consolidation of the rationalization of his symptoms."¹²³ In other words, symptoms can become fixed and lead to chronicity, resulting in the soldier's condition being refractory to psychiatric intervention. This stresses the importance of treatment given as immediate as possible, and in proximity of the front. Underscoring proximity and immediacy is the forward psychiatric principal of expectancy, which is conveying to the soldier that he is not a psychiatric case, but rather he is tired, and with rest, will recover. Therefore,

¹¹⁸ William Menninger, "Education and Training," in *Neuropsychiatry in World War II: Zone of the Interior*, ed. Albert J. Glass and Robert J. Bernucci, (Washington, 1966), 1:53-58. The fact that the Army school of Neuropsychiatry did not teach forward psychiatric treatment is also confirmed by Sanders Marble, Senior Historian, United States Army Medical Department of History and Heritage. Personal Communication, February 2014.

¹¹⁹ Albert J. Glass, "Army Psychiatry Before WWII", in *Neuropsychiatry in World War II: Zone of the Interior*, ed. Albert J. Glass and Robert J. Bernucci, (Washington, 1966), 1:3.

¹²⁰ Edgar Jones and Simon Wessely "Battle for the Mind: World War I and the Birth of Military Psychiatry," *The Lancet* 384, no.9955 (2014): [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)61260-5/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61260-5/fulltext).

¹²¹ Ibid.

¹²² Albert J. Glass and Franklin D. Jones *Psychiatry in the U.S. Army: Lessons for Community Psychiatry* (Bethesda, MD: Uniformed Services University of the Health Sciences, F. Edward Herbert School of Medicine, 2005) <http://www.dtic.mil/dtic/tr/fulltext/u2/a434841.pdf>

¹²³ Ibid.

expectancy is created as the central principal from which the others derive. A soldier close to his unit (proximity) can expect to return to it.¹²⁴ There is one other principle that can be applied to forward psychiatry and this is ‘simplicity’. Simplicity in forward treatment refers to the avoidance of Freudian psychoanalytic or psychodynamic explanations for the soldier’s stress reaction to combat. The principal of simplicity underlies the fact that simple treatment (rest, food, perhaps a shower, and reassurance) assists the soldier in not coming into any idea that he is sick, either physically or mentally.¹²⁵

Colonel Thomas W. Salmon, on assignment from the U.S. Army Surgeon General in 1917, “observed and synthesized the British and French experience.”¹²⁶ In his capacity as the Neuropsychiatry Consultant to the American Expeditionary Force (AEF) in WWI, he implemented a three-tiered system of treatment intervention toward the end of the war. This system is described by Glass as follows: 1) divisional psychiatric facilities which maintain treatment facilities for three to ten days of respite from combat that included rest, sleep, suggestion, reassurance, and other psychotherapeutic measures, under the supervision of a division psychiatrist; 2) neurological hospitals that would receive refractory cases from divisional facilities for two to three weeks of treatment and; 3) a psychiatric base hospital in the advanced communication zone which provided prolonged treatment for the most resistant of war neurosis.¹²⁷ According to Glass, this system took effect toward the end of WWI.¹²⁸ Colonel Salmon was cognizant of the potentially negative effects of assigning a discreet diagnosis “for the early, fluid manifestations of psychiatric casualties.”¹²⁹ This led the AEF medical staff to applying the term “N.Y.D.N. (Not Yet Diagnosed, Nervous)” to the early stages of combat associated psychiatric cases. This is an important contribution to psychiatric treatment because it emphasizes the most minimal of psychiatric disturbance. As well, it was thought that N.Y.D.N as an initial diagnosis might prevent a crystallization of symptoms. Additionally, how soldiers were

¹²⁴ Ibid. See Also: Franklin D. Jones, “Psychiatric Lessons of War,” in *War Psychiatry*, ed. Franklin D. Jones, Linette R. Sparacino, Victoria L. Wilcox, Joseph M. Rothberg, James W. Stokes, (Washington, DC: Office of the Surgeon General at TMM Publications, Borden Institute, Walter Reed Army Medical Center, 1995), 9.

¹²⁵ Jones, *Psychiatry in the U.S. Army*, 4.

¹²⁶ Franklin D. Jones, “Psychiatric Lessons of War,” in *War Psychiatry*, ed. Franklin D. Jones, Linette R. Sparacino, Victoria L. Wilcox, Joseph M. Rothberg, James W. Stokes (Washington, DC: Office of the Surgeon General at TMM Publications, Borden Institute, Walter Reed Army Medical Center, 1995), 9.

¹²⁷ Glass, *Neuropsychiatry*, 2:999.

¹²⁸ Ibid.

¹²⁹ Ibid., 989-990.

received and treated by medical personal could conceivably be influenced negatively by psychiatric diagnostic nomenclature.¹³⁰ Despite the adoption of N.Y.D.N, “shell shock” persisted as a diagnosis despite its differing and conflicting meanings and interpretations. Nonetheless, N.Y.D.N as a term was an early attempt in the Army Medical Services to prevent stigma associated with psychiatric intervention and treatment.

Another development associated with this system in WW1 was advice coming from the U.S. Army Surgeon General, Division of Neurology and Psychiatry, which resulted in the War Department developing the position of division psychiatrist carrying the rank of Major.¹³¹ According to Ingraham and Manning, the services that were to be provided by the division psychiatrist “were successfully employed in only one American division in AEF.”¹³² Nevertheless, it will be shown below how Colonel Hanson played a pivotal role in re-establishing the position of division psychiatrist in WWII during the Mediterranean campaign.

Interwar Years

It would be amiss not to mention a recommendation arising from the AEF psychiatric experience in WWI, which impinged upon Army psychiatry in WWII. This recommendation centered upon having strict guidelines for personnel selection. The idea was to exclude from military service those who were assessed to have a predisposition to psychiatric illness under conditions of stress. This justification for selection was markedly made evident in the interval between the World Wars by “high cost of veteran compensation for mental disability.”¹³³ No doubt, the premise for selection was also reinforced by psychiatry purporting to possess the intellectual tools to enact selection. This proved to be naïve. Glass indicates that selection in WWII was not successful in the least and failed to exclude “the military’s psychiatric problems at induction.”¹³⁴ Psychiatry simply was unable to predict who was psychiatrically fit or unfit for army service. In addition, Glass argues that psychiatric screening logically followed from the army’s disavowal or neglect to recognize the extent of “the psychiatric problem in war.”¹³⁵ Thus,

¹³⁰ Ibid.

¹³¹ Bailey, Williams, and Komora, *The Medical Department of the United States Army*, 26.

¹³² Ingraham and Manning, *Military Psychiatry*, 33.

¹³³ Ibid.

¹³⁴ Albert J. Glass, “Lessons Learned”, in *Neuropsychiatry in World War II: Zone of the Interior*, ed. Albert J. Glass and Robert J. Bernucci (Washington, 1966), 1:735-759.

¹³⁵ Ibid., 743; See Also: Dr. Eli Ginzberg, “Manpower Utilization in Industry” (Lecture, Industrial College of the Armed Forces, Washington, DC, November 29, 1959), 7.

the reliance upon screening is considered to have played a role in the lack of planning for psychiatric services in American Ground Forces at the time of Operation Torch (November 1942), which was corrected by Colonel Hanson's assignment to North Africa in February 1943 and is discussed below.

Added to the issue of selection whose purpose was to obviate the need for an appreciation of psychiatric issues associated with war, the U.S Army had pretty well forgotten the lessons of its psychiatric experience in WW1. Glass asserts that the lessons generated by the WWII experience demonstrated that "combat psychiatry . . . should be regarded as relearned and consolidated insights."¹³⁶ This applies to forward psychiatry also. Moreover, William Menninger, having served as Chief Consultant in Neuropsychiatry to the Surgeon General of the U.S. Army (1943-1946) also offers his opinion about why WWI psychiatry was neglected or forgotten. He reasons that the perception of psychiatry was negative and subject to prejudice in both the civilian and military sectors.¹³⁷ Additionally, Menninger went even further in his criticism in an address to the American Psychiatric Association in 1946, when he stated, "The most severe indictment that can be made must be laid at the feet of the psychiatric profession as a whole, we permitted the military to forget almost all the lessons that we learnt in the last war."¹³⁸

Fortunately, the British Army, under which Hanson trained, did not forget about the WWI implementation of forward psychiatry. The Consultant Psychiatrist to the British Army during WWII, Brigadier John Rawlings Rees, asserted that Salmon's contribution to Volume Ten, *Neuropsychiatry in the Great War* served as the prevailing guide for British military psychiatry at the start of WWII.¹³⁹ This is in contrast to the U.S. Army School of Neuropsychiatry whose curriculum did not include any course in forward psychiatry.¹⁴⁰

Prelude to Operation Torch

Prior to the launching of Operation Torch and Hanson's assignment to North Africa, he had undergone what seems to be a self-directed internship in organizing psychiatric services for soldiers. As the Neuropsychiatric Consultant to the U.S. Army stationed in Northern Ireland, and

¹³⁶ Glass, *Neuropsychiatry*, 2:989.

¹³⁷ Menninger, *Psychiatry in a Troubled World*, 7.

¹³⁸ William C. Menninger, "Psychiatric Experience in the War, 1941-1946," *The American Journal of Psychiatry* 103, no.5 (1947), 577-586.

¹³⁹ John R. Rees, *The Shaping of Psychiatry by War* (London: Chapman and Hall, LTD., 1945), 10.

¹⁴⁰ Glass and Bernucci, *Neuropsychiatry*, 1:56-57.

simultaneously serving as part-time consultant to the British Army, he had “coordinated neuropsychiatric services, had established outpatient and consultation services for extramural psychiatric problems, and was maintaining close liaison with ground forces in the screening, assignment, and classification of personnel in combat and replacement centres.”¹⁴¹

It is unknown why the then Captain Hanson, given his proficiency in establishing psychiatric services, was not part of the medical planning for Operation Torch.¹⁴² In fact, the Director of the Neuropsychiatric Branch of the U.S. Army Surgeon General’s Office was not “informed officially that an invasion of North Africa was even being contemplated.”¹⁴³ Given this development, it was to be foreseen that the need for providing psychiatric services to soldiers in North Africa was simply not resourced in medical planning. In addition, on January 3rd 1943, Captain Hanson attended a conference “presumably in England” with Lieutenant Colonel Long, the then Scientific Liaison Officer, Office of the Surgeon General ETOUSA, and General Hawley regarding psychiatric services anticipated in North Africa. It is at this conference that Hanson learned that psychiatric services had not been part of Operation Torch planning for “logistical reasons.”¹⁴⁴ Drayer and Glass surmise that there “existed honest doubt at high levels concerning the actual value of psychiatric services in combat areas.”¹⁴⁵ As well, Brigadier General Charles C. Hillman, Chief, Professional Service Division, Army Surgeon General’s Office, reported to General Hawley that staff of the Royal Army Medical Corps thought that the need for psychiatric services in North Africa was over estimated.¹⁴⁶ Nonetheless, the outcome of all of this was General Hawley assigning Captain Hanson sometime around the January 21st, 1943 to North Africa as Colonel Long felt that he needed a neuropsychiatric consultant in the theater.¹⁴⁷ The official history conveys the understanding that it would be Hanson’s services that would be sequestered for the latter phase of Operation Torch.¹⁴⁸

¹⁴¹ Glass, *Neuropsychiatry*, 2:5.

¹⁴² *Ibid.*

¹⁴³ *Ibid.*, 4.

¹⁴⁴ *Ibid.*, 6.

¹⁴⁵ *Ibid.*

¹⁴⁶ *Ibid.*

¹⁴⁷ *Ibid.*

¹⁴⁸ *Ibid.*, 5.

Hanson's Arrival in North Africa

The datelines for Operation Torch from November 8th, 1942 to May 13th, 1943, includes the Tunisia campaign from late fall 1942 until the Axis surrender in May 1943. The situation Hanson encountered upon arrival in North Africa was not a satisfactory one, there being no adequate psychiatric treatment for American ground troops. As U.S troops moved further East from Algeria into Tunisia, the number of psychiatric cases increased considerably. This increase resulted in a considerable amount of loss of manpower. This loss was created by a lack of frontline interventions with treatment being relegated to station and general hospitals.¹⁴⁹ Thus, psychiatric casualties were evacuated far to the rear, and prior to Hanson being posted for duty in North Africa, many were sent to the British 95th General Hospital in Algiers.¹⁵⁰ Many of these casualties did not return to their units, resulting in loss of manpower. The U.S. Army had no organized psychiatric services of its own in place to provide treatment in a combat zone. Psychiatry at this time was fairly subordinate to medicine and surgery in terms of status.¹⁵¹ Prior to Hanson's leaving for the North African campaign, he consulted with Colonel Thompson (Consultant in Neuropsychiatry, ETOUSA) as well as with the officer commanding the 36th station hospital in Northern Ireland. In addition, Hanson also consulted with other Army neuropsychiatrists. These meetings do appear, according to the official medical history, to have informed Hanson about planning needs for neuropsychiatric services.¹⁵² The organizational planning is articulated in a memorandum dated February 22nd, 1943 and authored by Hanson. The memorandum spells out the manner in which psychiatric services are to be organized and delivered in a combat zone. Moreover, it establishes the emphasis upon early treatment that is active with a view to preventing the crystallization of symptoms. Psychiatric services are organized as a three-tier delivery system. The first tier is understood as forward (at Battalion or Division level), augmented by a second tier of psychiatric services provided by evacuation hospitals and special neuropsychiatric hospitals. The third tier was a general hospital for long term treatment and reclassification with a predominance of cases going to the Zone of the Interior.¹⁵³ Drayer notes that "the three levels of psychiatric treatment evolved in an irregular

¹⁴⁹ Ibid., 6.

¹⁵⁰ Ibid.

¹⁵¹ Glass and Bernucci, *Neuropsychiatry*, 1:33.

¹⁵² Glass, *Neuropsychiatry*, 2:198.

¹⁵³ Ibid., 1029-1030.

fashion over a considerable time period.”¹⁵⁴ Nonetheless, this three-tiered (or echelon) system described by Hanson, is parallel to the system practised by the British Army Medical System in WWII.¹⁵⁵

Hanson Initiates Forward Treatment

Just prior to Hanson’s memorandum (February 22, 1943) outlining a three-echelon organization for delivery of psychiatric services, Colonel Long on February 12th, 1943 surveyed the combat zone. His observations were put into a report to the Surgeon for NATOUSA (North African Theater of Operations, U.S. Army) on February 21st, 1943. The report highlighted the growing cases of psychiatric casualties “produced when new and untrained troops were placed into battle for the first time.”¹⁵⁶ Meanwhile, Captain Hanson was posted at Sidi Bou Hanifia near Oran to work with a Major Lewis L. Tureen, and both assigned to II Corps toward the end of March 1943.¹⁵⁷

Hanson conducted research between arriving in North Africa and his being assigned to II Corps. This involved studying psychiatric cases from the battles of El Quettar and Maknassy in the South of Tunisia. This research was done on behalf of the theater surgeon to assist in determining the nature of the numerous psychiatric casualties.¹⁵⁸ Working with these cases at the II Corps clearing station, close to Maknassy toward the end of March 1943, Hanson discovered that 30% of the entire number of psychiatric cases, if receiving treatment in proximity to the combat area, were able to return to full duty inside of 30 hours.¹⁵⁹ The medical psychiatric intervention Hanson enacted was administration of heavy sedation upon admittance to the clearing station followed by admittance to an evacuation hospital with sedation continued as well as administration of supportive psychotherapy for a three-day period. Following treatment, the soldier was sent back to his unit, or if needed, sent to the communications zone for additional or more specific psychiatric treatment.¹⁶⁰ The significance of Hanson’s implementation of forward

¹⁵⁴ Calvin S. Drayer, "Introduction", in *Neuropsychiatry in World War II: Overseas Theaters*, ed. Albert J. Glass (Washington, 1973) 2:9.

¹⁵⁵ *Proceedings of the Royal Society of Medicine*, “Discussion: Forward Psychiatry in the Army,” (39) no.3, (January 1946): 137-142.

¹⁵⁶ Glass, *Neuropsychiatry*, 2:9.

¹⁵⁷ *Ibid.*, 8.

¹⁵⁸ Charles M. Wiltze, *The Medical Department: Medical Service in the Mediterranean and Minor Theaters* (Washington, DC: Office of the Chief of Military History, Department of the Army, 1965), 144-145.

¹⁵⁹ *Ibid.*, 145.

¹⁶⁰ *Ibid.*

psychiatry treatment is analyzed by Charles Wiltse in his overview of medical services in the Mediterranean Theater in which he indicated that the most significant unanticipated medical issue during the Tunisian campaign was the high frequency of psychiatric cases (battle fatigue). The unexpected numbers of cases placed a great onus on the forward medical units. Due to the absence of a forward psychiatry service many of these cases in the initial phase of the Tunisian campaign were sent to hospitals in the communication zone with less than 3% returning to combat duty.¹⁶¹ Casualty numbers were also noted by Drayer, stating that the Tunisian campaign (Battles of Kasserine Pass and Faid Pass) “produced a flood of psychiatric casualties” until forward treatment was implemented as close to the combat zone as possible. Drayer provides the example of the battles of Maknassy and El Quettar to illustrate that Captain Hanson’s intervention using forward treatment was responsible for returning over 70% of the 495 psychiatric casualties back to combat following 48 hours of psychiatric intervention.¹⁶² Hanson’s interventions were augmented by a Major Tureen, and described as quickly restoring “the majority of the remainder for duty in the base section.”¹⁶³

During combined operations in Bizerte (Tunisia) division surgeons were charged with providing “initial treatment” with psychiatrists providing follow-up at the following evacuation hospitals: the 9th, 11th, 15th, and 128th. Each one of these hospitals were situated in the “forward area.” Hanson worked out of the 48th Surgical Hospital, which was renamed the 128th Evacuation Hospital. Wiltse indicates that “cases returned to full duty without leaving the combat zone ranged from 58%-63%.”¹⁶⁴

Hanson’s conduct in the performance of his duties is noted in a memoir of an Army nurse on the front line. Hanson is described by this nurse, posted also at the 48th Surgical Hospital after the Kasserine Pass battle, as diligently examining numerous fatigue cases in a “low and calm” tone of voice. Hanson gave orders for nurses to ensure cases were put to bed, given a large dose of barbiturates, and to wake them up just for food and toileting needs. Hanson also added that he wanted the nurses to let the patients sleep and not to engage them with conversation.¹⁶⁵

¹⁶¹ Ibid., 44.

¹⁶² Glass, *Neuropsychiatry*, 2:8-9.

¹⁶³ Ibid., 9

¹⁶⁴ Wiltze, *The Medical Department*, 145.

¹⁶⁵ Cowdrey, *Fighting for Life*, 140.

Cowdrey emphasizes that Hanson and other neuropsychiatrists went about their work “from back to front.” This involved searching for methods dealing with psychiatric casualties in the rear and then providing intervention in forward areas over time until eventually the Army instituted the position of Division Psychiatrist.¹⁶⁶ Wiltse indicates that Hanson’s observations of treating psychiatric casualties associated with combat “close to the source of disturbance” alerted the War Department for the need of a psychiatrist assigned at division level. Thus, the War Department approved in October 1943, the assignment of psychiatrists to divisions. Hanson was asked by the U.S. Army Surgeon General to assist in the “indoctrination” of a number of psychiatrists on a trip he made to the Zone of the Interior (presumably Washington, D.C) to assist in the implementation of psychiatry at division level.¹⁶⁷ Presumably, Hanson would then have talked about his experience in the Tunisian campaign to this group and thus oriented them to the work that needed to be done by them.

Significance of Exhaustion as Diagnosis

Hanson is noted by Cowdrey as being able to secure a directive from General Omar Bradley’s II Corps. The directive (April 26, 1943) insisted that psychiatric casualties were to be treated in a facility close to the front. In addition, they were to be diagnostically designated as “exhaustion” cases, a label originating with the British 8th Army.¹⁶⁸ The use of “exhaustion” was understood to be the “initial diagnosis for all combat cases.”¹⁶⁹ The significance of designating combat psychiatric cases as “exhaustion” is to be understood as avoiding any intimation of mental illness and aptly described how soldiers in need of intervention actually perceived themselves.¹⁷⁰ Most importantly, the term “exhaustion” conveyed to the individual soldier that he did not have a permanent disability. Instead, he had a temporary or transient condition that was treatable with rest, a hot bath, an opportunity to express his feelings, and receive sedation if necessary. He was also given reassurance and words of comfort from a medical officer in authority that he would be alright. As Cowdrey noted, this was accomplished “all in a forward

¹⁶⁶ Ibid., 142.

¹⁶⁷ Wiltze, *The Medical Department*, 254.

¹⁶⁸ Cowdrey, *Fighting for Life*, 142.

¹⁶⁹ Franklin D. Jones, Linette R. Sparacino, Victoria L. Wilcox, Joseph M. Rothberg, James W. Stokes, ed., *War Psychiatry* (Washington, DC: Office of the Surgeon General at TMM Publications, Borden Institute, Walter Reed Army Medical Center, 1995), 12.

¹⁷⁰ Ibid.

location where air raids still occurred.” This meant that proximity and expectancy were practised as principals of forward psychiatry.¹⁷¹

John Ellis, a historian of WWII, has remarked that the term “combat exhaustion” was an inexact one, but rather importantly served the purpose of addressing the fact that psychiatric breakdown in combat can be explained by not one, but by “a whole variety of factors.”¹⁷² Thus, breakdown was not to be understood as solely driven by so-called weakness or deficits in a soldier’s psychological make-up. In addition, use of the term “exhaustion” opened the door to viewing psychiatric casualties from a multi-causal viewpoint, but not necessarily negating the soldier’s psyche. In addition, the term “exhaustion” avoided the utilization of competing theories of psychoanalytic schools of thought pertaining to causality of breakdown in the combat soldier. This meant that an assortment of conditions outside the soldier’s psyche could play a significant role in provoking breakdown. In this regard, Hanson’s psychiatric work in the Tunisian campaign conveyed to him a connection between excessive physical demands and the presence of psychiatric casualties.¹⁷³ Hanson asserts that “statistical measures” indicate that when infantry units engage enemy combatants in intense tactical operations, whether defensibly or offensively that, as a consequence, psychiatric cases outnumber those wounded. Furthermore, Hanson refers to collected data indicating that following four continuous days of combat, there is a “disproportionate increase in psychiatric casualties” compared to wounded in action.¹⁷⁴ Hanson ascribes this finding to the “increasing physical strain caused by fatigue and the increasing emotional impact of the unfavourable environment on the tiring soldier.”¹⁷⁵ Conversely, Hanson, citing statistics, indicates that battalion or smaller units engaging with enemy forces showing little resistance, experience slight emotional tension, displayed no increments in psychiatric casualties despite the fact that in the latter case “extreme physical fatigue” was present.¹⁷⁶ Hanson’s analysis of these two dissimilar combat conditions indicates that fatigue alone was not necessarily responsible in generating psychiatric casualties. Instead, it is the merging of

¹⁷¹ Cowdrey, *Fighting for Life*, 143.

¹⁷² John Ellis, *The Sharp End: The Fighting Man in World War II* (New York, NY: Charles Scribner’s Sons, 1980), 62.

¹⁷³ Frederick R. Hanson, “The Factor of Fatigue in the Neurosis of Combat,” *Bulletin of the U.S. Army Medical Department* 9 (1949): 147-150.

¹⁷⁴ *Ibid.*, 191-204.

¹⁷⁵ *Ibid.*

¹⁷⁶ *Ibid.*, 147-150.

emotional distress and physical fatigue that results in the “disproportionate increase in psychiatric casualties.”¹⁷⁷

Hanson relates that even a cursory physical examination of psychiatric casualties in forward treatment facilities demonstrated that soldiers exhibited a weariness to a degree indicative of exhaustion. In addition, the most significant of all factors resulting in this grading of fatigue was the ubiquitous sleep deprivation in the soldier’s life. Hanson provides a long list of circumstances on the battlefield contributing to lack of sleep. These are “continuous shelling, strange noises at night, flares, sentry and patrol duties, rain, snow, cold, heat, insects, and the ever-present threat of the enemy.”¹⁷⁸ All these conditions work together to interfere with the soldier not having even a semblance of adequate sleep. Still more, conditions conspire to deprive the soldier of sleep, such as prolonged time spent in exacting effort, a diet depleted of adequate amounts of physical calories compounded by rations that “that become distasteful through its monotony.”¹⁷⁹ Hanson asserts that it therefore becomes obvious that the infantrymen’s physical status simply worsens and as fatigue becomes greater with continued combat in the context of having to cope with “the emotional stress of fear,” that the combat soldier faces the likelihood of becoming a psychiatric casualty. High levels of fatigue create a situation that diminish the combat soldier’s capacity to handle emotional strain.¹⁸⁰ Despite this situation, Hanson asserts that it is neither a permanent condition nor one that results in a definitive change of the personality. Avoiding the medicalization of the psychiatric patient is understood to aid in the prevention of a condition of chronicity.¹⁸¹ Thus, Hanson’s observations leave him to say “it has been repeatedly demonstrated that soldiers who had a marked degree of fatigue before becoming psychiatric casualties almost invariably responded rapidly to the treatment and return to effective combat duty.”¹⁸² The return to combat duty not only served to conserve fighting strength but is facilitated by the forward psychiatric principal of expectancy.

Hanson’s conceptualization of psychiatric breakdown received considerable support from Menninger who oversaw U.S. Army psychiatry in WWII. Menninger noted that the psychiatric

¹⁷⁷ Ibid.

¹⁷⁸ Ibid.

¹⁷⁹ Ibid.

¹⁸⁰ Ibid.

¹⁸¹ Ibid.

¹⁸² Ibid.

experience in WWII demonstrated that a soldier's underlying personality configuration played a considerably less influence in psychiatric casualties than the kind and amount of "environmental stresses," the soldier underwent.¹⁸³

Perceived Value of Forward Treatment

Regarding forward treatment in terms of its expediency as practised by Hanson and other psychiatrists, including battalion medical officers, Menninger has offered his insight into its value. He reasons that "treatment therefore was aimed at improving a man sufficiently to function, not seeking perfection of his health."¹⁸⁴ Underlying this reasoning was the premise that once the soldier was judged to have recovered sufficiently, he was expected to return to duty. The principal of conserving fighting strength thusly appears to be implied here as not only exemplifying the Army Medical Department's motto, but also as a manpower policy.

The forward treatment initiated by Hanson promoted normal behaviour combined with expectancy in a military context. As an example, soldiers were made responsible for maintaining personal hygiene as well as being required to follow ward routines. They were also required to advance on their own to the mess hall. In addition, no soldier was permitted to remain in forward treatment beyond a three-day period. This limited stay was predicated by the observation that beyond three days, some soldiers exhibited hypochondriacal symptoms in order to extend their stay given a preference for safety over returning to combat.¹⁸⁵ Nonetheless, for the majority of soldiers, being away from the stressful demands of combat, albeit for a short time, did refresh them since it was combined with "sleep, a bath, verbalizing their experiences, and receiving comforting words from an authority figure in proximity to the front."¹⁸⁶

Cowdrey, commenting on forward treatment, relays that Hanson and his peers demonstrated that the combat psychiatrist works with the practical, atheoretical assumption that the combat situation was the trigger for breakdown. He states further that the methods employed were responsible for working "in the greatest number of cases, salvaged the greatest number of soldiers, and returned them to useful work either in combat or in non-combat jobs."¹⁸⁷

¹⁸³ Menninger, "Psychiatric Experience in the War, 1941-1946," 577-586.

¹⁸⁴ Menninger, *Psychiatry in a Troubled World*, 301.

¹⁸⁵ Cowdrey, *Fighting for Life*, 143.

¹⁸⁶ Ibid.

¹⁸⁷ Ibid.

The forward treatment initiated by Hanson can be considered instrumental in supplanting the belief in predisposing personality factors as responsible for breakdown, and instead were now replaced by the combat situation as the triggering factor. In addition, Hanson's experience in establishing forward psychiatry led him to the observation that relatively mentally healthy soldiers were not immune to combat exhaustion. Anyone could succumb to being a psychiatric casualty.¹⁸⁸ This also reversed the prewar belief that those predisposed to neurosis could be weeded out. The overselling of psychiatry at the start of WWII simply proved over-zealous and unwarranted - given the combat fatigue rate. In fact, until Hanson's arrival in North Africa and his implementation of forward treatment, soldiers exiting the front lines due to combat fatigue outnumbered those soldiers who could be sent to the North African Theater of Operations. This resulted in "cooks, mechanics, and other support personnel, being reassigned to infantry units."¹⁸⁹

Manpower Policy Issues

Administratively within the Army, problems existed with the replacement system that was evident during the Tunisian campaign before and after the Kasserine Pass battle.¹⁹⁰ In Rick Atkinson's words, soldiers were seen as "interchangeable parts."¹⁹¹ Hanson viewed the Army's manpower policy and replacement system in a post WWII paper as "this numerical approach" which added to psychiatric casualty rates and resulted in combat inefficiency.¹⁹² As an example, in mid February 1943, the need for replacements resulted in cannibalising soldiers from the 3rd Infantry Division and 2nd Armoured Division in Morocco. Many soldiers were competent, but "few Commanders could resist the chance to dump their troublemakers and bunglers, too."¹⁹³ However, many replacements were reported to have not completed basic combat training and substantial numbers were characterized as "physical or disciplinary derelicts."¹⁹⁴ Further, Atkinson refers to a study of replacements indicating that some 80% were not rifle qualified. The

¹⁸⁸ Ibid., 143.

¹⁸⁹ Brian H. Chermol, "Wounds without Scars: Treatment of Battle Fatigue in the U.S. Armed Forces in the Second World War," *Military Affairs* 49, no.1 (1985), 9-12.

¹⁹⁰ Rick Atkinson, *An Army at Dawn: The War in North Africa, 1942-1943* (New York, NY: Henry Holt & Co., 2002), 403.

¹⁹¹ Ibid.

¹⁹² Frederick R. Hanson, *Psychologic Factors of Adaptation in Combat* (Washington, DC: Dept. of Defense, Research and Development Board, 1951), 1-26.

¹⁹³ Atkinson, *An Army at Dawn*, 1:403-404.

¹⁹⁴ Ibid., 404.

2400 soldiers assigned as replacements to the 34th division included many who were considered too old for combat and not in physical shape to withstand the rigours of combat.¹⁹⁵ Importantly related to these manpower issues is the official neuropsychiatric history's observation which indicates a markedly pervasive nonaggressive characteristic of the American soldier as well as the finding that "everyone has his breaking point."¹⁹⁶ Thus, Hanson's concern over manpower policy would appear to support his contention that poor policy was a significant factor in contributing to the psychiatric casualty rate. As well, it did seem a given that soldiers both physically and psychologically unfit for combat were destined to become not only ineffectual soldiers, but also psychiatric casualties with a breaking point that came far too early.

Hanson's concern with U.S. Army manpower policy has also been echoed by Steckel. Steckel has elaborated upon manpower policy being responsible for morale problems in WWII combat soldiers. The morale issue is seen as connected to problems with achieving unit cohesion, contributing to adjustment problems in dealing with combat conditions. As well, soldiers "lacked combat knowledge, skills, and conditioning."¹⁹⁷ Again, policy played a role in facilitating a soldier's breaking point. This is reinforced by the Army's own official history referring to "personnel physically unqualified for overseas service" in the Summer of 1943.¹⁹⁸ In one sample of 12,000 soldiers, men were found to be under the Army average in height, weight, intelligence, and education.¹⁹⁹ In addition, the official history indicates that morale problems in soldiers undid what the soldier was trained to do.²⁰⁰ Again, policy in combination with substandard soldier material, played a role in facilitating a soldier's breaking point given his precariously deficient adjustment potential and capacity to be an effective soldier even prior to engagement in actual combat.

Psychological Role of Leadership

In addition to manpower policy, Hanson also views the subject of leadership as playing an important psychological role in a soldier's capacity to adapt to combat, although he

¹⁹⁵ Ibid.

¹⁹⁶ Glass, *Neuropsychiatry*, 2:18-19,50.

¹⁹⁷ Francis C. Steckel, "Morale Problems in Combat: American Soldiers in Europe in World War II," *Army History*, no.31 (1994): 1-8.

¹⁹⁸ Robert R. Palmer, Bell I. Wiley and William R. Keast, *The Army Ground Forces: The Procurement and Training of Ground Combat Troops* (Washington, DC: Historical Division Department of the Army, 1948), 595.

¹⁹⁹ Ibid., 3.

²⁰⁰ Ibid., 181-182.

underscores this by noting the fact that everyone has his breaking point. Hanson argues that leadership needs to be very present and felt, especially in combat. This is so because a soldier's existence and need to be safe from injury is preeminent. Hanson emphasizes that non-commissioned officers and junior grade officers are the primary persons that the individual soldier has direct contact with. As a result, the officers create an impact and impression, which is "irresistibly and powerfully felt by the soldier." Hanson indicates that in his experience, the loss of a good leader can result in "minor epidemics of psychiatric casualties." If a leader himself happens to develop a psychiatric problem requiring evacuation, this situation can adversely affect his platoon members and result in psychiatric casualties. For Hanson, the significance of a good leader helps to keep the psychiatric casualty rate down.²⁰¹ Hanson also argued that one of the ingredients missed in the leadership training of commissioned officers was that of psychology. Hanson believes that neglect of psychology in training prevents knowing what contributes to a soldier's emotional health and well being as well as morale. Hanson thought that training in individual and group psychology made better leaders, and their application of this learning could provide a prophylactic function against emotional breakdown or, at the very least, be a benefit in helping to mitigate against it.²⁰² Hanson's analysis of various factors contributing to the psychiatric casualty rate does receive support from an Army Ground Forces Observer Report. This report refers to "the observation that officers and infantry men in the Tunisian campaign were found to be psychologically unprepared for war."²⁰³ Additionally, the stress of combat makes the soldier look up to the officer to assume leadership, thus "everybody wants somebody to look up to when he is scared. It makes a lot of difference."²⁰⁴ In a post WWII survey of former U.S. Army Psychiatrists, "quality of leadership" was strongly equated with contributing to soldier morale and performance. Inadequate leadership was seen as contributing to soldier breakdown.²⁰⁵

Given the forgoing critique of leadership, it is noteworthy to mention that Hanson was known as "Phantom Freddy" for his uncanny propensity of showing up at the front lines on his

²⁰¹ Hanson, *Psychologic Factors of Adaptation in Combat*, 1-26.

²⁰² Ibid.

²⁰³ Headquarters, Army Ground Forces. Observer Report. Army War College, Washington, D.C. March 29th, 1943. Accessed: https://www.ibiblio.org/hyperwar/IIusa/tep/torch/torch_obsrpt/index.html

²⁰⁴ Ellis, *The Sharp End*, 193.

²⁰⁵ Eli Ginzberg, John Herma and Sol W. Ginsburg, *Psychiatry and Military Manpower Policy: A Reappraisal of the Experience in World War II* (New York, NY: King's Crown Press, 1953), 30-32.

own.²⁰⁶ Menninger explains that Hanson often circulated among soldiers in the Mediterranean Theater to ensure their physical comfort. Upon a recommendation by Hanson, who found soldiers feet wet for too long a period of time, the “Theater Quartermaster” made provisions “to provide a change of socks at definite intervals for the combat soldier.”²⁰⁷ Menninger states that Hanson’s actions and observations serve as an “example of a supportive physical comfort that could be provided even under the worst conditions was suggested by a psychiatrist.”²⁰⁸ This sheds light on Hanson’s character not only as a psychiatrist and physician bringing comfort to frontline soldiers, but also as an individual officer exercising leadership and compassion for the individual soldier’s plight in combat conditions. In a very real sense Hanson displayed a capacity to exercise concurrent roles as a soldier, physician, psychiatrist, and officer.²⁰⁹ The latter is very much in keeping with what was ideally expected as an Army Psychiatrist.²¹⁰

Hanson’s Promotion to Theater Consultant

Hanson’s talent for organizing the delivery of forward psychiatry to front line troops in II Corps did not escape recognition. In early June 1943, he was selected to be the Theater Consultant in Neuropsychiatry. Following the defeat of the German and Italian forces in Tunisia, Colonel Long provided this account: “during the Tunisian campaign, Captain Hanson made a brilliant record in the return of neuropsychiatric patients to combat duty and in the organization of the psychiatric facilities in the II Corps. On account of this, the consultant in medicine (Colonel Long) recommended to the Surgeon (NATOUSA) that Captain Hanson be designated as Consultant in Neuropsychiatry to the North African Theater. This recommendation was carried out by the Theater Surgeon early in June 1943 and subsequently the consultant in medicine acted solely in an advisory capacity in so far as neuropsychiatric problems were concerned.”²¹¹

Hanson’s appointment meant that a more defined psychiatric service could be envisioned theater wide by the NATOUSA Surgeon, Brigadier General Frederick A. Blesse. On June 12,

²⁰⁶ Menninger, *Psychiatry in a Troubled World*, 217.

²⁰⁷ Ibid., 94.

²⁰⁸ Ibid.

²⁰⁹ For role of psychiatrist in U.S. Army WWII See: *The Bulletin of the U.S. Army Medical Department*, “The Division Neuropsychiatrist” no.74 (1944), 29-34.

²¹⁰ Ibid.

²¹¹ Glass, *Neuropsychiatry*, 2:9-10.

1943, General Blesse issued Circular Letter No. 17 under the title *Neuropsychiatric Treatment in the Combat Zone*. This directive, to be overseen by Hanson, emphasized the importance and effectiveness of forward treatment being continued. In addition, it was directed that “exhaustion” be the exclusive diagnosis to be in use consistent with the order enacted by General Omar Bradley of II Corps dated April 26th, 1943. Furthermore, the directive reinforced the use of sodium amytal for purposes of sedating exhaustion cases. The directive was predicated by the fact that practically all medical officers serving in forward positions “had little or no training in the diagnosis and handling emotional disturbances.”²¹² The directive essentially endorsed the organized efforts of Hanson in establishing forward treatment.

Circular Letter No.17 was expanded by Brigadier General Blesse on June 15th, 1943 directing that report forms be utilized to collect data to be utilized for planning neuropsychiatric services. The data would be subjected to quantitative analysis. Hanson, as the Neuropsychiatric Theater Consultant, was the pivotal medical officer responsible for tackling this directive. Data on various forms was collected pertaining to the circulation of troops (both combat and non-combat) designated neuropsychiatric cases in the theater’s hospital census. Additionally, divisions provided documentary data on the relation between neuropsychiatric cases and those wounded in combat operations, and the sort of tactical activity engaged by every battalion in a regiment on a daily frequency. Data was also collected on the contributory circumstances, symptoms displayed, and response to treatment for each theater neuropsychiatric case. According to the official history, “recording of this information was organized that much of it could be utilized for punch card analysis after the war.”²¹³ Hanson kept duplicates of all the forms, running in the thousands, containing all the data for the rest of the war. All these record forms were sent to the Office of the Army Surgeon General when the war ended. Sadly, all of the records were trashed due to there being no space available for storing it.²¹⁴ What potential insights may have been gleaned from these records will unfortunately and regrettably never be known.

In addition to following directives emanating from the Theater Surgeon, Hanson’s professional activities as Theater Neuropsychiatric Consultant were quite manifold. The official

²¹² Ibid., 11.

²¹³ Ibid.,12.

²¹⁴ Ibid.

and professional duties of the Neuropsychiatric Consultant as well as Medical and Surgical Consultants were not formalized until the issue of the War Department Circular No.100, dated April 4th, 1946. Nonetheless, Menninger states that “despite absence of formalization, the consultant system worked so effectively on the basis of the experience in the practise of clinical medicine, surgery, and neuropsychiatry that specific instructions were not essential.”²¹⁵ Hanson’s responsibilities, despite this lack of formalization, can be described as: 1) representing the U.S. Army Surgeon General to ensure state-of-the-art neuropsychiatric diagnosis and treatment; 2) to assess, advance, and enhance further the caliber of neuropsychiatric care; 3) to consult, when necessary, with the U.S. Army Surgeon General in generating any professional courses of action and to assist putting these into effect; 4) assessing all aspects of the care and treatment of psychiatric casualties; 5) assessing the posting and qualifications of psychiatric personnel; 6) providing reports on psychiatric facilities for the Surgeon General; 7) providing consultation on any developments in psychiatry pertaining to diagnosis and treatment; 8) encouraging interest in professional development as well as stimulating interest in research; 9) encouraging professional educational endeavours such as conferences, patient rounds, and use of review of pertinent published literature in journal clubs; and 10) ensure availability of equipment and supplies needed for psychiatric care.²¹⁶ Field visits played a large part in carrying out these responsibilities which provided Hanson with a hands-on perspective for overseeing psychiatric services.²¹⁷

²¹⁵ William Menninger, “Education and Training,” in *Neuropsychiatry in World War II, Zone of the Interior*, ed. Albert J. Glass and Robert J. Bernucci (Washington, DC: 1966), 1:76-77.

²¹⁶ Glass, *Neuropsychiatry*, 2:76-77.

²¹⁷ *Ibid.*, 78-79.

Hanson's Theater Report

Hanson continued on as Theater Neuropsychiatric Consultant when NATOUSA was re-designated MTOUSA (Mediterranean Theater of Operations United States Army) as operations involved both Sicily and the Italian mainland. In his annual report to the Neuropsychiatry Consultant's Division, he presented a multitude of psychiatric observations on the North African Theater. This report contains input from a number of Hanson's subordinates, the most notable was that of the then Lieutenant Albert J. Glass (later Colonel).²¹⁸ Glass made the U.S. Army a career and became the foremost authority on combat psychiatry into the Vietnam war. The report presents a multi-causal understanding of the reasons for the occurrence of psychiatric disorders in combat troops in the North African Theater. In addition, this report is significant as it touches upon many issues that became the focus of research within the U.S. Army, both during and after WWII.

Hanson, now a Major, comments on seven factors in his report of what he considers important influences in instigating combat psychiatric casualties, they are: 1) "the length of the battle trauma, that is, number of consecutive days in action."; 2) the factor of physical fatigue, in addition to inadequate sleep, excessive physical exertion, not eating on regular basis, climatic conditions, and accentuated medically by such illnesses as dysentery; 3) unit morale; 4) being in close proximity to shell fire and other explosives; 5) seeing the death of comrades or their being severely wounded; 6) inadequate training and the dearth of faith in unit leadership; 7) conviction among soldiers that the war is not theirs to fight. Hanson also makes a distinction between psychiatric cases arising quickly in battle as opposed to those that happen at a later time. Those occurring early are characterized as happening "generally in an unstable background," whereas those that ensue on a later basis (around 70%) possess principally "normal background records." It is further noted that a proportion of psychiatric incapacity cases is greater in experienced soldiers of a squad or platoon compared to replacements to the same squad or platoon.²¹⁹ The second part of the report addresses non-combat associated psychiatric cases, making fairly clear that factors other than combat itself can precipitate psychiatric disturbance. Hanson outlined six causal factors in order of prominence. These are: 1) dissatisfaction with assigned military

²¹⁸ Ibid., 393.

²¹⁹ Glass and Bernucci, *Neuropsychiatry*, 1:393-394.

occupational specialty, combined with feeling unfulfilled with work duty; 2) issues surrounding nostalgia for home and concerns over family affairs; 3) temperamental unfitness for adapting to arduous living situations, such as deficient billets and unappetizing victuals; 4) exposure to air raids in reassigned psychiatric cases; 5) prolonged marking of time in the replacement center; 6) unduly long and unneeded hospitalization.²²⁰ The third section of Hanson's report focuses upon attitudes and beliefs in enlisted men and officers obtained by questioning when passing through clearing stations, evacuation hospitals as well as the theater neuropsychiatric hospital. One issue that arises is the belief that combat troops are treated as expendable without considering their need for being relieved from combat exertion. As well, soldiers felt a lack of concern for their physical safety. A prominent grievance encountered among long experienced troops was that they were not provided with an adequate amount of time to recuperate following the Tunisian campaign. This complaint was prevalent within veteran troops of the 1st Division, believing that they were the soldiers solely engaged in combat. In the 1st Division, this was compounded by the belief that they were given assurance of being posted back to the United States upon completion of the Tunisian campaign. Other complaints impinging negatively centered around a paucity of recreational facilities and access to them. Another complaint registered was that post exchange supplies could not be obtained in rest areas. Still other complaints centered on being mistaken targets by friendly fire such as artillery and by bombing and strafing. There were also grievances expressed that upon completion of the Tunisian campaign that veteran soldiers were not acknowledged for what they accomplished in combat, i.e., gallantry and valour. Discussions with neuropsychiatric patients also indicated a dread of replacement centers. Patients felt a lack of assurance about their placement compounded by a prolonged waiting period of having nothing meaningful to do. Furthermore, it was felt that cases at replacement centers were not dealt with in a timely manner. Complicating this was the patient's belief that they had not received the right classification at the start of their military service. As a result, they were doing jobs they disliked and not best qualified to do. There were also issues voiced regarding excessive holdups in receiving pay as well as in receiving mail.²²¹

Hanson's report also addressed commissioned officers as patients expressing complaints believing they were not properly assigned. Officers felt that they were performing

²²⁰ Ibid.

²²¹ Ibid.

inconsequential jobs that could be done by officers with lesser rank. They also expressed beliefs that acknowledgement and advancement were not forthcoming as a recompense for carrying out assignments in a productive, efficacious manner.²²²

The third part of Hanson's report focuses upon the issue of morale. Hanson asserts that a good number of soldiers do not possess a well-defined understanding of why they are in battle. Hanson further states that "they do not know their role in the war."²²³ He adds that many soldiers have difficulty trying to apprehend a reason why they were ordered to serve in a theater of war given the fact that countless number of men are stationed in the United States. Hanson characterizes the interviewee soldiers having been encouraged to develop both passive and dependent tendencies, but does not explain how. Presumably, this may have been fostered by lengthy hospitalization that was not needed. There are two final points Hanson addresses. One is that "rash promises" are generated, or falsehoods permitted to circulate in the military organization without their being declared untrue, i.e., soldiers would be assigned back to the United States at the conclusion of the Tunisian campaign. The second is the recurrent sentiment of having little faith pertaining to "unit leadership."²²⁴

Studies in Support of Hanson's Report

The significance of Hanson's Mediterranean Theater report is that it notes many issues which became subject matters for research study, both during and after WWII. For instance, the issue of leadership which Hanson and others noted above as having a bearing upon a soldier's morale and performance, is noted in the post-war analytical study by the U.S. Army. This study, referring to officer candidate school, indicates that "in 1942 rapid mobilization created a demand for graduates so great that standards were lowered and the quality of junior leadership available to the ground armies declined."²²⁵ It is noteworthy that this situation was occurring prior to the launching of Operation Torch and the subsequent Tunisian campaign, and was not significantly improved even at the end of WWII.²²⁶

²²² Ibid.

²²³ Ibid.

²²⁴ Ibid.

²²⁵ Palmer, *The Army Ground Forces*, 159.

²²⁶ Ibid., 160.

While noting the issue of the quality of junior officers, this same study also addressed the quality of enlisted men in the Army Ground Forces (AGF), again, prior to Operation Torch in November 1942. At issue was the quality of men entering the AGF, which was not considered adequate. Better quality men were being absorbed, especially by the AAF (Army Air Forces).²²⁷ By the end of 1943, long after the completion of the Tunisian campaign, an Army study demonstrated that “a sample consisting of 12,000 combat soldiers proved to be below the Army average in height, weight, intelligence, and in education.”²²⁸ Lieutenant General Lesley J. McNair, the Commanding General of the AGF, voiced concern over the latter. The Army official history indicates that “he became increasingly to believe that American soldiers were sustaining avoidable casualties and perhaps taking longer than necessary to win the war, because men assigned to ground combat units did not represent a fair cross section of the nation’s manpower.”²²⁹ Making matters worse was the problem of a shortage of qualified, competent trainers for men entering the Army as well as the general distaste for being in the Infantry.²³⁰ It was not until the latter part of 1944 that the War Department acted to make “high quality manpower” more available to the AGF.²³¹ Thus, it can be seen that the quality of both junior leadership and that of enlisted men at the time of Operation Torch was launched proved, to say the least, questionable. This does not obviate the assertion made by William Murray and Allan Millet that as the war progressed, the American Army showed “increasingly impressive capabilities.”²³² Nonetheless, it is fair to assume that adjustment problems ensuing from poor leadership and low-quality enlisted men, reinforced the psychiatric casualty rate during the Tunisian campaign.

The part of Hanson’s report dealing with the length of time in combat as a causal factor contributing to the neuropsychiatric rate in combat soldiers has been the subject of intensive investigation with comprehensive statistical analysis by Gilbert Beebe and John Appel in their post WWII published work, *Variation in Psychological Tolerance to Ground Combat in World War II*. They relate that WWII combat infantry soldiers possessed only so much resistance to

²²⁷ Ibid., 4,70-71.

²²⁸ Ibid., 3.

²²⁹ Ibid., 4.

²³⁰ Ibid., 19.

²³¹ Ibid., 53.

²³² Williamson Murray and Allan R. Millett, *A War to Be Won: Fighting the Second World War, 1937-1945* (Cambridge, MA: Belknap Press of Harvard University Press, 2001), 300.

succumbing to psychiatric breakdown due to stress. They relay further that there exist limits in any soldier as to his “physical strength and endurance” to withstand the stresses of combat.²³³ A soldier’s limits are expended by the duration and intensity of combat operations such that “about half of the psychiatric casualties occur in response to the ebb and flow of sheer combat intensity.”²³⁴ This has a temporal gradient which is directly related to the number of days a soldier is engaged in combat and unit attrition occurs.²³⁵ In addition, Beebe and Appel surmise from data collected that “once a psychiatric departure has occurred, and a man has returned to combat, he is much more likely to have a subsequent psychiatric departure than a man with no prior psychiatric departure.”²³⁶ Also, relevant to Hanson’s report regarding inadequate soldier training is Beebe and Appel’s assertion that the better a soldier is trained in infantry tactics, the more resilience he has to breakdown than a soldier whose training is poor.²³⁷ The research conducted by Beebe and Appel does provide statistical evidence to support Hanson’s part of the memorandum regarding training and amount of time in combat as having a bearing on the incidence of psychiatric breakdown.

In the latter part of the autumn of 1943, following combat operations in Sicily and the Italian Peninsula, the then Major Hanson sent a report to “High Command” in his capacity as the Mediterranean Theater Neuropsychiatric Consultant. He alerted Command to the fact that infantry soldiers kept in combat for too long a period of time, without respite, can end up as psychiatric casualties. Hanson’s recommendation to address this through preventative measures met with no success.²³⁸ The issue regarding length of time in combat and the development of psychiatric casualties appears again in his *Mediterranean Annual Report, Neuropsychiatry Consultants Division*. The fact that this issue is repeated points not only to its significance, but also to the issue of rotation of troops. Its significance lies in the fact that being too long in combat, without sufficient rest, diminishes a soldier’s efficiency as well as his motivation to fight. As well, morale suffers. However, the Army never did get around to having a rotation policy that met with adequate satisfaction. In the same study referred to above by Beebe and

²³³ Gilbert W. Beebe and John W. Appel, *Variation in psychological tolerance to ground combat in World War II* (Washington, DC: National Research Council, Division of Medical Sciences, 1958), 1.

²³⁴ *Ibid.*, 142.

²³⁵ *Ibid.*, 143.

²³⁶ *Ibid.*, 146.

²³⁷ *Ibid.*, 147.

²³⁸ Glass and Bernucci, *Neuropsychiatry*, 1:412.

Appel, their statistical analysis of psychiatric cases in the Mediterranean Theater of Operation (MTO), indicates that Hanson's concerns were well founded, which he had already expounded in his *The Factor of Fatigue* noted previously above. Beebe and Appel indicate that in the MTO, that statistical analysis demonstrates that the "average man can only take 88 days of MTO combat," after which he breaks down.²³⁹ This, according to Beebe and Appel, highlighted the need for rotation to conserve fighting strength facilitated through fixed tours.²⁴⁰ An (AGS) study report completed shortly after WWII provides further support for Hanson taking issue with length of stay in combat. The report indicates that due to there not having been enough Army divisions, that it was very problematic to provide infantrymen with any semblance of rest. The report goes on to say that "during periods of intensive combat an infantry division suffered about 100% losses in its Infantry regiments every three months."²⁴¹ The losses filled by replacements in a "continuous stream" resulted in divisions experiencing a deteriorating combat efficiency with such a high rate of personnel changes. This also resulted in such a level of stress for the infantrymen, who believed that despite the length of time spent in combat, he had to persist "until removed as a casualty."²⁴² This AGF report indicates this whole situation was directly responsible for the incidences of psychiatric cases. If an infantryman did not succumb to psychiatric breakdown, and became simply tired to the point of exhaustion, then the only ticket out of combat was getting "killed, wounded, or captured."²⁴³ This unfortunately sums up the existence of the MTO infantrymen and little effort is needed to realize why they broke down. Other compounding factors resulting in soldiers absconding from combat, as observed at Anzio (Operation Shingle, January 22nd, 1944) beside large numbers of psychiatric cases, were "AWOL's, desertions, and cases of self-inflicted wounds."²⁴⁴

In November 1944 as the Mediterranean campaign was well under way, Major General Norman T. Kirk, Surgeon General of the United States Army, also addressed the issue of the incidence of psychiatric casualties due to the infantrymen being in combat for too long in the North African Theater. This was also applicable as operations expanded into Sicily and the

²³⁹ Beebe and Appel, *Variation in psychological tolerance to ground combat in World War II*, 163-168.

²⁴⁰ *Ibid.*, 58-59, 65, 152-154.

²⁴¹ Robert Palmer, "The Mobilization of the Ground Army: The Army Ground Forces Study No.4," *US Army Center of Military History*, 1946. <https://history.army.mil/books/agf/AGF004/ch01.htm>.

²⁴² *Ibid.*

²⁴³ *Ibid.*

²⁴⁴ D'Este, *Fatal Decision*, 310.

Italian mainland. He recommended to the Assistant Army Chief of Staff for G-1 (Personnel and Administration) that acknowledgment be made that psychiatric casualties are inevitable in the infantry due to the distinct possibility that combat exposure can lead to death. In addition, the stress associated with this possibility is of such a magnitude that a man will go through a nervous collapse as dictated by the intensity and duration of combat. General Kirk advised further that on account of the latter, an infantryman should be relieved after “200 aggregate days,” and be granted a period of six-month relief and offered the choice of spending this time in the United States. He stated further that “loss of manpower involved would be insignificant since the number of men in rifle battalions who obtained the aggregate combat days is small and their subsequent value to the unit negligible.”²⁴⁵ Again, as noted above, there was no action taken on this recommendation by the War Department during the entire span of the Mediterranean campaign. In fact, no decision was made until V-E Day even though the recommendation had passed through the Army Chief of Staff, General George C. Marshall, and the Army Ground Forces Commander, General Joseph Stilwell, General McNair’s successor.²⁴⁶

It is easy to surmise that Hanson’s Mediterranean report regarding the length of combat and subsequent incidence of psychiatric breakdown bore a relationship to War Department manpower policy and supported above by Steckel. Another factor noted in Hanson’s report is the subject of morale as exacerbating or playing a role in the psychiatric breakdown of the infantryman. Morale became a subject for statistical research based upon questionnaires given to soldiers during WWII, and published by the Research Branch of the Special Service Division of Army Service Forces of the War Department. The research was published in one of the monthly periodicals *What the Soldier Thinks* right after the completion of the Tunisian campaign.²⁴⁷ The periodical points to 60% of soldiers having the attitude that they would prefer to be engaged in civilian work rather than being soldiers. As well, men showing reservations about the war effort or about the allies, show a preference for being engaged in civilian work. The periodical goes on to indicate the aversion to being a soldier is largely present in those troops that are married, of older age, and among those deemed of limited service. In addition, the reluctance of being a

²⁴⁵ Surgeon General’s Report, *Prevention of Loss of Manpower from Psychiatric Disorders*, 16 sept 1944, accessed from http://warchronicle.com/nonbattlecasualties/us_wwii/prevention.htm

²⁴⁶ William R. Keast, “Provision of Enlisted Replacements: The Army Ground Forces Study No.7,” US Army Center of Military History, <https://history.army.mil/books/agf/AGF007/ch14.htm>.

²⁴⁷ War Department, *What the Soldier Thinks*. No. 2 (August 1943) Retrieved from <https://www.marshallfoundation.org/library/collection/what-the-soldier-thinks/#!/collection=338>

soldier is worsened by the data indicating the “longer a private has been in the service, the less he believes he can contribute more as a soldier than as a civilian war worker.”²⁴⁸ Moreover, the survey shows that the longer a soldier has been in the Army, the less pride is shown in his unit. Additionally, the periodical links such attitudes above to be an obstacle to training and performing effectively in combat. As well, being satisfied with the job a soldier is assigned to do, is related to both morale and efficiency. Especially relevant to the subject of morale is that assignment to the infantry shows the least satisfaction. A particular issue related to a lack of satisfaction with infantry assignment was that 25% of enlisted personnel were 30 years old or older at the time of the Tunisian campaign.²⁴⁹ Soldiers being apathetic about the war is consistent with Hanson’s memorandum taking note of the fact that soldiers expressed the view that the war is really someone else’s, not an American one. This is compounded by soldiers not being knowledgeable about the reasons they need to fight. These views, according to *What the Soldier Thinks*, are ascribed to “soldiers who see their position as being less important than having a civilian job,” concomitant with being distrustful of the allies.²⁵⁰ The forgoing serves to highlight the fact that if a soldier does not possess the requisite combat motivation, then through a progression of attitudes, beliefs, and adjustment difficulties he increases his likelihood of psychiatric breakdown. The breakdown being, in one sense, the ticket out of the combat situation.

There are many points of convergence between the issues noted in Hanson’s memorandum and the research conducted by the Army, that it would deserve a separate paper. Nevertheless, before moving on to Hanson’s other activities, it would be amiss not to mention the voluminous research on motivational and social factors having a bearing on how soldiers adjusted both to the military and to combat indicated in Hanson’s memorandum. This research was conducted during WWII by Samuel Stouffer and his research associates on behalf of the Research Branch, a section of the Army Information and Education Division of the U.S. Army Service Forces.²⁵¹ Stouffer’s statistical studies led him to surmise that the factor of poor morale as well as an assortment of negative social attitudes played a role in the incidence of psychiatric

²⁴⁸ Ibid.

²⁴⁹ Ibid.

²⁵⁰ Ibid.

²⁵¹ Joseph W. Ryan, “Samuel A. Stouffer and The American Soldier,” *Journal of Historical Biography* 7 (Spring 2010): 100-137.

breakdown or on the development of psychoneurotic symptoms.²⁵² It is judged in one critique that Stouffer's research on morale was inextricably connected "to the trust soldiers had in their officers, their training, their outfit, their weapons, and their fellow soldiers."²⁵³ This same study emphasizes mental health being linked to group cohesion, the establishment of emotional ties among infantryman, and with their leaders.²⁵⁴ Thus, Stouffer's research findings can be seen as congruent with and supporting many of the issues raised above in Hanson's memorandum which, again, impresses as a template for conducting research in military psychiatry, not only pertaining to WWII but also perhaps for subsequent conflicts involving the U.S. Army.

During the Mediterranean Campaign, two of Hanson's staff conducted field research. These were the then Major Albert J. Glass and Captain Herbert X. Spiegel. Major Glass's published paper argues that there is a necessary limit that needs to be placed on the medical services credo of conserving fighting strength. He relays that the effectiveness of forward psychiatry has limits. He adds that "it is too much to expect that four or five days of rest or superficial psychotherapy can alter chronic anxiety states, poor morale, or the inadequate or emotionally unstable individual. It is important to note that those who have returned to successful duty have almost invariably performed efficiently prior to evacuation."²⁵⁵ This leads Glass to say that research substantiates the notion that forward psychiatry has its greatest impact on the successful recovery of soldiers presenting with the "acute battle anxiety state."²⁵⁶

Captain Herbert X. Spiegel made contributions to military social science with his observations during the Tunisian campaign. His paper establishes the importance that needs to be placed upon group cohesion for the maintenance of a soldier's mental health. The bonds created by group cohesion in conjunction with good leadership results in good morale which, in turn, translated into a "low psychiatric casualty rate."²⁵⁷ Glass in his post WWII summary of U.S.

²⁵² Samuel A. Stouffer, Arthur A. Lumsdaine, Marion H. Lumsdaine, Robin M. Williams Jr, M.B. Smith, Irving L. Janis, Shirley A. Star and Leonard S. Cottrell Jr, *The American Soldier: Combat and its Aftermath* (London, Princeton University Press, 1949), 411-455.

²⁵³ Hans Pols and Stephanie Oak, "War & Military Mental Health: The US Psychiatric Response in the 20th Century," *American Journal of Public Health* 97, no.12 (December 1, 2007), 2132-2135.

²⁵⁴ *Ibid.*

²⁵⁵ Albert J. Glass, "Effectiveness of Forward Neuropsychiatric Treatment," *Bulletin of the U.S. Army Medical Department*, vol.7 (December, 1947), 1034-1041.

²⁵⁶ *Ibid.*

²⁵⁷ Herbert X. Spiegel, "Preventative Psychiatry with Combat Troops," *American Journal of Psychiatry* 101, no.3 (November 1944), 310-315.

Army psychiatry, attributes the importance of group identification and processes to a soldier's mental health as a learned lesson.²⁵⁸ Hanson's lieutenants, it can be said, followed his example in demonstrating interest in observing and studying behaviour under combat conditions. As well as reinforcing the importance of morale issues captured in Hanson's memorandum.

Forward Treatment in Sicilian Campaign

At the conclusion of the Tunisian campaign, Hanson, true to his character inclinations, took part in the Sicilian landings as part of Operation Husky in July 1943. This certainly added to his previous experience participating in amphibious landings for purposes of observing soldiers under stressful combat conditions.

Hanson returned to headquarters in Algiers following his taking part in these amphibious landings. His professional activities during the Sicilian campaign centered upon his recommending that the 43rd Station Hospital close to Bizerte, Tunisia, be designated as a hospital exclusively focused on treating psychiatric casualties. This hospital started its work on July 19th, 1943, after receiving help in its being organized by both Major Hanson and the previously introduced NATOUSA Medical Consultant, Lieutenant Colonel Perrin Long. What underlined Hanson's recommendation was that even though evacuation hospitals in Sicily were assigned a psychiatrist to administer forward psychiatric treatment, it was discovered by experience that the arrangement proved ineffective as only 15% of cases returned to duty. The reason for this, according to the official history (and presumably for Hanson) was that "under active battle conditions, when psychiatric casualties are high as are battle casualties, evacuation hospitals are preoccupied with the care of acute surgical and medical cases. At such times, therefore, evacuation hospitals are not suitable for the holding and treatment of psychiatric patients."²⁵⁹ In addition, it was believed that medical cases, many in the process of expecting to be sent to base hospitals in the rear, negatively influenced psychiatric cases in terms of motivation to return to duty. Given that "expectancy" is one of the principles of forward psychiatry, then treatment of psychiatric cases in evacuation hospitals worked against this principal. Nonetheless, the setting up of the 43rd Station Hospital started the inauguration of what Hanson proposed in his

²⁵⁸ Glass, *Neuropsychiatry*, 2:999.

²⁵⁹ *Ibid.*, 13-14.

memorandum of February 1943 for the organization of a neuropsychiatric service delivery of a three-echelon system.²⁶⁰

Even though patients arrived at the 43rd Station Hospital between 24 to 48 hours (quicker than in the Tunisian campaign) after being processed by medical officers in Sicily, the rate of return to combat was exceedingly low at just 3%. The remaining 97% were reassigned to non-combat duty. A couple of reasons are offered by the official history to explain this. One is the distance from combat operations in Sicily to the Station Hospital in Tunisia. The distance was 90 miles. This was enough of a distance to provide the psychiatric casualty with the sense that he was out of combat and safe in the rear. This is believed to be a significant factor in patients holding onto their symptoms and thereby becoming unmotivated to get back to their unit. Another reason offered is that psychiatrists assigned to the 43rd Station Hospital did not possess sufficient experience to distinguish normal from abnormal responses to battle. Psychiatrists therefore assumed the patient was not capable of returning to combat duty. It was only late in the war when psychiatrists were assigned to forward areas, close to combat activity, that their experiences grew such that they became more competent at identifying the difference between normal and abnormal responses to combat.²⁶¹

The 43rd Station Hospital was simply too far to the rear and therefore not close enough within the earshot of combat to be effective enough to provide forward treatment. The “proximity principle” of forward treatment was simply not at work. This was not necessarily anyone’s fault. It was early in the war and it probably needs to be recognized that forward treatment was still a work in progress from an idea to an organized implementation combined with the accumulation of needed psychiatric experience.

Sedation of patients became a contentious issue at the 43rd Station Hospital. Major Hanson established prescribed sedation as a standard practice in the treatment of psychiatric casualties for the latter part of the Tunisian campaign. His thinking was that sedation was necessary for the symptomatic treatment of physical fatigue as well as protecting the patient from further anxiety and intrusive thoughts associated with the battle experience. On June 12th, 1943 the Theater Surgeon for NATOUSA in Circular Letter No.17 directed that sedation be

²⁶⁰ Ibid., 13.

²⁶¹ Ibid., 15.

administered on a continuum from battalion aid station and rearward through collection and clearing stations and on through to evacuation facilities and finally to the base hospital. This was to ensure that acute psychiatric patients could have two to four days of repose. The official history does not provide any information as to whether Major Hanson and the NATOUSA Theater Surgeon consulted with each other on the continuous sedation Circular. It can only be speculated that the Theater Surgeon was most likely aware of Hanson's position on sedation and then put out a theater wide Circular to be implemented. Nonetheless, psychiatrists assigned to the 43rd Station Hospital questioned not only the reasoning behind continuous sedation but also whether it really produced the desired effect. Usually, six grams of Sodium Amytal was administered at the battalion aid station and "repeated or reinforced" rearward through the evacuation chain. However, psychiatrists at the 43rd Station Hospital argued that their experience was showing that Hanson's prescribing practices based on the rationale that physical exhaustion was the primary instigator in causing psychiatric casualties in combat was not consistent in what they were seeing in some of the patients. For instance, they asserted that a good number of psychiatric casualties had breakdowns prior to being engaged in combat, and having nothing to do with the factor of fatigue. Or, patients shortly after exposure to combat broke down before fatigue could set in. Thus, the rationale for the need for continuous sedation was challenged, and the debate was not resolved, but "much debated and discussed until the end of the war."²⁶²

The official history indicates that as army psychiatrists gained experience, that it was shown that psychiatric casualties who did have physical exhaustion had resolution of their symptoms quickly within one to two days with minimal sedation. This was enough to facilitate needed recuperation by sleep and rest. It was also thought that continuous sedation provided no therapeutic benefit by delaying for a number of days the unloading of anxiety or the processing of psychological reactions to battlefield experiences. It was also believed that continuous sedation adversely affected one of the principles of forward psychiatry - it being "expectancy" due to generating "dependency and helplessness, with a subsequent loss of confidence relative to return to combat hazards and hardships."²⁶³ When psychiatry at the division level was

²⁶² Ibid., 16.

²⁶³ Ibid.

established later in the Mediterranean Campaign, sedation was judiciously applied only as needed to provide a basic 24-hour period of sleep and repose.²⁶⁴

Observations by army psychiatrists in the Sicilian campaign of psychiatric casualties closely converge with what was previously discussed in Hanson's memorandum pertaining to the Tunisian campaign. For instance, they found that problems with leadership, poor group cohesion, and inadequate military training were precipitating factors in producing psychiatric casualties. As well, climatic conditions, environmental factors, and fatigue, as Hanson noted, were also contributing factors.²⁶⁵ Major Hanson's observations, as well as those of other psychiatrists in the Sicily Campaign, in pointing to issues of leadership, training and cohesion, most likely signified to the growing pains associated with a mass Army being quickly organized, having to also endure the extraordinary impact of combat stresses.

Major Hanson, following the Sicilian campaign, asked Captain Drayer to visit him at theater headquarters in Algiers. The purpose of the visit was to provide a report on the psychiatric situation in Sicily as experienced by the 43rd Station Hospital. Captain Drayer was one of the first psychiatrists to be assigned to the 43rd. His report, dated August 24th, 1943, noted the importance of placing psychiatric cases in the facility separate from patients with physical injuries or medical diseases. Drayer emphasized that the separation of psychiatric from medical cases made the former realize "they no longer needed to search for justifying physical basis for their illnesses, and were led rapidly to a realization that their disability did not need to be permanent."²⁶⁶ Drayer continues to emphasize that, as a result, symptoms did not take on a life of their own in such a manner that they became fixed. This meant that the principle of creating expectancy in forward psychiatric treatment was established, at the very least, to Drayer's satisfaction. The positive effects of early treatment noted by Drayer serve to reinforce the principle of immediacy in forward psychiatry. In addition, Drayer reported that the majority of psychiatric cases verbalized a desire to not be sent back to combat roles, and instead requested to be stationed in Africa in order not to be posted to the continental United States before the war was over. Drayer ended his account by relating a significant problem, it being that there were not enough noncombat positions for psychiatric patients after completing treatment. The official

²⁶⁴ Ibid.

²⁶⁵ Ibid., 19.

²⁶⁶ Ibid.

history indicates this issue was never adequately addressed in the Mediterranean Campaign for the duration of WWII.²⁶⁷ Drayer also noted that the 43rd Station Hospital had a “limitation,” it being fairly close to Bizerte. It was in the pathway of German bombing runs to the harbor outside of Bizerte to bomb shipping. This resulted in psychiatric patients who had improved, decompensating due to the “sounds and flashes of furious anti-aircraft fire,” despite the fact that the hospital was not being targeted by the enemy.²⁶⁸

Major Hanson judged the 43rd Station Hospital to have shown enough of a sufficient degree of success to warrant setting up another unit devoted exclusively to psychiatric treatment. This unit was the 51st Station Hospital with a 500-bed capacity, and began functioning on September 28th, 1943 near Oran with Major Tureen as the chief of its psychiatric delivery system. The psychiatric work of the 43rd Station Hospital was transferred to the 500 bed 114th Station Hospital for the duration of the war.²⁶⁹ In addition, other psychiatric facilities were organized for station and general hospitals at a number of localities in North Africa, numbering no less than five.²⁷⁰ This indicated the extent of the need for psychiatric services in the Mediterranean Theater of Operations, especially as the Sicilian campaign ended and Operation Avalanche (allied landings at Salerno, September 1943) was well underway. Given Major Hanson’s duties as Theater Consultant, his professional role in overseeing administratively the planning, organization, staffing, and equipping of these facilities was no small endeavor in addressing the psychiatric problems associated with combat for the American soldier.

It would be amiss not to mention the behavior of General Patton (Commander of the 7th United States Army), during the Sicily campaign, as it pertained to the psychiatric treatment of the U.S. soldier, and importantly the recognition of psychiatric breakdown as legitimate casualties of combat. As noted in many accounts, General Patton acted out abuse towards a couple of psychiatric casualties on August 3rd and 10th, 1943; one occurred at an evacuation hospital, and another at a clearing station. The official history explains that regardless of what can be theorized to explain Patton’s behavior, that his actions conveyed a way of thinking that was not uncommon among commissioned officers of the line or medical officers - it being that

²⁶⁷ Ibid.

²⁶⁸ Ibid., 20.

²⁶⁹ Ibid.

²⁷⁰ Ibid., 20-21.

casualties of a psychiatric nature demonstrated “cowardice or poor motivation or weakness of character.”²⁷¹ This attitude was an obstinate one, even though available facts existed to demonstrate conclusively that the duration and intensity of combat exposure could result in a limited emotional breakdown in soldiers having a normal personality. In no uncertain terms, the persistence of this belief blocked the need for proper medical arrangements to be made for forward treatment of soldiers experiencing combat associated psychiatric conditions.²⁷² No doubt, Army psychiatry in dealing with these institutional attitudes, had an uphill battle on their hands to provide treatment for soldiers requiring it. Hanson had no easy task in surmounting this to promote psychiatric treatment for the American soldier. Eli Ginsberg has offered a number of reasons why psychiatry experienced difficulty in becoming established in the Army. He asserts that the War Department simply made no serious provisions in envisioning a need to deal with casualties of a neuropsychiatric nature. As well, psychiatry was treated dismissively by Army staff officers, and thusly ignored psychiatric recommendations that could have been utilized to address prevention and treatment, as well as assessment of neuropsychiatric issues in the Army. As a result, according to Ginsberg’s analysis “little progress had been made as late as 1943.”²⁷³ It was only in late 1943 that Army psychiatry achieved a status equal to medicine and surgery in the Office of the Army Surgeon General.²⁷⁴

Major Hanson, in spite of the institutional culture and negative staff attitudes, played a large part in demonstrating the value of psychiatry in terms of enumerating the causes of psychiatric problems in the combat soldier and need for treatment. As well, his noting of a variety of environmental causal triggers contributing to the rate of neuropsychiatric casualties are noted above in his memorandum on the Tunisian campaign. Major Hanson continued to advance the cause for psychiatry with another memorandum, this being a neuropsychiatric report on the Sicily Campaign. The report was requested by the NATOUSA Surgeon, Brigadier General F.A. Blesse who, in turn, was directed on August 20th, 1943 by the Army Surgeon General’s Office Consultant in Neuropsychiatry, to provide an account of neuropsychiatric activities during the Sicily campaign. General Blesse sent Hanson’s report to the Surgeon General of the United

²⁷¹ Ibid., 21.

²⁷² Ibid., 22.

²⁷³ Eli Ginzberg, “Logistics of the Neuropsychiatric Problem of the Army,” *The American Journal of Psychiatry* 102, vol 6 (1946): 728-731.

²⁷⁴ Ibid.

States Army, Major General Norman Kirk, on October 14th, 1943. The report states that for the Sicilian campaign, that the percentage of soldiers restored to combat duty was 39% of all neuropsychiatric cases. Total number of cases are not specified in the report. The 39% figure is believed to be predicated by the effectiveness of treatment modalities instituted in the Tunisian campaign. The report refers to “unselected cases,” a designation not defined, which arrived at a hospital in North Africa for treatment. The cases are all depicted as arriving “within 24 hours of being invalidated with under 3% being able to resume their former combat roles.” Hanson attributes the very low return to combat duty to the paucity of psychiatrists assigned to the evacuation hospitals in Sicily. Of particular note in the memorandum is Hanson’s emphasis that veteran combat soldiers did not experience less incidence of psychiatric breakdown. He backs up this assertion by citing two combat experienced divisions where 66% in one division and 88% in another of neuropsychiatric cases that occurred in experienced combat soldiers who participated in the Tunisian campaign who had no previous history of breakdown. He states further that the incidents of neuropsychiatric cases are greater in veteran soldiers compared to those who are not. Hanson indicates that psychiatric disorders developed in combat can occur in persons who have a “normal past emotional stability.” He adds that the immense stresses associated with modern warfare can be responsible for the neuropsychiatric casualties, whether in those predisposed by history or not. He states further that any person can “crack” with prolonged time in combat, adding that this is not something line officers are willing to believe, in contrast to those trained in psychiatry who know it as a fact from what they have observed of the effects of prolonged combat exposure. The report emphasized that the goal of two neuropsychiatric facilities in North Africa is to provide “short term therapy” for those who are not returning to combat roles. Further, Hanson relates that cases of psychosis and patients requiring extended treatment are to be serviced at General Hospitals. The report continues with Hanson stating that general hospitals are to be viewed as having a “limited function” as their purpose is not to discharge psychiatric cases back to combat other than in “minor numbers.” He ends by stating that these hospitals can also serve as research facilities to conduct psychiatric research for purposes of ascertaining causal factors in psychiatric cases.²⁷⁵

²⁷⁵ Glass, *Neuropsychiatry*, 2:23.

Hanson's Sicily memorandum, though not as detailed as his Tunisian one, does reinforce the fact that psychiatric casualties are an inevitable outcome of combat. He also emphasizes a role for general hospitals to conduct research to gather knowledge of the ways in which soldiers react to stresses associated with combat. Furthermore, as the official history correctly emphasizes, even though facilities existed to the rear such as the neuropsychiatric centers that were established, the need for treatment to be provided closer to the front was needed to maximize cases going back to combat duty. Army psychiatry at the end of the Sicily campaign, although becoming more organized, was still undergoing development.²⁷⁶ On the positive side, the Sicily campaign added strength to the results obtained by psychiatry in North Africa. This being that early treatment of psychiatric casualties is essential and patients treated at the front have a higher probability of resuming duty.²⁷⁷

Psychiatry during the Italian Campaign

The next military operation by the U.S. Army (Fifth Army) was Operation Avalanche - the amphibious assault on the beaches of Salerno, south of Naples, off Italy's West Coast. D-Day for this operation was September 8, 1943. As this and other operations unfolded in Italy, further growth in Army psychiatry took place, which further led to a more organized delivery of forward psychiatry services.

There exists no indication that Major Hanson was consulted by either the Fifth Army Surgeon, Colonel (later Major General) Joseph L. Martin, or General Blesse, Theater Surgeon (NATOUSA) regarding planning for delivery of psychiatric services for the Salerno landings. In addition, the official record indicates that during early 1943, the Fifth Army formulated no planning for a course of action regarding psychiatric cases whether in terms of prophylactic intervention or treatment. Eventually, on the August 21, 1943, the Fifth Army announced an official psychiatric policy emanating from the Office of the Fifth Army Surgeon, which proved to be inadequate. The policy came out late given its issuance was only three weeks before the Salerno landings. The time was too short to address or rectify resistance to this policy and institutional prejudices about psychiatry. It does appear that the policy did fail to consider Hanson's efforts in establishing combat psychiatric treatment in the Tunisian campaign.

²⁷⁶ Ibid.

²⁷⁷ Wiltze, *The Medical Department*, 172.

Compounding this was Lieutenant General Patton's memorandum as the Commander in the Sicily campaign of the Seventh U.S. Army, which referred to soldiers designated as "nervously incapable of combat" to be understood as "cowards." This memorandum was issued on August 5th, 1943. The slapping incident by Patton on August 10th, 1943 and his apology on August 22nd, 1943, may have played a role in making the Fifth U.S. Army Surgeon deem it necessary to have a policy dealing with psychiatric casualties in the amphibious invasion of Italy.²⁷⁸ The policy, as understood by the official history, encountered opposition from both medical and many line officers. Adding to this resistance, Major General (later Lieutenant General) Lucien K. Truscott (Fifth Army IV Corps Commanding General) had little confidence in the skills of medical officers to differentiate between "genuine" and "fake" cases of psychiatric impairment associated with combat exposure. His distrust of the abilities of medical officers to differentiate these cases was such that he ordered each soldier diagnosed as having a psychiatric disability in the 3rd Infantry Division to be screened by military lawyers to assess whether the soldier was a malingerer. This presumed that battalion surgeons as well as medical officers at division level were not capable. Nonetheless, "psychoneurotics" would be evacuated as quickly as possible through regular medical channels. This neuropsychiatric policy, included in the Fifth Army medical plan, contained a "Patton-like statement" that "stragglers and malingerers" found at medical facilities are to be handed to the Provost Marshall. The neuropsychiatric directive did state that the evacuation hospital would serve as the terminal point for psychiatric service where the only accessible psychiatrists were assigned. In addition, it was stipulated that all psychiatric casualty cases with an unfavourable outcome for returning to duty were to be immediately evacuated and placed under a sedative. Psychiatric cases could not remain at the evacuation hospital for more than four days in contrast to the previous II Corps directive of seven days at the 9th Evacuation Hospital in Tunisia. The neuropsychiatric directive, which was subsumed in the medical plan, indicated that "transportable casualties will be loaded for evacuation to destinations afloat." Thus, it can be surmised that no definitive organized plan was ever evolved for the Salerno landings or for the tactical push on Naples. However, it does need to be kept in mind that the psychiatric plan had to be secondary to the primary objective of saving the lives of soldiers. Psychiatric casualties being non-fatal in nature could not

²⁷⁸ Glass, *Neuropsychiatry*, 2:26-27.

legitimately, from a strict medical perspective, be of primary concern²⁷⁹. Even though there existed no definitive, articulated psychiatric plan, a psychiatrist was posted to each evacuation hospital. This did not prove satisfactory. The efforts of the psychiatrist were not integrated into any semblance of organization. As an example, the psychiatrist was frequently hampered by the fact that his patients were dispersed among wards. This made it exceptionally hard to systematize psychiatric care and treatment in each evacuation hospital. The patients that were evacuated to North Africa symptomatically resembled those in the Sicily campaign, being described as mild cases. These cases rapidly improved in the non-threatening surroundings of North Africa, a good distance from the combat operations on mainland Italy. However, despite improvement, these cases were found to be outright opposed to returning to their former combat roles.²⁸⁰

Eventually, the tactical situation permitted the 8th Evacuation Hospital to be located near Caserta (North-East of Naples) in October 1943. The psychiatrist attached to this facility was Captain (later Lieutenant Colonel) Calvin S. Drayer, Medical Corps. In the month of November 1943, he is noted to have been successful in returning 55%-60% of psychiatric cases to combat assignments. This parallels the results of psychiatric intervention in the last portion of combat operations in the Tunisian campaign achieved by Major Hanson. Nevertheless, there existed a less than adequate integration of the delivery of psychiatric services in the Fifth Army. For instance, at this time (Fall 1943) in the Fifth Army, only one psychiatrist was posted for each evacuation hospital. They experienced problems in not being able to consult with each other due to there being no one psychiatrist in a leadership role to coordinate their efforts to have an agreed upon psychiatric treatment program. Compounding this was poor communication to and from the psychiatrists assigned to the evacuation hospitals and medical services at division level. Further problems in communication existed between the evacuation hospitals and the Fifth U.S. Army Surgeon's Office in that the contact was restricted to supplying "statistical reports."²⁸¹ The problem with communication added to the fact that no one psychiatrist had overall supervision of psychiatric service development. This resulted in the low return to duty of only 17.9% in the Fifth U.S. Army in the month of November 1943. This meant that 82.1% of psychiatric casualties in the Fifth U.S. Army ended up being transferred further to the rear or to base hospital

²⁷⁹ Ibid., 27-29.

²⁸⁰ Ibid., 30-31.

²⁸¹ Ibid., 33.

facilities. As Army psychiatry became more formally organized during the Italian campaign, by October 1944 these figures were reversed, and thusly more fighting strength was conserved.²⁸²

By the latter part of November 1943, Major Hanson received permission to set foot on the Italian mainland. This visit to the Fifth U.S. Army was about two and a half months after the landings at Salerno. The reasons why Major Hanson's visit was put off so long, according to the official record, cannot be "known with certainty." However, one reason that has been offered is that specialty consultants, such as Hanson, were perceived more as "inspectors from a higher headquarters" than as someone who could be of assistance to command. In addition, during the early phases of the Italian campaign, there still persisted a reluctance to see psychiatric casualties as resulting from the duration and intensity of combat. Additionally, much Army thinking was that "psychiatric breakdown was regarded as dishonorable failure in combat which in a way reflected unfavorably upon command." Permission eventually was granted to Hanson by Colonel Martin, the Theater Surgeon, who was given authority to arrange such a visit by the Army Field Commander. Colonel Martin may have been concerned that having Hanson around, given his exploits in participating in previous tactical operations; and also felt responsible in case Hanson became a casualty himself.²⁸³

Major Hanson, securing the assistance of Captain Drayer, conveyed to Colonel Martin that it was essential for the Fifth U.S. Army to organize a better concentration of psychiatric service delivery. This resulted in the 3rd Platoon of the 601st Clearing Company, 161st Medical Battalion identified to function as the Fifth U.S. Army Neuropsychiatric Center. This center became the 601st. The 601st started up on December 21st, 1943 and was first situated 15-20 miles from the front at Pignataro Maggiore on the No.6 highway. This location was on the Fifth U.S. Army logistics route. The 601st evolved into a "special psychiatric field facility" by the addition of staff and necessary equipment to service 250 psychiatric casualties. Four Army psychiatrists were assigned to the 601st. The 601st was able to function as an integrated psychiatric service to deal with the heavy numbers of psychiatric casualties in the Fifth U.S. Army. This is considered an improvement from previous endeavors. Its setting served as a mirror of the "recent combat" where artillery fire was still within earshot. Patients continued to dress as soldiers. All this served

²⁸² Ibid.

²⁸³ Ibid., 37.

to preserve the soldier's identity, as well as ties to his unit, which was proximate to the 601st. Although the official history is silent on the following, it is hard not to imagine Major Hanson in his capacity as Theater Neuropsychiatric Consultant, not having a hand in the development of the 601st. The establishment of the 601st meant that psychiatry in the Mediterranean Theater now had moved from psychiatric facilities based in North Africa to the mainland of Italy. The 601st developed into a laboratory for the critical discussion of the evolution of Army combat psychiatry, and the merits, or otherwise, of particular psychiatric theories and treatment.²⁸⁴ This intellectual climate can be traced to Major Hanson, who organized Army psychiatrists to essentially conduct field research on the work they were performing. They were encouraged to write it up formally. This generated a body of knowledge dealing with both the organization of combat psychiatry through all echelons as well as articulating its theory and practice as applied to the care and treatment of psychiatric cases. The result of this research took the form of a published textbook on combat psychiatry to be discussed further below.²⁸⁵ An example of the field research supported by Hanson was presented by the then Captain Ranson at the 601st. Captain Ranson's research paper *The Normal Combat Reaction*, was instructive in providing a much clearer understanding of the need to differentiate "extreme battle discomfort from psychiatric symptomatology."²⁸⁶ The significance of this paper lies in the learning a psychiatrist required to formulate and understand the differential comparison between combat soldiers displaying the behavioral effects of stress needing a break, but not in need of psychiatric care treatment, and those displaying signs and symptoms of stress reactions significant enough and disabling to warrant being designated a psychiatric casualty. Delineating what specifically constituted a genuine psychiatric casualty also perhaps defined better, by corollary, how to recognize the malingerer looking for a ticket out of combat.

Psychiatric services continued to expand with the Anzio landings (Operation Shingle) on January 22nd, 1944. For a good period of time the Anzio beachhead had existed with a non-existent rear. Hospital facilities were just 6 miles from the battle lines with the sea behind them. Although the 601st still served as the Fifth U.S. Army Neuropsychiatric Center, a re-organization

²⁸⁴ Ibid., 39.

²⁸⁵ This publication appeared under the title, Colonel Frederick R. Hanson, *Combat Psychiatry-Experiences in the North African and Mediterranean Theater of Operation, American Ground Forces, World War II* (Washington: U.S. Government Printing Office, 1949).

²⁸⁶ Glass, *Neuropsychiatry*, 2:39-40.

of this was demanded by the conditions at Anzio. Thus, Captain Drayer of the 601st, a psychiatrist, was asked to appraise the situation at Anzio sometime in the middle of February 1944. He was quickly followed by Major Hanson in his capacity as Theater Consultant. The visit coincided with the Anzio beachhead being deemed safe for the moment, following the major general offensive fizzling out. This beachhead was relatively small, 50 miles long and about 7 miles wide, and still prone to German artillery fire. These conditions determined that no unit similar to the 601st could be established at Anzio. Nonetheless, psychiatric services that were judged to be required demanded an improvised, adaptive approach in order that psychiatric casualties could be seen quickly for assessment and treatment. To this end, the 56th Evacuation Hospital provided two good sized tents to serve as patient wards to function as the neuropsychiatric center at Anzio. The center was run by a psychiatrist assigned to the 56th Evacuation Hospital, a Lieutenant (later Captain) Samuel R. Rosen, M.C., who was previously assigned to the 114th Station Hospital (base psychiatric facility in Tunisia). Despite the setting up of the neuropsychiatric tent center at the Anzio beachhead, problems were encountered. There was an insufficient number of beds, resulting in patients not being held beyond a two-day period, as well as the Anzio beachhead still being considered dangerous. For example, 26 personnel were killed and another 64 sustained wounds at the 95th Evacuation Hospital on February 7th 1944 from enemy fire. The situation at Anzio thusly promoted more anxiety than was over-and-above that initially experienced by the psychiatric casualties. Due to this rather dangerous, anxiety provoking treatment environment, only 9.6% of the 483 psychiatric hospitalizations recorded at the 56th Evacuation Hospital were classified as being able to resume combat roles. This low percentage of return to duty increased a bit more with the assistance of two additional psychiatrists from the 601st. The 56th Evacuation Hospital was bombed by German aircraft in early April 1944, and had to be replaced by the 38th evacuation hospital with Captain Herald S. Wright, M.C., as an attending psychiatrist as well as Captain Ranson and another Army psychiatrist. By late April 1944, the previously introduced Captain (later Colonel) Albert J. Glass, who had been assigned previously to the 601st, took the place of Captain Ranson at the 56th Evacuation Hospital at Anzio.²⁸⁷

²⁸⁷ Ibid., 41-45.

The organization of psychiatric services at Anzio demonstrated that further development of combat psychiatry was needed. The assignment of psychiatrists to divisions was one missing factor. To this end, Hanson exerted a significant influence on the continued organization of combat psychiatry and forward treatment. With psychiatrists working in the combat area, more forward treatment could be delivered. As Hanson demonstrated in the Tunisian campaign, the more forward the treatment, the higher the likelihood of a soldier returning to duty. Hanson provided evidence for this, resulting in General Kirk, the U.S. Army Surgeon General, requesting that Hanson return to the Zone of the Interior (the United States) and orient perspective division psychiatrists in what to do and what to expect in their practice of psychiatry in a combat environment. Coinciding with Hanson's visit, the War Department approved the assignment of a psychiatrist to each division in October 1943 with final authorization dated November 9th, 1943. Division level psychiatry became functional at Anzio in March 1944.²⁸⁸

Thus, practically two years following Pearl Harbor, "it became possible to duplicate the three-echelon organization for treatment of combat casualties which had become so effective during WWI."²⁸⁹ This three-echelon organization was comprised of: 1) entry into division level psychiatry, referred to as forward psychiatry; 2) augmenting the first, were organized psychiatric services physically housed at the Army level; 3) psychiatric services delivered at base hospitals for combat casualties, requiring care and treatment beyond what could be provided at the first or second echelon.

The base hospital also served as a treatment center for psychiatric cases that emerged outside the combat line in the rear.²⁹⁰ Credit for this development can be ascribed to Hanson. He exercised diligent, professional leadership combined with a knowledge of the shape combat psychiatry should assume in his capacity as the Theater Neuropsychiatric Consultant. As much is noted by two psychiatrists that knew and worked with Hanson in the Mediterranean Theater of Operations, Lieutenant Colonel Calvin S. Drayer (M.C., AUS), and Colonel Albert J. Glass (M.C., AUS). Both judged Hanson to be the pivotal figure around which combat psychiatry was organized. In addition, they assert that Hanson was the one who understood the significant

²⁸⁸ Ibid., 45; Wiltze, *The Medical Dept*, 254; Hanson, *Combat Psychiatry*, 33, 45.

²⁸⁹ Glass, *Neuropsychiatry*, 2:45.

²⁹⁰ Ibid., 1.

particulars about what constituted combat psychiatry and advanced its cause with untiring lobbying to “responsible authorities.”²⁹¹

During the Mediterranean Campaign, Hanson promoted the tenets of combat psychiatry to educate other psychiatrists at conference meetings. One such conference was held on February 13th, 1943. This was the “first official” conference held of U.S. Army psychiatrists and the venue was at the head office of the Royal Society of Medicine in London, England. Hanson presented on the topic of *Services Forward of Fixed Hospitals*. Various such conferences were held in a number of convenient locations during the war to disseminate information relevant for the practice of military psychiatry.²⁹²

Another conference Hanson is noted to have presented a topic was at a meeting of allied military psychiatrists on June 5th, 1943. The location of the conference was described as being at “a base hospital overseas,” the actual location is undisclosed. Nonetheless, Hanson spoke on “experiences in the forward area.” This lecture occurred before the U.S. Army’s three-echelon delivery of psychiatry was finalized. Hanson spoke of blast injury cases being designated as exhaustion to avoid the label of shell-shock. He discussed the prescribing of sedative medication and dosages as well as the need to separate those cases severe enough in symptomatology to require evacuation compared to those who could be treated in four to five days at the evacuation hospital. He added that all effort was made to avoid the atmosphere of a hospital and soldiers were expected to behave as such. He asserted that after a four to five-day period of treatment, psychiatrists designated which patients improved sufficiently to return to duty and those in need of further evacuation to the rear. Group therapy was applied to cases having common symptoms, and Hanson claims a 60% return to combat duty with research indicating that in 44 cases following 3 weeks of combat, 89% continued in combat fighting.²⁹³ One can see in this lecture and others, Hanson’s advocacy of early treatment in forward areas juxtaposed to conserving fighting strength to avoid manpower loss.

Hanson’s other activities included providing consultations to the ETO. He visited the ETO in the month of January 1944 for a conference with Colonel Thompson, his counterpart in the ETO. Hanson is noted to have influenced the shape of ETO psychiatry policy through his

²⁹¹ Ibid.

²⁹² Ibid., 218-219.

²⁹³ S.A. McKeith, “Recent Experiences of War Neurosis,” *British Medical Journal* 2 (September, 1943): 236-237.

emphasis, based on experiences in North Africa and Italy of the need for special neuropsychiatric treatment services between evacuation facilities and general hospitals in the rear. In addition, this conference established in the ETO a recognition that forward neuropsychiatric treatment in a specialized facility was in need of planning.²⁹⁴ On November 11th, 1944 Colonel Thompson requested from Hanson, information on a table of organization and equipment required for a neuropsychiatric unit.²⁹⁵

Hanson and School of Neuropsychiatry

When the 36th Station Hospital was sent to England, this provided the ETO with the opportunity to set up a School of Neuropsychiatry to be run by this hospital. In organizing the school, advice was solicited from a number of individuals, including allied military psychiatrists. Hanson, in his capacity as Theater Consultant in MTOUSA, provided accounts and descriptions of combat conditions and associated topics from the Mediterranean experience that had a bearing upon psychiatric planning and organization that would aid in creating an “objective and practical as possible” curriculum. Hanson’s contribution, in combination with that provided by others, resulted in the School of Neuropsychiatry providing its first course of instruction in April 1943, and was attended by 13 Medical Officers. In May 1943, the school provided instruction and training for ten nurses and nine enlisted men.²⁹⁶ These courses continued to be offered and were instrumental in the training of general medical officers and battalion surgeons in the treatment and care of psychiatric casualties which could be handled in forward areas with knowledge of the signs and symptoms of combat exhaustion, again all learned from the Mediterranean experience. From December 27th 1943 to July 15th 1944, some 700 general medical officers took instruction in a seven-day course in neuropsychiatric first aid.²⁹⁷

Furthermore, Hanson provided Colonel Lloyd Thompson (the ETO Senior Neuropsychiatric Consultant) much needed information, pertaining to a list of the organizational needs that needed to be planned and developed as well as the required equipment to operationalize the work of division psychiatrists, hospitals to be utilized as assessment facilities,

²⁹⁴ John B. Coates, Jr., *Activities of Medical Consultants*, vol. 1, *Internal Medicine in WWII* (Washington, DC: Medical Department, United States Army, 1961), 352.

²⁹⁵ *Ibid.*, 353.

²⁹⁶ *Ibid.*, 367-368.

²⁹⁷ *Ibid.*, 370.

and for the functioning of general hospitals with assigned neuropsychiatrists. Following Thompson's visit (late 1943) to consult with Hanson in North Africa, both went together to the ETO, and Hanson provided the essential organizational details for organizing forward treatment, which was utilized by all the American Field Armies in the ETO. While in Europe, Hanson also found time to provide instruction at the School of Neuropsychiatry and his experience was most likely of inestimable value in the lectures he provided. Following another visit by Hanson to the ETO, Colonel Thompson's letter of November 11th, 1944 stated: "once more let me say that your visit in this theater was extremely helpful and stimulating. We all look forward to you as the pioneer in things that we are now trying to do."²⁹⁸ Colonel Thompson possessed an appreciation of the need for early forward treatment of psychiatric casualties as was the case with a good number of Canadian and British Army Psychiatrists with whom he consulted. However, it was his relationship with Hanson and his initial British training that put it all together in the ETO as far as establishing the need for forward treatment. It was Hanson's organizational ability and his advocacy of forward treatment that made what he did in the Mediterranean serve as the prototype of U.S. Army psychiatry in the ETO. Hanson's experience was pivotal to the psychiatric services that were eventually organized and delivered in the ETO as D-Day (Operation Overlord, allied landings on Normandy Coast, June 6th, 1944) approached and thereafter until the end of the war.

The Development of a Textbook on Combat Psychiatry

Hanson made a notable contribution to the U.S. Army's body of psychiatric knowledge. This was through his editing and compiling of a textbook on combat psychiatry as applied to U.S. Army ground troops. Hanson proved to be quite adept at exercising leadership among his medical colleagues by organizing them to conceptualize their practice of military psychiatry. Under his direction, Army psychiatrists in the 5th and 7th Armies were encouraged to write papers in the winter months of 1944-1945. These papers pertained to the different organizational stages of combat psychiatry as it evolved in the Mediterranean Theater of Operations.²⁹⁹ This resulted in a textbook published in November 1949 in the issue of the Bulletin of the U.S. Army Medical

²⁹⁸ Ibid., 392-394.

²⁹⁹ Albert J. Glass and Calvin S. Drayer, "Italian Campaign (1 March 1944 -- 2 May 1945), Psychiatry Established at Division Level", in *Neuropsychiatry in World War II: Overseas Theatres*, ed. Albert J. Glass (Washington, 1973), 2:96-97.

Department titled *Combat Psychiatry*. This publication became a manual for the practice and theory of combat psychiatry during the Korean War.³⁰⁰

Combat Psychiatry contained not only the structure and organizational delivery system of psychiatric services to soldiers, but also speaks of numerous timely and relevant observations of clinical utility for the practice of combat psychiatry. Further, this book provides a discursive description of forward psychiatry for the would-be army psychiatrist in the post WWII period. Furthermore, it provides an overview of combat psychiatry for the medical officer not trained as a psychiatrist. Another intrinsic value to the book is that, as noted by Cowdrey, it is free of any contentious theory and sheds light on what are normal reactions to combat as opposed to abnormal ones requiring treatment at the appropriate echelon.³⁰¹ The various echelons are described by Hanson in the text, which starts at the battalion aide station and progresses to regimental aide stations, then to divisional clearing stations, and further on to Army neuropsychiatric centers and then to Army base section hospitals. Hanson emphasizes in *Combat Psychiatry* that the text describes Army combat psychiatry as it appeared by the end of WWII.³⁰² This suggests that there was ongoing development of combat psychiatric services throughout the war. This further implies that the organization and delivery of psychiatric services to ground combat soldiers was uneven and therefore not uniform throughout the war period. This was due to both a lack of planning in operations to account for the need to provide psychiatric services, in combination with both organizational and institutional obstacles that needed to be surmounted. It would appear that Hanson's diligence and perseverance certainly played a critical role to reverse the Army's lack of medical planning at the start of the war for psychiatric casualties in ground combat troops. As Hanson left his stamp on the ETO through the professional work he provided in the Mediterranean, so too did he leave his mark on the Korean and Vietnam Wars regarding delivery of psychiatric services with the existence of *Combat Psychiatry*, which articulates the formulary for forward psychiatric services.

Hanson's Post WWII Activities

Hanson's last known active-duty assignment, given the available source material, is noted to be in early 1946. Hanson is moved from the Mediterranean Theater and is assigned to G-1

³⁰⁰ Hanson, *Combat Psychiatry*; Glass, *Neuropsychiatry*, 2:97.

³⁰¹ Cowdrey, *Fighting for Life*, 143-144.

³⁰² Hanson, *Combat Psychiatry*, 33.

(Personnel and Administration) at the War Department in Washington, D.C. He was posted to G-1 without the Surgeon General of the Army being advised. Who pulled Hanson from the Mediterranean and why is unknown, and what Hanson actually did at G-1 is rather obscure. However, Menninger provided some clue as to what Hanson's assignment may have entailed. Menninger indicates that the assignment dealt with the psychiatric implications of a variety of problematic personnel policies in the United States Army presumed to have an adverse effect on a soldier's psychiatric health and adjustment to military service. He states that "those of us in psychiatry were delighted with Hanson's assignment."³⁰³ Menninger provides no further information on the outcome of Hanson's G-1 posting, or whether any report resulted in publication. Efforts to secure sources on any published report bearing on this G-1 assignment were to no avail. Nonetheless, if any clues can be ascertained to this G-1 assignment, this might be found in Hanson's post-war report *Psychologic Factors of Adaption to Combat*, which provides commentary on personnel issues affecting a soldier's psychological adjustment to military service. This report was produced as a result of his temporary Army Reserve assignment to the Office of the Surgeon, First Army, sometime between 1946-1948. This report is the last we hear of Hanson's professional work in the United States Army Medical Service.

After separation from the Army, believed to be sometime in 1946, Hanson returns to his original place of training in Canada, and takes a position as Assistant Professor of Psychiatry at McGill University in Montreal as well as having duties at the Royal Victoria Hospital and its Allen Memorial Institute from 1946-1951.³⁰⁴ From 1951 until his passing away in July 1964, it is difficult to secure any sources as to his activities. However, the American Psychiatric Association biographical sketch, indicates that he resided in New York City, and engaged in private psychiatric practice and maintained professional affiliations with various psychiatric organizations. Attempts to secure information as to whether Hanson left any papers, diaries, or documentation regarding his professional work yielded no results at the time of this writing. Hanson passed away in July 1964 while vacationing in the Caribbean.

³⁰³ Menninger, *Psychiatry in a Troubled World*, 532.

³⁰⁴ Biographical Listing of Frederick Randolph Hanson In, *Biographical Directory of the American Psychiatric Association* (New York, New York: R. R. Bowker Co, 1958).

Conclusion

This essay shows that the available historical record indicates that Colonel Hanson redressed the U.S. Army's lack of planning for psychiatric casualties during WWII. The Army's policy at the start of the war was that its screening process would eliminate individuals at psychiatric risk from entering the United States Army. Hanson rectified the failure of the screening process by reinstituting the forgotten WWI forward psychiatry treatment principles, which he learned through his British training as a member of the Royal Canadian Army Medical Corps before transferring to the United States Army Medical Corps. This training made Hanson the conduit through which this treatment was reestablished in the United States Army. As well, he is the pivotal figure for reinstituting the three-echelon system for psychiatric care and treatment. It was fortuitous for the United States Army that he transferred to it from the Canadian Army, as it is a matter of conjecture as to how U.S. Army psychiatry in WWII may have developed without him. Thusly, Hanson can be seen as the foremost medical officer largely responsible for U.S. Army psychiatry's baptism by fire on the battlefields of Tunisia. Hanson also left his stamp on the European Theater of Operations. His organization and delivery of psychiatric services in the North African and Mediterranean Theaters became the prototype for the ETO in time for Operation Overlord.

His having assumed the role of a soldier by participating in actual combat operations gave him the opportunity to observe battlefield violence up close and its effects on ground combat soldiers. As well, his penchant for showing up at the front lines unannounced as 'Phantom Freddy' to check on the troops, points to the fact he wasn't at all timid to be where the action was. He was therefore, by experience and identity, very much a soldier-psychiatrist.

Hanson's editing of *Combat Psychiatry* emphasizes that the diagnosis of combat exhaustion was not viewed as a medicalized condition. Neither did it confer any indication of permanent disability or stigma. *Combat Psychiatry* may potentially prove useful in fostering discussion and debate as to how contemporary psychiatric conceptualizations of combat stress are formulated and differ from WWII U.S. Army psychiatry, especially in our era of medicalization of psychiatric conditions and pharmacologically driven treatments, which have largely overtaken talking therapies of the 1940's. Furthermore, Hanson's military psychiatric work indicated to him that besides combat exhaustion, that there are a multitude of factors other

than battlefield experiences which do place soldiers at psychiatric risk. Some of these factors pertain to group cohesion, leadership, training, combat motivation, dissatisfaction with military job, personnel and administrative policies, and rotation and length of deployment. These factors can also be discussed and debated to determine if past historical findings possess relevance to the U.S. Army's contemporary situation in addressing psychiatric issues.

Hanson's contribution to U.S. Army psychiatry in WWII, his energetic and untiring advocacy for the mental health of soldiers, and his diligence in the performance of professional duties, in combination with spearheading of clinical field research – all suggest that he is a pivotal personality to appreciate in U.S. Army medical history. This adds positively to its heritage in terms of pointing to an example of a soldier-psychiatrist. His achievements were no small feat in an institution whose primary purpose is not the practice of medicine. One historical legacy Hanson left behind him is to convey clearly that there is no solution to there being psychiatric casualties associated with battlefield violence. It is a constant of war making. Equally important are the multitude of factors outside the arena of combat that can potentially act negatively upon soldier adjustment and his or her psychological stability. It is for these reasons that Hanson's observations remain relevant and enduring in what is conveyed to today's U.S. Army. Finally, Hanson's professional activities buttressed by his observations of soldiers in both combat and non-combat situations underlies the importance of maintaining the soldier's psychological health as a central aspect of leadership, reinforced by manpower and personnel policies, and in the preparation and planning of psychiatric services as part of *operations* in the event of armed conflict.

Chapter 6: Bibliographical Essay on Literature Pertinent for Further Study in Military Psychiatry

No one essay (or group of them), or even a book can hope to cover every question and detail on the topic of military psychiatry. Much is left out of the essays in this short compendium, and the following bibliography is an attempt to correct a number of omissions for the reader so that further critical study can be made. The bibliography is believed to support and sustain further research on military psychiatry that is focused upon WWII, but some reference material is post WWII. In no way is this appendix exhaustive, it is only a slice of what has been published, which is voluminous.

1. In terms of critical published literature questioning the merits of forward psychiatry see:
 - a. Jones, E. and Wessely, S. “‘Forward Psychiatry’ in the Military: Its Origins and Effectiveness.” *Journal of Traumatic Stress* 16, no. 4 (2003): 411–19.
<https://doi.org/10.1023/a:1024426321072>.
 - b. Jones, E., Thomas, A. and Ironside, S. “Shell Shock: an Outcome Study of a First World War ‘PIE’ Unit.” *Psychological Medicine* 37, no. 2 (2007): 215–23.
<https://doi.org/10.1017/s0033291706009329>.
 - c. Russell, M. and Figley, C. “Do the Military’s Frontline Psychiatry/Combat and Operational Stress Control Doctrine Help or Harm Veterans? — Part One: Framing the Issue.” *Psychological Injury and Law* 10, no. 1 (2017): 1–23.
<https://doi.org/10.1007/s12207-016-9278-y>.
 - d. Russell, M. and Figley, C. “Do the Military’s Frontline Psychiatry/Combat Operational Stress Control Programs Benefit Veterans? Part Two: Systematic Review of the Evidence.” *Psychological Injury and Law* 10, no. 1 (2017): 24–71.
<https://doi.org/10.1007/s12207-016-9279-x>.
 - e. Russell, M. and Figley, C. “Is the Military’s Century-Old Frontline Psychiatry Policy Harmful to Veterans and Their Families? Part Three of a Systematic Review.” *Psychological Injury and Law* 10, no. 1 (2017): 72–95.
<https://doi.org/10.1007/s12207-016-9280-4>.
 - f. Glass, Albert J. “Effectiveness of Forward Neuropsychiatric Treatment,” *Bulletin of the U.S. Army Medical Department* vol. 7 (1947): 1034-1041.

2. For a historical account of the U.S. Army's preventative psychiatry program and its mental hygiene consultation service during WWII, see:
 - a. Perkins, M. "Preventive Psychiatry During World War II." In *Preventive Medicine in World War II*, Volume 3, edited by Hoff, E. 3:171–232. Washington, D.C: Office of the Surgeon General, 1955.
3. A report of an official inquiry into the status of psychiatry in World War II that is not only informative, but insightful is:
 - a. Brigadier General Elliot D. Cooke. *All but Me and Thee: Psychiatry at the Foxhole Level*. Infantry Journal Press, Washington D.C., 1946.
4. A well researched monograph on the psychological toll of combat violence is:
 - a. Gabriel, R. *No More Heroes: Madness and Psychiatry in War*. New York, NY: Hil and Wang, 1987.
5. A large selection of published journal articles in military psychiatry from World War II with an international perspective, and surveying a large number of articles pertaining to the U.S. Army is found in:
 - a. Engle, B. and Lewis, N. eds. *Wartime Psychiatry: a Compendium of the International Literature*. New York, NY: Oxford University Press, 1954.
6. No understanding of military psychiatry can be meaningful without reference to the physical and mental stresses associated with the experience of combat. To this end, the following may prove useful:
 - a. Ellis, J. *The Sharp End: the Fighting Man in World War II*. New York, NY: Charles Scribner's Sons, 1980.
 - b. Linderman, G. *The World within War: America's Combat Experience in World War II*. Cambridge, MA: Harvard University Press, 1997.
 - c. Holmes, R. *Acts of War: the Behavior of Men in Battle*. New York, NY: Free Press, 1985.
 - d. Kindsvatter, P. *American Soldiers: Ground Combat in the World Wars, Korea, and Vietnam*. Lawrence, KS: University Press of Kansas, 2003.
 - e. Hamner, C. *Enduring Battle: American Soldiers in Three Wars, 1776-1945*. Lawrence, Kan., KS: University Press of Kansas, 2011.

7. An attempt to combine operational research with historical analysis to study combat stress in soldiers is:
 - a. Rowland, D. *The Stress of Battle: Quantifying Human Performance in Combat*. London: The Stationary Office, 2006.
8. For a study of the American soldier in World War II from the draft to training and combat, see:
 - a. Kennett, L. *G.I.: the American Soldier in World War II*. Norman: University of Oklahoma Press, 1997.
9. For understanding the social and psychological experience of the American black soldier in World War II and its attendant racism, refer to:
 - a. Motley, M. *The Invisible Soldier: the Experience of the Black Soldier, World War II*. Detroit: Wayne State Univ. Press, 1975.
10. The human experience of War as it pertains to battlefield carnage and fear of being wounded or killed is psychologically without equal. Added to this is killing the enemy in combat. This subject matter is of importance to both military history and military psychiatry, and has been admirably addressed in:
 - a. Stephenson, M. *The Last Full Measure: How Soldiers Die in Battle*. New York, NY: Crown Publishers, 2012.
11. The issue of good and evil in waging war and all its moral quandaries is scholarly researched in:
 - a. Burleigh, M. *Moral Combat: a History of World War II*. New York, NY: Harper Collins Publishers, 2011
12. A circumspect psychological research study of learning to kill and its psychological implications for mental health has been researched by:
 - a. Grossman, D. *On Killing: the Psychological Cost of Learning to Kill in War and Society*. New York, NY, NY: Little, Brown and Company, 2009.
13. For a psychiatric study of combat stress in the North Africa Campaign not cited in the essay on Colonel Hanson, see:
 - a. Grinker, R, and Spiegel, J. *War Neuroses in North Africa; the Tunisian Campaign, January-May 1943*. New York, NY: Prepared and distributed for the Air Surgeon, Army Air Forces, by the Josiah Macy, Jr. Foundation, 1943.

14. For an allied history of Military psychiatry in the British Armed Forces see:
- a. Rees, J. R. "Three Years of Military Psychiatry in the United Kingdom." *British Medical Journal* 1, no. 4278 (1943): 1–6. <https://doi.org/10.1136/bmj.1.4278.1>.
 - b. Evans, R.G. "An Outline of the Role of the Medical Services in the Second (British) Army's Campaign in North-West Europe (1944-45)." *Royal Army Medical Corps.* 3, no. 95 (1947): 165–85.
15. Appraisal of the application of Military psychiatry in World War II from the allied British perspective can be appreciated by reference to:
- a. L'etang, H.J.C.J. "A Criticism of Military Psychiatry in the Second World War, Part I, Introduction." *Journal of the Royal Army Medical Corps.*, no. 97 (1951): 192–97.
 - b. L'etang, H.J.C.J. "A Criticism of Military Psychiatry in the Second World War, Part II, Experiences in general practice (1946-1949)." *Journal of the Royal Army Medical Corps.*, no. 97 (1951): 236-244.
 - c. L'etang, H.J.C.J. "A Criticism of Military Psychiatry in the Second World War, Part III, Historical survey (1864-1938)." *Journal of the Royal Army Medical Corps.*, no. 97 (1951): 315-327.
16. For an evaluation of the practice of forward psychiatry in the British Army of World War II, see:
- a. Cantile, N. "Forward Psychiatry - an Address to a Conference on Psychiatry, August 8, 1944." *Journal of the Royal Army Medical Corps.*, no. 91 (1948): 93–95.
17. An assessment of combat psychiatry from the American perspective dealing with themes of history and theory is:
- a. Artiss, K. "Combat Psychiatry: From History to Theory." *Military Medicine* 162, no. 9 (1997): 605–7.

18. The subject of post-combat disorders has been addressed by:
- a. Jones, E. "Historical Approaches to Post-Combat Disorders." *Philosophical Transactions of the Royal Society B: Biological Sciences* 361, no. 1468 (2006): 533–42. <https://doi.org/10.1098/rstb.2006.1814>.
19. A discussion of forward psychiatry in the British Army by various military psychiatrists involved with its implementation is:
- a. "DISCUSSION: FORWARD PSYCHIATRY IN THE ARMY." *Proceedings of the Royal Society of Medicine* vol. 39,3 (1946): 137-42.
20. British and American application of psychiatry at the military division level can be studied by:
- a. Davis, P.J.R. "Divisional Psychiatry; Report to the War Office." *Journal of the Royal Army Medical Corps.*, no. 86 (1946): 254–74.
 - b. Office of the Surgeon General. "The Division Neuropsychiatrist." *The Bulletin of the U.S. Army Medical Department*, no.74 (1944):29-34.
 - c. Menninger, W. "Neuropsychiatry for the General Medical Officer." *The Bulletin of the U.S. Army Medical Department*, vol. IX, no.3, (1945): 341-343.
 - d. Glass, A. J. "Preventive Psychiatry in the Combat Zone." *United States Armed Forces Medical Journal* 4, no. 5 (1953): 9–17.
21. An article on management of psychiatric cases in the U.S. Armed Services during World War II is:
- a. Chermol, B. H. "Wounds without Scars: Treatment of Battle Fatigue in the U.S. Armed Forces in the Second World War." *Military Affairs* 49, no. 1 (1985): 9–12. <https://doi.org/10.2307/1988270>.
22. A paper concisely summarizing the U.S. Armed Forces psychiatric reaction to 20th century wars is:
- a. Pols, H., and Oak, S. "WAR & Military Mental Health." *American Journal of Public Health* 97, no. 12 (2007): 2132–42. <https://doi.org/10.2105/ajph.2006.090910>.

23. A study of psychiatric decompensation associated with battlefield violence exposure juxtaposed to the factor of motivation has been evaluated by:
- a. Wessely, S. "Twentieth-Century Theories on Combat Motivation and Breakdown." *Journal of Contemporary History* 41, no. 2 (2006): 268–86.
<https://doi.org/10.1177/0022009406062067>.
24. The late Herbert Spiegel wrote a retrospective monograph detailing his World War II experience as an Army psychiatrist. It is both instructive and informative regarding the practice of combat psychiatry:
- a. Herbert X. Spiegel, "Silver Linings in the Clouds of War: A Five-Decade Retrospective," in *American Psychiatry after World War II*, ed. Roy W. Menninger and John C. Nemiah (Washington, DC: American Psychiatric Press, 2000).
- Spiegel has also written a primary source article on his observation as an infantry battalion medical officer dealing with psychiatric issues during the Tunisian Campaign. He was a contemporary of both Albert J. Glass and Frederick R. Hanson. See:
- b. Spiegel, H. "Psychiatric Observations in the Tunisian Campaign." *American Journal of Orthopsychiatry* 14, no. 3 (1944): 381–83.
<https://doi.org/10.1111/j.1939-0025.1944.tb04892.x>.
25. For a paper on the Tunisian Campaign pertaining to U.S. Army psychiatry, providing critical commentary on Hanson's implementation of forward psychiatry and its results, refer to:
- a. Pols, H. "The Tunisian Campaign, War Neuroses, and the Reorientation of American Psychiatry During World War II." *Harvard Review of Psychiatry* 19, no. 6 (2011): 313–20.
26. The concepts of masculinity, patriotism, and citizenship are subjects of consideration in contrasting civil war soldiers with infantrymen of WWII, offering a novel understanding of combat motivation, and can be studied by reference to:
- a. Rodgers, T. "Billy Yank and G.I. Joe: An Exploratory Essay on the Sociopolitical Dimensions of Soldier Motivation." *The Journal of Military History* 69, no. 1 (2005): 93–121. <https://doi.org/10.1353/jmh.2005.0044>.

27. The role played by the U.S. Army psychiatry among ground troops in World War II has been researched by:
- Wanke, P. "American Military Psychiatry and Its Role among Ground Forces in World War II." *The Journal of Military History* 63, no. 1 (1999): 127–46.
<https://doi.org/10.2307/120336>.
28. The place of prevention in the psychiatry of the British Military in World War II regarding concepts of trauma is:
- Shephard, B. "'Pitiless Psychology': the Role of Prevention in British Military Psychiatry in the Second World War." *History of Psychiatry* 10, no. 40 (1999): 491–524. <https://doi.org/10.1177/0957154x9901004005>.
29. The role of the U.S. Army psychiatry in the European Theater in World War II is recorded in:
- Thompson, L. J. "Neuropsychiatry in the European Theater of Operations." *Journal of Nervous and Mental Disease* 105, no. 3 (1947): 304–7.
30. A historical account of how neuropsychiatry in the U.S. Army took measures to address psychiatric issues in the European Theater in World War II, is presented by:
- Casey, J. F. "History of the Development of Neuropsychiatry in the European Theatre of Operations." *American Journal of Psychiatry* 102, no. 6 (1946): 721–27. <https://doi.org/10.1176/ajp.102.6.721>.
31. Regarding the concept of nostalgia as a psychological problem of historical interest affecting soldiers, see:
- Rosen, G. "Nostalgia: a 'Forgotten' Psychological Disorder." *Psychological Medicine* 5, no. 4 (1975): 340–54. <https://doi.org/10.1017/S003329170005697X>.
32. An often referred to paper on the interaction between American psychiatry and the Second World War is:
- Grob, G. 'World War II and American Psychiatry', *The Psychohistory Review* 19 (1990), 41–69

33. The subject matter of the social history of soldiering in the United States that questions stereotyping and proposes courses of research to consider is articulated by:
- a. Kohn, R. "The Social History of the American Soldier: A Review and Prospectus for Research." *The American Historical Review* 86, no. 3 (1981): 553–67.
<https://doi.org/10.2307/1860370>.
34. The volumes comprising *The American Soldier* were produced by the research branch within the Morale Division of the War Department of the United States after World War II. The research conducted is within the parameters of social psychology. This is the subject of an experiment for encouraging research on military affairs having an impact for students of military psychiatry:
- a. Williams, R. "The American Soldier: An Assessment, Several Wars Later." *The Public Opinion Quarterly* 53, no. 2 (1989): 155–74.
35. The significance of Samuel A. Stouffer as the principal author of *The American Soldier* is examined for appreciating how social psychology is vital for studying military organizations and soldier behaviour. Refer to:
- a. Ryan, J. W. "Samuel A. Stouffer and The American Soldier." *Journal of Historical Biography* 7 (2010): 100–137.
36. Relevant to military psychiatry, and for an understanding of how military morale differs from civilian morale, and how the former is shaped into a capable force to defend the nation, refer to:
- a. Ulloa, J. "Military Morale." *American Journal of Sociology* 47, no. 3 (1941): 321–30.
37. On the relation between soldier morale and control of anxiety, see:
- a. Tureen, L. "A Study of Moral, Psychosomatic Symptoms, and Neurotic Tendencies in Groups of Overseas Soldiers." *Transactions of American Neurological Association* 9, no. 13 (1946): 9–13.
38. A historical study on a variety of psychiatric conditions associated with war service can be found at:
- a. Palmer, I. "War Syndromes from 1900 to the Present: Symptom Patterns and Long-Term Health Outcomes." Prepared for: *U.S. Army Medical Research and Materiel Command*. Department of Defense, Fort Detrick: MD, 2001.

39. From both a historical and psychosocial perspective on what leads to combat effectiveness, see:
- a. Strachan, H. "Training, Morale and Modern War." *Journal of Contemporary History* 41, no. 2 (2006): 211–27. <https://doi.org/10.1177/0022009406062054>.
40. A lengthy listing of American published literature on psychiatry dealing with WWI:
- a. Fenton, N., and D. E. Morrison. "A Bibliography Of American Contributions To War Neuropsychiatry." *American Journal of Psychiatry* 83, no. 3 (1927): 507–17. <https://doi.org/10.1176/ajp.83.3.507>
41. A post World War II publication listing a nomenclature of psychiatric conditions for use by the U.S. Armed Forces is:
- a. "Nomenclature and methods of recording psychiatric conditions." Department of the Army, Bureau of Medicine and Surgery, U.S. Navy, Department of the Air Force. Washington: D.C. 1949.
42. The experience and lessons of war can be found at:
- a. Menninger, R. W., J. C. Nemiah, and F. Jones. "Military Psychiatry Since World War II." Essay. In *American Psychiatry after World War II: (1944-1994)*. Washington, DC, D.C: American Psychiatric Press, 2000.
43. For a summary of the state of the art in military psychiatry and its application in the U.S. Army in the early World War II period, refer to:
- a. Porter, W. "Military Psychiatry." *Military Medicine* 2, no. 4 (1942): 543–50.
44. A study of the condition of combat exhaustion and its treatment conducted by the U.S. Army in the European Theater of Operations directly following the secession of hostilities is:
- a. The General Board, United States Forces, European Theater. "Combat Exhaustion." June 1945

Available through the Command and General Staff College combined Arms research digital library website.

45. A paper explaining General Patton's understanding of shell shock based upon his World War I combat experience is used to shed light on the slapping incidents in the Sicily campaign, in:
- Lovelace, A. "'Slap Heard around the World': George Patton and Shell Shock." *U.S. Army War College* 49, no. 3 (2019): 79–92.
46. On the practice of psychotherapy in psychiatric casualties with a focus on Tunisian Campaign, see:
- Grinker, R. R., & Spiegel, J. P. "Brief psychotherapy in war neuroses." *Psychosomatic Medicine*, 6, (1944). 123–131.
<https://doi.org/10.1097/00006842-194404000-00002>
47. A study on the number of psychiatric disorders detected in the U.S. Army during World War II is:
- Appel, J. W. "Incidence Of Neuropsychiatric Disorders In The United States Army In World War II." *American Journal of Psychiatry* 102, no. 4 (1946): 433–36. <https://doi.org/10.1176/ajp.102.4.433>.
48. An observational report on anxiety and fear in combat soldiers of World War II is:
- Schwab, R.S. "Observation of Anxiety and Fear in Non-Hospitalized Functioning Combat Personnel." *Transaction of the American Neurological Association*, 1946. 13-18.
49. A widely cited and comprehensive World War II article on combat exhaustion in the U.S. Army is:
- Bartemeier, L. H., Kubie, L. S., Menninger, K. A., Romano, J., and Whitehorn, J. C. "Combat Exhaustion." *The Journal of Nervous and Mental Disease* 104, no. 4 (1946): 358–89. <https://doi.org/10.1097/00005053-194610000-00002>.
50. Another widely cited article attempting to study how combat exhaustion may be related to the neuroses, and providing data on how combat exhaustion is staged is:
- Swank, R. L., and W E. Marchand. "Combat Neuroses: Development of Combat Exhaustion." *Archives of Neurology & Psychiatry* 55, no. 3 (1946): 236–47.
<https://doi.org/10.1001/archneurpsyc.1946.02300140067004>.
51. A criticism of the use of Military Psychiatry is:
- Link, H.C. "The Errors of Psychiatry." *American Mercury*, 1944. 72-78.

52. A study dealing with the relationship between combat induced stress and brain trauma from World War I to the wars in Iraq and Afghanistan is:
- a. Anderson, R. J. "Shell Shock: An Old Injury with New Weapons." *Molecular Interventions* 8, no. 5 (2008): 204–18. <https://doi.org/10.1124/mi.8.5.2>.
53. The importance of planning for psychiatric services as part of military operations is highlighted by:
- a. Ingraham, L. H., and Manning, F. J. "Psychiatric Battle Casualties: the Missing Column in a War without Replacements." *Military Review* 60, no. 8 (1980): 18–29.
54. The role of military psychiatry at induction, in training, and in combat is surveyed by:
- a. Mcneel, B. H. "War Psychiatry In Retrospect." *American Journal of Psychiatry* 102, no. 4 (1946): 500–506. <https://doi.org/10.1176/ajp.102.4.500>.
55. A wide sweeping historical account of what is asked of soldiers in terms of sacrifice and motivation, and what they experience with psychological import is:
- a. Keegan, J., and Holmes, R. *Soldiers: A History of Men in Battle*. London: Hamish Hamilton, 1985.
56. An interdisciplinary team of researchers (The Conservation of Human Resources Project) was inaugurated at Columbia University by General Dwight D. Eisenhower in 1950. The team carried out extensive research on U.S. Army World War II manpower problems. It focused upon soldier performance, psychiatric breakdown and recovery, and wastage of valuable manpower during wartime. See:
- a. Ginzberg, E., Anderson, J.K., Ginsberg, S. and Herma, J. *The Ineffective Soldier: Lessons for Management and the Nation*. New York: Columbia Univ. Press, 1959.
- Vol. I: The Lost Division
Vol. II: Patterns of Performance
Vol. III: Breakdown and Recovery
57. A large history of published research on battle fatigue is the following:
- a. Kaufman, L., Golembe, E.H., Seevers, M.J. *Bibliography of Battle Fatigue Literature*. U.S. Army Medical Research Unit- Europe, 7th Medical Command, APO New York 09102-4428: January 16, 1986.

58. A fairly large history of 736 published papers on military psychiatry in the post World War II time period is:
- a. Roos, C., and Barry, J. *Bibliography of Military Psychiatry, 1952-1958*. Washington, D.C: U.S. Department of Health, Education and Welfare. Public Health Service, 1959.
59. On the relationship between exposure to combat and health in World War II veterans, refer to:
- a. Elder, G.H., Shanahan, M.J. and Clipp, E.C. "Linking Combat and Physical Health: the Legacy of World War II in Men's Lives." *The American Journal of Psychiatry* 154, no. 3 (1997): 330–36. <https://doi.org/10.1176/ajp.154.3.330>.
60. A study of the persistence of psychological problems associated with World War II combat experience is the following:
- a. Lee, K.A., Vaillant, G.E., Torrey, W.C. and Elder, G.H. "A 50-Year Prospective Study of the Psychological Sequelae of World War II Combat." *The American Journal of Psychiatry* 152, no. 4 (1995): 516–22. <https://doi.org/10.1176/ajp.152.4.516>.
61. A historical overview of war-related illnesses is:
- a. Hyams, K. C. "War Syndromes and Their Evaluation: From the U.S. Civil War to the Persian Gulf War." *Annals of Internal Medicine* 125, no. 5 (1996): 398–405. <https://doi.org/10.7326/0003-4819-125-5-199609010-00007>.
62. On the role of psychiatry in warfare, see:
- a. Strecker, E. A., and Appel, K. E. *Psychiatry in Modern Warfare*. New York, NY: Macmillan, 1945.
63. On the subject of shell shock from the British perspective, see:
- a. Bogacz, T. "War Neurosis and Cultural Change in England, 1914-22: The Work of the War Office Committee of Enquiry into 'Shell-Shock'." *Journal of Contemporary History* 24, no. 2 (1989): 227–56. <https://doi.org/10.1177/002200948902400203>.

64. Psychiatric observations, diagnosis, and descriptions of treatment in U.S. Army World War II troops is:
- a. Grinker, R. R., and Spiegel, J. P. *Men under Stress*. London: J & A Churchill, 1945.
65. For how war informed psychiatry in World War II from a British perspective, see:
- a. Rees, J. R. *The Shaping of Psychiatry by War*. New York, NY: W.W. Norton & Co., 1945.
66. The realities of war for men under fire, the battlefield environment, the issue of command, why men fight, and other issues impinging on World War II psychiatry is:
- a. Marshall, S. L. A. *Men against Fire: The Problem of Battle Command*. Norman: University of Oklahoma Press, 2000.
67. A historical study of screening in the military:
- a. Jones, E., Hyams, K. C. and Wessely, S. "Screening for Vulnerability to Psychological Disorders in the Military: An Historical Survey." *Journal of Medical Screening* 10, no. 1 (2003): 40–46.
<https://doi.org/10.1258/096914103321610798>.
68. A psychosomatic study of heart disease in soldiers can be found in:
- a. Howell, J.D. "'Soldier's Heart': The Redefinition of Heart Disease and Specialty Formation in Early Twentieth-Century Great Britain." Essay. In: Cooter, R., Harrison, M., Sturdy, S. *War, Medicine and Modernity*, 85–105. Thrupp Stroud: Sutton Publishing, 1998.
- This study can be surveyed alongside:
- b. Wood, P. "Ideology of Da Costa's Syndrome." *British Medical Journal* 1, no. 845 (1941): 845–51.
69. Enumerating the psychiatric lessons from World War II in the U.S. Army is:
- a. Glass, A. J. "Lessons Learned" In: eds. Mullins, W. and Glass, A.J. *Neuropsychiatry in World War II, Vol. II*, Government Printing Office, 1973.

70. For those interested in how U.S. Army Medical Officers functioned in a neuropsychiatric capacity in World War II, re.: selection, use of diagnostic categories, prevention, essentials of conducting a neuropsychiatric history, prognosis, treatment modalities, disposition of cases, and administrative duties, refer to:
- a. Farrell, M.J. and Kaufman, M.R. "A Compendium on Neuropsychiatry in the Army." *Army Medical Bulletin*, 66 (1943): 1-112.
71. For a comprehensive portrayal of the work of William Menninger as a military psychiatrist in the World War II U.S. Army see:
- a. Menninger, W. W. "Contributions of Dr. William C. Menninger to Military Psychiatry." *Bulletin of the Menninger Clinic* 68, no. 4 (2004): 277–96.
<https://doi.org/10.1521/bumc.68.4.277.56641>.
72. A post World War II study on the course of development of psychiatric disorders that occurred either prior to or during War service that necessitated treatment was conducted by:
- a. Brill, N. Q., and Beebe, G. W. "Follow-Up Study of Psychoneuroses." *American Journal of Psychiatry* 108, no. 6 (1951): 417–25.
<https://doi.org/10.1176/ajp.108.6.417>.
73. The relationship between U.S. Army veterans with a history of psychoneurosis and mortality is captured in:
- a. Keehn, R.J., Goldberg, I.D. and Beebe, G.W. "Twenty-Four Year Mortality Follow-Up of Army Veterans with Disability Separations for Psychoneurosis in 1944." *Psychosomatic Medicine* 36, no. 1 (1974): 27–46.
<https://doi.org/https://doi.org/10.1097/00006842-197401000-00003>.
74. The U.S. Army, just following World War II, produced a new method of recording a psychiatric diagnosis and a revised nomenclature that became the forerunner of DSM-1 (diagnostic and statistical manual of the American Psychiatric Association). This was printed in:
- a. "Nomenclature of Psychiatric Disorders and Reactions." *Journal of Clinical Psychology* 56, no. 7 (2000): 289–96.

75. A history of how War Department Technical Bulletin, Medical 203 was adapted to become DSM-1, can be found at:
- a. Houts, A.C. “Fifty Years of Psychiatric Nomenclature: Reflections on the 1943 War Department Technical Bulletin, Medical 203.” *Journal of Clinical Psychology* 56, no. 7 (2000): 935–67.
76. A short and concise overview of the tenets of military psychiatry is:
- a. Ellard, J. “Principles of Military Psychiatry.” *ADF Health* 1 (2000): 81–84.
77. The topic of the notion of risk and psychiatric breakdown in war juxtaposed to the concepts of risk aversion and resilience is covered by:
- a. Wessely, S. “Risk, Psychiatry and the Modern Military.” In *Human Dimensions in Military Operations – Military Leaders’ Strategies for Addressing Stress and Psychological Support* (pp. KN2-1 – KN2-16). *Meeting Proceedings RTO-MP-HFM-134, Keynote 2*. (2006) Neuilly-sur-Seine, France: RTO. Available from: <http://www.rto.nato.int/abstracts.asp>
78. A study published during the course of World War II traces a number of sociological and psychological characteristics of U.S. Army life, and conducted by:
- a. Maskin, M. H. and Altman, L.L. “Military Psychodynamics: Psychological Factors in the Transition from Civilian to Soldier.” *Psychiatry* 6, no. 3 (1943): 263–69. <https://doi.org/10.1080/00332747.1943.11022456>.
79. A paper of historical importance to the discipline of military psychiatry dealing with a nuanced thesis on the utilization of the defense mechanism of repression associated with war service is:
- a. Rivers, W.H.R. “An Address ON THE REPRESSION OF WAR EXPERIENCE.” *The Lancet* 191, no. 4927 (1918): 173–77. [https://doi.org/10.1016/s0140-6736\(01\)23233-4](https://doi.org/10.1016/s0140-6736(01)23233-4).
80. A historical survey of shell shock and post-concussion syndromes can be found by referring to:
- a. Jones, E., Fear. N and Wessely, S. “Shell Shock and Mild Traumatic Brain Injury: A Historical Review.” *The American Journal of Psychiatry* 164, no. 11 (2007): 1641–45. <https://doi.org/https://doi.org/10.1176/appi.ajp.2007.07071180>.

81. The inadequacy of the term “shell shock” is discussed in conjunction with the multitude of psychological effects of war service that render soldiers unable to perform is found at:
- a. Smith, G.E, and Pear, T.H. *Shell Shock and Its Lessons*. England: Manchester University Press, 1917.
82. Supplementing Albert J. Glass’ historical narrative of U.S. Army psychiatry in the inter-war period in the essay above, and covering the years 1941-1943, and reporting on: selection; treatment of psychiatric cases in both the continental U.S.A and combat areas; rehabilitation of psychiatric cases; the role of mental hygiene consultation services; mental health lectures to soldiers; psychiatric reports on merchant marine seamen; U.S. Navy personnel and U.S. Marines at Guadalcanal; forward psychiatry and psychiatry in Army Air Forces is:
- a. Deutsch, A., and Zilboorg, G. “Military Psychiatry: World War II, 1941-1943.” Chapter. In *One Hundred Years of American Psychiatry*, New York, NY: Columbia University Press, 1944.
83. A lengthy study on the relationship between stress associated with War service and the development of psychiatric problems is:
- a. Kardiner, A., and Spiegel, H.X. *War Stress and Neurotic Illness*. New Delhi: Iska Books, 2013.
84. For a lengthy commentary on induction selection, the use of psychiatric examination, the rejectee, oversees physical standards, and the inadequacy of the U.S. wartime psychiatric selection techniques in World War II, refer to:
- a. Menninger, W. C. “Choosing the Soldier.” Chapter. In *Psychiatry in a Troubled World*. New York: Macmillan, 1948.

This publication also contains fairly detailed information on the status of psychiatry prior to World War II and the problems of instituting it in the Army. The social psychiatry of the soldier is also covered as well as clinical observations of various psychiatric conditions. It covers the administration and practice of U.S. Army psychiatry in World War II, and contains a listing of pertinent Army publications and circulars relevant to military psychiatry. It also presents a considerable amount of data relevant to Army psychiatry. William Menninger was well positioned by experience and knowledge to

write this book after WWII, and having served as Chief of Psychiatry in the Office of the U.S. Army Surgeon General.

85. A paper dealing with the training of civilian physicians entering the U.S. Army to be educated and trained in the application of military psychiatry is:
 - a. Porter, W. C. “The School of Military Neuropsychiatry.” *American Journal of Psychiatry* 100, no. 1 (1943): 25–27. <https://doi.org/10.1176/ajp.100.1.25>.
86. A presentation from two prominent U.S. Army psychiatrists working in the Surgeon Generals Office, explaining how the Army utilizes psychiatry is:
 - a. Halloran, R. D., and Farrell, M.J. “The Function of Neuropsychiatry in The Army.” *American Journal of Psychiatry* 100, no. 1 (1943): 14–20. <https://doi.org/10.1176/ajp.100.1.14>.
87. The influence of culture on the presentation of War related medical symptomatology has been studied by:
 - a. Jones, E., and Wessely, S. “War Syndromes: The Impact of Culture on Medically Unexplained Symptoms.” *Medical History* 49, no. 1 (2005): 55–78. <https://doi.org/10.1017/s0025727300008280>.
88. The effect of culture affecting military personnel attitudes to mental health issues received attention in:
 - a. Langston, V., Gould, M. and Greenberg, N. “Culture: What Is Its Effect on Stress in the Military?” *Military Medicine* 172, no. 9 (2007): 931–34. <https://doi.org/https://doi.org/10.7205/MILMED.172.9.931>.
89. A study assessing long-term usefulness of forward psychiatry in service members of the Israeli Defence Forces was conducted by:
 - a. Solomon, Z., Shklar, R. and Mikulincer, M. “Frontline Treatment of Combat Stress Reaction: A 20-Year Longitudinal Evaluation Study.” *American Journal of Psychiatry* 162, no. 12 (2005): 2309–14. <https://doi.org/10.1176/appi.ajp.162.12.2309>.

90. Changes in how psychological trauma is depicted in 20th century thinking and having a bearing upon military psychiatry is:
- a. Jones, E. and Wessely, S. "A Paradigm Shift in the Conceptualization of Psychological Trauma in the 20th Century." *Journal of Anxiety Disorders* 21, no. 2 (2007): 164–75. <https://doi.org/10.1016/j.janxdis.2006.09.009>.
91. An article providing a psychodynamic as well as a psychosocial analysis of killing in combat is:
- a. Jones, E. "The Psychology of Killing: The Combat Experience of British Soldiers during the First World War." *Journal of Contemporary History* 41, no. 2 (2006): 229–46. <https://doi.org/10.1177/0022009406062055>.
92. A philosophical approach to analyzing the effects of combat on soldier behaviour, attitudes, and personality can be studied with reference to:
- a. Gray, J. G. *The Warriors: Reflections on Men in Battle*. Lincoln: University of Nebraska Press, 1998.
93. A history-based study of post-combat disorders over the past century, and their variety of forms is:
- a. Jones, E. "Historical Approaches to Post-Combat Disorders." *Philosophical Transactions of the Royal Society B: Biological Sciences* 361, no. 1468 (2006): 533–42. <https://doi.org/10.1098/rstb.2006.1814>.
94. For a history of psychotherapy techniques used in the combat zone from World War I to the Korean War, see:
- a. Glass, A. J. "Psychotherapy in the Combat Zone." *The American Journal of Psychiatry*, 110, (1954) 725–731. <https://doi.org/10.1176/ajp.110.10.725>
95. A World War II study analyzing a variety of psychoneurotic states examined in a fixed hospital away from the combat zone in U.S. Army soldiers is:
- a. Mcelroy, R. B. "Psychoneuroses, Combat-Anxiety Type." *American Journal of Psychiatry* 101, no. 4 (1945): 517–20. <https://doi.org/10.1176/ajp.101.4.517>.
96. A primary source for the experiences of a U.S. Army foot soldier during World War II is:
- a. Blunt, R. C. *Foot Soldier: A Combat Infantryman's War in Europe*. Cambridge, MA: Da Capo Press, 2002.

97. For an insightful, unique look at combat from the individual soldier's viewpoint and experience refer to:
 - a. Keegan, J. *The Face of Battle: A Study of Agincourt, Waterloo and the Somme*. London: Jonathan Cape Ltd., 1976.
98. A World War II study of how soldiers experienced and perceived combat fatigue is:
 - a. Johnson, P.M. "Every Man Has His Breaking Point: the Attitudes of American Infantrymen Towards Combat Fatigue in World War II." University of Wisconsin History B.A. Theses, 2007. <http://digital.library.wisc.edu/1793/8516>
99. The theme of killing in combat juxtaposed to notions of obedience, morality, remorse, and personal responsibility is studied by:
 - a. Bourke, J. "In The Presence Of Mine Enemies: Face-To-Face Killing In Twentieth Century Warfare." In: *British History in the Twentieth Century [E-seminar]*, Institute of Historical Research. (Unpublished), 1998.
100. A study of neuropsychiatric battle casualties in the Canadian Army in World War II is:
 - a. Flavelle, R. "Help or Harm: Battle Exhaustion and the RCAMC During the Second World War." *Journal of Military and Strategic Studies* 9, no. 4 (2007): 1–22.
101. The roles of group cohesion, realistic training, and competent, ethical leadership are seen as vital ingredients in forestalling psychological casualties in war service, and is competently addressed in:
 - a. Shay, J., Nash, W., March, C., Gibson, D., Darte, K., Gudmundsson, B. and Stokes, J. "Preventing Psychological and Moral Injury in Military Service." PsycEXTRA Dataset, 2007. <https://doi.org/10.1037/e517322011-038>.
102. An article dealing with how the "Jim Crow" U.S. Army of World War II failed to provide psychiatric services for African American soldiers is:
 - a. Dwyer, E. "Psychiatry and Race during World War II." *Journal of the History of Medicine and Allied Sciences* 61, no. 2 (2006): 117–43. <https://doi.org/10.1093/jhmas/jrj035>.

103. Dealing with stress during combat operations is a subject matter found in:
- a. Glass, A.J. "The problem of stress in the combat zone," In *Army Medical Center Graduate School, Symposium on Stress*. Washington, D.C.: Walter Reed Army Medical Center, 1953.:90-102.
 - b. Gabriel, R. "Stress in Battle: Coping on the Spot." *Army* 32 (1982): 36–42.
 - c. Hales, R. E., and Jones, F.D. "Teaching the Principles of Combat Psychiatry to Army Psychiatry Residents." *Military Medicine* 148, no. 1 (1983): 24–27.
<https://doi.org/10.1093/milmed/148.1.24>.
 - d. Marlow, D and Ingraham, L. "Emphasizing Cohesion, Morale Can Help Prevent Battle Stress." *Army*, 33 (1983): 16-17.
 - e. Standish, A. "Crisis in Courage." *Combat Forces Journal*, 1952.:13-24.
 - f. Moran, C. *The Anatomy of Courage*. Boston: Houghton Mifflin Company, 1945.
 - g. Flora, D.B. "Battlefield Stress: Causes, Cures, and Countermeasures." Thesis. U.S. Army Command and General Staff College in Partial Fulfillment of the Requirements for the Degree: Master of Military Art and Science. Fort Leavenworth, KS: 1985.
104. Knowledge of the circumstances in which soldiers served and died, as well as their expectations of distress, and how they lived through combat is studied by a multitude of military history scholars, and is relevant as to what is conveyed to military psychiatry, can be found in:
- a. Addison, P., Deighton, L. and Calder, A. *Time to Kill: the Soldiers Experience of War in the West, 1939-1945*. London: Pimlico, 1997.
105. For what is acclaimed to be a classic World War II memoir depicting experiences in training and in combat, as well as depicting the horrors of battlefield violence from which no one escaped without either dying, being wounded, compromising their health and some, their sanity, refer to
- a. Sledge, E. B. *With the Old Breed: at Peleliu and Okinawa*. New York: Presidio Press, 2007.

106. The U.S. Army's accumulated wisdom on leadership formulated into a doctrine with implications for its practice as a mental health multiplier and of relevance to military psychiatry, past and present is:
- a. FM6-22 (FM22-100). Army Leadership: Competent, Confident, and Agile. Headquarters, Department of the Army, Washington, D.C., 12 October 2006. Available at: Army Leadership Online (www.u.s.army.mil) and at www.train.army.mil
107. An articulate, yet short account of what constitutes the cornerstones of leadership in the U.S. Army in terms of character, courage, and competence presented as an address to the U.S. Army Command and General Staff College (19 May, 1966), and relevant to students of military psychiatry is:
- a. Ridgway, M. "Leadership." *Military Review*. 1966: 40-49.
108. Combat stress is today seen as a command responsibility. Leadership in the U.S. Army is expected to play a significant role in its identification, management, and treatment. This is relevant as it impinges on the practice of military psychiatry from an operational viewpoint. This can be studied, compared, and contrasted with the practices in World War II. The citation is:
- a. FM6-22.5 Combat Stress. Headquarters, Department of the Army, Washington, D.C. 23 June 2000. Available at: <https://www.globalsecurity.org/jhtml/jframe.html#https://www.globalsecurity.org/military/library/policy/army/fm/6-22-5/fm6-22-5.pdf>