

**PSYCHIATRY IN THE U.S. ARMY:
Lessons for Community Psychiatry**

By

Albert Julius Glass, M.D., F.A.P.A.*

Franklin D. Jones, M.D., F.A.P.A.**

Edited by

Franklin D. Jones, M.D., F.A.P.A.

Linette R. Sparacino, M.A.

Joseph M. Rothberg, Ph.D.

*Colonel (Ret) (deceased), U.S. Army; formerly Division Psychiatrist, 85th Infantry Division (World War II); formerly Chief Psychiatric Consultant to the Far East Command (Korean War); formerly Psychiatry and Neurology Consultant, Office of The Surgeon General, U.S. Army; formerly Director, Oklahoma Department of Mental Health; formerly Director, Illinois Department of Mental Health

**Colonel (Ret), U.S. Army; Clinical Professor, Uniformed Services University of the Health Sciences; Past President and Secretary and current Honorary President of the Military Section, World Psychiatric Association; formerly Psychiatry and Neurology Consultant, Office of The Surgeon General, U.S. Army

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PREFACE

This volume is a companion book in chronological sequence to *Neuropsychiatry in the World War*¹ (World War I), published in 1929; *Neuropsychiatry in World War II, Volume I, Zone of the Interior*,² published in 1966; and *Neuropsychiatry in World War II, Volume II, Overseas Theaters*,³ published in 1973. The previous volumes of this series focused almost exclusively upon the establishment and operation of neuropsychiatric services under wartime conditions. In contrast, the present volume deals with significant events of Army psychiatry in peace and war since the end of World War II.

There are compelling reasons why this more recent history of Army psychiatry encompasses both peacetime and wartime periods. Soon after World War II, repeated "cold war" crises required the mobilization and at times commitment of American armed forces in West Germany, Taiwan, Greece, Thailand, Laos, Lebanon, Cuba, and other areas including Korea, which erupted into a prolonged war. The World War II Selective Service System or "draft" was permitted to expire in 1947,^{2(p735)} but was promptly reinstated in the initial phases of the Korean War.

Even during the relatively quiet times after the Korean War Era, the Army, Navy, and Air Force did not return to the small peacetime forces which existed prior to World War II. In effect, since World War II, the armed forces have been maintained in a more or less wartime posture. During the 19th

and 20th centuries, social changes, advances in medicine, the greater recognition of mental disorders and the increasing destructiveness of warfare have markedly influenced the concepts and practices of military medicine and military psychiatry. For these reasons and to appreciate better the psychiatric events since the end of World War II, a summary of the development of military psychiatry in the U.S. Army is indicated.

1. Bailey P, Williams FE, Komora PO. *The Medical Department of the United States Army in the World War, Vol. X, Neuropsychiatry*. Washington, DC: US Government Printing Office; 1929: 1-12.
2. Glass AJ, Bernucci R (eds). *Medical Department, United States Army, Neuropsychiatry in World War II, Vol. I, Zone of Interior*. Washington, DC: US Government Printing Office; 1966.
3. Glass AJ (ed). *Medical Department, United States Army, Neuropsychiatry in World War II, Vol. II, Overseas Theaters*. Washington, DC: US Government Printing Office; 1973.

Chapter 1

OVERVIEW

By Franklin D. Jones, MD, FAPA

THE BEGINNINGS OF MILITARY PSYCHIATRY

As early as the American Civil War treatment of mentally ill soldiers was recognized as an important ingredient in the welfare of the soldier, not only in recognizing the psychotic, but also in handling character problems of alcoholism and "nostalgia." From 1861 to 1865 the Union Army officially recognized almost 2,500 cases of "insanity" and twice as many cases of "nostalgia" requiring hospitalization at the Government Hospital of the Insane (now St. Elizabeths) in Washington, DC.^{1(p3)} Probably still in the realm of psychiatric casualties, in this same conflict there were approximately 200,000 Union deserters and 160,000 cases of "constipation," the latter reminiscent of the "precombat syndrome."² During and after the Civil War, there was little intrinsic to the medical service to provide psychiatric care. Psychiatry became organized within the military just before and during World War I. Table 1 reveals the lessons learned and the lessons available in various wars.

Insert Table 1: Psychiatric Lessons of War

Prior to the influx of Europeans fleeing Nazi persecution, American psychiatry was largely organicist, descriptive and social following the influence of Adolph Meyer.^{3(p2052)} Although the American Psychoanalytic Association was founded in 1911 with Meyer as a founding member,^{3(p2053)} and the first psychoanalytic institute was set up in New York City in 1931,^{4(p410)} it was the European immigrants who brought Freudian psychodynamic formulations to

predominance. American psychiatry since World War II has often been characterized by oscillations among emphases on biological, social and psychodynamic approaches.⁵ World War II, producing extraordinary psychological and physiological stresses on combat participants, helped to integrate these three approaches, ultimately leading to the current biopsychosocial model of illness and wellness.^{6(pp43-44)} Table 2 reveals the biopsychosocial factors and military situations which influence combat breakdown.

Insert Table 2: Combat Stress Factors

RATIONALE OF PRINCIPLES OF COMBAT PSYCHIATRY

The first principles discovered were those of *proximity* and *immediacy*. Russian physicians during the Russo-Japanese War of 1904-1906 reportedly first utilized specialists in the treatment of combat psychiatric casualties both at the front and upon return to home territory.⁷ This war also provided the first good description of war neurosis. Unfortunately there was an emphasis on treatment of "insane" soldiers and no distinction was made between psychotic and neurotic soldiers. Although statistics for recovery were not kept, it is known that some returned to combat. Despite this Russian contribution we owe the discovery of the importance of proximity or forward treatment to the British and French forces during World War I. The neuropsychiatric disorder of that war was "shell shock," an entity thought due to the explosion of shells producing a blast effect to the brain of the victim. The German, Oppenheimer^{8(pp838-839)} hypothesized a "molecular derangement" of brain cells as the pathologic agency; however, a number of observations discredited this theory. Soldiers nowhere near an explosion developed "shell shock." German prisoners of war exposed to shelling or bombing did not develop "shell shock" while their allied captors did. Soldiers exposed or thinking themselves exposed to toxic gases developed

"shell shock." Finally, Farrar⁹ after observing scores of Canadian soldiers with severe head injuries from shrapnel and gunshot wounds, noted that symptoms of psychosis or traumatic neurosis practically never occurred. He concluded "...trench neuroses occur usually in unwounded soldiers."^{9(p12)}

The British had been evacuating neuropsychiatric casualties back to England and finding them most refractory to treatment. By 1917 when Salmon made his famous report,¹⁰ one-seventh of all discharges for disability from the British Army had been due to mental conditions and of 200,000 soldiers on the pension list of England one-fifth suffered from war neurosis. However, within a few months of the onset of hostilities, British and French physicians had noted that patients with war neuroses improved more rapidly when treated in permanent hospitals near the front 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.

The importance of immediacy also quickly became obvious when vicissitudes of combat prevented early treatment of war neuroses even in forward settings. Those who had to be left to their own devices due to a large influx of casualties were found more refractory to treatment and more likely to need further rearward evacuation. The soldier's time away from his unit weakened his bonds with it and allowed time for consolidation of his rationalization of his symptoms. The rationalization might take many forms but it basically consisted of a single line of logic: "If I am not sick then I am a coward who has abandoned his comrades. I cannot accept being a coward, therefore I am sick."

The psychiatrist offers an alternative hypothesis: "You are not sick nor a coward. You are just tired and will recover when rested."

Thus *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.

Similarly the principle of *simplicity* derives from this concept. The application of involved treatments such as narcosynthesis¹¹ or electroshock treatment (both were used during World War II) may only serve to strengthen the soldier's rationalization that he is ill physically or mentally. The fact that these more elaborate procedures were occasionally useful in refractory cases merely reinforces the pre-eminent role of expectation since they might in such cases give the implied message: "Yes, you had a mild ailment; however, we have applied a powerful cure and you are well." It should be noted that narcosynthesis and hypnosis may still be useful techniques in treating acute reactions in which amnesia is present and in treating some refractory PTSD cases.

The role of expectancy can be seen in the labelling of these casualties. Soldiers in World War I who were called "shell-shock" indeed acted as if they had sustained a shock to the central nervous system. As recounted by Bailey and others, "There were descriptions of cases with staring eyes, violent tremors, a look of terror, and blue, cold extremities. Some were deaf and some were dumb; others were blind or paralyzed."^{12(p2)}

When it was realized that concussion was not the etiologic agent, the term "war neurosis" was used. This was hardly an improvement since even the lay public was aware that Freud had coined the term "neurosis" to describe rather chronic and sometimes severe mental illnesses. The soldier could just as readily grasp this medical diagnosis as proof of illness. Finally, all medical personnel were instructed to tag such casualties as "N.Y.D. (Nervous)" for not yet diagnosed (nervous). The term "N.Y.D. (Nervous)" gave them nothing definite to cling to and no suggestion had been made to help them in formulating their disorder into something which was generally recognized as incapacitating and requiring hospital treatment, thus honorably releasing them from combat duty. This left them open to the suggestion that they were only tired and a little nervous and with a short rest would be fit for duty.

Eventually some of these patients began to be referred to simply as "exhaustion" then, with the rediscovery of the principles during World War II,

as "exhaustion," which became "combat exhaustion" and finally "combat fatigue," which came to be preferred in that it carried more exactly the expectation desired.

The Israeli experience in the 1973 Arab-Israeli War saw the production of large numbers of psychiatric casualties, sometimes after only a few hours of combat. Reasoning that such men have not had time to become fatigued, the Israelis have preferred the term "combat reaction." This may be an error since the term "reaction" gives too much latitude for response and does not make the expectancy explicit. Perhaps such a term as "transient battle reaction" may be considered for future American casualties in whom fatigue is not a factor. Glass has pointed out that much of the rationale of using a term such as combat fatigue is to avoid definitive diagnoses "which emphasize the liabilities of individuals and ignore the setting in which failure of adjustment has occurred."^{13(p994)} Table 3 reveals combat stress symptoms found in various wars.

Insert Table 3: Symptom Clusters in Various Wars

The final concept of *centrality* was recognized since World War I in the provision of methods for evacuation of casualties out of the combat zone; however, its importance was not fully realized until the Vietnam War. In the latter stages of that war, drug abuse became an "evacuation syndrome." A soldier need only show a positive finding of heroin in his urine to be sent by airplane back to America. Eventually attempts were made to stem this tide by development of detoxification and drug treatment programs in Vietnam. Follow-up studies have shown that very few of the identified heroin users in Vietnam continued the use in America and that most who did had the addiction prior to going to Vietnam.¹⁴ A central screening mechanism of out of combat evacuees allows early recognition of potential evacuation syndromes.¹⁵

PSYCHIATRIC LESSONS FROM MILITARY EXPERIENCE

Selection of Personnel

Many studies, reviewed by Arthur¹⁶ reveal that mass psychiatric screening of personnel for induction into the military beyond minimal testing for normal intelligence, absence of psychotic disorders, and absence of significant criminal behavior is markedly inefficient. Following World War I which had resulted in large numbers of psychiatric casualties, an attempt was made at the beginning of World War II to reject draft registrants who might break down in combat.

At the outset of World War II Harry Stack Sullivan was the psychiatric consultant to the Selective Service Commission. Captive to his theory that anxiety is universally pathogenic, Sullivan promoted policies that resulted in the rejection of young men being conscripted if they showed any taint of anxiety or neurotic tendencies, including so-called "neuopathic traits" such as nail biting, enuresis, running away from home, etc. These policies were also applied to soldiers after induction, resulting in what Ginsberg et al labeled "lost divisions" of about 2.5 million men.^{17(p11)} Of 18 million screened nearly 2 million were rejected because of an emotional or mental defect and another three quarters of a million were prematurely separated for the same reasons, the total ineffective group included approximately one out of every seven men called for service.

Menninger reviewed World War I and World War II statistics and showed that the liberal selection policy of World War I resulted in the rejection of about 2% of soldiers at induction for neuropsychiatric reasons and about 2% breakdown of the total while the more stringent policy of World War II resulted in the rejection of 11% inductees but a higher rate of breakdown of 12% of the total.^{18(pp338-341)}

Although about 1,600,000 registrants were classified as unfit for induction during World War II because of mental disease or educational deficiency, a disqualification rate about 7.6 times as high as in World War I,

separation rates for psychiatric disorders in World War II were 2.4 times as high as in World War I.^{19(p740)} Not only was screening ineffective in preventing breakdown, but also the liberal separation policy for those presenting with neurotic symptoms threatened the war effort.²⁰ For instance, in September 1943 more soldiers were being eliminated from the Army than accessed; most of those separated were for psychoneurosis (35.6/1,000 troops/year).

Studies attempting to find predisposition to psychiatric breakdown in combat have revealed more similarities between psychiatric casualties and their fellow soldiers than differences. For example, in a comparison of the combat records of 100 men who suffered psychiatric breakdowns requiring evacuation to an army hospital in the United States and an equivalent group of 100 surgical casualties, Pratt found no significant difference in numbers of awards for bravery.²¹ Glass remarked, "Out of these experiences came an awareness that social and situational determinants of behavior were more important than the assets and liabilities of individuals involved in coping with wartime stress and strain..."^{13(p1024)} The reliance on screening to prevent psychiatric casualties was recognized as a failure when large numbers of these casualties occurred during fighting in North Africa. Since no provision for treatment had been made, they were shipped to distant centers from which they never returned to combat.

Arthur¹⁶ found that it is possible to predict success (for example, selecting inductees with high school diplomas markedly increases the probability of satisfactorily completing military service); however, attempting to screen out those who might become casualties results in the elimination of nine out of ten who would have succeeded in order to eliminate the one out of ten who would not succeed in the military. It is possible to justify such profligacy in high risk or costly training such as that of pilots, nuclear technicians, etc.

Rediscovery and Extensive Application of Principles

The United States became involved in World War II 2 years after its outbreak in Europe. The American Psychiatric Association was ignored in its attempts to assist the military in developing programs for anticipated psychiatric casualties and at the onset of American involvement in World War II military medical personnel were unprepared to carry out the program of forward psychiatry that had been devised by World War I psychiatrists.^{18(pp10-12)}

No psychiatrists were assigned to combat divisions and no provisions for special psychiatric treatment units at the field army level or communications zone had been made.^{19(pp739-740)} American planners had believed that potential psychiatric casualties could be screened out prior to induction.

Mira²² had published an excellent account of forward treatment in the Spanish Civil War and Strecker²³ reviewed forward treatment in World War I but both publications came out too late to influence events in World War II.

World War I style forward treatment was relearned during two battles of the Tunisian Campaign in March and April 1943.^{24(pp3-11)} An American, Captain (CPT) Fred Hanson, served with Canadian forces prior to American entry into the war and may have been familiar with Salmon's principles since the British were using *The Medical Department of the United States Army in the World War, Volume X, Neuropsychiatry* in their planning.²⁵ He became a U.S. Army psychiatrist when the United States entered World War II and was assigned with American forces in North Africa. He avoided evacuation and returned more than 70% of 494 neuropsychiatric patients to combat after 48 hours of treatment, which basically consisted of resting the soldier and indicating to him that he would soon rejoin his unit.

On 26 April 1943, in response to the recommendations of his surgeon, Colonel (COL) Perrin Long, and psychiatrists, CPT Hanson and Major (MAJ) Tureen, General Omar Bradley issued a directive which established a holding period of 7 days for psychiatric patients and further prescribed the term "exhaustion" as the initial diagnosis for all combat psychiatric cases. The word exhaustion was chosen because it conveyed the least implication of mental disturbance and came closest to describing how the patients really felt. The

World War I principles had been rediscovered! Toward the end of the war a distinguished group of civilian psychiatrists were commissioned to evaluate U.S. military psychiatric treatment in Europe. They found that about half of the casualties were never recorded because of the success of forward treatment at the battalion and regimental aid stations. Those treated in the holding company were returned to duty in at least two thirds of cases.²⁶

Discovery of Mediating Principles

In addition to rediscovering the principles of treatment applied so effectively in World War I, and the ineffectiveness of large-scale screening, World War II psychiatrists learned about the epidemiology of combat stress casualties (direct relationship to intensity of combat, modified by physical and morale factors) and the importance of unit cohesion both in preventing breakdown and in enhancing combat effectiveness. During the war prospective studies conducted by Stouffer and colleagues²⁷ conclusively showed that units with good morale and leadership had fewer combat stress casualties than those without these attributes when variables such as combat intensity were comparable.

Insert Figure 1: Combat Intensity and Neuropsychiatric Casualties

The dependent relationship of combat stress casualties to combat intensity, as measured by rates of wounded in action, can be seen in Figure 1 taken from Beebe and Debakey.²⁸ The absence of such a relationship in the Southwest Pacific Theater was explained by Beebe and Debakey as a collection problem; however, this may be a phenomenon of sporadic combat. In such warfare neuropsychiatric casualties take the form of venereal disease, alcohol and drug abuse, and disciplinary problems. This phenomenon, which has been described by Jones,²⁹ will be discussed later.

Another finding during World War II was the chronology of breakdown in

combat. It had long been recognized that "new" and "old" men in combat units were more prone to breakdown. "New" or inexperienced troops were more likely to become stress casualties and have usually accounted for over three-fourths of stress casualties; however, with increasing exposure to combat after one or two combat months, an increasing rate of casualty generation also occurs. Sobel³⁰ described the anxious, depressed soldier who broke down after having lived through months of seeing friends killed, as "the old sergeant syndrome."

Today it would probably be called chronic post-traumatic stress disorder. Swank and Marchand³¹ devised a graph of combat exposure and combat effectiveness to show this relationship, which this author has modified (Figure 2). Thus the theory of ultimate vulnerability was promulgated and usually expressed as "everyone has his breaking point." Hanson and Ranson³² found that while a soldier who broke down after his unit experienced 4 to 5.5 months of combat exposure could be returned to full combat duty in 70% to 89% of cases, those exposed over 1 year returned in only 32% to 36% of cases.

Insert Figure 2: Casualties by Setting

Beebe and Appel³³ analyzed the World War II combat attrition of a cohort of 1,000 soldiers from the European Theater of Operations (ETO). They found that the breaking point of the average rifleman in the Mediterranean Theater of Operations (MTO) was 88 days of company combat, that is, days in which the company sustained at least one casualty. A company combat day averaged 7.8 calendar days in the MTO and 3.6 calendar days in the European Theater of Operations (ETO). They found that due to varying causes of attrition including death, disease, wounding and transfers, by company combat day 50 in both theaters nine out of ten "original" soldiers had departed. In their projections Beebe and Appel found that if only psychiatric casualties occurred, there would be a 95% depletion by company combat day 260; however, due to other causes of attrition (transfer, death, wounding, illness), the unit would be virtually depleted by company combat day 80 or 90, approximately

the breaking point of the median man.³³

Noy³⁴ reviewed the work of Beebe and Appel and found that soldiers who departed as psychiatric casualties had actually stayed longer in combat duties than medical and disciplinary cases and that their breakdowns were more related to exposure to battle trauma than were medical and disciplinary cases.

From studies of cumulative stress such as these as well as observations of the efficacy of a "point system" (so many points of credit toward rotation from combat per unit of time in combat or so many combat missions of aircrews) used during World War II, the value of periodic rest from combat and of rotation came to be understood and applied in the Korean and Vietnam Wars with fixed combat tours. The fixed tours did, however, result in the "short-timer's syndrome," an anxious, tense state not uncommon in combat participants during the final weeks of the stipulated tour of combat duty.^{13(p996)}

The final and perhaps most important lesson of World War II was the importance of group cohesion not only in preventing breakdown,¹³ but also in producing effectiveness in combat. This latter point is demonstrated by Marshall's³⁵ account of soldiers parachuted into Normandy. The imprecision of this operation resulted in some units' being composed of soldiers who were strangers to each other and others with varying numbers who had trained together. Uniformly those units of strangers were completely ineffective. In *Men Against Fire* Marshall^{36(pp54-58)} had also observed that only a small percentage (about 15%) of soldiers actually fired their rifles at the enemy during World War II but that in group firing activities, among members of crew-served weapons teams such as machine guns, the percentage was much higher.^{36(pp54-58)}

This element of group cohesion has already been alluded to in terms of morale and leadership. Marshall graphically made the point in reviewing his experiences in World War I, World War II, Korea, and various early Arab-Israeli Wars:

When fire sweeps the field, be it in Sinai, Pork Chop Hill or along the Normandy Coast, nothing keeps a man from running except a sense of honor, of bound obligation to people right around him, of fear of failure in their sight which might eternally disgrace him.^{37 (p304)}

Cohesion is so important in both prevention and treatment of psychiatric casualties that Matthew D. Parrish, an eminent psychiatrist who served in combat aircrews during World War II and as Army Neuropsychiatry Consultant in Vietnam, has suggested it as another principle of forward treatment,³⁸ which he termed "membership":

...[T]he principles of *proximity, immediacy, simplicity, expectancy*...seem to imply that the medics are trying to get the individual so strong within his own separate self that he will be an effective soldier...There is no ... mention of the principle [of]...the maintenance of his bonded membership in his particular crew, squad or team (at least no larger than company). This bonding maintained, he never faces combat alone. In Vietnam, when possible, the entire such primary group would visit the casualty, keep him alive to the life of the group and show him the other members' need for him. Often an "ambassador" would visit and leave a sign on the casualty's bed announcing that he was a proud member of his unit.

What did we call this 5th principle? All I can think of is membership. ...[I]t is ultimately a command responsibility--yet its effectiveness is in the hands of team leaders and the troops themselves...³⁸

In summary, World War II taught combat psychiatrists that psychiatric

casualties are an inevitable consequence of life-threatening hostilities, that they cannot be efficiently screened out ahead of time, that their numbers depend on individual, unit and combat environmental factors, and that appropriate interventions can return the majority to combat duty.

After World War II military psychiatrists, following the lead of William Menninger,^{18(pp455-467)} who had developed the Army psychiatric nomenclature which became the basis for the American Psychiatric Association's first Diagnostic and Statistical Manual, began applying these principles in non-combat settings.

Army Community Psychiatric Services

Halloran and Farrell,³⁹ Cohen,⁴⁰ and others established mental hygiene consultation programs at replacement and training centers within the first years of United States entry into World War II. Initially these furnished a kind of orientation and "pep talk" for soldiers being sent overseas. Later as the success in decreasing psychiatric casualties through such strengthening of morale became recognized, they spread to other settings and by the end of the war were an integral part of the mental health program of the Army.

Note: Dr. Jones will add text here to complete the chapter

Chapter 1

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Chapter 2

ARMY PSYCHIATRY THROUGH THE CIVIL WAR

By Albert J. Glass, MD, FAPA

DEVELOPMENT OF U.S. ARMY PSYCHIATRY

Origin

It should be recognized that organized clinical psychiatric programs as integrated elements of U.S. Army medical service did not exist before the United States participation in World War I (6 April 1917-11 November 1918).^{1(pp5-38)} However, awareness of and attention to mental disorders in U.S. Army personnel occurred at least as early as during the Civil War (April 1861-July 1865). Thereafter development was gradual, concurrent with the evolution of civil psychiatry in the United States and Europe. In this respect, civil psychiatry in the United States has been considered to have had its origin in October 1844 with the formation of the Association of Medical Superintendents of the American Institutions for the Insane.^{2(px1)} Initially this precursor of the American Psychiatric Association had 13 members. Two of the institutions were founded before the Revolutionary War (the University of Pennsylvania Hospital, Philadelphia, Pennsylvania, established in 1752, and Eastern State Hospital, Williamsburg, Virginia, established in 1773), with the remainder established during the early decades of the 19th century.^{4(pp148-156)}

The presumed later origin of psychiatry in the United States as compared to France, England, and Germany perhaps reflected the lesser status of American mental institutions which received inadequate support from the various states and communities and were too few to provide for most of the severely mentally ill. For this reason the vast majority of the insane continued to be confined in penal facilities.^{4(pp25-26)} However, about this time period, approximately 1840 to 1845, "the country balanced on the brink of

progress, reform was in the air as never before."^{4(p26)} Here reform represented more of a social humanitarian movement than progress in medicine or psychiatry.^{4(pp26-27)}

Contribution of Dorothea Dix

It is likely that the creation of the Association of Medical Superintendents of American Institutions for the Insane during this humane movement was part of an impetus to provide more and better asylums for the proper care of the mentally ill. Most important in this regard was the emergence of Dorothea Dix, an ex-school teacher reared in the social ideals of the Unitarians. In March 1841 she observed the sufferings of "lunatics" in jails. From this time she became a persistent and highly effective advocate for the proper care of the mentally ill in asylums. She displayed unusual eloquence for this appeal to state legislatures who responded by providing for the establishment of more than 30 state mental institutions during her lifetime.^{4(p27)}

With respect to military psychiatry, in 1852 Miss Dix persuaded Congress to appropriate \$100,000 for the insane of the Army and the Navy. As a result the U.S. Government Hospital for the Insane was established in 1855, in Washington, D.C., for the mentally ill of the Army, Navy, and the District of Columbia. In 1916 the institution was officially renamed St. Elizabeths Hospital from the original designation of the tract of land on which it is located.^{5(pp46-48)} This facility became the major hospital for the mentally ill of the Army and the Navy from its inception. Thereafter it was utilized to a considerable extent during and after World War I and during World War II by the Army and Navy.

U.S. ARMY PSYCHIATRY BEFORE THE CIVIL WAR

The belated development of psychiatry in the United States could explain

the lack of reference to mental disorders of American military personnel in the Revolutionary War and the War of 1812. But records were not even kept of medical care for the sick, wounded, and disabled of these conflicts.^{5(pp27, 33-34)}

During the Mexican War, (1846-1848) there was considerable morbidity and mortality from disease in U.S. Army troops for which the Medical Department was "woefully unprepared."^{5(p36)} Of 79,000 American participants, there occurred 1,700 battle deaths and 1,500 deaths from disease, mainly malaria, dysentery, and yellow fever. Apparently Army medical services were so preoccupied with this huge caseload in which there were more American combatant deaths than in the Revolutionary War, the War of 1812, and the Indian Wars combined, that available records did not discuss the occurrence of mental illness. Between major conflicts and during the minor Indian Wars (1817-1858) the U.S. Army was quite small. The Regular Army strength, at the beginning of 1861 stood at 16,367 enlisted men and officers.^{5(pp35-36, 50)}

THE CIVIL WAR (APRIL 1861-JULY 1865)

This prolonged major conflict included circumstances which were favorable to the causation, recognition, and acceptance of wartime mental disorders in U.S. Army personnel for a number of reasons. Increased mental disorders were caused by the rapid and marked expansion of tiny armies to large scale operations with the vast majority of participants new to battle and the military service since troops new to battle are more prone to breakdown. Increased mental disorders were related to repeated major battles with large numbers of personnel locked into intense combat on offense or defense and high death rates from battle casualties and nonbattle disease and injury since mental casualties vary directly with battle intensity. The Union Armies reported 110,238 battle deaths, 249,200 deaths from nonbattle causes, and 240,040 wounded. Estimated Confederate losses were 94,000 battle deaths, 59,300 nonbattle deaths, and 100,000 wounded.^{5(p49)}

Enrollment of the Union forces in the more than 4 years of the war was

2,325,000. However, total on-duty strength never at any time reached half that number due to the short terms of enlistment, over 200,000 discharges for disability, heavy battle and nonbattle losses, and a high desertion rate, almost 200,000 during the war. It is estimated that total Confederate enrollment was 781,200 with similar high rates of attrition.^{5(pp49-50, 56)}

Recruitment practices promoted the induction of the physically and mentally ill. It included recruitment by competitive bounty, unpopular substitute draft provisions, and faulty induction medical examinations. Most recruitment in the Union armies was stimulated by the Federal bounty. States and localities eager to raise their allotted quotas of men often added their own bounties to the Federal bounty in local competition to obtain recruits. Only 6% were enrolled by the highly unpopular procedure of 1863 in which the more affluent were permitted to avoid military duty by the hiring of substitutes.^{4(p371), 5(p52)}

Early in the war, Union Army induction medical examinations were performed in a superficial and careless manner which included a common failure of medical officers to examine recruits unclothed as per regulations. Thus it was reported that 400 women successfully enrolled in the Union Army as men.^{5(p49)} As a consequence of such faulty induction, there occurred excessive medical discharges for disability in 1861 due to pre-enlistment defects and disease. War Department orders were issued in August and December 1861, requiring regimental surgeons to properly examine their men and providing punishment for delinquent surgeons.^{5(p50)}

The bounty system together with the draft clause allowing the rich to hire substitutes resulted in pernicious practices. "Bounty brokers" arose who obtained recruits and "substitutes" sharing in the monies received. Apparently for a considerable number of recruits, the bounty became a lucrative racket. Many with disqualifying ailments would conceal their symptoms at induction. Once accepted, they would expose their defects and obtain a discharge, then repeat the process of enlistment under another name, receive the bounty, obtain a discharge, etc.^{4(pp371-372)}

In contrast to the above conditions of hazard, deprivation, and frustration which adversely affected adaptation in the Civil War there were favorable circumstances for the recognition and acceptance of mental disorder in military personnel. Already described has been the considerable social humanitarian reform movement of several decades before the Civil War, which included the continued efforts by Dorothea Dix and the Association of Medical Superintendents of American Institutions for the Insane to provide proper care in asylums for severe mental illness. Part of this reform was the founding of the U.S. Government Hospital for the Insane in 1855, which received the insane of the Union Forces during the Civil War.^{5(pp45-46)}

From the same humanitarian movement came major contributions toward upgrading medical services in the Union armies. Promptly after the surrender of Fort Sumter (15 April 1861), many northern civic groups arose to insure that the country would not neglect its responsibilities to the military sick and wounded. A commission of prominent civilians modeled after the British Sanitary Commission of the Crimean War (1854-1856) actively sought and obtained authorization from President Lincoln on 9 June 1861 for broad powers to investigate, advise, and assist in the sanitation and health of troops.^{5(pp52-53)}

As part of such assistance were actions of this non-official commission in the reorganization of the Army Medical Department along with the replacement of the elderly incumbent Union Army Surgeon General with the young, vigorous Dr. William A. Hammond, who actively fostered programs for the study and treatment of neurological disorders, functional heart disease, nostalgia, and other unique wartime medical problems in the Civil War, including banning the utilization of the commonly overly used cathartic, calomel. Dr. Hammond became a controversial figure; he founded the Army Medical Museum, and recommended the establishment of the Army Medical School and the Surgeon General's Library, both of which were later adopted, the latter being the forerunner of the National Library of Medicine.^{4(pp367-369)}

The U.S. (Sanitary) Commission organized some 7,000 local aid societies

throughout the North which set up lodges of food and shelter for convalescent military personnel, helped keep soldiers in touch with their families, and sponsored sanitary fairs. These fairs raised millions of dollars to purchase medical supplies, bedding, blankets, clothing, and food to supplement the needs of Union hospitals. The commission distributed among Army Surgeons some 5,000 monographs on recent advances in medicine, outfitted hospital ships to transport wounded from Virginia to hospitals in New York and New England, kept itself informed of the sanitary conditions of the various camp sites, provided aid to Union personnel in Confederate prisons "whenever the door has been opened" and extended care to Confederate prisoners. In July 1862, the commission brought its influence to bear against the "atrocious" recruiting examinations still practiced by the Union Army. All in all, the climate of humane consideration fostered by this extraordinary and sustained civilian effort had a powerful impact in facilitating the recognition of both physical and mental disease and disability with acceptance of the need for their proper treatment by the Union Army medical services.^{5(pp53-56)}

PSYCHIATRY IN THE CIVIL WAR

As a consequence of the above stated conditions, the following psychiatric symptom disorders and behavioral problems were prominent in military personnel during the Civil War. Because of the increased and ready availability of medical case records, pertinent statistics, and other official and unofficial medical source material of the Northern armies as compared to the quite meager medical information relative to the Confederate forces, this presentation will include psychiatric data mainly of the Union Army.

Insanity

For more than a century prior to the Civil War and decades thereafter "insanity" had become the traditional and major designation for overt mental

illness. As so employed, insanity indicated obvious manifestations of mental disease regardless of cause but of considerable severity which in later years would be described as of "psychotic" proportions. The Hippocratic designations of Mania, Melancholia, and Dementia were the major types of insanity. Hypochondriasis was well known, also Nostalgia (to be discussed later) but confusion existed as to whether these conditions were genuine mental diseases. When severe, however, they were considered insanity as nostalgic or hypochondriacal melancholy.^{6(p156), 7(pp232-234)} As yet, there was little recognition or accepted categories for less severe, temporary, or situationally induced mental disorders. Hysteria was considered a unique affliction of women and therefore of little interest in the exclusively male military population.

Only 2,410 cases of insanity were recorded in white troops of the Union Army from 1 May 1861 to 30 June 1866. An additional 193 cases were recorded from Negro troops from 1 July 1863 to 30 June 1866 for a total of 2,603 cases from Union forces.^{8(pp638-639, 711)} Official sources explained that monthly reports of sick and wounded from such Negro troops as were mustered into service prior to 1 July 1863 were too few and fragmentary to serve a statistical basis.^{8(p651)}

However, the incidence of insanity in white and Negro troops was quite comparable for the years both were recorded.

As in later wars of the U.S. Army, insanity in the Civil War was infrequent. During and since the Civil War it has been demonstrated that personnel of the U.S. Army have the highest incidence of insanity or psychosis in their first year of military service. Thus during the beginning of war and general mobilization when the Army has its highest proportion of personnel new to the service, there occurs the highest rate of insanity or psychosis. This is generally the first year of war, as shown in Table 4 and also demonstrated in World War II.^{9(pp1002-1005)}

(Insert Table 4: Psychiatric and Psychosomatic Disorders)

Other noteworthy events relative to insanity in the Civil War included decreased civilian mental hospital admissions and neglect of discharged insane soldiers. The expectation of an increased rate of civilian mental hospital admissions during the Civil War was not realized. The annual report of the U.S. Government Hospital for the Insane for 1864 to 1865 noted that civilian admissions had increased but 10% over the 4-year prewar period although the permanent population of Washington, D.C., had risen 100% in the 4-year war period and the city (Washington, D.C.) was "situated in the very midst of the perturbation of war." Decreased civilian hospital admissions for insanity were confirmed by the heads of two other large mental hospitals in northern states.^{10(pp380-383)} A veteran writer on mental health pointed out that decreased civilian mental hospital admissions in the Civil War "harmonizes" with subsequent reviews of the impact of war on civilian mental health in this country during World War I and World War II.^{10(p383)}

During the Civil War, there developed a common practice of turning discharged insane soldiers loose to find their way home as best they might. As a result there were complaints of insane soldiers found wandering in the streets of cities, incompetent to provide for their needs and often the victims of robbery. In an effort to resolve this problem in 1863, at the request of the Union Army Surgeon General, the War Department issued General Order No. 69, forbidding the discharge of insane soldiers through Certificates of Disability. Apparently General Order No. 69 was not effective; although, beginning in 1863, there occurred a marked reduction of Certificates of Disability Discharge (CDD) for insanity (see Table 4). Somehow insane soldiers were permitted to leave for home without formal discharge proceedings. At the annual meeting of the Association of Medical Superintendents of American Institutions for the Insane held in Washington on 10 May 1864, several members presented observations indicating continuing neglect of insane soldiers who were apparently discharged without providing for their safe return home or subsequent care and treatment.^{10(pp378-379)} A committee of the Association wrote to The Surgeon General, addressing

practical questions as to what should be done with such discharged insane soldiers, as well as those who became insane while on furlough.

In reply, The Surgeon General furnished the following guidance:^{10(pp379-380)}

- (1) Official regulations required that all insane soldiers be sent to the U.S. Government Hospital for the Insane at Washington, D.C. Civil asylum superintendents could best cooperate by arranging to transfer all their military patients there.
- (2) Insane soldiers found at large without protection might be sent to the nearest asylum until arrangements for their transfer to the government asylum in Washington. Reimbursement for transportation and asylum board would be paid by the War Department.
- (3) Should a furlough expire during active insanity, the sworn statement of an asylum superintendent would relieve the charge of desertion and secure transfer or extension of furlough. Discharge for Disability could be effected only when there were friends or guardians to provide safekeeping.

Similar problems concerned the U.S. Government Hospital for the Insane relative to recovered soldiers discharged from the hospital and the Army and left to journey home by themselves. During the last 6 months of the war, no such patients were permitted to leave the institution except under personal protection of friends or officials.^{10(pp383-384)}

Nostalgia

This well known mental disorder of the Civil War was described as a "species of melancholy or mild type of insanity caused by disappointment and a continuous longing for home is daily met in its worst form in our military hospitals and prisons."^{11(pp75-76)} As recorded from the Union armies, Nostalgia was somewhat more than twice as frequent as insanity (see Table 4).

There were 5,547 cases with 74 deaths in the Union Army from 1 May 1861 to 30 June 1866.^{8(pp638-639, 646-647, 711, 716)}

Experiences of the Union forces demonstrated an intimate causal relationship of nostalgia with physical disease and other adverse circumstances, particularly prisoner of war confinement. While there was a propensity for suicide, deaths associated with nostalgia were mainly the result of physical disease.

The following summary of the causes, symptoms, clinical course, treatment, and prevention of nostalgia and its complications was taken from various official and unofficial sources, including articles, and books; also presentations at a military medical meeting held on 10 February 1864 at which a paper was given on "Nostalgia As A Disease Of Field Service" by J.T. Calhoun, M.D., Surgeon of the Second Division with discussion by other field medical officers.¹²⁻¹⁴

Calhoun pointed out that "pure uncomplicated cases of nostalgia requiring treatment are seldom met with in the field. It is more frequently a complication or a cause of other disease."^{13(p131)} Thus, the above stated incidence of nostalgia represented mainly cases associated with physical disease which required treatment, often hospitalization, rather than simple homesickness that was quite widespread in the Union armies.¹³

As to the cause of the associated physical disease, observers agreed that the initial symptoms of nostalgia--namely, depression, loss of appetite, irregular action of the bowels including constipation, indifference to external influences and especially neglect of personal cleanliness--were favorable to the contraction of physical diseases or coexistent with them. Calhoun and others noted that sometimes nostalgia is produced by physical disease, the severe physically ill patient becomes disgusted with his conditions, sighs for the comforts of home and his yearning for home becomes morbid. A discussant remarked that there appeared little difference of opinion in regard to the general importance of nostalgia as a cause and/or a concomitant of disease in the Army.^{13,14}

From much observation, Assistant Surgeon DeWitt Peters described the causation of nostalgia in prisoners of war stating, "It is the worst

complication to be encountered as the writer can truthfully affirm after a few months experience in treating several hundred of these prisoners under the most favorable of circumstances."^{11(p75)}

A common belief of many medical officers held that youthful soldiers were especially vulnerable to nostalgia.^{11(p75)} Indeed, the Union Army Surgeon General, Dr. William A. Hammond recommended raising the minimum age of recruitment from 18 years to 20 years. However, no evidence was presented, statistical data or otherwise, to support these impressions.^{10(p373)} Moreover, it was apparent that older persons were not free from nostalgia, particularly married men who were separated from their families for the first time.^{8(p885)} The following case history is illustrative.

Case 1.1 -- Fatal Nostalgia

A middle-aged Union Army prisoner of war in a Confederate prison was described as a reasonably intelligent person, a competent mechanic who before entering the Army had a happy home life. He would sit for hours with his face in his hands and elbows on his knees, gazing out upon the mass of men and huts with vacant lack-lustre eyes. We could not interest him in anything. We tried to show him how to fix his blanket up to give him some shelter, but he went back to work in a disheartened way and finally smiled feebly and stopped. His mind seemed to be fixed on his wife and children. When he first arrived, he ate his rations but finally began to reject them. In a short time he was delirious with hunger and homesickness. He would sit in the sand for hours, imagining that he was at the family table, dispensing his frugal hospitalities to his wife and children. In a short time he died.¹²

Calhoun placed much emphasis upon a commonly held belief that recruits from the country were especially susceptible to nostalgia.¹⁵ He cited

examples of regiments recruited from rural districts who lost many men by diseases and death while adjoining regiments of city-bred men had comparative immunity from sickness although they drank the same water, ate the same food, and had the same campsite. [FDJ: Similar observation had been made by students of European wars.¹⁶]

Discussants at the medical meeting agreed that men recruited from the city were less apt to become sick in camp or in the field. However, some preferred the explanation of "crowd poisoning" instead of nostalgia as the cause for the difference between country bred and city-bred recruits. The term "crowd poisoning" attributed to the Union Army Surgeon General Hammond postulated that men from the country being habituated to a purer atmosphere, plenty of fresh air, and sunlight were more readily affected by the poisonous "effluvia" (expired air) generated in crowded vessels and other places than those who in the cities have habitually breathed an impure atmosphere and whose systems had become less susceptible to these "effluvia."¹⁴ A discussant favoring "crowd poisoning" pointed out the example of two regiments embarked for shipment from New England to Virginia. Scarcely 2 weeks elapsed when large numbers of the rural regiment were taken sick as compared to the small number of sick in the regiment recruited from cities. He argued that 2 weeks was too short a period for the development of nostalgia in such severity.¹⁴

Another discussant referred to a company in his regiment made up of men from the country that became most healthy, having once passed through the first period of sickness.¹⁴ In this regard, authoritative sources reported that physical disease in the Union Army occurred in two waves. The first wave came soon after induction as epidemics of childhood type diseases such as measles, mumps and whooping cough in young conscripts and recruits particularly from rural areas. Knowledgeable troop commanders were aware of this initial disease period.¹⁷ In considering the unawareness of germ theory and transmission of infectious disease, "crowd poisoning" was an advanced concept.

In regard to the treatment and prevention of nostalgia, all participants

of the military medical conference agreed on certain aspects. Furlough was considered excellent treatment. However, the prevailing practice of granting 20% (of troop strength) furloughs only to those sick in a general hospital was considered injurious to the morale of troops in the field, particularly patients suffering from nostalgia. It was claimed that men will aggravate their condition to be sent to general hospitals. All advocated a regular furlough system in the field of perhaps 5% of the strength throughout the year, giving all the privilege of going home. Such a system would provide the opportunity of curing men of nostalgia before they arrived at a state of mental and physical depression which would require transfer to a general hospital, and as an incentive would prevent demoralization and desertion.¹⁴ Perhaps here for the first time was suggested the establishment of a regularly occurring period of rest and relaxation (called R & R) or of rotation of troops in combat, which finally came to pass mainly after World War II. [FDJ: There is also a beginning recognition of the concept of "evacuation syndromes" -- contagious behaviors which allow evacuation from combat under honorable medical aegis.¹⁸]

All agreed with Calhoun that "battle is to be considered the great curative agent of nostalgia in the field."^{13(p131)} He cited examples of regiments before and after a particular battle engagement. "When men have passed through the baptism of fire together, they feel they have something in common. They have a common fame and a common interest which diverts their thoughts away from home."^{14(p150)} Perhaps this is the earliest recognition of the beneficial effects of group identification in achieving group cohesiveness and thus improved adaptation of combat troops.

According to Calhoun, when furloughs cannot be obtained and nostalgic patients "cannot be laughed out of it" or "cannot be reasoned out of it" and there is no campaign in progress with its marches and battles, then "they should be kept at work. Idleness is provocative of home sickness. Let the patient be hard at work all day and he will give enough relish for his rations and sleep soundly at night, having little time to think of home." If the

nostalgia is coexistent with some other disease, "Use every endeavor to keep him cheerful and divert his thoughts from home." But, "If he is suffering from chronic dysentery or typhoid or malarial fever or be inclined to phthisis and he becomes decidedly nostalgic, be guarded in your prognosis. The patient will very probably die."^{13,14} [FDJ: Calhoun's recommendations are reminiscent of those of Baron Larrey, a physician of the Napoleonic Wars who published his treatment of nostalgia more than a decade before the U. S. Civil War.¹⁹]

To briefly recapitulate, conditions in the Civil War were optimal for the elaboration and recognition of a combined mental illness and physical disease entity termed "nostalgia" for the following reasons.

First, the existence of a persistent longing for home, or homesickness was widespread in the Union Army, also most likely in the Confederate forces.

As noted by J.T. Calhoun "Ours is emphatically a letter writing army. At all times and amid the most varied scenes, the American soldier is in correspondence with home....some of the rebels remarked to me....they killed not a few of our men with letters in their pockets dated on that bloody field.

The constant correspondence with home serves to keep vividly before the imagination, home scenes and home ties."^{13(pp130-131)}

While not specifically so mentioned, the circumstance that Civil War participants remained within their own country at varying distances from their homes was most probably as important as correspondence in maintaining a persistent longing for home. Being so near and yet so far very likely was related to the previously mentioned high desertions of almost 200,000 from the Union armies. Calhoun did note that he "agreed with Dr. Hammond's opinion that men in hospitals near home are much more liable to be homesick."^{14(p151)}

Second, physical illness, particularly infectious disease was most common among participants in the Civil War. The magnitude of the physical disease problem is indicated by 249,290 deaths in the Union Army from disease and non-battle injury as compared to 110,238 battle deaths.^{5(p49)}

Diarrhea and dysentery alone from the Union Armies totalled 1,739,139 cases with 44,558 deaths. Next in frequency was malaria with 1,319,955 cases

and 10,063 deaths. Third most frequent was typhoid fever with 29,336 deaths.

Other serious common diseases were cholera, smallpox, tuberculosis, pneumonia, yellow fever and chronic problems of rheumatism, gout, anemia, hernia, and "debility."^{17(pp11-13)}

Third, with the two essential ingredients of widespread homesickness and a high incidence of physical disease, there remained only a necessary recognition of nostalgia which was well known during the Civil War.

Origin and Development of Nostalgia

Nostalgia was first described and so named in 1688 by Johannes Hofer in his Medical Dissertation for a doctoral degree at the University of Basel (Switzerland).²⁰ Hofer, with others, had known of the mental distress of subjects, mainly Swiss, when away from their homeland called "das Heimweh" (homesickness). Interspersed among these cases were certain young people so "afflicted by fever or consumed by wasting disease that unless they returned to their native land they had met their last day on foreign shores."^{20(p376)} Hofer felt the disease lacked a medical name. Thus, he derived the word "Nostalgia," Greek in origin, from "Nostos" return to the native land and "Algos" signifying suffering or grief.

With respect to etiology, Hofer explained that the "mind in nostalgia has attention only for the Fatherland." As a consequence, "[T]he animal spirits....are diminished." Eventually "[L]angour of the whole arises....circulation of the blood loses vigor....and becomes denser and thus apt to receive coagulation...even produces slow fevers....Finally by consuming the spirits....it hastens death." However, a previous disease "whatever it may have been, aggravates the seriousness or...furnishes the occasion for the nostalgia."^{20(p376)} He cited cases of young persons and adolescents, also one older person. He admitted that nostalgia also occurred in the "remaining tribes of Europe....nevertheless the Helvetian [Swiss] race are seized most frequently of all."^{20(p376)}

In regard to treatment, Hofer urged purging, emetics and bleeding by venesection, the traditional treatment of the times. However, he recommended that such patients be returned to their native land "even if weak or dying....as nostalgia....admits no remedy other than a return to the homeland."^{20(p376)} He cited case reports in which symptoms abated while en route to the native land with recovery either promptly or within several days after return home without treatment.

Thus Hofer established a new disease. He also created its name, "Nostalgia," and set forth its basic elements as a persistent longing for home associated with serious physical disease and potential fatal outcome.²⁰

Nostalgia Before and During the Civil War

In 1710, 1745, and 1757, publications on nostalgia appeared, largely from Swiss authors.²⁰ In the early 19th century, nostalgia became well known as a severe mental and physical illness in the French Revolutionary and Napoleonic armies. During "1820-1825, no fewer than ninety-seven soldiers in the French Army fell a sacrifice to this disease. Young men and those from the country are more liable to be thus attacked....the inhabitants of mountain districts...the Highlander and the Swiss are observed readily to...become nostalgic when abroad."⁷ Nostalgia appeared as a clinical entity in well-known European textbooks on mental disorders before and after the Civil War up to relatively modern times.^{6, 21, 22}

The celebrated French medical officer of Napoleon's armies, Baron M. Larrey, observed a large number of nostalgia cases. He believed mental faculties were the first to undergo aberration.

This was evidenced by the great exaltation of the imaginative faculty. The prospect of their native home presented itself to their mind's eye....depicted in.... extravagant and delusive hues which a morbid fancy alone could suggest. All this is often in

violent contrast to the rude, uncivilized and poverty-stricken home which their better reason would represent as the sober reality....This stage of cerebral excitement is accompanied....by corresponding physical symptoms. The heat of the head is increased, by the pulse accelerated, there is redness of the conjunctivae and unusual movements of the patient....The bowels are constipated, there is a general feeling of oppression and weariness....The symptoms which succeed are a sense of weight and pain all the viscera. The deficiency of nervous power produces a torpid and partially paralysed condition of the stomach and diaphragm. The symptoms of gastritis or gastroenteritis immediately intervene....the phenomena next presented as the febrile symptoms increase....the great derangement of the digestive functions accompanied by fever....the prostration of strength. The third period of the disease is very great. The mental depression keeps pace with the decline of bodily strength and is often manifested by weeping, sighing or groaning....A propensity to suicide is not unduly manifested when the debility becomes extreme....generally death is the result of a gradual loss of the vital powers."⁷(pp229-230)

Larrey had witnessed during the retreat from Moscow a number of his comrades perish in a similar condition of the body, from the effects of intense cold. In this regard it had been noted that inhabitants from the moist countries, the Dutch, and those from mountainous districts, the Swiss, were most susceptible to nostalgia. Troops enlisted from these two nations were precisely those which during the cruel vicissitudes of the disastrous retreat from Moscow afforded the greatest number of victims to that morbid condition so similar in its symptoms to nostalgia.⁷(pp230-232)

In contrast, according to Larrey, "the Army of Napoleon which served in Egypt did not produce a single case exhibiting the least symptom of nostalgia.

The soldiers became exceedingly attached to the climate so as almost to consider it a second home."^{7(p231)}

[FDJ: French physicians of the Napoleonic Era recognized numerous factors important in producing or preventing nostalgia; many of the same factors influence combat breakdown in the modern era. These physicians assessed the importance of conditions ranging from cultural (rural versus urban conscripts), and social (boredom versus rigorous activity and organized versus disorganized camp conditions), to environmental (clement versus inclement weather), and battle (victorious armies suffering few cases of nostalgia versus those experiencing reverses having many cases).²³

Larrey prescribed a course of treatment which, while ostensibly biologically oriented, reveals a keen awareness of social factors and is surprisingly close to modern handling of combat psychiatric casualties, both preventively and curatively:

[T]o prevent this sort of cerebral affection in soldiers who have lately joined their corps, it is necessary not to suffer those individuals who are predisposed to it more repose than is necessary to recruit their strength, exhausted during the day; to vary their occupations, and to turn their labours and recreations to their own advantage, as well as to that of society. Thus after the accustomed military exercises, it is desirable that they should be subjected to regular hours, gymnastic amusements, and some mode of useful instruction. It is in this manner, especially, that mutual instruction, established among the troops of the line, is beneficial to the soldier and the state. Warlike music, during their repasts, or at their hours of recreation, will contribute much to elevate the spirits of the soldier, and to keep away those gloomy reflections which have been traced above.^{23(p348)}

One could hardly ask for a better prescription to ensure physical bodily integrity and thus to produce a conviction of health, to give a sense of

mastery of weapons and, as Larrey points out, especially to effect an integration into the unit through "... mutual instruction, established among the troops of the line..." This regimen prevents evacuation home (the treatment approach of earlier physicians) and minimizes any secondary gain from illness.]

Functional Heart Disease

Beginning early in the Civil War, there occurred numerous cases of so-called functional heart disturbance in Union Army personnel termed "irritable heart" (Da Costa) or "cardiac muscular exhaustion" (Hartshorne) stated to be "the most notable product of the war."^{8(p862)} As defined by Da Costa, functional disorder of the heart included "direct symptoms of a cardiac disorder--pain, palpitations, irregular actions....when no recognizable structural changes have taken place."^{24(p275)}

Functional heart disease seemed to be a result of active field service. While cases were attributed to the drills and double quick movements of training effected under a full burden of arms and accoutrements, particularly when individuals were debilitated from diarrhea or convalescing from typhoid fever, the greater number dated from overaction of the heart during a particular battle or campaign. Here, overactivity of the heart was stated to be due as much to the nervous excitement and anticipation of danger as to the overexertion. Thus, at the Battle of Williamsburg on 5 May 1862, some fifteen cases of functional heart disease originated in which the pulse remained for days from 110 to 120 per minute. Similarly, many cases of "irritable heart" were received in general hospitals after the continued exertion, anxieties, and excitement of the seven days fight from Richmond to Harrison's Landing, Virginia.^{8(pp862-863)}

Affected soldiers with functional heart disease were subject to attacks of palpitation with precordial pain, dyspnea and at times dizziness and dimness of vision. At first "exertion or mental emotion was required to

induce them, but in aggravated cases, the slightest effort sufficed to call them forth." In such cases, slowly walking a few yards produced a pulse of 120 to 130 per minute, or a heart rate of up to 174 per minute on walking the length of a ward. In some cases, attacks were precipitated merely by sleeping on the left side. Precordial pain during a paroxysm of accelerated heart action was acute, sometimes radiating to the left axilla, arm, or shoulder blade; during the intervals, there was a feeling of uneasiness, discomfort, or dull pain.^{8(p863)}

Two major explanations existed for the origin of functional heart disease of soldiers. Perhaps best known was that of Da Costa who contended that the irritable heart of military personnel was but one form of a large category of functional heart disorders which could be produced by the direct excitement of the organ or by its being sympathetically disturbed by some source of irritation remote from it or in the system at large. Thus the heart could be constantly excited by remote deranged conditions of the stomach, liver, or in gout and rheumatism, or be excited directly by the abuse of tea, coffee, tobacco, masturbation, excessive sexual indulgence, or laborious studies with insufficient sleep, rest, food, or exercise. Functional heart disorders were noted in women who are hysteric or whose uterine function was disordered, in so-called nervous persons, also anemia, scurvy, and old persons who have flabby heart walls. Finally, functional heart disease occurred in Graves' Disease or hyperthyroidism in which continued excitement of the heart may lead to hypertrophy and dilatation.

It should be evident that Da Costa did not regard functional heart disorders as being necessarily of psychological or nervous origin but rather represented a precursor or transition state prior to the establishment of structural changes. Da Costa believed that palpitation or other rapid action of the heart like other muscles, if placed in constant or active motion, would cause hypertrophy, increase in size, and show structural changes. Thus he argued that functional disorders of the heart should not be neglected but "aim at removing the condition which keeps the organ in a state of irritation lest

it suffer a mishap that no exercise of skill can wholly repair."^{24(p275)} Da Costa insisted that in functional heart disorders, the symptoms determine the disease and that physical signs present the most certain if not the only means of distinguishing the functional from the organic disease^{24(pp275-278)} and thus determine "whether the symptoms are removable or associated with conditions which no therapeutic means that have yet been devised can fully remedy."^{24(p280)}

Da Costa found the "irritable heart" of soldiers to require special study. In December 1862, he called attention to this cardiac disorder and arrangements were made by which these cases were sent to his wards in the Turner's Lane Hospital, a special Union Army Hospital in Philadelphia. Here he demonstrated the transition from irritability to hypertrophy. In two hundred cases carefully examined, there were twenty-eight of undoubted hypertrophy, one hundred and thirty-six of the functional disorder, and thirty-six of doubtful or mixed category in which irritability was passing into hypertrophy; he rarely discovered dilatation of the heart.^{24(p862)} It should be recognized that the above findings were obtained entirely by physical signs on inspection, palpation, percussion, and auscultation. Radiology and electrocardiography were not yet available.

Da Costa was uncertain as to causation of the "irritable heart." He cited its occurrence following fatiguing marches and, in some cases, after fevers or diarrheas. He observed no connection with scurvy, anemia, or abuse of tobacco and noted the general aspects of subjects "which is often that of ruddy health."^{24(p280)}

Less well known was the explanation of Hartshorne who had considerable experience with the functional heart disease of soldiers and considered these cases to be "cardiac muscular exhaustion."²⁵ In general he agreed with the concept of functional cardiac disorders due to direct or remote excitement or irritation of the heart. However, he found that the largest number of such cases in soldiers occurred from the excitement and overactivity of active field service, particularly in battle. Hartshorne also concurred that such cases had no extension of dullness of the heart by percussion and were free

from murmurs. He noted that autopsies of such cases were not available as the disease was not fatal. However, in inspecting bodies of soldiers who died of other diseases but had previously the symptoms of functional heart disorders, he found the heart to be attenuated and pale although admittedly no minute examinations were made.²⁵ From these observations, Hartshorne concluded that the affliction of functional heart disease was of an atrophic character. He believed that this analysis was supported by the softening of the heart in typhoid fever. Thus, Hartshorne ascribed the causation of functional heart disease in soldiers to be the result of prolonged overexertion with a deficiency of rest and often of nourishment. He therefore designated these cases as "cardiac muscular exhaustion." He concurred in the principle that any organ will become stronger and larger with exercise but only so long as sufficient intervals of rest and sleep are allowed. He argued that the continued effect of exhaustion with atrophy will follow without such sufficient rest, food, and other healthy conditions. He noted as had others that in the peninsula campaigns of McClellan, early in the war, the soldiers suffered from great and prolonged exertion with deprivation of rest, deficient food, bad water, and malaria.²⁵

The incidence of functional heart disease in soldiers was considered quite high by both Da Costa and Hartshorne. Unfortunately, no separate designation of "irritable heart," "cardiac muscular exhaustion," or functional heart disorder was recorded in the medical statistical data gathered by the Union Army. Some indication of its high incidence can be noted in a report of 4,901 Union Army personnel discharged for disability at Convalescent Camp, Virginia, during the early part of 1863: 2,323 cases were certified on the grounds of heart disease; 1,123 were said to have been organic; and 1,200 functional.^{24(pp862-865)}

Rest constituted the essential of treatment, tonics and diet the adjuvants. Of the special remedies, digitalis gave the best results. Ten drops of the tincture were given three times daily and continued for weeks and months without any evidence of cumulative effects. In slight cases, this

remedy lowered and steadied the pulse in about a week and gradually led to permanent improvement. In severe cases, its action was much slower, but ultimately as decided. In some cases, however, it failed. Aconite was valuable when hypertrophy was in progress. Veratrum viride often calmed cardiac irritability, but its action was not permanent like that of digitalis.

Belladonna was particularly valuable in cases of irregular action but not in irritability without irregularity. Strychnine, valerian, ergot, hyocyanus, and cannabis indica (marihuana) failed to give decided results.

Progress to recovery was slow; months of rest and treatment in the hospital failed in many cases to do more than improve the condition of the heart. Nevertheless 38 percent of Da Costa's two hundred cases were returned to duty with their regiments after being tested by running and other exercises "and the cure in many of these is known to have been permanent."²⁴(p865) In addition, cases treated by Da Costa improved sufficiently to be discharged to less strenuous duties.²⁴(pp863-864)

Constipation, Headache, and Neuralgia

As indicated, participants of the Civil War were subjected to widespread manifestations and hazards of physical disease. It was the last major war of the pre-microbial era. Infectious disease was rampant and propagated naturally, unchecked by any prevention except for a moderate usage of smallpox vaccination. Measures to improve sanitation were fostered, but to achieve cleanliness, freedom from unpleasant odors and other socially desirable upgrading of the environment. There was yet no awareness of the role of microbes in the origin and transmission of infectious diseases.¹⁷(pp11-13)

During the Civil War preoccupation with physical disease there occurred a considerable prevalence of subjective somatic symptom disorders, the most common of which were subsumed under the diagnoses of constipation, headache, and neuralgia. While these syndromes were of relatively mild severity; nevertheless, such involved military personnel were often placed on sick

status and received treatment in quarters or in hospitals. Indeed, the lack of serious organic pathology in these entities was well known to medical observers of the times who noted that any rare deaths from these disorders should be considered an accident based upon the assumption of errors in diagnosis or the unrecorded supervention of some fatal disease.^{8(pp873-874)}

Psychological or psychosomatic concepts relative to the origin of somatic symptomatology were unknown during these times while temporary, situational or neurotic type psychiatric disorders were simply not recognized.

Constipation was the most frequent of the subjective symptom disorders and also the most common disease of the digestive system in Union Army personnel. There were 163,164 cases from white and Negro troops with 29 deaths and 13 discharges for disability (none in Negro troops -- see Table 4).

Constipation was found to be most frequent during the earlier months of the war which was ascribed to changes in food and habits of recruits soon after induction. Thereafter it followed a seasonal pattern, being considerably less frequent during the winter months, beginning in 1862. This seasonal change was again attributed to the advent of a preponderance of new accessions during the summer months of 1862, 1864, 1865 and 1866. In the summer of 1863 seasonal increase of constipation was much less because of a deferral of new accessions in May, June and July.

An intimate correspondence was noted by comparing lines of frequency of constipation with those of diarrhea and dysentery, thus constituting the only apparent similarity between the statistical curves of these functionally dissimilar affections. However, the variations of constipation were small as compared to the more prevalent diarrheas.

The increased prevalence of constipation in the summer months was also attributed to the irregularity introduced into the habits of men during the season of active campaigning. Even the calls of nature on the march or other "toilsome" services must be deferred until a more convenient opportunity, which, when available found nature unresponsive. Many of the cases culminated in a subsequent diarrhea which was reported, although the prior constipation

may have been unnoted.

Curiously while there was interest in the above type theoretical concerns, there was little critical reference to standardizing such a vague descriptive syndrome as constipation relative to the number and type of bowel excretions per unit of time.^{8(pp873-874)}

Headache was the most frequent disorder listed under Diseases of the Nervous System, Union Army. There were recorded 66,826 cases in white troops with one death, and 14,732 in Negro troops with one death for a total of 81,094 cases and forty-two discharges for disability all from white troops (see Table 4). Headache incidence followed the frequency of constipation in both white and Negro troops. The parallelism of these two statistical curves was considered striking and "suggests the Army might have been preserved from much of its sickness reported under the term headache had the cause of constipation been better known and more effectively shunned."^{8(pp873-874)}

Neuralgia was the second most common disease of the nervous system in the Union Army. There were 58,774 cases from white troops with 18 deaths and 6,018 cases in Negro troops with 5 deaths. Discharges for disability were 261 in white troops and 5 from Negro troops. Totals were 64,792 cases, 23 deaths and 266 discharges by Certificate of Disability Discharge (CDD) (see Table 4).

Fluctuation in the frequency of Neuralgia was slight and irregular. The causes of this condition appeared to have been constantly in operation with little variation in intensity. No influence of season or region was discerned. Neuralgia seems to have been due to conditions within the individual rather than his surroundings. Since no particular description of Neuralgia was given, it would also appear that manifestations under this diagnosis may have constituted heterogeneous types of symptomatology rather than the more uniform complaints of headache or constipation.^{8(pp873-874)}

NEUROLOGY IN THE CIVIL WAR

Advances in neurology have been considered a major contribution of

military medicine in the Civil War. Much credit for this progress was attributed to the new Union Army Surgeon General, William A. Hammond, M.D., for sponsoring a neurological team headed by S. Weir Mitchell, M.D., together with establishing in Philadelphia during May 1863 a special Union Army Neurological Hospital (Turner's Lane Hospital) for the study and treatment of wounds and other injuries of the nervous system.^{10(pp367-370), 26(p725)}

As the wounded of each campaign were cured, invalided, discharged or died, there remained in each Union Army General Hospital one or more instances of wounds or injuries of the nervous system with unusual or disabling manifestations rarely observed or described in texts. It was these problem patients who were transferred to the special neurological facility in Philadelphia. Such cases were received generally two or more months after wounding or injury and remained for many months of evaluation, treatment, and rehabilitation.²⁷

In dealing with this refractory caseload, the team of S. Weir Mitchell, M.D., George R. Morehouse, M.D., and W.W. Keen, M.D., took meticulous histories from each patient relative to the circumstances of wounding or other injury with emphasis upon immediate subjective experiences in addition to detailed records of later symptoms, findings, diagnoses, and progress. From these extensive data, there were derived various conclusions concerning the prompt symptomatology, clinical course, complications, and the results of treatment, which became the subjects of several publications.²⁷⁻³¹ Because there were no deaths at the special neurological facility, studies of the team included little information relative to the microscopic or gross pathology of injuries of the nervous system.

All cases of head wounds were transferred to the special neurological facility at a late date because of epilepsy, cerebral palsy, chorea, or insanity as a consequence of the original injury. Thus the team had little opportunity to observe the clinical course of brain injuries. However, Fulton in retrospect (1914) pointed out that "Mitchell clearly recognized the presence of motor centers in the forebrain and that they controlled

musculature in the opposite side of the body."³² Thus he was "well prepared for the discovery of the area when it was announced by Fritsch and Hitzig in 1869-1870."³² Mitchell also noted that muscular atrophy rarely occurred in cerebral palsy except from disuse, in contrast to progressive muscle atrophy that eventuated from the destruction of spinal cord centers or peripheral nerves supplying these muscles.^{27(pp74-76)}

Except for the foregoing observations on cerebral palsy, advances in neurology during the Civil War came mainly from experiences with injuries to peripheral nerves and to a lesser extent the spinal cord.

Local Shock

Studies indicated that a bullet or miniball passing near any large nerve would sometimes reflect injuries as severe and lasting in the loss of function as the severance of nerve fibers. This effect of local shock,^{27(pp21-38)} apparently included edema, vascular pathology and concussive vibrations in the near neighborhood of the peripheral nerve which could cause immediate motor paralysis with partial or entire loss of sensation in the area of its innervation. Because of local shock it became impossible to classify wounds of nerves on the basis of immediate functional loss. Thus, of 43 gunshot wounds of large nerves, 32 exhibited immediate motor paralysis with part or entire loss of sensation. Of these cases, within hours or days some returned to volitional motor control, in a few cases completely. In most instances, there remained residual weakness or paralysis of single muscle groups.^{27(pp21-38)}

Spinal Cord Concussion

Spinal cord concussion^{27(pp13-18)} was noted, particularly in gunshot wounds of the neck in close proximity to the cervical vertebrae. In such cases, there was immediate paralysis of all four extremities with varying sensory loss. Return of motion and sensation occurred in hours or days leaving

residual losses in function in one or more of the cervical or cranial nerves that were involved in the neck wounds. Similar cases of spinal cord concussion resulted from blows on the dorsal or lumbar vertebrae.

Nerve Wounds

Other immediate effects of nerve wounds were noted.^{27(pp13-20)} Only one-third of cases experienced immediate pain or discomfort, whereas all wounds of the lower extremities produced prompt falling but no loss of consciousness. Unconsciousness occurred entirely from wounds of the upper one-third of the body. In many cases, unconsciousness was only minutes in duration. In nearly every case of severe nerve wounding with or without falling or loss of consciousness, there was more or less general and nearly instantaneous motor weakness. From experiences with gunshot wounds of mixed (motor and sensory) nerves, it was difficult to explain the high frequency of prompt total loss of motor function, with lesser degrees of immediate loss of sensation.

Causalgia

The clinical team described a strange burning pain which occurred not infrequently as a later consequence in injuries of peripheral nerves. This complication became known as causalgia.^{30(pp76-118), 32(pvi)} Causalgia was found in nineteen of fifty cases of slight to severe partial nerve wounds. None occurred in complete destruction of a peripheral nerve or where the involved nerve fibers were entirely separated from its nerve cells. Symptoms could begin within days but usually occurred later when the wound seemed to be healing, especially if associated with inflammatory reactions. The location of the burning pain varied, the trunk of the nerve seemed never attacked; also causalgia rarely occurred in the arm or thigh and not often the forearm or leg. Favorite sites were the palm of the hand or palmar surfaces of fingers, less often the dorsum of the foot; scarcely ever involved was the dorsal

surface of the hand or the sole of the foot.

Duration of causalgia could be slight, lasting several weeks; more commonly, however, it continued for many months. The intensity of pain varied from trivial burning sensations to a state of torture which involved the whole economy of the individual. In such cases the part affected became exquisitely hyperesthetic so that a touch or tap of a finger caused severe exacerbation of pain. These patients avoided exposure to air with such care as seemed absurd.

Some kept their affected hand constantly wet by carrying a sponge and bottle of water. With continued painful discomfort, these patients became increasingly irritable with anxious faces and a look of suffering. Sleep was restless. The rustling of a newspaper, steps on the ward, a current of air, vibrations from music or other sources increased the burning pain. These patients were often accused of exaggerating their symptoms because they seemed worse when others were present. But when alone, they had less fear of being hurt by the actions of others including talk or movement.

In addition, depending upon the extent and severity of the partial nerve damage, causalgic patients were subject to varying degrees of muscle atrophy, trophic changes of the skin and nails, and stiff joints some with fibrous ankylosis, all of which followed, rather than preceded, the burning pain.

Treatment and Rehabilitation

The more important advances of neurology in the Civil War were made in the treatment-rehabilitation of disability caused by nerve injuries.^{27,30} As previously stated, this progress was the product of a planned endeavor. A specific program for particular battle casualties was elaborated and implemented. The results obtained were enhanced by favorable circumstances which in part at least were made possible by the design of the program.

Patients were transferred to the special neurological facility two or more months after injury. Thus, attention was focused upon manifestations of disability which was exhibited by almost all cases and included varying loss

of motor function and sensation along with atrophic and trophic degenerative changes in addition to bed sores, other secondary infections and some cases of severe persistent causalgia.

Studies of these patients produced considerable understanding of the clinical course, complications, and consequences of peripheral nerve, and nerve cell injury. With these insights, the medical team was enabled to formulate appropriate treatment and rehabilitation plans for each patient aimed at the preservation of muscle and other soft tissue and their optimal preparation for recovery upon regeneration of the nerve supply.

The neurological program as planned permitted patients to remain under treatment-rehabilitation by the same medical and nursing staff for many months or as long as needed to achieve the maximum possible recovery of function. Not only did such circumstances create opportunity for positive relationships between staff and patients, but also new cases could readily observe and become motivated by the progress made by other patients to continue the various modalities of treatment and rehabilitation despite its discomforts, monotony, and at times little perceptible improvement.

The treatment-rehabilitation program of the special neurological facility included several modalities which were usually accomplished daily. As described, the program seemed to be quite sophisticated in its broad scope, variety of modalities, and persistence. Intensive care was provided for bed sores and instances of secondary infection, also eczema and trophic degenerative changes of skin and appendages. In addition efforts were made to promote the general nutrition of the patient by tonics and a liberal diet.

Passive motion of joints was initiated early with gradual increases in range of motion to prevent or overcome contractures, atrophy of disuse, and stiffness or fibrous ankylosis of joints. Ether anesthesia was utilized if needed to overcome fibrous ankylosis. Massage, termed "shampooing", of affected muscles and soft tissues was utilized as were douches, using hot and cold water.

Galvanic and faradic current from batteries, newly introduced in

medicine by Duchenne (France), were utilized by the medical team for diagnosis, prognosis to determine electro-muscular contractibility, electromuscular sensibility (galvanic current) and treatment using faradic current (faradization) daily for passive exercise of affected muscles to prevent muscle atrophy and maintain a favorable status to receive regenerating nerve fibers. As patients became ambulatory, they were assigned to augment the nursing staff or perform administrative duties as part of the rehabilitative process.

"Reflex Paralysis"

At the special Union Army Neurological facility in Philadelphia, cases were encountered with motor paralysis and/or loss of sensation of a part or parts of the body remote from the existing gunshot wound. Patients with such remote loss of functions, termed "Reflex Paralysis,"^{31(pp42-67), 32} were infrequent.

Of sixty carefully studied gunshot wounds transferred to the special neurological facility because of apparent nerve injury, only seven were found to have remote paralysis and/or loss of sensation of sufficient magnitude to be considered severe or prolonged. For six of these seven patients, the remote loss of function was so distant as to preclude any possibility of its causation by commotion of a nearby nerve supply or concussion of the spinal cord. Typical examples of such remotely distant loss of function are as follows:³²

Case 1.2 (No II): Flesh wound of the right thigh; no large nerve involved; shell fragment not deep and removed the next day. Upon wounding, subject fell half conscious, had immediate paralysis of all four extremities. Within minutes, speedy recovery of left upper extremity, tardy recovery of other limbs, subsequent midline analgesia of the right side of body.

Case 1.3 (No IV): Gunshot wound of right testicle which was almost entirely destroyed. Subject fell insensible, regained consciousness in a minute, found he had paralysis of right foot and also loss of flexion of left foot which responded promptly to faradic current. Right foot recovered after several months of massage, douches, and faradic stimulation.

Case 1.4 (No VI): Gunshot wound of right thigh about 10 inches above the patella. Patient fell but was conscious, felt stinging pain over the right side of the body including right upper extremity. Right lower extremity lost all motion and some sensation. Three days later, the right upper limb which was feeble became paralyzed, but improved with treatment.

The single instance of doubt relative to "Reflex Paralysis" was described as follows:

Case 1.5 (No I): Wounded May 1862, a ball wound traversed the neck from right to left, broke the hyoid bone and injured the pharynx. Patient fell half conscious with repeated hemoptysis, felt that both upper limbs were paralyzed but painful, which pain was increased by their passive motion. Within 10 days left upper extremity rapidly improved, right arm had complete paralysis of deltoid, biceps, triceps and brachialis anticus, right forearm muscles nearly as much paralysis. In four weeks, paralysis of left upper extremity entirely recovered, with slight loss of touch in the ultimate ulnar distribution; motion and sensation improved in right forearm but right arm had no abduction or reflexion at the elbow. July 1863, findings at the special neurological facility: right forearm -- all movements restored except supination; right arm still had loss of abduction and flexion at

the elbow; right biceps, brachialis anticus and long supinator muscles almost entirely atrophied; all right shoulder girdle muscles except for trapezius and rhomboid nearly useless and wasted. Treatment from July to September 1863, faradization, active and passive movements resulted in steady gain in all motions, also diminished pain and hyperesthesia in right upper extremity. The medical team believed that only the transient paralysis of left upper extremity was an instance of "Reflex Paralysis" and thought loss of function of right upper extremity was secondary to a commotion injury of right brachial plexus. The temporary paralysis of left upper extremity could have been caused by concussion of the spinal cord from the ball traversing the neck.

Reflex paralysis cases were reviewed by the medical team of the special neurological facility with the following conclusions:³²

- (1) Circumstances of mental and physical excitement at the time of wounding may have something to do with reflex paralysis. It may be that a person wounded when moving violently about or when excited is more liable to reflex paralysis.
- (2) In most cases reflex paralysis was instant and severe, therefore could not have been due to loss of blood which in some cases was copious.
- (3) Pain - Four of seven cases had stinging, smarting or burning pain in the parts that were paralyzed reflectively; pain was an early symptom which disappeared in all cases after a time. Three cases had no pain.
- (4) Clinical Course - however grave the paralysis or loss of sensation, there was early improvement until nearly recovered, but in almost every instance some relic remained, in some weakness, in others some loss of sensibility.

- (5) There was relatively little wasting of muscle except that which could be ascribed to mere lack of use. In none was there muscle atrophy except in the right upper extremity of Case 1.5 (No.I) which is doubtful as an example of reflex paralysis.
- (6) Electrical examination did not provide useful information. In only one instance, again the right upper extremity of Case 1.5 (No. I), did muscles display loss of contractility, which increased the doubt that this loss of function was one of reflex paralysis.
- (7) Two causative mechanisms for reflex paralysis were considered: "Either the shock of the wound destroys directly the irritability or vital power of a nerve centre or it causes paralysis of the vaso-motor nerves of the centre with consequent congestion and secondary alterations." However, the team noted, "No one has shown that capillary contraction can exist as a permanent state in a nerve centre," also that division of the sympathetic nerve in the neck which involves dilation of blood vessels in the brain, gives rise to no disturbance. Thus the team supported the causation of nerve force. An analogy was presented of shock, like a strong electric current or stroke of lightning, which can destroy the irritability of all excitable tissue.

Comment: It is noteworthy that this sophisticated medical team or any other medical authority in the Civil War did not even consider the psychological origin of apparent physical symptoms. Indeed neither in nostalgia nor functional heart disease were the manifestations of physical disease attributed to psychological disturbance. The Civil War era was two to three decades early for the concepts of neurosis or psychoneurosis, however, the term "neuroses" was introduced by William Cullen, M.D. about 1785 as one of four classes of disease in a synopsis of nosology. But the

"neuroses" included all disturbances of "sense" and "motion" from apoplexy to idiocy, also asthma, mania and melancholia.³³ It was not until the latter decades of the 19th century that the term "neuroses" was reduced to present day definitions largely by the efforts of Janet and Freud. Thus in World War I, similar manifestations as noted in "Reflex Paralysis" were promptly designated as "hysteria."

Perhaps the situation existing in the Civil War can be best described as stated by Charcot: "In the last analysis, we see only what we are ready to see, what we have been taught to see. We eliminate and ignore everything that is not part of our prejudices."^{34 (p335)}

[FDJ: LESSONS LEARNED

The Civil War saw the beginning of practical attempts to treat psychological conditions (insanity and nostalgia) without any understanding of psychological causation in many of these cases. Similarly, great strides were made in treating neurological conditions despite an understanding of the underlying pathology except in the grossest of cases (severed nerves).]

Note: Dr. Jones adds text here for the summary

Chapter 2

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Chapter 3
ARMY PSYCHIATRY IN THE POST CIVIL WAR ERA
1866-1914

by Albert J. Glass, MD, FAPA

TRANSITION TO PEACETIME

Following the Civil War, the Union Army reverted to its prewar status of a limited force widely distributed in many small posts and commands from Alaska to the Rio Grande. Its functions included protection of frontier settlements, control of hostile Indian groups, manning coastal forts, safeguarding lines of travel across the plains, and similar other duties.^{1(p15), 2(pp7-8), 3(pp6-7), 4(p10)}

The initial years of the transition mainly involved the rapid demobilization of the large Union Armies. Then occurred a more gradual decrease of the Army caused by a discontinuance of garrisons in the recent states of the Confederacy.^{3(p7)} [FDJ: Reconstruction with military occupation of the former Confederate States ended with the compromise election of President Rutherford B. Hayes in 1876.] After 1880, came closure of posts in the Southwest and far West without reduction of Army strength due to the buildup of frontier populations and the decline of Indian warfare. These changes are shown in Table 5.

(Insert Table 5: Strength of the Army)

HEALTH OF THE ARMY (1866-1884)

During this period, rates of illness, injury, and their consequences in Army personnel, after a modest decrease in the first 5 years, continued at

high levels until 1885 (see Table 6). However, also during this time adverse circumstances occurred which influenced the treatment and incidence of disease and injury.

(Insert Table 6: Rates of Illness, Disability, and Death)

Shortage of Medical Officers

With continued decrease of the Army, there was a corresponding decline of medical officers. The widespread distribution of the decreasing postwar Army among many small posts and stations created a relative shortage of medical staff. This shortage was worsened by a suspension of all promotions and appointments in the Medical Corps by Congressional action of 13 March 1869. On duty 30 June 1869, there were 161 medical officers to provide care for 32,896 troops in 239 posts and commands. To remedy this deficiency, civilian physicians were employed by contract which was more costly and considered less satisfactory than the services of medical officers.^{4(p10), 5(p10)6(pp6-7)}

Each year of the suspension aggravated the shortage. The Annual Report of the Surgeon General for 1872 noted,

Many of our best medical officers....disheartened by the faint prospect of advancement are resigning and numbers of most desirable candidates after waiting years for examination have established themselves in civilian practice.^{7(pp10-11)}

Finally partial relief of the suspension occurred by congressional action of June 23, 1874.^{8(pp20-21)}

While the formal shortage of medical officers was eventually alleviated, there remained a vulnerability in medical officer availability during this period due to the many small isolated garrisons and commands. However, in

time, the number of military posts continued to decrease without a decline in Army strength or medical officers (see Table 5) and the problem was resolved.

Increased Intensity of Indian Warfare

Prior to 1875, the Surgeon General's annual reports made occasional references to wounds and surgery incident to troops engaged in Indian country.^{4(p9)} However, beginning in 1875, repeated and intense engagements with hostile Indians occurred which were regularly reported. Specific information was furnished by the Surgeon General's Annual Reports relative to battle casualties and the number and types of engagements until subsidence of Indian warfare after 1887 as shown in Table 7. Clearly, during the period 1875-1885 wounds and deaths from Indian warfare considerably augmented the medical caseload.

(Insert Table 7: Indian Warfare Casualties')

Severe Infectious Diseases

Most important of the circumstances adversely influencing the incidence of disease and death during this period were microorganisms which produced epidemics or frequent cases of cholera, malaria, yellow fever, typhoid fever, diarrhea, and dysentery, and respiratory diseases including pneumonia. These serious infectious diseases, also quite prevalent during the Civil War, persisted in the post-war period. With time and experience came gradual increasing awareness of pathogenic microbes including conditions favorable for their propagation and transmission of disease. However, such information was sparse in the early post-war years.

An epidemic of cholera threatened in 1866. A rigid quarantine of the southern Atlantic sea-board was established and sanitary precautions enforced. It was stated that these measures controlled or kept the disease in check,

even though some cases occurred.^{2(p4)} However, many cases appeared in military garrisons of southern states, causing 1,258 deaths in 1867 and 228 deaths in 1868. In addition, epidemics of yellow fever produced 452 deaths of military personnel in 1868.^{3(pp3-4),9(pp3-4)} Yet, some progress was made. During 1869 and 1870, except for a single yellow fever epidemic, the health of the Army was improved over that of the previous two years (see Table 6).

A single outbreak of yellow fever at Key West, Florida involved a garrison of 13 officers and 103 enlisted in which 42 cases occurred with 18 deaths. In this epidemic it was demonstrated that the removal of military personnel several miles to a non-infected location prevented new cases. This movement technique was repeated under similar conditions with good results depending upon the promptness of such removal soon after yellow fever cases became manifest either in civilians of nearby communities, or in military personnel, or their dependents living at the garrison. The removal technique became regularly used as a preventive medicine procedure with excellent results^{4(pp4-5),8(pp10-12),10(pp7-9),11(p7),12(pp6-7),13(pp10-12),14(p17)} although empirically developed without knowledge of the cause of yellow fever or its transmission by a mosquito vector.

By 1875 the above insights had become expanded and made more explicit. During July and August, Fort Barancus, Florida, suffered an epidemic of yellow fever with 74 cases and 29 deaths involving military personnel and their dependents without the usual prior warning of nearby civilian cases. The Surgeon of the post, George M. Sternberg, noted that the source of the epidemic was a ship with four cases of yellow fever which anchored opposite the Post only for the night of 28 June before going into quarantine. He stated, "I can only account for these cases by supposing that germs from this vessel were wafted or conveyed ashore and having effected a lodgement have since multiplied sufficiently to have given rise to the disease."^{15(pp6-7)} Apparently Post Surgeon Sternberg only lacked knowledge of the mosquito vector in which the "germ" had been "conveyed" ashore and also served as the "lodgement" for the germ to have "multiplied sufficiently" and transmitted the

disease. Later Major Sternberg became a prominent bacteriologist and Surgeon General of the Army. It is of some interest that Surgeon General Sternberg initiated the research of Walter Reed and his associates which established the vector role of the mosquito in the transmission of yellow fever.

Studies of typhoid fever from 1867 to 1884 were reported in 1884.^{14(pp10-17)}

The report found that essentially typhoid fever was dependent upon local causes for its origin and propagation and "is intimately dependent upon impure water, defective sewerage, polluted soil and overcrowded dwellings. It is in fact a preventable filth disease." The rate for the past year (1883) 11/1,000/year was more than three times higher than the average annual occurrence for the previous 16 years and double the highest rate since the Civil War. This unprecedented increase among American troops "requires special consideration." The report was gratified to note that the rate of fatal cases for 1883 exhibited a decrease during the previous 16 years from 21% to somewhat over 16% for white troops and from 43% to about 37% for Negro troops. The rate of typhoid fever among white troops was one-third greater than among Negro troops; while the mortality in Negro troops was double that of white troops.^{14(pp10-17)}

As a result of increasing knowledge relative to the environment, the situation, and other circumstances and the incidence of disease and injury, more elaborate medical statistics were reported by the Surgeon General beginning in 1883. Statistical tables were presented which listed rates of principal diseases and injuries which impaired the strength of the Army. Listed in Table 8 are rates of injury and diseases arranged in numerical sequence relative to impairment of the effective strength of the Army as determined by total admissions to sick report in calendar years 1883, 1884, and 1885 for both white and Negro troops.

(Insert Table 8: Total Admissions)

Professional Academic Activities

A favorable influence during this era, which had its impetus during the Civil War, was the focus of Army Medicine upon the establishment of several long-term professional activities.

The Army Medical Museum

This project was initiated by the Union Army Surgeon General William A. Hammond. On 21 May 1862 he issued a circular directing all medical officers to collect and forward to his office various types of clinical specimens. After the War, hundreds of specimens each year created the surgical, medical, anatomical, and miscellaneous sections of the museum. Later photographs and microscopic photographs were added and catalogues were maintained. Periodically larger facilities were required for the accumulated specimens and their security. Increasing thousands of professional personnel visited the museum annually.²⁻³¹ In modern times, the Museum has been associated and lodged with the Armed Forces Institute of Pathology, located at The Walter Reed Army Medical Center, Washington, DC.

The Medical and Surgical History of the War of The Rebellion

The history was also started by Surgeon General Hammond in 1862 when he assigned Assistant Surgeon J.J. Woodward and Brigade Surgeon J.H. Brinton to plan its implementation. After the War, the writing of the history was pursued with skill and persistence. The six large volumes of the history were completed and published during the years 1870 to 1888.³²⁻³⁷

The history was a notable achievement as perhaps the first comprehensive detailed account of military medicine in a major prolonged war. It has left for posterity a wealth of descriptive, factual information, and statistical data which can be utilized to understand better the successes and failures of military medicine in the premicrobial era of the Civil War.^{1(pp20-25)}

The Surgeon General's Library

In 1818, during the 18-year tenure of Surgeon General Joseph Lovell, a small collection of professional books was gathered for use of the personnel of his office. In 1840 the library totalled 240 volumes. During Surgeon General Hammond's tour of office (1862-1864) 359 volumes were added.

With the appointment of Dr. Josh S. Billings as librarian December 31, 1864, the library entered upon an era of sophisticated expansion; \$80,000 was allotted for books. In October 1865, the library had 2,253 volumes. During 1871, the 13,300 volume library occupied space in Ford's Theatre which it shared with The Army Medical Museum. In 1873, the library had catalogues of 25,000 volumes.

During 1879, a monthly bibliography (Index Medicus) of the world's recent medical literature was begun by Billings and his associate, Dr. Richard Fletcher. Publication of the Index Medicus was assumed by the Carnegie Foundation in 1903, but continued to be edited by the staff of the Surgeon General's Library. In 1927 the monthly Index Medicus of the library was merged with the Quarterly Index published by the American Medical Association.^{1(pp20-22)}

After World War II, The Surgeon General's Library was taken over by the U.S. Public Health Service, becoming the National Library of Medicine, which currently occupies modern facilities in Bethesda, Maryland adjacent to the National Institutes of Health.

HEALTH OF THE ARMY (1885-1897)

With time, experience and the need to provide medical care in isolated commands, medical officers developed skills in surgery and the new field of preventive medicine including sanitation.

Surgery

Surgical capability was of vital necessity in dealing adequately with the wounds of Indian warfare, or accidental injuries as well as urgently needed removal of the appendix, gall bladder, tumors, incisions of abscesses, and the like. Such necessary surgery could not be delayed or wait upon slow transportation over many miles to a special surgical facility.

Preventive Medicine

Medical officers during this time required knowledge in the expanding new field of microbiology in order to safeguard members of isolated garrisons from infections and contagious diseases. Moreover, as surgeons, they were challenged by the need for sterility in the operating room. Many became advocates of Lister techniques in achieving asepsis during surgery by the use of carbolic acid (phenol) mist.

The major concern, however, was control or prevention of cholera, malaria, yellow fever, dysentery, typhoid fever, and respiratory diseases (especially pneumonia) each of which caused high rates of morbidity and mortality. Most pertinent in this regard was the need for more knowledge of pathogenic microorganisms, their means of propagation, and transmission of disease. Such information became of daily concern to medical officers in sanitary inspection relative to sewage disposal, sources of potable water and the adequacy of quarters (crowding). Already described has been the study of typhoid fever conducted by the Army Medical service with its conclusion that it was a preventable "filth disease." Also the removal of military personnel to a non-infected location promptly upon awareness of yellow fever cases in or near the post served to prevent new cases arising in such relocated personnel.

Establishment of a Formal Role of the Medical Officer in Preventive Medicine

Because of need and perhaps due to the above interests and studies particularly of typhoid fever, an event of major significance for the role of the medical officer in preventive medicine occurred in 1885. By the direction of the Secretary of the Army 15 July 1885 paragraph 2315 of Army regulations was amended as follows:

An important part of the duty of a medical officer of the Army is the supervision under the direction of his immediate commander, of the hygiene of the post or command to which he is attached and the recommendations of such measures as he may deem necessary to prevent or diminish disease among the troops. For this purpose he shall at least once a month examine and note in the medical history of the post, the sanitary conditions of the quarters including all buildings belonging to the post, the character and cooking of the rations, the amount and quality of the water supply, the drainage and the clothing and habits of the men, and make a report thereon in writing to the commanding officer with such recommendations as he may deem proper. If the recommendations be approved and carried out, the medical officer shall note the fact in the medical history of the post. If the action recommended be deemed impracticable or undesirable, the commanding officer shall indorse his objections on the report and forward it to the department commander. A copy of such indorsement shall be furnished to the medical officer who shall record it in the medical history of the post. A copy of each report and of the action of the commanding officer thereon will be furnished as soon as practicable through the usual military channels to the Surgeon General for his information.^{24p73)}

Under conditions of this directive, preventive medicine became a

specialty of most Army medical officers. Beginning in fiscal 1887, the annual reports of the Surgeon General summarized monthly reports of sanitary inspections of the various posts.^{24(pp74-87)} Considerable beneficial changes occurred in the decrease of disease and improvement of environmental living conditions. Table 6 shows a consistent reduction in rates of disease, disability and death beginning in calendar year 1885.

The Army Medical School

Efforts to insure that regular Army medical officers were adequately prepared to function at a high level of professional capability reached a logical culmination in 1893. At this time by order of the Secretary of War, the Army Medical School was established.^{30(pp14-14),38}

Beginning in 1893, all newly appointed medical officers also other younger medical officers who made application, were given four months (increased to five months in 1894) intensive post-graduate medical training in seven distinct areas:

- (1) surgery -- included cadaver surgery;
- (2) military medicine -- focused particularly upon infectious diseases;
- (3) military hygiene -- included instruction in sanitary inspections of posts and camps, standards for the adequacy of housing, proper disposal of sewage, potable water, preparation and cooking of rations, clothing and bathing facilities;
- (4) pathology -- included a course in bacteriology with the use of culture media, coverslip staining, and inoculations into animals for the identification of pathogenic bacteria, the Widal Test for typhoid fever, and microscopic studies of urine, blood, sputum, tumors, and pathological histology, given by Major (MAJ) Walter Reed, Secretary of the faculty;
- (5) additional lectures were given in military law, medical

- jurisprudence, malingering, and parasitology;
- (6) four clinical sessions in mental illness held at the U.S. Government Hospital for the Insane (later St. Elizabeths Hospital); and
 - (7) instruction was also given in close order drill and horseback riding.

SUMMARY OF THE POST CIVIL WAR PERIOD (1866-1897)

Enhancement of Professional Medical Capability

A dominant theme of the Army Medical service during the decades following the Civil war was consistent efforts to overcome lack of knowledge relative to pathogenic microorganisms, especially their method of propagation, and transmission of disease. Gradual success in these efforts made it possible for medical officers to establish increasing capability in preventive medicine and surgery.

In addition participation in several major long-term professional medical projects further enhanced the professional medical image of Army medicine. These projects, the Army Medical Museum, the Medical and Surgical History of the War of the Rebellion, and the Surgeon General's Library came to have national recognition and utilization.

Annual Reports of the Surgeon General, U.S. Army

The professional progress of the Army Medical service during Post-Civil War decades is reflected in the extraordinary expansion, diversity, and excellence of the medical information and contributions contained in the Annual Reports of the Surgeon General for the years 1866 to 1897.^{2-31, 39-41}

The Surgeon General's report of Fiscal 1866² had only 7.5 printed pages which briefly included statements of financial expenditures, notes on the

health of the Army with little statistical data, activities of the Division of Surgical and Medical Records and the Army Medical Museum, the results of examination of candidates for the Army Medical Corps, with the number of permanent and temporary posts during the fiscal year, and lastly announcements of the deaths of medical officers, active duty and retired.

In contrast, the Annual Report of 1897⁴¹ has 241 printed pages which includes an appendix with elaborate statistical tables, showing the rates of disease and injury for the whole Army, its various geographic subdivisions, and individual posts as related to white and Negro troops. The statistical tables contain relationships of individual diseases to rates of total admissions on sick report, those constantly on sick report, discharges for disability, and deaths. These relationships are further examined as to specific differences because of age, ethnic origin, branch of service, and length of service also compared to rates of the previous year and previous decade.

In the body of the Annual Report are summarized the monthly inspections of each post, including recommendations made and actions taken. The report also analyzed the rates of common diseases and injuries of various Posts and the whole Army for indications for possible improvement. A major feature of the Annual Report are special contributions by various medical officers on techniques and results of various surgical procedures, reports of epidemics of fevers with results of studies that were conducted, reports of unusual cases such as hydrophobia from a cat bite, unusual types of contact dermatitis, etc.

Indeed the Annual Report served as a summary of the medical, surgical, and preventive medicine experiences for the year.

Military Psychiatry

Only meager information on mental disorders of the military is contained in the Annual Reports of the Surgeon General, U.S. Army or other available military medical writings of the post-Civil War decades.

Insanity

Despite the elaborate statistical data furnished in the surgeon General's Annual Reports of this era, the incidence of insanity is only included in calendar years 1882, 1883, 1884 and 1885.^{13(AppA), 14(p38), 22(p48), 23(p38)} In these years rates of insanity are given as 1-3/1,000/year, which is similar to the incidence of insanity during the Civil War and that of psychosis in the U.S. Army of the 20th century. However, there are no reports or discussions relative to the referral or treatment of mental diseases. It is presumed that as during the Civil War, in the post-Civil War period, cases of insanity in military personnel were sent to the U.S. Government Hospital for the Insane (St. Elizabeths Hospital) in Washington, DC.

Alcoholism

In contrast, alcoholism, acute and chronic, produced considerable attention and comment from medical officers as set forth in the Annual Reports of the Surgeon General. No indication was made that alcoholism was associated with or caused by mental disorders. Rather it was considered a bad habit, wasteful of time and military effectiveness, requiring repressive measures which, if not successful, warranted a punitive discharge from the Army. Much of the treatment or management consisted of exhortation and admonitions. Some medical officers, used apomorphine repeatedly in a planned effort to produce vomiting associated with alcohol ingestion, and thus induce a conditioned aversion to the whiskey. This was stated to give good results and preceded the similar studies of Russian followers of Pavlov by several decades. Perhaps the above stated attitudes and repressive measures accounted for the gradual decrease of admissions for alcoholism from rates of approximately 70/1,000/year for 1882 and 1883 to rates of 29-30/1,000/year for the years 1894 to 1896. As stated previously, the distinctive lower rates of alcoholism in Negro troops as compared to white troops continued during the entire post Civil War Period.^{13, 14(p38), 39(pp42-43), 40(pp84-89), 41(p89)}

Headache and Neuralgia

As during the Civil War, headache and neuralgia were statistically recorded under diseases of the nervous system but not separately identified except that there was rarely produced disability or death, similar to the Civil War. Apparently these conditions were considered minor disorders of some prevalence during the Civil War but provoked little comment or discussion in the Post Civil War period.^{13, 14, 39-41}

Preventive Medicine

Perhaps the most pertinent contribution of the post-Civil War era to military psychiatry was the role of preventive medicine that was established formally in 1885. A similar role in preventive psychiatry was first utilized by division psychiatrists in World War I. However, in World War II the preventive function of the division psychiatrist was expanded and made explicit with bimonthly reports to the Division Surgeon and Theatre Psychiatric Consultant through channels. A similar but less formal function was adapted by the Consultation Services in training posts of the Zone of the Interior during World War II. During and after the Korean War, this preventive psychiatry function including regular reports played a prominent role in division psychiatry and the mental hygiene consultation services during peace and war.

HEALTH OF THE ARMY (1898-1901)

The Spanish American War (1898)

During the 1890s, the Cuban Revolution against Spain engaged the sympathies of the American population. On 15 February 1898 in Havana Harbor, explosions caused the U.S.S. Maine to sink with a loss of 2 officers and 258 men. An outcry arose in the United States holding that Spain was responsible

or negligent. On 25 April 1898 Congress declared that a state of war existed between the two countries retroactive to 21 April 1898.

The war was fought on opposite sides of the world. Its major engagements, two at sea and one on land were quick victories. On 1 May 1898, an American fleet commanded by Commodore George Dewey destroyed a Spanish fleet in Manila Bay. On 3 July, an American fleet commanded by Admiral W. T. Sampson destroyed the Spanish Atlantic fleet as it attempted to escape from Santiago, Cuba. From actions on 1 July, 1898 at El Caney and San Juan Hill in Cuba, an American landing force under Gen W.R. Shafter forced the Spanish garrison to surrender on 16 July, 1898. An American landing in Puerto Rico on 25 July 1898 was virtually unopposed and remaining scattered resistance ceased 12 August 1898.

To secure the victory won by Dewey, on 13 August 1898, Gen W. Merritt led an assault on Manila. The city surrendered, and General Merritt assumed governorship of Manila 23 August 1898. On 12 August 1898 an armistice was signed by the United States and Spain. A peace treaty was signed in Paris 10 December 1898.^{42 (pp83-84)}

Philippine Insurrection (1899-1902)

In February 1899, the Filipinos under Emilio Aguinaldo rebelled against the occupying Americans. Aquinaldo was captured in March 1902. The Philippine Insurrection was declared ended by proclamation on 4 July 1902.

Boxer Rebellion (1900-1901)

In 1900, antiforeign sentiment broke out actively in Peking and other cities of Imperial China. The name of the Chinese secret society which fomented this sentiment was roughly translated "righteous fists," therefore the name Boxer Rebellion was given by English speaking people to this movement.

With American and other embassies and consulates being burned and looted, the United States joined Great Britain, France, Russia, Germany, and Japan in the "China Relief Expedition" during June 1900 - May 1901 which put down the movement.^{42(p84)}

A Closer Examination of the Spanish American War Era

Military Medicine

During the closing years of the 19th century, medicine began a series of major discoveries. The new sciences of bacteriology and hygiene were established. Radiology ("Roentgenography") and diphtheria antitoxin had come into use.

This medically advanced era provided the first major experience of the U.S. Army in overseas, combat and non-combat conditions. The major problems were not battle casualties caused by the enemy but infectious disease. Typhoid fever developed in every regiment in eastern U.S. Army camps and in Cuba due to the universal belief that typhoid was transmitted only by contaminated water. Equally unknown was that malaria and yellow fever were mosquito borne, and there was little knowledge of the causes and epidemiology of dysenteries.

On 4 August 1898, the health situation in the Cuban expedition became so serious that its commander, General Shafter, supported by subordinate commanders and senior surgeons notified the War Department that it was "absolutely and immediately necessary that the Army be withdrawn from Cuba... This Army must be moved at once or it will perish." Fortunately, the Spanish having surrendered at Santiago on 16 July, and an armistice signed with Spain on 12 August, it was possible "to begin the evacuation of the Army from Cuba at once."^{42(p85)} The Puerto Rican and Philippine campaigns did not so nearly approach disaster from disease as did the Cuban Expedition.¹²⁵

Mental Disorders

Insanity. During this period for the first time, it was noted that increased rates of insanity in military personnel occurred under wartime conditions because of the "rapidity with which recruiting was effected during 1898 and 1899." The Surgeon General's report of 1900 explained that

It is well understood by Army Medical officers that among recruits, there are always more mentally unsound men than a similar number of civilians of the same age and experience. The most careful physical examination often fails to detect a man whose brain works irregularly but who is sane enough to go to the recruiting office....and must be eliminated after muster in the service..... the first two years of military life are apt to develop many such cases. Hence it was to be expected that active recruiting of the past two years would bring into the rank men who would increase the insanity admission rate of the Army.^{43(p281)}

Here, as in the Civil War was documented that the rate of insanity in Army personnel was related to the high proportion of new accessions to the service which commonly occurs under wartime conditions. Table 9 is illustrative.

(Insert Table 9: Insanity During Peace and War)

The report of the Army Surgeon General for 1900 concluded,

It was not deemed necessary to do more than present these official figures to silence the sensational newspaper paragraphs which have been published during the past year relative to the unusual number of cases of insanity which have been returned to the United States from our troops operating in the Philippine Islands.^{43(p282)}

The new accessions which "caused the rapidity" with which recruiting was effected, came after 25 April 1898 when with the declaration of war, the President called for 125,000 volunteers. In addition, arrangements were made to recruit the Regular Army to war strength. The minimum age for enlistment and for volunteer was reduced to 18 years.^{44(p109)} In this respect, the Surgeon General stated,

In my opinion this reduction of the age limit had a notable influence in increasing the prevalence of disease among the troops. All military experience shows that young men under 21 years break down readily under the strain of war service and every regiment had many of these youths in its ranks.^{44(pp109-110)}

Unfortunately, these eclectic general impressions, as in this instance are rarely supported by a documented relationship such as age with the incidence of disease or "break down" from "the strain of war service."

Curiously, little or no comment was made in later wars of the U.S. regarding the probability of increased rates of insanity or psychoses under wartime conditions. However, reports of the Army Surgeon General during the severe depression years of 1931 to 1933 did note a decline of psychiatric admissions with decreasing proportions (10%-14%) of new accessions to the Army. These data will be discussed later in the post World War I period.^{45(p5), 46, 47}

During the war period of 1898 to 1899 many cases of insanity evacuated from the Philippines recovered during the trans-Pacific voyage or during their detention at the general hospital, Presidio of San Francisco, California and never reached the Government Hospital for the Insane in Washington, DC. That this "recovery" was not uncommon was further confirmed in the calendar years 1898 and 1899 when there were noted in monthly reports of sick and wounded for regulars and volunteers, 347 cases of insanity. Only 202 of these cases or 58.2% were committed to the Government Hospital for the Insane. One hundred thirty-five cases or 66.7% of these commitments recovered in an average period

of 3.9 months, 13 were improved, 6 died and 48 remained unimproved. Ninety-six of the 347 cases were reported in troops serving in the Pacific Islands. Of these cases 32 or 33.3% were sent to the Government Hospital for the Insane. Seventeen of these cases or 53.1% recovered in an average period of 3.6 months, 2 were improved, 2 died and 11 remained under treatment.^{43(p282)}

From these data, it would appear that Army Medical Services had established a diagnostic, observation and treatment function for insanity in Army General Hospitals. Apparently some cases recovered and were returned to duty. If so, no follow-up information was furnished.

Suicide. As indicated in Table 10, suicide rates in military personnel as in civil life were definitely lower in a wartime period than during peace.

(Insert Table 10: Suicide Rates)

Alcoholism, Acute and Chronic. During this and past periods, alcoholism, acute and chronic with consequences of delirium tremens, brain damage and death was common, not classified as a mental illness, but separately as a disease. It was considered also as an undesirable habit to be discouraged by punitive measures and a possible reason for administrative separation from the Army which could be in the form of an undesirable discharge. Annual reports of the Surgeon General during this period set forth statistical data on alcoholism in Table 11.

(Insert Table 11: Admissions for Alcoholism)

From the above table it is evident that admissions for alcoholism were more frequent during peacetime garrison activities than among troops in war. Further data confirms that in 1899 from troops on garrison duty the rate was 49.37/1,000/year. Also from troops only in garrison duty in Cuba, alcohol admissions were 26.33/1,000/year whereas in the Philippines troops in active

wartime service, the alcoholism rate was 6.29/1,000/year. A similar pertinent variable in alcohol admissions was its much higher rate from Regular Army troops as compared to wartime volunteers. In 1899 with troops on garrison duty in Manila, a rate of 21.70/1,000/year came from the smaller number of Regular Army troops as compared to the rate of 4.71/1,000/year for the larger number of wartime volunteers for a total rate of 9.69/1,000/year.^{43(pp280-281), 44(p40), 48(pp303-304), 49(p172)}

Continued Improvements in the Health of the Army

During this era admission rates to sick report for illness and injury, the noneffective rate, discharges for disability, and deaths from all causes, resumed the decline which had been in progress prior to the war years (1898-1901). In 1914 this decline attained the lowest levels ever recorded in the U.S. Army. Much of this success was achieved by the continued reduction of typhoid fever, malarial fevers, tuberculosis, yellow fever and dysentery, which followed increasing knowledge of the causes, methods of transmission and epidemiology from which preventive procedures and methods such as typhoid vaccine had been developed.^{50(pp16-75), 51(pp12-88)}

The desirability of having medical officers receive instruction in psychiatric disorders received increased emphasis during this period. The four clinical sessions in mental illness given initially through the Army Medical School in 1893 had by 1915 been increased to 24 hours of lectures and clinical demonstrations. Many of the lectures were given by William Alanson White, M.D. prominent Superintendent of the Government Hospital for the Insane.^{51(p199)}

Beginning in 1909, it became customary to detail one regular medical officer each from the Army and the Navy to the Government Hospital for the Insane for 2 years of training and study in mental disorders. Thus a cadre of career Army and Navy psychiatrists was initiated.

On 1 January 1912 "Insanity" as the single designation for mental illness was replaced by Diseases of "Mental Alienation" in conformity with new classifications of mental disease. Mental Alienation not only included

dementia praecox and other functional and organic psychoses but also defective mental development (mental retardation), constitutional psychopathic state, hypochondriasis and nostalgia.

A prompt result of this change was the increased rate of Mental Alienation of 3-4/1,000/year compared to 1-2/1,000/year of insanity.^{52(p76)} Mental Alienation replaced insanity as the highest cause for disability, with dementia praecox as the leading single disease causing discharge for disability. Excluded from Diseases of Mental Alienation were neurotic or nervous disorders such as neurasthenia, psychasthenia, psychoneurosis, hysteria, and later the "war neuroses" which were usually placed under Diseases of the Nervous system, with neuralgia, and neuritis.^{52(pp44-45)}

Alcoholism, acute or chronic and its results and narcotic addiction continued to be classified separately from mental disorders. During this period (1912) by Act of Congress, the pay of officers and enlisted men was stopped when incapacitated for duty due to alcoholism or drug addiction. From this time, there occurred a further decline of hospital admissions for alcoholism.^{53(p76)}

SUMMARY

Note: Dr. Jones writes summary for this chapter.

Chapter 3

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Chapter 5
AN INTRODUCTION TO PSYCHIATRY IN THE KOREAN WAR

by Albert J. Glass, MD, FAPA

BACKGROUND TO THE KOREAN WAR

The Soviet-sponsored government of North Korea, having failed to conquer its southern neighbor by less violent means, invaded South Korea (the Republic of Korea) on 25 June 1950. When the United States with other members of the United Nations came to the aid of the South Koreans, a war of over 3 years resulted that cost the Americans more than 110,000 battle casualties (19,353 KIA and 92,363 WIA) and over 365,000 non-battle admissions for disease and injury including 13,565 psychiatric disorders.^{1,2}

The campaigns set in motion by the invasion of South Korea came to be considered a "limited war." The fighting was deliberately confined in geographic terms, political decisions placed restrictions upon military strategy and none of the belligerents with the exception of the two Korean governments used its full military potential.^{2(pp1-6)} Thus, actual combat between Communist and South Korean-United Nations forces was contained within the Korean peninsula proper including coastal waters. The United States and its allies did not extend hostilities across the borders of North Korea to attack bases from which came the Chinese Communist offensive or to interfere with the Soviet bases in the maritime provinces of Russia which sent armaments and other military supplies to the North Korean Army.

US Army Strength and Deployment: June 1950

In June 1950 the active U.S. Army was about 591,000 and included 10 combat divisions. About 360,000 were within the Zone of the Interior.

Another 231,000 were overseas, many performing occupation duties. The largest group, 108,500, was in the Far East. In Europe 80,000 were in Germany, 9,500 in Austria, and 4,800 in Trieste. Over, 7,000 were assigned to the Pacific area, and about 7,500 to Alaska. In the Caribbean were about 12,200 troops. Several thousand troops were assigned to other military missions throughout the world.

The forces designated to carry out the U.S. Army's emergency assignment were called the General Reserve. Except for one regimental combat team (RCT) in Hawaii this force consisted of 5 combat divisions and small support units in the Zone of the Interior (ZI). The major General Reserve Units on 25 June 1950 were the 2d Armored Division, 2d Infantry Division, 3d Infantry Division, 82d Airborne Division, 11th Airborne Division (minus one RCT) 3d Armored Cavalry Regiment, 5th RCT, (Hawaii) and the 14th RCT.^{2(pp43-60)}

US Army Far East Command: June 1950

In June 1950 US Army forces in the Far East Command comprised four understrength infantry divisions and seven anti-aircraft artillery battalions in Japan and one infantry regiment and two anti-aircraft artillery battalions in Okinawa. Major combat units were the 1st Cavalry Division (actually infantry) in Central Honshu, Japan, the 7th Infantry Division in Northern Honshu and Hokkaido, Japan, the 24th Infantry Division in Kyushu, Southern Japan, the 25th Infantry Division in South Central Honshu, Japan, and the 9th anti-aircraft artillery group in Okinawa.

Eighth Army, the main combat force of the Far East Command, had 93% of its authorized strength on 25 June 1950. Each division had an authorized strength of 12,500 men as compared to its authorized war strength of 18,900. Each division was short of its war strength by nearly 7,000 men, 1,500 rifles and 100 90-mm antitank guns, three rifle battalions, six heavy tank companies, three 105-mm field artillery batteries, and three anti-aircraft artillery batteries.

Until 1949 the primary responsibility of military units in the Far East Command was to carry out occupation duties. No serious effort was made in these years to maintain combat efficiency at battalion or higher level. This changed markedly beginning in April 1949, when General MacArthur issued a policy directive in which combat divisions of the Eighth Army were progressively relieved of the majority of their purely occupational missions and directed to undertake along with Far East Air Force (FEAF) and US Navy, Far East (NAVFE) an intensified program for the establishment of a cohesive and integrated naval, air, and ground fighting team. However, there still remained many administrative features of the occupation which constituted a barrier to the full development of the planned training program.

The readiness of combat units within the Far East Command (FEC) was not enhanced by the quality of enlisted personnel received from the ZI. Replacements arriving from the United States during 1949 had a high percentage of lower intelligence ratings. In April 1949 43% of Army enlisted personnel in FEC, rated in class IV and class V (the two lowest classes) on the Army General Classification Test.

All units of Eighth Army had completed the battalion phase of their training by the target date of 15 May 1950. Reports on Eighth Army's divisions in May 1950 showed estimates ranging from 84% to 65% of full combat efficiency for the four divisions in Japan.

Equipment for FEC troops was mostly of World War II vintage. Much of it had been through combat. Vehicles, particularly, had been serviced and maintained with difficulty during the years of occupation. There was unusual dependence upon Japanese workmen, in the absence of U.S. Army service units, to duties ranging from menial mess hall tasks to highly technical functions.

By mid-1950 the American forces in the Far East had begun a gradual shift away from occupational duties to acquiring combat skills. However, these forces were understrength, inadequately armed, and sketchily trained as commanders sought to overcome the inertia of years of occupation and the prevailing uneasy peace.^{2(pp43-60)}

PSYCHIATRY IN THE KOREAN WAR

Three separate, often different, but linked psychiatric programs of evaluation and treatment were simultaneously being operated in the several geographic areas of the Far East Command (FEC). In Korea, psychiatry at the division level, (1st echelon, which included mainly the combat zone) would affect the numbers moved rearward and types of psychiatric cases evacuated to the army communication zone level (2nd echelon) psychiatric services which determined the numbers and types of mental disorders sent to neuropsychiatric services in Japan (3rd echelon). Psychiatric units in Japan or at the army level in Korea could return unfit individuals to combat duty and complicate the problems of division psychiatry. During the initial months of the Korean War, psychiatric facilities in Japan inappropriately evacuated many psychiatric cases to the ZI because "Limited Service" of World War II had been abolished in 1947. Also the neuropsychiatry (NP) staff during this early period were meager and lacked sophistication in combat psychiatry.

At the beginning of the Korean War on 25 June 1950, there were only nine psychiatrists and neurologists in the Far East Command (FEC). Eight of the nine were residents with one or more years of training at Letterman, Fitzsimons, or Walter Reed General Hospitals who had been sent to the FEC with residents in other medical specialties in May 1950, for 3 months temporary duty to provide care for the occupation troops and their dependents. As American forces entered Korea in early July 1950, this small group of psychiatrists and neurologists were deployed in Korea, Japan, and Okinawa.

In response to urgent needs of the FEC for medical officer personnel, psychiatrists, neurologists, and other medical specialists began to arrive in Tokyo by airlift beginning in mid-July 1950. As additional increments of psychiatrists and neurologists arrived in succeeding months, it became necessary to indoctrinate the new arrivals with information relevant to combat psychiatry.

The orientation was conducted at the 361st Station Hospital in Tokyo, the "NP Center" of the FEC to which most incoming psychiatrists and neurologists were initially assigned. This preliminary assignment also made possible a coordination of the qualifications and desires of new arrivals with the needs of the Theater.

During this era, there was not the plethora of medical specialists available to the Army that existed in World War II. Even recall to active duty of many reserve medical officers and later the "doctor's draft" brought into service mainly young medical officers with partial training and experience in the various medical specialties. Army Medical Service was therefore compelled to utilize its few career medical specialists as supervisors. In this regard, the author, a senior Regular Army specialist board certified in psychiatry and neurology with extensive experience in World War II combat psychiatry, arrived in Tokyo during late September 1950 to assume the position of Theater Consultant in Neuropsychiatry. Soon he participated in the orientation and assignment of psychiatrists and neurologists new to the theatre. Fortunately, the Neuropsychiatric Consultant to the U.S. Army Surgeon General, COL John Caldwell MC, had caused to be published a supplemental Issue of the Bulletin of the U.S. Army Medical Department in November, 1949 entitled "Combat Psychiatry." The Supplemental Issue was entirely devoted to describing in some detail the establishment and operation of an echeloned system of combat psychiatry as developed in the Mediterranean Theater of World War II. "Combat Psychiatry" became the textbook for the orientation of neuropsychiatric personnel in the Far East Command.

"COMBAT EXHAUSTION" ON THE EVE OF THE KOREAN WAR

Beginning during World War I (1914-1918) the manifestations and frequency of most psychiatric disorders in participants of modern warfare were found to be related to the battle casualty rate i.e., killed-in-action (KIA),

wounded-in-action (WIA), missing-in-action (MIA), and various aspects of the prevailing tactical situation. These relationships were again demonstrated in World War II and noted early in the Korean War.

Such combat related psychiatric disorders became differentiated in World War I, and in World War II from the less frequent traditional peacetime mental illnesses in which causation apparently originated within the person rather than from stressful battle situations.³

As previously stated in Chapter 1, the term "exhaustion" was created during the Tunisian campaign of the Mediterranean Theater in World War II to designate combat-induced psychiatric disorders. [FDJ: It may have been selected from review of World War I literature since the term was occasionally used then and Hanson may have been familiar with the Salmon lectures.] After World War II, this wartime designation was made permanent as "Combat Exhaustion" on 19 October 1950, by the U.S. Army, which terminology was adopted by the Veterans Administration and later by the American Psychiatric Association.^{4(pp1-2),5(p756)}

The treatment of "Combat Exhaustion" was understood during the Korean War; however, some difficulties were encountered in its implementation. Commonly such cases were regarded as psychiatric casualties. Because of the background circumstances described above, combat-induced psychiatric disorders and their management including prevention and treatment during the Korean War will be described in successive time phases as related to battle casualties, existing tactical situations and associated combat conditions.

Chapter 6
THE NORTH KOREAN INVASION
(25 June 1950 - 15 September 1950)

by Albert J. Glass, MD, FAPA

THE TACTICAL SITUATION

Initially, during this period, medical and psychiatric support for 24th Division troops was necessarily limited to emergency care and evacuation which, in itself posed difficult problems because of frequent retrograde movement of divisional medical facilities. This tactical situation made impossible the holding of any type patients for intradivisional treatment.^{1(pp3-20)} CPT James Hammill MC (1 1/2 years Army neurology residency at Fitzsimons General Hospital) was assigned to the 24th Division. Because of need and the tactical situation, he was utilized as commander of a clearing platoon, a component of the divisional medical battalion. CPT Hammill demonstrated coolness and leadership under fire. His clearing platoon was the last medical facility to leave Taejon as enemy tanks entered the city. His behavior under combat conditions achieved the respect of both line and medical officers which facilitated his later function as 24th Infantry Division Psychiatrist.

Neither the 1st Cavalry Division that arrived in Korea on 18 July nor the 25th Infantry Division whose first elements reached Korea on 15 July had met the enemy until the 24th Division was relieved on 22 July. These fresh elements and ROK forces fought off the North Korean Army with stubborn determination, strengthened the weak United Nations' position, and allowed for some semblance of a battle line. But more enemy troops were hurled into the attack, forcing a continuation of United Nations' withdrawal and delaying tactics. It was still impossible to hold patients for any type of intradivisional treatment because of enemy infiltration and the realistic fear of medical facilities being overrun. Therefore it was not a serious

deficiency that neither the 1st Cavalry Division nor the 25th Infantry Division had an assigned psychiatrist at this time.^{1(pp3-4), 2(pp115-125)}

Admissions for psychiatric disorders during July 1950 occurred at a rate of 209/1,000/year the highest in the Korean War to which was associated the highest KIA rate (769.04), the second highest WIA rate (950.97), and a high incidence of MIA (some 2,400) from the 24th Division, many of whom were later declared dead or died of wounds or disease.^{3(pp108,116)} The large majority of American troops in Korea during July 1950 were divisional with only a minority less exposed to combat (28,817 divisional vs 3,793 non-divisional).^{3(pp15-18)}

This was in keeping with the accumulated experiences of World War II which indicated that the highest rates of psychiatric casualties occur during the initial severe battle experiences of combat units new to battle before the acquisition of combat skills, the development of group cohesiveness, and the removal of less effective immediate combat leaders. Thus, in July 1950 the most favorable circumstances existed for the causation of psychiatric casualties, namely high battle casualties in units new to intense combat.⁴

PSYCHIATRY AT THE DIVISION LEVEL: AUGUST 1950

The almost continuous intense defensive fighting of August was responsible for the third highest battle casualties (KIA and WIA) of the Korean War and the third highest rate of psychiatric admissions. As the battle lines stabilized, it became possible for division clearing stations to hold and treat mild non-battle casualties. This action was also dictated by a desperate need to rapidly conserve and rehabilitate all available manpower in order to hold the thinly-manned perimeter defense lines. Under these circumstances divisional psychiatric treatment (1st echelon) began in latter August 1950.

CPT James Hammill assumed full time function as the 24th Division psychiatrist. CPT Paul Stimson (1 1/2 years civilian psychiatry residency)

arrived in the 1st Cavalry Division to initiate division psychiatry. Lieutenant Colonel (LTC) Philip Smith (completed 3 years Army psychiatry residency and Board eligible) was assigned to the 25th Infantry Division in early August and soon thereafter began intradivisional psychiatric treatment. CPT Martin John Schumacher (completed almost 3 years Army psychiatry residency) arrived with the 2nd Infantry Division in mid-August and began division psychiatry at the end of the month.

In early September, the enemy hurled their strongest assaults at various points of the Pusan Perimeter. As the fighting proceeded at this intensity, heavy casualties of all types were produced in United Nations' troops. Intradivisional psychiatric casualties were in full operation as 100 to 200 psychiatric casualties were receiving care in each of the division treatment centers. Three of the divisions utilized facilities and resources of holding platoons of division clearing companies as psychiatric centers. Additional cots, litters and other needed items, also personnel were somehow obtained by the respective division surgeons who quickly became aware of the project's value; and, driven by the same need to salvage manpower, instituted similar programs for the intradivisional treatment of patients with mild organic illness or injury. CPT Schumacher of the 2nd Infantry Division improvised a separate unit for intradivisional psychiatric treatment. The necessary equipment and personnel were obtained with the aid of the division chaplain.

Many psychiatric casualties were noted to have a large element of physical exhaustion, which was readily relieved by the 2 to 4 day period of sleep and rest provided in the treatment regimen. Other cases, less numerous, were more severe, exhibiting dissociative states and marked startle reaction.

Gross hysteria such as blindness and extremity paralysis were stated by two division psychiatrists (Schumacher and Smith) to comprise 10% of the case load. Individuals with somatic complaints were quite frequent, but showed relatively little overt anxiety.

All division psychiatrists explored the use of amytal or pentothal interviews in therapeutic endeavors. Schumacher claimed his results were

quite successful, particularly with hysterical reactions, in restoring complete function. He returned such recovered patients promptly to combat duty and insisted that there were few recurrences.

The other division psychiatrists were not as impressed with the value of barbiturate interviews. All agreed that employment of the simple therapeutic technique of reassurance, explanation, and ventilation, when combined with a regimen of rest, sleep, food, and a short respite from battle stress accomplished miraculous improvement in haggard, apathetic, tremulous, weary, patients. Division psychiatrists learned that it was necessary to use a firm matter-of-fact approach to patients that indicated in the initial interview that they were not disabled, but temporarily worn out, that such a reaction was understandable and common, that recovery will occur after several days of rest and relief from battle following which return to the combat unit would be expected. In general, the principles of forward psychiatric treatment set forth in "Combat Psychiatry" as previously described were well known to division psychiatrists and utilized in treatment programs.

The results of intradivisional psychiatric treatment were uniformly 50% to 70% return to combat duty with relatively few recurrences. This success in salvaging needed combat personnel convinced division commanders, the Eighth Army Surgeon, and various division surgeons that division psychiatry was of practical value. The efforts of the four division psychiatrists, LTC Philip Smith, CPTs James Hammill and Martin J. Schumacher, and 1LT (later CPT) Paul Stimson, firmly established division psychiatry in the Korean War. Thus it can be stated, that as a result of lessons learned in World War II, the reiteration of these principles in training memoranda and other Army publications, and the invaluable inclusion of psychiatrists in the Tables of Organization and Equipment (TOE) of combat divisions that in the Korean War, division psychiatry become operational within 6 to 8 weeks after an unprepared onset of battle in contrast to the 2-year delay in instituting a similar program in World War II. It is this achievement that spurs planning and efforts to further progress because it disproves that old adage that "men

learn from history only that men learn nothing from history."^{1(pp5-8),2(pp125-137)}

PSYCHIATRY AT THE ARMY LEVEL

Korea: Rear Area

In sharp contrast to the prompt application of psychiatry at the division level, psychiatric efforts at the Army level were meager and ineffective. It was evident that a need to support division psychiatry by a second echelon of psychiatry at the Army level was not recognized although such a need was first demonstrated in World War I and in World War II. This lack of recognition was unfortunate since two qualified psychiatrists were available in Eighth Army to provide the professional nucleus for a second echelon Army level psychiatric facility.

CPT (later MAJ) W. Krause (1 year civilian psychiatry residency and 1 year Army psychiatry experience) arrived in Korea on 7 July 1950 as the assigned psychiatrist with the 8054th Evacuation Hospital. This unit soon became operational in Pusan as the major medical facility serving Eighth Army, receiving thousands of sick and wounded during July, August, and September 1950. CPT Krause, while in charge of the psychiatric section had other duties because of medical officer shortage. It was impossible to establish a psychiatric treatment program as bedspace was scarce. Only non-transportable sick and wounded were held for emergency treatment. Evacuation was considered the only means of providing beds to receive the daily flow of patients from the combat zone. CPT Krause stated that he returned about 10% of psychiatric patients to duty during August and September 1950, and evacuated about 1800 others to Japan. CPT Krause was not even able to obtain a separate room or small wall tent for privacy in psychiatric evaluation or treatment.

CPT (later MAJ) F. Gentry Harris (2 years Army psychiatry residency at Letterman General Hospital, San Francisco, California) was one of the residents

sent to the Far East Command in May 1950 for 3 months temporary duty. When American troops entered Korea in early July 1950, CPT Harris was assigned to Eighth Army Headquarters, then at Taegu, where he operated a general dispensary.

CPT Harris had received considerable indoctrination in combat psychiatry during residency training and he made repeated requests to serve as a psychiatrist. After some time he was placed in charge of a convalescent unit of the 8054th Evacuation Hospital. It is unclear as to the purpose or expectations of function for this convalescent facility. In mid-August 1950, CPT Harris found a suitable building and proposed that he and CPT Krause be permitted to function as a psychiatric unit; however, he was unable to obtain necessary support of supplies and personnel from the Commanding Officer of the 8054th Evacuation Hospital, the senior medical officer in Pusan, who did not believe the project to be practical. At this time, because of the tenuous tactical situation, senior medical officers in Pusan were not sympathetic to holding psychiatric patients for treatment who could be readily evacuated. CPT Harris stated that during this time there was never any explicit or formal recognition of need for a psychiatric facility at the Army level.

In latter September 1950, CPT Harris was transferred to the 64th Field Hospital, then temporarily providing care for North Korean prisoners of war near Pusan. CPT Harris did give psychiatric treatment to a small number of mainly psychotic patients despite a major language barrier. At this time, the author saw CPT Harris and planned for his utilization at the Army level.

Thus it was that the plans and efforts of CPTs Harris and Krause were largely ineffective, although they clearly saw the need, understood their role, and desired to function but were unable to obtain the necessary logistical support. It should be appreciated that this was a time of confusion and tension. Medical support was difficult to obtain with supplies and personnel in great shortage. The evacuation and care of wounded assumed first priority and a need to maintain open beds for this purpose was a major concern of responsible senior medical officers. Last but not least was the

overall anxiety that defenses would be overrun and patients lost to the enemy.

Thus, it seemed reasonable to move every patient out of Korea as soon as possible to keep the medical resources free to handle the daily load of new casualties. It was not uncommon for adverse news of battle to create more apprehension in the rear than in forward areas where the situation was better known at first hand as witness the fact that in mid-August 1950 with the establishment of the Pusan Perimeter, combat divisions began the treatment of psychiatric casualties.

Information relative to the above situations during July, August, and September 1950 was obtained by the author in early October 1950, from the two psychiatrists, CPTs Krause and Harris, the commanding officer and other medical officers of the 8054th Evacuation Hospital, the Eighth Army Surgeon, and other line and medical officers. It would be presumptuous to be critical of their efforts when everyone was so sorely pressed. The following comments are made in a constructive spirit in the hope that this early experience of the Korean War may provide a worthwhile lesson for the future.

Necessity And Advantages

The major problem in dealing adequately with psychiatric casualties has been failure to appreciate the effectiveness of combat psychiatry in the field. It has been a source of amazement to senior line and medical officers, even those with considerable experience and training in the field, that one or several psychiatrists with a minimum of equipment and personnel can return to effective combat duty so many of their patients. In practice more than one-half of acute psychiatric casualties can be rehabilitated for combat duty within 2 to 4 days. This technique has been demonstrated in World War I, World War II, and the Korean War where it was shown that a single psychiatrist can handle 50 to 100 patients at any one occasion. For the time, effort and logistics required, it is perhaps the most economical type of medical care.

It would have been only necessary in the Pusan area during this early

period to have established a minimum field or fixed facility which included cots, a simple mess, a water source, some sedative drugs, shelter, and a small number of personnel. Patients wore their uniforms and did not require frequent changes of bed linen, but towels were needed. The two available psychiatrists would have been sufficient. At least 50% of acute psychiatric casualties who were evacuated from Korea in July and August 1950 could have been restored to combat duty. This is precisely what occurred when division psychiatry became operational in latter August 1950. For those cases evacuated from division psychiatry to psychiatry at the Army level, experience indicated that about 30% were returned to combat units with most of the remainder utilized for combat support and non-combat duties. This pertinent usage of field combat psychiatry should receive emphasis in the training of career army medical officers who should become thoroughly aware that acute psychiatric casualties can be readily salvaged with a small expenditure of equipment and personnel.

Even the admission and evacuation of psychiatric casualties as was performed at the 8054th Evacuation Hospital required 1 to 2 days with CPT Krause working without privacy sitting on cots of patients in crowded wards. Yet he managed to return 10% of mainly directly received psychiatric casualties to combat duty. By doubling the time of 1 to 2 days to 2 to 4 days in an organized treatment program, it is likely that 50% of directly received psychiatric casualties could have been removed from the evacuation flow to Japan.

There are other benefits of psychiatry at the Army level. A unit of this type removes psychiatric patients from the stream of sick and wounded, thus, decreasing the overload of evacuation channels and admissions to base hospitals in Japan. Also psychiatry at the Army level (2nd echelon) supports combat forces in battle when withdrawal or other tactical circumstances makes it impossible to treat patients at the division level. As already indicated, an Army level psychiatric service could have salvaged psychiatric casualties in July and August 1950 when division psychiatry was "impractical."

Army level psychiatric service should be included in medical planning of any battle campaign since commonly in its early phases problems in deployment and other tactical circumstances tend to nullify division psychiatry. Following World War II, it was proposed to include a platoon of a separate clearing company with the addition of psychiatrists and other professional personnel as needed to constitute an Army level psychiatric service. After much discussion, it was deleted on the basis that such a unit could be readily created when needed, and its inclusion would only increase the complexity of already large Army medical facilities. In 1946, the author was present at a War Department Medical Board meeting held at Brooke Army Medical Center San Antonio, Texas during a discussion of the subject. All psychiatrists at the meeting agreed that there would be inevitable delay and much time lost before some future Army Surgeon could be convinced that Army level psychiatric units were needed. The psychiatrists argued that it should be part of a finite organized plan, but others rebutted that this knowledge was well known and mollified the objections of the psychiatrists by a decision that the use of Army level psychiatric centers would be made a part of teaching doctrine. Time has proved the accuracy of the psychiatrists' predictions. Failure to provide Army level psychiatric services in the initial phase of the Korean conflict again points to the necessity of formally establishing psychiatric function as an integral component of medical services of a combat army. It should not be forgotten that the relatively rapid establishment of division psychiatry in the Korean War was largely due to the inclusion of psychiatrists and ancillary personnel in the Tables of Organization of every combat division.^{5(pp9-13)}

BASE SECTION PSYCHIATRY IN JAPAN

The sudden impact of war found medical facilities in Japan unprepared to receive the casualties that were evacuated from Korea in increasing numbers. Prior to hostilities, medical support barely met minimum requirements for the

occupation troops and their dependents. These resources were now further reduced by the loss of medical personnel and provisional hospitals that were sent to Korea.

Psychiatric facilities and personnel shared in the professional shortage. As the psychiatric casualties entered Japan 3-5 July the following facilities and personnel were present.

Tokyo

The Neuropsychiatry Service of the 361st Station Hospital, previously the Neuropsychiatry Center of the Far East Command (FEC). Personnel were a psychiatrist, a neurologist and two psychologists as follows:

MAKE THIS TEXT A FOOTNOTE:

Psychiatrist:	COL Eaton Bennett MC USA (2 years Army psychiatry residency)
Neurologist:	MAJ (later LTC) Roy Clausen (1 year neurology residency plus 5 years experience)
Psychologists:	1LT (later CPT) James Hoc 1LT Ann Laue

Also present were several enlisted psychological and social work assistants. Facilities included closed and open wards with a capacity of 200 inpatients, EEG Machine and electroconvulsive (ECT) apparatus.

Osaka

Psychiatric Section of the Osaka Army Hospital. Personnel were a psychiatrist, a psychologist and a social worker as follows:

MAKE THIS TEXT A FOOTNOTE:

Psychiatrist: LTC Weldon Ruth (1 1/2 years Army psychiatry residency)
Psychologist: Master Sergeant (M/Sgt) David Kupfer (excellent training)
Social Worker: CPT Topfer MSC (some experience, no formal training)

Facilities included open and closed wards with a capacity of 80 patients. The psychiatrist became ill in early August 1950 and required medical evacuation to the ZI. He was replaced by a general medical officer with the 7th Infantry Division in Northern Japan. The new psychiatrist and the neuropsychiatry team developed an effective treatment program.

Fukuoka, Kyushu (Southern Japan)

Psychiatric Section of the 118th Station Hospital. Personnel was a psychiatrist:

MAKE THIS A FOOTNOTE:

Psychiatrist: MAJ James Bailey (2 years Army psychiatry residency)

Facilities included an open ward with a capacity of 60 patients. Closed facilities were available for transient care.

118th Station Hospital (Southern Japan)

A large majority of all patients evacuated from Korea in July 1950 arrived first at the 118th Station Hospital in southern Japan, a short distance from the Korean Strait, southeast from Pusan. This hospital rapidly

expanded as it assumed the functions of major triage for the transfer of patients to other hospitals in Japan.

MAJ Bailey at the 118th Station Hospital was caught up in the increasing flow of incoming patients as was his counterpart with the 8054th Evacuation Hospital in Pusan, CPT Krause. Also, he could do little in establishing a treatment program since beds were available only for non-transportable patients. Further, he was needed in the sorting and triage of evacuees from Korea as the small medical staff often worked around the clock to keep patients moving north so that incoming casualties could be processed. MAJ Bailey stated that he managed to return 10% of psychiatric evacuees to combat duty but triaged the remainder to the 361st Station Hospital in Tokyo.

The 361st Station Hospital (Tokyo)

On 15 July 1950, **(make this a footnote: LTC Arthur Hessin MC [completed psychiatric residency and board eligible])** arrived to join the 361st Hospital as Chief of the Neuropsychiatry Service. He was followed soon thereafter by a second **(make this a footnote: LTC Oswald Weaver [completed 3 years of Army psychiatry residency, also board eligible])**. An internist, **(FN: CPT Fancy)** and a general medical officer **(FN: CPT Dermott Smith)**, who desired psychiatric training were added to the neuropsychiatry staff which also included two other psychiatrists **(FN: COL Eaton Bennett and LTC Ray Clausen)**. Physical facilities were expanded to include the adjoining detachment barracks which became an annex mainly for the Neuropsychiatry Service whose census averaged between 500 and 600 for August and September 1950. Somewhat over 50% of psychiatric admissions to the 361st Station Hospital during this period were evacuated to the ZI as the lack of available bedspace and other problems apparently forced this means of disposition.^{6(pp14-16)}

An administrative problem soon arose when it became apparent that many psychiatric admissions could function on a non-combat status but not in combat. However, such a designation was not permitted since the term "Limited

Service" utilized for this purpose during World War I had been deleted from Army Regulations. G-1 (personnel), GHQ Far East Command (FEC) finally resolved the problem temporarily at least by the designation of "general service with waiver for duty in Japan" to be accompanied by an appropriate change of the physical profile (PULHES) under the S category (Stability). PULHES, borrowed from the Canadian Military, had been also introduced after World War II. The geographic limitation was not a medical recommendation but a G-1 stipulation to insure filling depleted service units in Japan. At the end of 30-60-90 days as so stipulated, they were reexamined by a psychiatrist. A surprising proportion of up to 50% were found fit for combat, often with approval of involved persons, and returned to the original combat unit thus preventing accumulation of the category "For duty only in Japan." When the examination indicated unfitness for combat the individual remained in Japan to be reexamined usually in 90 days.

Return to combat duty had advantages for the individual other than increased self-esteem, as those in combat units became more quickly eligible for rotation to the United States than persons in non-combat assignments in Japan. But, difficulties arose later when replacements for service units in Japan were not needed in large numbers. By this time, fewer psychiatric casualties were evacuated to Japan as the first and second echelons of psychiatric services became fully operational in Korea.^{6(p16)}

Clinical Severity

The clinical picture of psychiatric casualties observed at the 361st Station Hospital was described as severe with florid manifestations of "free floating anxiety" including startle reactions, gross tremors, battle dreams, dissociative reactions, hysteria and outbursts of irritability or aggressive behavior. Observers were impressed by the incidence of severe reactions; however, it is common for the early psychiatric casualties of a war to be regarded as more severe and more frequent than later reactions when combat units have acquired battle skills, developed group cohesiveness, and removed

less effective leaders.

A further explanation lies in the time and place where psychiatric casualties are observed. In the Tunisian campaign after the North African invasion of World War II, early psychiatric casualties were evacuated hundreds of miles to Algiers, Constantine, Casablanca and Oran over several days where they were observed by psychiatrists in rear Army hospitals to exhibit severe clinical symptoms much like that described in psychiatric casualties evacuated from Korea to the 361st Hospital.⁷

At the 361st Hospital, patients were described as more severe than noted in Korea. When observed early, many showed marked improvement. Thus CPT Krause at Pusan, Korea was able to return 10% to duty after only an evaluation; similarly MAJ Bailey did so in southern Japan. After repeated evacuation over many days, psychiatric casualties exhibit increased severity of symptoms as if to justify their evacuation from combat. Another explanation for increased severity of symptoms at the 361st Hospital was the fact that large number of psychiatric patients were being evacuated to the Zone of the Interior (United States). Logically, they were selected on the basis of severity of symptoms. All of the above noted reasons may have played a role in producing the severe reactions observed at the 361st Hospital in the early phase of the Korean War; but, as the conflict continued these severe type cases became increasingly rare.

Previous Combat in World War II

Observers at the 361st Hospital were impressed by the seemingly large number of psychiatric casualties who claimed to have experienced combat in World War II. As explained by many of these individuals, they were more vulnerable to combat stress in Korea because dormant trauma in World War II had been revived. Most troops initially engaged in the Korean fighting were career army personnel with many World War II veterans.

In discussions of this issue by line officers during early October 1950, it was their consensus that men with previous combat experience were more

effective than newcomers to battle. These officers placed emphasis upon the psychological and physiological unpreparedness of occupation troops for return to the rigors and hazards of war. This viewpoint was also expressed by many psychiatric casualties in discussing their inability to adapt to sudden change from the standpoint of training and state of mind.

A small but troublesome subcategory of psychiatric patients at the 361st Hospital during this period were career commissioned and non-commissioned officers who had been classified as "Limited Service" during World War II because of partial mental or physical disability. After World War II some continued in the Army, while others reentered after a brief time in civil life. When "Limited Service" was abolished after World War II, they were placed on general service with their knowledge and consent.

These individuals functioned quite well in peacetime assignments and were promoted one or more times. The outbreak of hostilities found them in the occupation forces in Japan or assignments elsewhere, mainly the ZI. When ordered to Korea, many became prompt psychiatric casualties with anticipatory anxiety which caused hospitalization in Korea or in Japan enroute to Korea. These individuals became part of the caseload of the NP Service at the 361st Hospital. They exhibited dependency intermixed with resentment, as they complained that an implied promise to them had been broken by the Army who should have known of their limitations and insured a continuation on non-combat duty. It would be paradoxical, however, to foster career non-combat personnel in an Army whose primary mission is combat.

Perhaps, such personnel should seek positions in a civil governmental agency if the objective is security of employment. These patients were usually included in the group evacuated to the ZI for disability discharge, which could not readily be accomplished overseas.^{6(pp17-19)}

Visit By Karl Bowman, MD Psychiatric Consultant - In July 1950

The Far East Command was visited in mid-July 1950 by Dr. Karl Bowman, Psychiatric Consultant to the U.S. Army Surgeon General. He stayed in Japan for several weeks visiting US military psychiatric facilities. Dr. Bowman saw many incoming psychiatric casualties. He was impressed by the severity and frequency of psychiatric patients and recommended that a special psychiatric hospital be established in southern Japan with a capacity of 1,000 beds, although initially 200 beds would suffice. It was a logical suggestion because he saw so many patients with so few facilities. He also suggested instituting forward psychiatric treatment and that a Theater Consultant in Psychiatry be added to the Medical Section of GHQ (General Headquarters) Far East Command (FEC). The recommendation of Dr. Bowman to initiate forward psychiatric treatment was of great value. It provided the impetus toward implementing the assignment of psychiatrists to combat divisions in August 1950.^{6(pp19-20)}

[FDJ: SUMMARY

After an initial retreat and surrender of territory to gain time for replacements, American forces created a firm perimeter around the southern part of Pusan by the end of July. The division psychiatrists after having a stable front were able to implement principles of forward treatment. The second echelon of evacuation at army level was still in disarray mainly due to the failure of commanders to recognize psychiatric casualties as replacement resources. Third echelon treatment in Japan was scarcely any better with continued evacuation of casualties to ZI.]

Chapter 6
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Chapter 7
THE UNITED NATIONS OFFENSIVE
(15 September - 26 November 1950)

By Albert J. Glass, MD, FAPA

TACTICAL CONSIDERATIONS

Inchon Landing and Capture of Seoul, 15-30 September 1950

General MacArthur, foreseeing the enemy's vulnerable disposition early in the war even before the first clash between American and North Korean troops, had decided that a seaborne strike against the North Korean rear was a logical solution. A chance to strike deep behind the enemy's mass to cut lines of supply, then attack front-line divisions from two directions was enticing to the general, who in World War II had proved so well the value of amphibious envelopment against the Japanese. Before such a blow could be struck, General Walker had to halt the North Korean Army short of Pusan and General MacArthur had to build an amphibious force almost from the ground up.

By the opening of September 1950, both generals had progressed considerably in meeting these essentials.^{1(pp139-154)}

Operation Chromite - The Inchon Landings

General MacArthur planned his bold amphibious venture at Inchon sustained only by hope and promises. At no time during planning did he have the men and guns he would need. The Joint Chiefs of Staff (JCS) frequently told MacArthur that with military resources of the United States at rock-bottom and with the short-fused target date (15 September 1950) on which

General MacArthur adamantly insisted, the needed men and guns might not arrive on time.

Disagreements over time, place, and method of landing occurred. MacArthur knew that even with fullest support by Washington, he might not have by his chosen D-day enough men and equipment to breach the enemy's defenses and exploit a penetration by X Corps. The nature and location of the planned landing dictated its direction by a tactical headquarters which was separate from Eighth Army. General Walker had his hands full with the Pusan Perimeter and could not easily divide his attention, effort, or staff. The size of the landing force, initially set at about two divisions, indicated a need for a corps command.

On 21 August 1950 General MacArthur requested permission to activate from sources available in the Theatre, a Headquarters X Corps. Department of the Army readily agreed and X Corps was formally established 26 August 1950. The Special Planning Staff, General Headquarters became Headquarters X Corps and Lieutenant General Edward M. Almond became its Commanding General in addition to duties as Chief of Staff and Deputy Commander, Far East Command of United Nations Command. On 1 September 1950 MacArthur assigned the code name, Operation Chromite, to the planned landing at Inchon.

The Assault in Readiness

X Corps at embarkation, numbered less than 70,000 men. Included as its major units were the First Marine Division, the 7th Infantry Division, the 92nd and 96th Field Artillery Battalions, the 56th Amphibious Tank and Tractor Battalion, the 19th Engineer Combat Group, and the 2nd Engineer Special Brigade. The 1st Marine Division had 25,040 men including 2,760 Army troops and 2,786 Korean Marines; the 7th Marines, which arrived on 21 September 1950 added 4,000 men to the division strength.^{1(pp155-172)}

Results

Events dramatically justified General MacArthur's firm confidence.

American Marines, backed by devastating naval and air bombardment, assaulted Inchon on 15 September 1950 and readily defeated the weak, stunned, North Korean defenders. By mid-day Marines had seized Wolmi-do, the fortress island dominating Inchon harbor. By nightfall more than a third of Inchon had fallen.

Operation Chromite stayed on schedule. In the wake of the Marines, the 7th Division landed and struck south toward Suwon. Kimpo Airfield fell to the Marines on 19 September 1950 and on 20 September General MacArthur could tell the Joint Chiefs of Staff that his forces were pounding at the gates of Seoul.

So far American forces had suffered only light casualties while the North Koreans had lost heavily. At Inchon supplies were being unloaded at a rate of 4,000 tons daily. Kimpo Airfield had swung into round-the-clock operation. When General Almond took command at 1800 on 21 September, he had almost 6,000 vehicles, 25,000 tons of equipment and 50,000 troops.^{1(pp173-174)}

Breakout From The Pusan Perimeter: 16-27 September 1950

On 16 September 1950, Eighth Army and ROK troops, the Pusan Perimeter defenders, reinforced by the 27th British Brigade, began an all out offensive to coordinate with the Inchon invasion. Fortunately, the success of MacArthur's plan did not depend upon a prompt juncture of Eighth Army and X Corps. The North Korean Army fought as fiercely on 16 September as on 14 September and for nearly a week stood off all attempts by Eighth Army to punch through their defenses.

By 22 September signs of enemy weakness had appeared; the next day the North Korean Army, at last feeling the effects of severed lines of communication and a formidable force in its rear, began a general withdrawal from the Pusan Perimeter. The withdrawal turned into a rout. During the next week Eighth Army pursued the fleeing enemy. On the morning of 26 September 1950 a task force from the 1st Cavalry Division of Eighth Army met elements of the 7th Infantry Division of X Corps near Osan to mark the juncture of the two

forces.

PSYCHIATRY AT THE DIVISION LEVEL:EARLY EXPERIENCES

Psychiatric admissions were elevated for several days with high battle casualties at the beginning of the Eighth Army offensive, then dropped precipitously, as to be expected when victorious troops are rapidly advancing with few battle casualties. The combat troops were far ahead of their clearing company facilities as they outran the slower support troops. In this happy tactical situation, division psychiatric centers could not operate effectively because they were dislocated from the combat troops and too far in the rear. It is fortunate that such occasions do not require psychiatric support as mental patients who may be produced are too few to be of practical importance.

Meanwhile X Corps had enlarged its holdings in the Inchon-Seoul area. The reinforced enemy gave stubborn battle for Seoul which forced street-by-street and house-to-house fighting. Seoul was finally secured on 28 September with the aid of 7th Division elements who attacked from the south; however, marines bore the brunt of the fighting and suffered heavy battle casualties.

Psychiatric casualties from the marine division were also numerous, but neither a division psychiatrist or intradivisional psychiatric treatment was present. Together with battle casualties, marine psychiatric casualties were initially evacuated to the Navy hospital ship "Consolation" at Inchon harbor and later to army hospitals that became operational in the X Corps area. Lieutenant Commander (LCDR) Wade Boswell MC, psychiatrist with the hospital ship, reported to the author in early October 1950 that he had little success in returning marine psychiatric casualties to combat duty. Apparently the superior living conditions of the hospital ship were not conducive to improvement and return to combat hardships despite proximity of the hospital to the battle action and prompt placement of psychiatric casualties under treatment. This was in sharp contrast to the somewhat later results obtained at the relatively primitive setting of an army field hospital where it was

possible to return about 50% of marine psychiatric patients to combat duty within a 1 to 3 day period of rest and brief psychotherapy.^{1(pp174-177), 2(pp21-23)}

7th Infantry Division

The 7th Infantry Division had relatively light battle casualties, and consequently had few psychiatric casualties. A psychiatric treatment section was included in the division clearing company facilities. It was headed by CPT David Markelz, who had a one year Army residency in internal medicine and who was assigned as the assistant division psychiatrist because a psychiatrist was not available. CPT Markelz briefed himself on his new position by various readings, including "Combat Psychiatry," a Supplemental Issue of the U.S. Army Medical Bulletin published November 1949. He saw about ten psychiatric patients from the relatively brief combat action of the 7th Infantry Division. These cases did not impress him as being severe and six were returned to duty after a short period of rest and sedation.^{2(p22)}

Psychiatric Casualties: September 1950

For the month of September 1950, which included intense combat in both defense and offense mainly by Eighth Army, there occurred the highest U.S. Army rate for WIA and the second highest for KIA. The rate of psychiatric admissions (includes cases only excused from duty) from U.S. Army personnel in September was also the second highest for the Korean War and the effect of tactical situations.³

PSYCHIATRY AT THE DIVISION LEVEL: LATER EXPERIENCES

Psychiatric Casualties: October 1950

The psychiatric admission rate for October of 34.21/1,000/year, the

lowest during the first 18 months of the Korean War, reflects the optimism that pervaded all ranks as well as light battle casualties for the month.³ It was not surprising that morale was high. The fortunes of war had been quickly and almost miraculously reversed and there was widespread expectations that soon the fighting would be over and return to comfortable Japan would be accomplished.^{2(p23)}

Changes in Division Psychiatry

Early in October 1950, LTC Philip Smith, 25th Infantry Division Psychiatrist, was medically evacuated to Japan. He was replaced in late October by CPT W. Krause of the 8054th Evacuation Hospital who volunteered for a divisional assignment. Fortunately few psychiatric or battle casualties occurred in the division during October, as the division remained near Taejon to combat guerrillas and mop up bypassed enemy remnants.

X Corps forces were increased by the addition of the 3rd Infantry Division, the first elements of which disembarked at Wonsan in early November. This division was unique in arriving with two psychiatrists, CPT (later MAJ) Clarence Miller (3 years Army psychiatry residency) assigned as the division psychiatrist and 1LT (later CPT) Clay Barritt (1 year civilian psychiatry residency under Army auspices) assigned as the assistant division psychiatrist.

In November 1950 further gains of Eighth Army and X Corps became increasingly limited due to stiffening enemy resistance, difficulties of maintaining adequate logistical support to forward troops, and onset of the severe North Korean winter with its numbing effect. This month, with its increasing enemy activity, saw a moderate rise of battle casualties (KIA and WIA) with a corresponding rise in the psychiatric admission rate as optimism of the previous month began to wane. In addition, there were significant increased rates for disease and non-battle injury--frostbite. Eighth Army continued to advance above Pyongyang and X Corps expanded its control over

much of northeast Korea including the Chosin Reservoir district. By 25 November 1950, the United Nations' forces were ready for a final offensive to the Yalu River with Eighth Army 75 to 80 miles above Pyongyang and X Corps anchored at the Manchurian border on the east by elements of the 7th Infantry Division in readiness to wheel westward and coordinate with the northward push of Eighth Army.^{2(pp23-24)}

Surveys of Divisional Psychiatric Programs

Surveys of divisional psychiatric programs by the author during October and November 1950 revealed some common problems. While all division surgeons appreciated the value and need for intradivisional psychiatric treatment, they were unaware of or resistant to the function of the division psychiatrist in prevention. For this reason and because most division psychiatrists were unfamiliar with this aspect of their duties, they confined their efforts mainly to treatment and evaluation of referred or evacuated cases. This use of division psychiatrists was necessary during the Pusan Perimeter period when large numbers of psychiatric casualties focused attention upon treatment. This early role presumed that treatment was the major function which could be performed by a psychiatrist.

As a consequence, and consistent with the knowledge of division surgeons at this time, two divisions in Korea assigned their only psychiatrist as the assistant division psychiatrist. This designation insured restriction of preventive aspects in division psychiatric programs as assistant division psychiatrists were subordinate to division clearing and medical battalion commanders. Thus, the mission of the only psychiatrist could and was curtailed by the whims and ideas of clearing company commanders. These psychiatrists could not visit and make recommendations to combat units or in one instance obtain permission to discuss problems with the division surgeon including policies and methods for treatment of psychiatric casualties. Also, the assistant division psychiatrist was subject to performing routine duties

of the clearing company which in one division interfered with psychiatric treatment.^{2(pp24-25)} Experiences with abuses which occur when the Table of Organization for a combat division permits two psychiatrists, when seldom can more than one be made available, leads the author to seriously question the value of this change from the Table of Organization in World War II combat divisions which contained a single psychiatrist specifically designated as the division psychiatrist and assigned to the office of the division surgeon. Even in the future, there will be too few psychiatrists available to assign two per division. In actual practice a general medical officer of the division clearing company can be readily trained to serve as assistant to the division psychiatrist when such help is needed.^{2(p25)} After the Korean War a change was made replacing the assistant division psychiatrist with an officer psychiatric social worker or clinical psychologist as available. These officers became division social worker or division psychologist with the single division psychiatrist assigned to the office of the division surgeon.

In the course of the survey an effort was made to orient psychiatrists assigned to divisions in assuming a role in preventive psychiatry to coordinate with efforts to remove obstacles to such a program. The young psychiatrists were receptive to such a function. It was agreed that division psychiatrists should regularly visit battalion and other divisional units when conditions permitted. In general a program of prevention was to be established as set forth in the November 1949 Supplemental Issue of the Bulletin U.S. Army Medical Department entitled "Combat Psychiatry."

Two administrative problems associated with division psychiatry were resolved in October 1950. The first concerned the Emergency Medical Tag (EMT) diagnoses of combat psychiatric casualties. All types of designations were used from "shell shock" to "psychosis," including the ubiquitous "Psychoneurosis-anxiety state." This practice caused a similar iatrogenic trauma to patients and semantic confusion to medical officers that occurred early in World War II. The Eighth Army Surgeon agreed to corrective action. An Eighth Army directive was issued implementing the use of "Combat

Exhaustion" to designate all psychiatric casualties in combat troops, equivalently prescribed in current army regulations as "Combat Fatigue."

The second problem was also resolved when the Eighth Army Surgeon agreed to issue a directive that all combat divisions submit periodic biweekly (semimonthly) reports giving data on battle casualties and psychiatric admissions, focused at the battalion level. The form used was identical with that utilized in World War II. From data in these reports division charts were constructed. The division psychiatric reports became a pertinent part of efforts to expand preventive aspects of psychiatric programs at this time, as they pinpoint differences of the various divisional elements and raise questions by command. As in World War II, during the Korean War, they became powerful levers for interest and research in preventive psychiatry.^{2(pp28-29)}

A prompt result of efforts to establish preventive psychiatry programs within combat divisions occurred in the 24th Infantry Division. Here, MAJ Hammill enjoyed the full confidence of senior medical officers. He was properly assigned to the office of the division surgeon and had access to all divisional units. As a staff officer, he began the orientation of line and medical officers on pertinent psychiatric problems. Prior to leaving the division in November 1950 to complete residency training, he worked jointly with his replacement, CPT (later MAJ) William Hausman (2 years civilian psychiatry residency under Army auspices) for a 10-day period. During this time there were visits to the various divisional elements where CPT Hausman was personally introduced to key line and medical officers. By this transition process, MAJ Hammill transferred his prestige, status, and gains for psychiatry in the division to CPT Hausman, who further developed the divisional program. This orientation of new incoming psychiatrists became a preferred procedure in the many changes of division psychiatrists that occurred in the Korean War.^{2(pp25-26)}

The improper assignment of CPT Paul Stimson to the 1st Cavalry Division as the assistant division psychiatrist instead of division psychiatrist was corrected after discussion with the division surgeon. CPT Stimson assumed an

increasing staff function as he developed a superior psychiatric program. Efforts to remedy a similar situation in the 2nd Infantry Division initially met failure after two attempts but was resolved several months later after the division surgeon and CPT Schumacher, the assigned only psychiatrist in the division, left Korea.

There was no problem in the assignment or function of CPT William Krause the assigned psychiatrist to the 25th Infantry Division. The only requirement was for a psychiatrist to implement an intradivisional psychiatric program. The division surgeon recognized the necessity of both treatment and prevention in divisional psychiatry. He was happy to receive CPT Krause and gave him whole-hearted support.

The lack of a trained psychiatrist in the 7th Infantry Division was remedied in early November 1950. CPT (later MAJ) Wilmer Betts (1 1/2 years civilian psychiatry residency under Army auspices) was assigned to the 7th Infantry Division after prior discussion with the division surgeon on the comprehensive utilization of the division psychiatrist and a promise that CPT Betts would be correctly assigned and be permitted full function. The division surgeon not only kept the agreement, but his strong encouragement and support of CPT Betts facilitated the development of a superior divisional psychiatric program.

Efforts to persuade the 1st Marine Division to establish intradivisional psychiatric treatment initially failed but was later implemented. In November 1950, while at Hamhung, an important northeastern coastal port in North Korea, it became evident that a considerable number of Marine psychiatric casualties were being admitted to the 121st Evacuation Hospital at Hamhung, who provided medical support to the 1st Marine Division. It was suggested to the Marine Division Surgeon that he request a division psychiatrist who would conserve manpower by treatment and prevention. The Marine Division Surgeon was quite surprised to learn that so many psychiatric casualties were being produced in his division. After confirmation by his subordinates that Marine psychiatric casualties were indeed being sent to the 121st Evacuation Hospital, he agreed

that the author could transmit to Navy Headquarters in Tokyo his willingness for the 1st Marine Division to receive a division psychiatrist. This was accomplished on the author's next return to Tokyo but a further delay occurred. In March 1951, a Navy psychiatrist was assigned to the 1st Marine Division. From all reports, a superior 1st Marine Division psychiatric program was developed.^{2(pp26-29)}

PSYCHIATRY AT THE ARMY LEVEL

This period saw a marked improvement in Army level psychiatric facilities, the second echelon of psychiatric treatment, which took place in late October 1950. In the second half of September 1950, CPTs Krause and Harris continued their efforts at Pusan but the rapid forward movement of United Nations' combat troops in late September and October 1950 negated the value of the Pusan area, which became too rear for useful function. Medical facilities that were tactically situated to better support the combat troops were the 121st Evacuation Hospital and the 4th Field Hospital, units of X Corps medical services which became operational in the Inchon-Seoul sector during latter September and early October 1950, respectively. Both hospitals were receiving psychiatric patients, mainly from the 1st Marine Division at the time of the author's visit to this area in early October. The 121st Evacuation Hospital was preparing to cease operations in order to move with other X Corps elements south to Pusan to participate in the next amphibious invasion. The 4th Field Hospital was transferred to the control of Eighth Army and remained at the site of Ascom City between Inchon and Seoul. Currently the 121st Evacuation Hospital is at this location.

The 4th Field Hospital had no trained psychiatrist, but CPT James Gibbs who had been accepted for Army psychiatry residency training, was assigned to this duty at his request. The author saw about 20 psychiatric patients in treatment-evaluation interviews with CPT Gibbs during a most concentrated course of psychiatric training, as in 24 hours an attempt was made to

indoctrinate him in both the sociodynamic concepts and treatment methods pertinent to combat psychiatric casualties. CPT Gibbs was an apt student, but further supervision was required at least for a time.

The 121st Evacuation Hospital had admitted about 40 patients to the psychiatric section during the brief period of its operation at Yongdongpo near Seoul. The assigned psychiatrist, CPT Thomas Glasscock (1 year psychiatry residency under Army auspices) also required instruction in combat psychiatry and was introduced to the techniques of hypnosis and barbiturate interviews. As noted with CPT Krause of the 8054th Evacuation Hospital, CPT Glasscock had not been given such facilities as a small wall tent to permit privacy in work with patients. This difficulty was not uncommon at this time as two division psychiatrists were similarly handicapped. The necessity for such privacy was repeatedly stated by various psychiatrists as essential for proper functioning; but, their contentions were not seriously considered. On the surface it would appear to be a minor matter; nevertheless, it required personal guarantees to respective hospital commanders and division surgeons that psychiatrists obtained their best results by listening and talking to patients in an atmosphere which was conducive to privacy. Later, however, these same senior medical officers come to regard their psychiatric services as effective and valuable and freely gave their support.

In early October 1950 a conference was held with the Eighth Army Surgeon and the author on improving psychiatric services at the Army level (2nd echelon). The author accepted his decision that a separate psychiatric unit to support divisional psychiatry patients was not feasible at this time for reasons of difficulties in maintaining security in unstable rear areas and because supplies and personnel for such a facility were scarce. We agreed that a psychiatric team could be made operational in an already functioning hospital. Not acceptable was his suggestion that a Pusan area military hospital was the logical site for the psychiatric team. It was over 300 miles to the rear of the combat zone and literally miles out of the "war." The author suggested the 4th Field Hospital near Seoul, only 30 to 40 miles back

of the forward troops. Here also there was assurance of support from COL L.B. Hanson, the Commanding Officer of the 4th Field Hospital. Initially this proposal was rejected by the Eighth Army Surgeon, who insisted on Pusan. The author argued that CPT Harris should be moved from Pusan to join with CPT Gibbs in forming the nucleus of a psychiatric team at the 4th Field Hospital.

The matter was left at this stage but, to the author's pleasant surprise, the Eighth Army Surgeon moved CPT F. Gentry Harris 3 weeks later to the 4th Field Hospital where he and CPT Gibbs formed a harmonious team, trained the needed medical corpsmen, established a treatment program, and by the end of October 1950, demonstrated that 80% of psychiatric admissions were returned to combat or non-combat duty. In late November CPT Harris was returned to the ZI to complete psychiatry residency training. He was replaced by 1LT (later CPT) Harold Kolansky (1 1/2 years civilian psychiatry residency).

The 171st Evacuation Hospital that arrived in Korea in mid-September 1950 became operational for the first time at Pyongyang about 1 November 1950.

As the most forward large medical facility soon the hospital was receiving all types of casualties. The assigned psychiatrist, CPT Richard Cole (1 year civilian psychiatry residency under Army auspices) lacked experience with military psychiatric patients. The author spent several days of supervision with CPT Cole which focused upon brief evaluation and treatment of combat psychiatric casualties. Cases were seen together with later discussion.

The 121st Evacuation Hospital was visited again in early November 1950 at a new location in the X Corps sector near Hamhung. CPT Glasscock had excellent facilities for privacy of patient interviews at this time. He had improved in confidence and competence as he developed an efficient treatment program. This psychiatric section became the Army level psychiatric center for X Corps.

The 8054th Evacuation Hospital was mainly utilized for support of non-combat troops based in Pusan and Taegu. CPT Hausman replaced CPT Krause in late October and remained for several weeks prior to assignment with the 24th Infantry Division. Latter November 1950 found psychiatric facilities at Army

level expanded and functioning effectively. The 171st Evacuation Hospital and the 4th Field Hospital gave adequate support to Eighth Army combat forces. The 121st Evacuation Hospital supported X Corps troops.

At this time another conference was held with the Eighth Army Surgeon to decide on the best location for an Army level psychiatric center to support the forthcoming United Nations' offensive. This attack was publicized as a drive to the Yalu River with the goal of ending the war by Christmas. It was agreed that the Pyongyang area offered the best location. For this reason it was planned to establish a psychiatric team at the 64th Field Hospital then about to move to Pyongyang. The author agreed to personally supervise the project. Initially CPT Cole, to be detached from the 171st Evacuation Hospital and the author, would constitute the psychiatric team. If all went well, CPT Kolansky, at the 4th Field Hospital would be moved to the psychiatric center at Pyongyang.

From the author's visits to hospitals at Eighth Army and X Corps, it became evident that large numbers of military personnel were evacuated from combat units for subjective somatic complaints or mild non-disabling physical defects. Many such patients were observed in the various Army level psychiatric services where the underlying problems were defects in motivation and group cohesiveness. Efforts to correct these problems were directed at line and medical officers in the Far East Command. The concepts utilized and general orientation to these problems were described by the author in the Surgeon's Circular, Far East Command, entitled "Medical Evacuation and the Gain in Illness," January 1951, which was reproduced in the "Symposium on Military Medicine in the Far East Command" Bulletin of the U.S. Army Medical Department, September 1951. Cases were more frequent as combat and the winter became more severe. As in the Mediterranean Theatre of World War II, a subgroup of this category were manifested in persons whose spectacles were lost or broken. It was necessary to evacuate such individuals to hospitals at Army level for refraction and the furnishing of glasses. While in the hospital, other complaints were common. An average of 10 days per person was

lost from duty. Later during the winter of 1951 optical units were established in each division which finally resolved the problem.^{5(pp30-34)}

BASE SECTION PSYCHIATRY

During this period, a reorganization of psychiatric facilities in Japan was initiated. The current practice of concentrating most psychiatric evacuees from Korea at the 361st Station Hospital in Japan had serious disadvantages in treatment and disposition. Many psychiatric patients were seemingly adversely affected by the hospital setting, allowing them either to maintain a persistence of symptoms or to develop more severe manifestations than were previously noted. This resistance toward improvement and return to duty cannot be considered surprising when the comfortable atmosphere of a fixed hospital situated in the midst of peaceful urban Tokyo, where pleasures abound, is contrasted with the monotonous, primitive, and hazardous existence of Korea. In addition, patients at the 361st Hospital could readily observe and envy the evacuation to the United States of other psychiatric patients who were apparently being rewarded for persistent or severe manifestations of mental illness by being sent home.

It should not be assumed that reasons for continuing the gain in illness were in any large degree unconscious to individuals concerned since such matters were openly brought forward by them in treatment interviews and not infrequently were discussed among patients. In this connection, the concentration of patients at the 361st Hospital who had similar battle experiences, symptoms, conflicts, and desires fostered a negative group attitude toward return to duty even of a non-combat type. Patients reinforced each other in justifying complaints and contaminated new admissions with stories of "nothing being done for them" as they indoctrinated the newcomer on what the "score" was in this institution.

The psychiatric casualty when evacuated to Japan was especially vulnerable to group suggestion. Separated from the positive motivating forces of his combat unit, often troubled by guilt for leaving them, he was figuratively alone with his conflict and readily seized upon any support which would aid his symptom defense, the only excuse he had for patient status. The hospital patient group offered him such support by persons who had similar problems and needs. Their presence and numbers gave him justification for symptoms and facilitated the projection of painful self-directed criticism outward to hospital personnel and others who had not endured the hardships and hazards of combat and therefore could not appreciate or understand his problems.

A person rarely acts entirely upon his own wishes or needs. It is more usual to be part of some group since being alone is to be defenseless. Within the group the individual can solidify neurotic defenses or antisocial behavior. When the psychiatric patient was part of the 361st hospital group that sanctioned the use of symptoms for tangible benefits, he was encouraged to obtain further gain of illness. For this reason, many patients at the 361st Station Hospital had a recurrence or persistence of symptoms which related to combat stress, such as startle reaction, insomnia, battle nightmares, and the like. In the hospital it seemed that psychiatric patients were fighting another battle, the battle to go home.

The adverse influence of large psychiatric patient groups in rear hospitals was a well known problem of base section psychiatry in World War II.

Efforts were made to oppose this negative attitude including group therapy, a more rapid evaluation and disposition of less severe cases, a full program of physical activity, and finally successful program in forward zones (division and army levels) which limited the number evacuated to base sections. At this time therapeutic efforts of psychiatrists at the 361st Hospital were almost wholly occupied in contending with gain in illness. The 361st Hospital, located in a densely populated area of Tokyo, Japan, had little space for a physical reconditioning program. Instead, reliance was placed on indoor

activities, mainly of a recreational nature including motion pictures, Red Cross and special services entertainment, occupational therapy, and evening passes to Tokyo. All of these activities made the thought of return even to non-combat duty an unpleasant prospect of resuming daily obligations and irksome tasks. In truth, it was difficult to establish positive rapport for the therapist had little to offer the patient compared with the tangible benefits of remaining disabled.

Any efforts to minimize or correct the errors of current psychiatric treatment in Japan involved decreasing the admission of non-psychotic mental patients to fixed medical installations such as the 361st Station Hospital. Steps in this direction had already been taken by improvement of the psychiatric program in Korea at division and army levels which prevented evacuation of cases to Japan. The next phase was to limit the transfer of patients to the 361st Hospital from other areas in Japan, particularly the 118th Station Hospital in southern Japan which received most of the psychiatric evacuees from Korea. Finally, it was planned to establish psychiatric consultation and treatment at various locations in Japan to circumvent transfers to the 361st Station Hospital of any patient who showed no evidence of organic disease or psychosis. Thus, the total effort involved the decentralization of psychiatric facilities so that mental patients could be dealt with early and near the origin of situational difficulties. By this plan psychiatric evacuees from Korea would be evaluated and treated at whatever psychiatric center was first reached in Japan. Similarly psychiatric problems that arose from patients in Japanese hospitals or originated from nearby military units could also be treated locally, preferably on an outpatient basis. In effect the psychiatric program in Japan duplicated that of Korea where psychiatry at division and army levels represented a decentralized approach to evaluation and treatment near the origin of situational conflict. The 361st Station Hospital continued as a neuropsychiatric center but was utilized mainly for psychoses, severe neuroses, neurological disorders, or other problem cases who required fulltime

inpatient services for care or diagnosis.^{6(pp35-39)}

Additional Neuropsychiatric Personnel

Additional psychiatry, neurology, psychology, and social work personnel needed to implement such a decentralized program began to arrive in early October 1950, when a neuropsychiatric team was assigned to the Far East Command. Several of its members have been previously mentioned as replacements for various positions in Korea. The team included the following:

CPT Stephen May	completed 3 yrs Army psychiatry residency
CPT William Hausman	completed 2 yrs civilian psychiatry residency under Army auspices
CPT Wilmer Betts	completed 1.5 yrs civilian psychiatry residency under Army auspices
CPT William Allerton	completed 2 yrs civilian psychiatry residency under Army auspices
CPT Philip Dodge	completed 2 yrs civilian neurology residency under Army auspices
CPT Ralph Morgan	Army psychiatric social worker, adequate training and experience under Army auspices

The new arrivals were temporarily assigned to the 361st Station Hospital in Tokyo for a 7- to 10-day period of orientation to the neuropsychiatric problems of the Far East Command (FEC) which gave the author an opportunity to evaluate the aptitude and competence of the recent arrivals. Patients were seen together in individual case conferences and also lectures were given. This pre-assignment orientation became a standard procedure for all incoming neuropsychiatric officer personnel to the FEC. It made possible a more appropriate assignment from the standpoint of individual preference and needs of the theatre. Such a policy made for uniformity in methods of treatment and

criteria for disposition which facilitated transition from civil to military psychiatry. Because most of the new neuropsychiatric personnel were relatively young in age and experience, eager to learn, and willing to consider other viewpoints and methods of therapy, this made the task of indoctrination far easier than perhaps if older and more experienced neuropsychiatric personnel with fixed opinions and methodology had been involved.^{6(pp39-40)}

Further Decentralization in Japan

As part of the decentralization of psychiatric facilities in Japan, a treatment section at the 118th Station Hospital in southern Japan was established in early November 1950. Previously this hospital served as the receiving facility for most casualties evacuated from Korea and also as a triage center for psychiatric evacuees. An arrangement was made with the Commanding Officer of this hospital to permit the psychiatric section to have a minimum of 30 beds for short term treatment. MAJ Bailey, the assigned psychiatrist was returned to the ZI to complete psychiatric training in November 1950. He was replaced by CPT (later MAJ) William Allerton. The decreased psychiatric casualties in October and November 1950 enabled the psychiatric section to begin functioning with the understanding that Allerton would transfer all severe cases to the 361st Station Hospital and hold mild cases for treatment.

Further progress toward decentralization in Japan included the increase of psychiatric facilities in the Osaka area. LTC Philip Smith, previously medically evacuated to Japan from Korea replaced CPT John Black, psychiatrist of Osaka Army Hospital in early November 1950, who was returned to the ZI for completion of residency training. An additional psychiatrist, a neurologist, and a clinical psychologist were to be assigned with LTC Smith when available, with the ultimate goal of establishing a psychiatric service of 80 beds with closed and open wards, instead of the extant psychiatric section. An ECT

machine already on order along with an existing EEG apparatus would enable the expanded neuropsychiatric service to render a similar level of treatment as at the 361st Hospital. The transfer of patients from the Osaka area to the 361st Hospital in Tokyo would be unnecessary, especially since evacuation to the ZI could be accomplished directly from Osaka. The lack of psychiatric facilities in the Yokohama area was remedied in early November 1950 by arrival of the 141st General Hospital and the utilization of its neuropsychiatric service as an outpatient consultation and treatment center. Adequate space and facilities were found in the outpatient building of the 155th Station Hospital in Yokohama. The professional staff of the Neuropsychiatry Service included the following:

LTC Herman Wilkinson	Chief of NP Service, board certified in psychiatry, Regular Army
CPT Kenneth Kooi	2 years civilian training in electroencephalography
CPT Philip Duffy	1 year civilian neurology residency under Army auspices
1LT Roger Pratt	experienced, adequately trained, Army psychiatric social worker

Subsequent operations of the Neuropsychiatry Service demonstrated that both consultation and treatment was provided for a large number of patients from local units and dependent families. Here, decentralization prevented a flow of both inpatients and consultations to the 361st Hospital in Tokyo. Prior services by the 361st Station Hospital was unsatisfactory because distance between Yokohama and Tokyo was sufficiently far as to make communication difficult with an inevitable delay in forwarding reports. The Yokohama center was able to render more meaningful advice and reports because unit commanders and other pertinent persons could be directly contacted either to elicit further information or give suggestions for assignment or

disposition. Outpatient treatment was readily available for military persons or dependents with minimum time lost from work.

A visit to the 395th Station Hospital at Nagoya, Japan in mid-November 1950 by the author found that the hospital served as a medical facility for both nearby Air Force units and casualties evacuated from Korea. A trained psychiatrist was not present. It was decided to assign a trained psychiatrist to the hospital when available in order for the decentralized program to function, particularly with respect to frequently referred flying personnel. CPT Robert Yoder, MC (3 years civilian psychiatry residency) was assigned to the 395th Station Hospital in December 1950.^{6(pp40-43)}

Non-Convulsive Shock Therapy

Dr. Howard Fabing, M.D., Civilian Consultant to the U.S. Army Surgeon General in Neuropsychiatry arrived in the FEC in early November 1950 for a 30-day tour. He was interested in determining if non-convulsive (also termed subconvulsive) shock therapy was beneficial in the treatment of combat neuroses. He brought with him a new Reiter apparatus to instruct various Neuropsychiatry Service staff members of the 361st Station Hospital in the technique of non-convulsive treatment. Dr. Fabing's preliminary results were encouraging. After completing his tour of psychiatric facilities in Japan and Korea, he obtained permission for an additional 2 weeks stay at the 361st Hospital in order to personally supervise the treatment of acute combat neuroses by subconvulsive shock therapy. The group selected for treatment consisted of 20 recently evacuated combat psychiatric casualties from Korea. They were given daily non-convulsive therapy for 7 to 10 days.

The results can be summarized as follows: approximately 50% of treated cases showed varying degrees of improvement. Neuropsychiatry staff members of the 361st Hospital were of the opinion that this type of therapy was only of limited value because similar or better results could be obtained with less inconvenience to both patients and hospital personnel. It should be noted,

however, that cases available for selection by Dr. Fabing at this time were relatively fixed character disorders upon which battle stress had found fertile soil.

Such individuals were made even more refractory to treatment by the gain in illness incident to evacuation and hospitalization in Japan. Perhaps it was expecting too much for any rapid somatic therapy to alter basic personality particularly in an adverse therapeutic environment. More suitable cases were not available because of the lessened incidence of acute psychiatric casualties during October and November 1950 and that effective forward psychiatric treatment had been established in Korea beginning in latter August 1950. Psychiatric casualties who possessed relatively good motivation and a stable personality were returned to duty from treatment in Korea at division or army level. Persons with more disturbed personality substrate were evacuated to Japan. Because of current effective forward psychiatric treatment, it is doubtful whether non-convulsive shock therapy would be of benefit in the early phase of combat psychiatric breakdown. Moreover, time required for such treatment, namely 7 to 10 days, militates against its success since 2 to 4 days was the optimum period for best results of treatment at the division level. Even the more severe cases returned to Japan were later found to demonstrate more consistent improvement in a convalescent setting than the formal treatment of any type given in a comfortable fixed hospital atmosphere. Since time and place or setting has been demonstrated to be of major importance in the treatment of acute combat psychiatric casualties, perhaps Dr. Fabing should have determined the results of non-convulsive shock therapy in Korea at the Army level.^{6(pp44-45)}

Japanese B Encephalitis

In early November 1950, a study of residual cerebral dysfunction from Japanese B encephalitis was initiated at the 361st Station Hospital. This was occasioned by an epidemic of some 300 cases from combat troops in Korea that

occurred in the late summer and early fall of 1950. Clinically the victims ran the gamut from mild to severe with death in 100 of these cases. The more severely ill had an acute onset with headache, stiff neck, and fever, followed rapidly by an altered sensorium, confusion, delirium, and coma. The febrile phase was present for 7 to 10 days during which time constant nursing care, attention to nutrition, and adequate air passageways were crucial in sustaining life. In favorable cases the temperature returned to normal by lysis leaving the patient in a more or less vegetative mental state from which there was gradual but striking improvement in most cases.

Two hundred patients who had recently recovered from the febrile stage were gathered and studied at the 361st Station Hospital. Thirty of the group with the most severe loss of mentation were evacuated to the ZI. The remainder were thoroughly studied for residual brain damage by neurological examination, serial EEG's psychological test batteries, and psychiatric evaluation including a complete background history. The vast majority of the examined group were returned to limited duty status in the Tokyo area. The subjects were re-evaluated at 3-month intervals over a period of 6 months. The common symptoms were headache, irritability, and tension feelings similar to the posttraumatic concussion syndrome. Very little organic residuals were demonstrated. After discharge to limited duty the persistence of symptoms largely depended upon adjustment to their assignments.

The clinical severity of the disease bore no relationship to the symptoms of headache or tension. Pre-illness personality and motivation for duty were apparently pertinent in determining the persistence of complaints. Outpatient psychotherapy and support was of value in facilitating adjustment to the resumption of duty. As with other organic disease, secondary gain in illness was strongly evident in complicating the rehabilitation of these patients. Pertinent in this respect was the semantic disadvantage inherent in the word "encephalitis." A complete report of this project was prepared by LTC Oswald Weaver of the 361st Station Hospital.^{6(pp44-46)}

Chapter 7

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Chapter 8
THE CHINESE COMMUNIST OFFENSIVE
(26 November 1950 - 15 January 1951)

By Albert J. Glass, MD, FAPA

CHINESE COMMUNIST INTERVENTION

On 25 November 1950, Eighth Army began an all-out offensive in the western sector of the North Korean front to coordinate with the attack of X Corps on the east to reach the Yalu River (boundary between North Korea and Manchuria) and quickly end the Korean War. The Eighth Army attack proceeded unopposed for almost two days. On the night of 26-27 November, several fresh Chinese Communist armies counterattacked with a major thrust at the right flank, then held by ROK II Corps. The ROK troops collapsed exposing the 2nd Infantry Division, the Turkish Brigade and the 27th British Brigade to enemy onslaughts in the flank and rear. The position of other Eighth Army units was also untenable and they disengaged in an orderly withdrawal to the Pyongyang area to avoid entrapment. The 2nd Infantry Division and the Turkish Brigade were forced to fight their way out of entrapment during which enemy roadblocks and flank attacks caused heavy casualties. The Chinese broadened their offensive on 27 November 1950 with attacks against X Corp. On 28 November Chinese units slipped southeastward past the Marines and cut their supply route.

This wide display of Chinese strength swept away General MacArthur's doubts. Instead of fighting fragments of the North Korean Army reinforced by token Chinese forces, Eighth Army and X Corps now faced Chinese armies of about 300,000. MacArthur stated "We face an entirely new war...which broadens the potentialities...beyond the sphere of decision by the Theater Commander." MacArthur announced that for the time being he intended to pass

from the offensive to the defensive making adjustments as the ground situation required.^{1(pp274-293), 2(p48)}

PSYCHIATRY AT THE DIVISION LEVEL

As initially in the Korean conflict, divisional medical support was limited to emergency care and evacuation because holding any type patient for treatment was impossible or hazardous. Even meager medical support was difficult to accomplish in the 2nd Infantry Division, which lost five medical officers (MIA) in the desperate retreat. Despite appreciable battle casualties (KIA and WIA) psychiatric admissions were not high in November (74.5/1,000/year) and December 1950 (59.8/1,000/year although definitely higher than October 1950 (34.51/1,000/year) when American forces were proceeding almost unopposed in pursuit and mopping up operations north of the 38th Parallel. As stated previously this relative low incidence of psychiatric casualties to battle casualties during rapid withdrawal was characteristic in World War II and the Korean War indicating lessened contact with the enemy, moving away from danger, and inability of division medical services during such times to detect or diagnose psychiatric problems.^{2(pp48-49)}

Psychiatric admissions during this period were evacuated to medical facilities at the Army level since divisional psychiatric centers were dislocated and on the move. Intradivisional psychiatric treatment did not become operative until December 1950 when the evacuation of Pyongyang was completed and stabilized defensive positions were established along the 38th Parallel. For several weeks enemy contact was slight and serious fighting not resumed until December 1950.

The battered 2nd Infantry Division was placed in Eighth Army reserve for rest, retraining, and absorption of replacements. The division personnel had been through a harrowing experience and were disheartened. CPT Schumacher, the division psychiatrist, was also adversely affected by his recent combat experience. However, his psychiatric unit with the 2nd Medical Battalion had

suffered no battle casualties as, along with the 38th Infantry Regiment of the 2nd Infantry Division, they were enabled to withdraw along an alternate route, thereby avoiding enemy roadblocks and flank attacks that traumatized the other divisional units. Yet the experience contained elements of sustained anticipatory anxiety and tension from nearby combat. During this period when the 2nd Infantry Division was placed in army reserve, Brigadier General S.L.A. Marshall, using his debriefing techniques of combat units as utilized in World War II, again demonstrated that only 15-25% of riflemen fired their individual weapons in combat. Crew-served weapons such as machine guns, mortars, or artillery, however, were fired without such inhibition.³

In early January 1951, CPT (later MAJ) Hyam Bolocan (3 years civilian psychiatry residency and board eligible) replaced CPT Schumacher, 2nd Infantry Division Psychiatrist, who was returned to the ZI to complete professional training.

Similar massive Chinese Communist assaults in northeast Korea forced the withdrawal of X Corps. This was readily accomplished except in the mountainous Chosin Reservoir area where the 1st Marine Division and 7th Infantry Division elements were forced to fight their way out of encirclement.

The story of their almost 10-day battle to reach safety, including air evacuating thousands of wounded and injured (also frostbite) from rapidly constructed improvised airfields, severe physical deprivations, intense cold, and the overwhelming numerical superiority of an enemy who attacked from all sides, was an epic in American military history. Despite the large number of wounds, injuries, and frostbite casualties, relatively few psychiatric casualties were diagnosed during this time. Here again was a situation with little or no gain in illness. Air evacuation was uncertain and mainly utilized for the obviously physically disabled; all others had to fight their way out.

Case 8-1. Intermittent Hysterical Paralysis

An illustration of the impact of reality upon mental mechanisms in

such an environment was exemplified by a patient with hysterical paralysis of both lower extremities. His paralysis occurred during combat in early December 1950. During the fighting retreat he was transported in a 2 1/2 ton truck with other disabled patients as a litter case. When the convoy encountered enemy fire, the patient promptly recovered sufficient function to leave the defenseless vehicle and take cover. He repeated this temporary recovery several times until the convoy reached safety in the large airfield at Hungnam when the paralysis promptly recurred. By this time the patient's repeated temporary recovery was apparent to others. Initially the patient had complete amnesia for these events, but they were vividly recalled as he relived battle experiences during a pentothal interview. In this session he portrayed dramatically how impossible it was for him to remain paralysed in the vehicle and how he moved rapidly and instinctively to seek safety.^{2(pp49-51)}

On 9 December 1950, relief troops mainly composed of 3rd Infantry Division and Marine elements reached the retreating column. By 11 December all United Nations' troops had withdrawn to the coastal plain at Hungnam with the perimeter defenses of X Corps. Then followed a gradual evacuation by sea as the defensive perimeter, mainly manned by the 3rd Infantry Division strongly supported by the guns and planes of naval vessels standing off shore, was progressively narrowed. Total evacuation was completed on 24 December. X Corps troops were brought into southern Korea to become an integral component of Eighth Army. For the first time since September 1950 all United Nations' troops in Korea had a single field commander, Lieutenant General Matthew B. Ridgeway, who took command of Eighth Army on 27 December following the accidental death of Lieutenant General Walton Walker.

The end of December saw a renewal of the communist offensive against the insecure defense lines of Eighth Army along the 38th Parallel. United

Nations' troops resumed an orderly withdrawal and by 4 January 1951 the enemy recaptured Seoul. By 7 January Eighth Army had withdrawn to a line along the general level of P'yongt'aek in the west, Wonju in the center, and Samshok on the east coast. Here stubborn resistance was offered to further enemy advances. At Wonju in early January the 2nd Infantry Division with attached French and Dutch Battalions made a historic stand against severe enemy onslaughts. This successful defense marked the end of retreat for Eighth Army who consolidated a defense line across the waist of south Korea.

The period of December 1950 and early January 1951 found morale of United Nations' troops at a low ebb. The expectations of an early victory in late November had turned to bitter defeat in December. There seemed to be no way of stopping the mass infantry tactics of the Chinese Communists who seemingly came on like hordes of locusts climbing over their own dead to move forward. The discouraging loss of hard won territory, the bitter cold and uncomfortable field existence, and continued withdrawals produced a defeatist attitude with many rumors that Korea was to be evacuated. Indeed for a time the decision as to continuance of the Korean War was uncertain.^{2(pp51-52)}

The lowered morale of American troops was not reflected in psychiatric admissions, but rather in the rise of disease and non-combat injury, including self-inflicted wounds. It was true that inclement weather did cause increased respiratory and other infectious diseases including pneumonia, and no doubt the numbing cold and icy roads were responsible for much frostbite and accidental injury. Yet to the observer at this time, it was plainly evident that many psychiatric casualties were concealed among the numerous evacuees for subjective complaints and non-disabling conditions. In particular were cases of so-called frostbite who had no objective findings of cold injury, even after several days of observation. This 'syndrome of the cold feet' was compounded out of the usual numbing sensations of feet in intense cold weather, a conscious or unconscious wish for gain in illness and poor motivation. One can only speculate as to the greater vulnerability of psychiatric casualties to frostbite. It may well be that increased

sympathetic stimulation, in such fear ridden persons, causes excessive vasoconstriction of the extremities and might account for lessened psychiatric cases noted at this time when frostbite casualties were so high.⁴ [FDJ: The complex interaction of physiological and psychological forces in frostbite is addressed elsewhere.⁵]

SELF-INFLICTED WOUNDS, ACCIDENTAL INJURY, AND AWOL FROM BATTLE

The increase of self-inflicted wounds among American combat troops in North Korea during this winter period represented another source of manpower loss for psychological reasons. Almost invariably, it was explained by the involved person as a combination of numbed fingers and carelessness. Environmental conditions made it seem reasonable to expect many such unavoidable errors. Yet the relative innocuous nature of most current self-inflicted wounds and their occurrence in safe rear positions where there was no cause for haste, pointed to the purposeful nature of the accident. The increase of other accidental injuries tended to the belief that a dispirited, unhappy, individual may become apathetic to an injury which could remove him from a traumatic environment. In this vein when rotation had been established in May 1951, serial signposts noted on a highway in North Korea were appropriate as follows: "Never fear....Rotation is here....Accidents unnecessary....Drive carefully."

In further considering manpower loss from psychological causes it should be recognized that there were relatively few United Nations' troops who were "AWOL" (absent without leave) from battle. This was in sharp contrast to numerous instances of such overt reactions to fear that occurred in the European and Mediterranean Theaters of Operations in World War II. In Korea, there was simply no safe place to which such an inclined person could go. It was dangerous to leave one's unit and wander in rear areas from the standpoint of both guerrilla activity and the weather. The only escape from the hazards

and discomforts was evacuation through medical channels. For this reason in December 1950 and January 1951 a more accurate indication of manpower loss for psychological causes can be found in the increased incidence of disease and injury rather than the relatively low psychiatric rate that reflected lessened enemy contact during the period (See Table 9).^{2(pp53-54)}

PSYCHIATRY AT THE ARMY LEVEL

Psychiatric facilities at the Army level were prepared at this time to support divisional psychiatric programs. The previously mentioned plan of establishing a psychiatric center at the 64th Field Hospital near the airfield in Pyongyang was implemented on 27 November 1950. Sufficient accommodations for 100 patients were made available in a building adjacent to the main hospital. CPT Richard Cole, detached from the 171st Evacuation Hospital and the author constituted the psychiatric team along with several corpsmen from the 64th Field Hospital. The psychiatric center at the 4th Field Hospital remained in operation headed by CPTs Kolansky and Gibbs. The 8054 Evacuation Hospital in Pusan, the most rear hospitalization point in Eighth Army, had a small psychiatric unit headed by CPT (later MAJ) Stephen May who had replaced CPT Hausman in early December 1950. X Corps sector in northeast Korea was served by the psychiatric section of the 121st Evacuation Hospital at Hamhung headed by CPT Thomas Glasscock and supported by the psychiatric service of the Naval Hospital Ship "Consolation" under Lieutenant Commander (LCDR) Wade Boswell.

Neuropsychiatric personnel at the Army level were deliberately dispersed rather than concentrated in any area or unit by assigning one or two psychiatrists to various hospitals strategically located to receive the majority of psychiatric patients. This arrangement served a dual purpose; first, it provided alternative treatment services when divisional medical facilities were forced to dislocate due to battle reverses, thereby insuring continued psychiatric services at the Army level particularly needed in any

large withdrawal action when intradivisional psychiatric care was not feasible. Second, such dispersion made it possible for psychiatric facilities to adapt to air evacuation. At this time in Korea the majority of battle and other casualties from forward areas were evacuated by air. This rendered difficult if not impossible the triage of psychiatric cases to any one area or hospital. Whether patients were brought to this or that hospital depended upon weather, the condition of landing strips, the number of vacant beds, and even the needs of the flight crew. For this reason it was necessary that psychiatric services be situated wherever large numbers of all types of patients were brought for treatment.

As result of the Communist offensive of late November 1950, thousands of sick and wounded poured into Pyongyang by plane, train, ambulance, and truck.

All available medical facilities were soon overtaxed, forcing prompt re-evacuation to medical units in the Ascom City - Seoul area and Pusan.

All psychiatric cases were brought to the 64th Field Hospital as planned. Admissions did not exceed 20 per day, relatively few compared to the large number of wounded even though there was little prior screening by division psychiatrists who were on the move rearward with their divisions. Most psychiatric casualties were of the mild to moderate type, readily treated by physical restorative measures and brief psychotherapy. Patients who could not be returned to combat duty were evacuated to the 4th Field Hospital at Ascom City for prompt disposition to non-combat duty. The adverse tactical situation at Pyongyang made limited duty to this area impractical except for some patients placed on duty temporarily with the medical detachment of the 64th Field Hospital that was understrength and needed all possible help. After 5 days of operation it became evident that Pyongyang was untenable and withdrawal of our forces from the city inevitable. When the 64th Field Hospital prepared to close, CPT Cole and the author moved to the 4th Field Hospital where they joined CPTs Kolansky and Gibbs to become the major psychiatric service of Eighth Army. The 4th Field Hospital also became the principal hospitalization center in Korea as most other medical units were

dislocated. The Commanding Officer, COL L.B. Hanson, demonstrated characteristic energy and resourcefulness as he rapidly improvised added facilities to receive the large influx of casualties. In early December the 4th Field Hospital had about 2,000 beds in operation besides providing temporary quarters and meals for personnel of the 64th Field Hospital, 171st Evacuation Hospital, 10th Station Hospital, and nurses from three Mobile Army Surgical Hospitals (MASH). Many personnel of these hospitals participated in treatment of the large inpatient population. COL Hanson produced large stocks of food and reserve supplies; and, with his hospital warmed by steam heat and serving ice cream daily, it was a veritable oasis in the cold, dreary, and discouraging period that was the Korean War in December 1950.

The psychiatric service of the 4th Field Hospital had sufficient facilities and personnel to adequately deal with 20 to 40 daily psychiatric admissions. The effectiveness of treatment steadily improved. An account of this experience was reported.⁶ The rapid effective methods of the psychiatrists influenced their medical and surgical colleagues to adopt a similar management of mild illness and those persons with only subjective complaints. This emphasis upon prompt evaluation and treatment for return to duty rather than medical evacuation was also fostered by COL Hanson. As a result 150 to 200 patients were daily returned to duty from the 4th Field Hospital during this time.^{7(pp55-58)}

BASE SECTION PSYCHIATRY

The large influx of casualties caused by the Chinese counteroffensive again overflowed medical facilities in Japan. As before most evacuees were flown to southern Japan where the 118th Station Hospital at Fukuoka functioned as an evacuation hospital, retaining non-transportable cases for treatment and transferring the remainder by plane and train to hospitals in the Tokyo and Osaka areas. For a brief period in late November and early December 1950, the 118th Station Hospital received over 1,000 patients daily. The Commanding

Officer, COL Lyman Duryea, enlarged the hospital to 1,600 beds and perfected a smoothly functioning medical and administrative team which received, fed, and triaged thousands of patients during this hectic period.

In early December 1950 the 141st General Hospital that was recently established in the Yokohama area was ordered to Camp Hakata (18 miles from Fukuoka) to increase medical facilities in southern Japan and lessen the burden of the 118th Station Hospital. The neuropsychiatric patients patients were made available in an area separated from the main hospital which had sufficient space for an outdoor recreational program. Arrangements were made for CPT William Allerton, psychiatrist of the 118th Station Hospital, to continue receiving all psychiatric evacuees from Korea who arrived in southern Japan. He was to maintain a census of 20 to 30 less severe cases for treatment and return to duty, transferring the remainder to the 141st General Hospital; however, more severe except for psychiatric, neurological, and other problem patients would be sent to the 361st Hospital in Tokyo. The plan became operational in latter December 1950. By early January 1951 the psychiatric service of the 141st Hospital had over 100 patients. It became apparent that ECT apparatus, an EEG machine, and substantial closed ward facilities were needed for more complete coverage of psychiatry and neurology in this region. Steps were initiated to achieve this objective.

The 361st Station Hospital in Tokyo received most of the psychiatric casualties that arrived in Japan during late November and early December 1950. Many of these cases were prematurely evacuated to the ZI on the erroneous assumption that the large incoming patient load would continue and there would be insufficient beds at the 361st Station Hospital to receive them.

At this time a number of professional mental health personnel, recently arrived to the Far East Command, were receiving orientation at the 361st Station Hospital in Tokyo. They included six young naval medical officers with civilian residency training in psychiatry or neurology who were on loan to the Army for 6 to 9 months. A list of the new arrivals in late November, December 1950 and early January 1951 follows:

MAJ Henry Segal	completed 3 yrs Army psychiatry residency
CPT Richard Turrell	1.5 yrs civilian neurology residency under Army auspices
1LT (later CPT) Richard Conde	1 yr civilian psychiatry residency
CPT (later MAJ) Robert Yoder	3 yrs civilian psychiatry residency
1LT (later CPT) Herbert Levy	1 yr civilian psychiatry residency
1LT Stonewall Stickney	1 yr civilian psychiatry residency
1LT (later CPT) James Corbett	2.5 yrs civilian psychiatry residency
1LT Francis Hoffman	1.5 yrs civilian psychiatry residency
LTjg Shane Mariner	1 yr civilian psychiatry residency
LTjg Richard Blacher	1.5 yrs civilian psychiatry residency
LTjg Haskell Shell	1.5 yrs civilian psychiatry. residency
LTjg Simon Harris	1.5 yrs civilian psychiatry residency
LTjg James Allen	0.5 yr civilian neurology residency
LTjg Norman Austin	1 yr civilian neurology residency
1LT (later CPT) Frank Hammer	MSC PhD. Experimental Psychology

CPT Turrell had a primary medical specialty (MOS) of Internal Medicine due to 2 years of residency in that specialty; however, he was mainly interested in Neurology and was assigned to this specialty at his request. CPT Turrell was sent to the 361st Station Hospital where he replaced MAJ Roy Clausen who was returned to the ZI for completion of neurology residency. CPT Turrell displayed superior professional competence in Neurology.

1LT Hammer was assigned to the 361st Station Hospital for on-the-job training (OJT) in clinical psychology under 1LT James Hoch and made rapid progress. The period of instruction given at the 361st Station Hospital for mental health specialists newly assigned to the Far East Command included the following orientation.

Psychiatric casualties or cases of "combat exhaustion" were not fixed

neuroses but amorphous, transient, emotional breakdowns due to situational battle stress with lowering of resistance for fear stimuli, either because of continued intense combat or inability of involved individuals to obtain emotional support from their combat units (group cohesiveness) or combinations of both conditions. The newly arrived specialists also received orientation in administrative procedures involved in military settings, medical-legal issues relative to courts-martial, manifestations and prevalence of gain in illness, brief directive methods of psychotherapy, and the use of hypnosis and barbiturate interviews as uncovering therapeutic techniques. In treatment, emphasis was placed on factors of time and distance from the traumatic episode, the environmental circumstances under which therapy was given, and the attitude of the therapist and the treatment team toward return to duty.

The availability of new psychiatrists, neurologists, and other professional mental health personnel made possible the implementation of decentralizing neuropsychiatric programs. By such a system psychiatric patients would receive evaluation and care near the source of situational disorders and prevent the evacuation of such cases to the 361st Hospital which would then continue to be utilized for more severely ill and diagnostic problems. To accomplish this objective the following assignments and change were made in December 1950 and January 1951.

LTjg James Allen and LTjg Simon Harris were assigned to Osaka Army Hospital as part of a team headed by LTC Philip Smith, (board eligible psychiatrist) to operate a neuropsychiatric service for the Osaka area. A Reiter ECT apparatus was given to this center to provide more comprehensive services and negate the need for transfer of patients to the 361st Hospital in Tokyo. LTjg Haskell Shell was assigned to the 141st General Hospital at Camp Hakata in southern Japan to bolster the neuropsychiatric service as only Lieutenant COL H. Wilkinson (board certified psychiatrist) Chief of the Neuropsychiatry Service was trained in psychiatry. A new Reiter ECT apparatus was also sent to this unit.

CPT Robert Yoder moved to the 395th Station Hospital in Nagoya to insure

the availability of psychiatric consultation in the special problems of flight personnel. For similar reasons 1LT Stonewall Stickney was sent to the 376th Station Hospital at Tachikawa that served the Air Force in the Tokyo area.

MAJ Henry Segal was assigned as psychiatric consultant to Tokyo Army Hospital where he was in position to render prompt psychiatric consultation and treatment to large numbers of medical and surgical inpatients. The assignment of psychiatrists and neurologists as set forth was soon reflected by lower admission rates to the 361st Station Hospital which were further decremented by the utilization of convalescent hospitals.

USE OF CONVALESCENT HOSPITALS

Two convalescent hospitals were established in Japan during this period. These facilities at Omiya (25 miles from Tokyo) the other at Nara (25 miles from Osaka) began receiving patients 9 December 1950. The convalescent hospitals were designed to relieve congestion in major hospital centers by receiving organic illness, wounds, or injuries that required several weeks of convalescent care prior to return to duty. Thus, the use of convalescent hospitals made available hundreds of hospital beds in fixed hospitals that were vitally needed at this time to provide for the influx of new casualties who mainly required active surgical or medical treatment. From the psychiatric standpoint the opening of convalescent hospitals was an event of the first magnitude. It made available a realistic environment for psychiatric treatment which offset the vexing gain in illness unwittingly fostered by the atmosphere of the usual fixed hospital. In contrast the convalescent hospital put all patients in fatigue uniforms and had a full daily program of calisthenics, marches, training, and athletic activities. Psychiatric patients under this regimen found little benefit in clinging to symptoms and were not adversely affected by suggestive evidence that evacuation to the ZI was possible. Indeed everyone was going to duty. Psychiatric patients were deliberately dispersed among individuals recovering

from organic disease or injury who gave little support to somatic symptoms or complaints of nervousness. The single assigned psychiatrist found less resistance to treatment as psychiatric patients turned to the therapist for assistance. An account of psychiatric treatment in the convalescent hospital setting can be found in the "Symposium of Military Medicine - Supplemental Issue of the Surgeon's Circular Far East Command," September, 1951. 1LT Francis Hoffman was assigned to the Nara Convalescent Hospital in early January 1951. LTjg Shane Mariner was sent to the Omiya Convalescent Hospital in latter December 1950 but was replaced by LTjg Richard Blacher in mid-January 1951. LTjg Mariner moved back to the 155th Station Hospital and reopened the psychiatric outpatient and Consultation Service which had been dormant since the 141st General Hospital was transferred to southern Japan.

The end of this period found neuropsychiatric facilities in Japan staffed and distributed to implement a decentralized program aimed at the outpatient and convalescent treatment for largely non-psychotic patients and the inpatient care of psychotic and neurological patients in three neuropsychiatric centers strategically located in major hospitalization areas.^{8(pp59-65)}

Chapter 8
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Chapter 9
THE UNITED NATIONS WINTER OFFENSIVE
(15 January - 22 April 1951)

By Albert J. Glass, MD, FAPA

CEASE-FIRE NEGOTIATIONS

By late January 1951, local successes of United Nations' forces and a renewed offensive spirit within General Ridgeway's command had altered the combat scene and improved the outlook. No longer was there a real threat of further evacuation.

PSYCHIATRY AT THE DIVISION LEVEL

As indicated, by 15 January 1951 momentum of the Communist attack had reduced considerably and United Nations' forces turned to aggressive patrolling. On 21 January began the United Nations' tactics (Operation Killer) of employing armored counterattacks supported by infantry air, and artillery, designed to inflict a maximum of enemy casualties with minimum self losses. By the end of January our limited offensive reached north of Suwon and Inchon. In February 1951 the United Nations' offensive continued scoring gains against stubborn resistance and by 14 February United Nations' troops had seized Inchon, Kimpo Air Field, and secured a line along the south bank of the Han River. Then followed vicious enemy delaying actions. The Communist used road mines and dug-in positions, destroyed bridges, and demonstrated their ability to hold hill masses by repeated counterattacks. By mid-March 1951 resistance diminished. The enemy withdrew, fighting only rear guard actions as United Nations' troops recaptured Seoul and pushed north toward the 38th Parallel. It was known that the Communists were building up a powerful reserve striking force. Yet they offered only sporadic resistance and by 8

April 1951 all enemy east of the Imjin River withdrew from south Korea. Bitter opposition occurred thereafter, particularly against United Nations' offensive moves in the central and eastern sectors.

The winter offensive caused increased battle casualties and a consequent rise of the psychiatric casualty rate which remained at higher levels through February, March, and April 1951 paralleling aggressive United Nations' tactics. However, the psychiatric incidence never reached levels that could be expected from uphill combat in such a bleak, desolate environment with living and fighting in sub-zero weather. There were many reasons for relatively low neuropsychiatric rates during this period. The battle line was more secure as United Nations' combat units were placed tightly across the waist of the Korean Peninsula with none of the rear infiltration and confusion that plagued United Nations' forces in previous periods of the Korean War. Enemy positions and territory were methodically and carefully taken with an obvious regard for sparing the lives of infantrymen. Operation Killer was well named and publicized as a procedure calculated to destroy the enemy with less emphasis upon capturing ground.

The resurgence of morale under this leadership and by this method of fighting was a remarkable phenomenon as defeatism was turned to grim determination and finally aggressive confidence when it became apparent that concentrated firepower and carefully planned assaults could overcome the previously feared human wave tactics of the Chinese Communist Armies. An added factor that maintained psychiatric admissions at reasonable levels was improved medical discipline. The now experienced divisional medical officers had learned to realistically appraise subjective complaints and firmly close the door of medical evacuation except for those disabled from mental or physical causes. Last but not least was the promise of rotation in March 1951. This most pertinent morale stimulus gave hope that relief was possible. Indeed the first rotatees left Korea on 18 April 1951.

During this period psychiatrists consolidated and organized functioning within divisions. Aid stations were visited regularly and battalion surgeons

indoctrinated in techniques of psychiatric evaluation and treatment. Division psychiatrists were consulted by medical and line officers on morale, mental health, and personnel problems as they gradually became emancipated from a restricted role of mainly treatment and evaluation of referred cases.

In early January 1951 CPT Hyam Bolocan (3 years civilian psychiatry residency and board eligible) was assigned as the 2nd Infantry Division Psychiatrist replacing CPT M.J. Schumacher who was returned to the ZI to complete professional training. In April 1951, CPT Bolocan received a well-deserved promotion to major. As soon as MAJ Bolocan became a staff officer, he began to visit all divisional units and was thus available for consultations and discussions with line and medical officers.^{2(pp67-69)}

It was commonly observed that when the division psychiatrist visits forward areas, he becomes highly regarded by combat personnel. His presence demonstrates that he shares their interest and viewpoint. By such visits the psychiatrist gains first hand knowledge of combat problems. His recommendations display understanding of battle situations. Basically visits by division psychiatrists evoke mechanisms of identification that on the one hand includes sharing by psychiatrists, even briefly, in the trials and tribulations of combat troops while on the other hand there was participation of combat line and medical officers with efforts of psychiatrists at prevention and treatment. The division psychiatrist who remains in the rear becomes resented as one who fears to share hardships and danger, even for a short period, and therefore does not belong in their world of anxiety and deprivation. This viewpoint of combat personnel was valid though based on an emotional bias for the psychiatrist can best understand mental processes by having had similar actual experiences, thus being enabled to objectively evaluate the symptoms and feelings of referred patients.^{2(pp60-70)}

As in World War II semimonthly division psychiatric reports were important instruments by which combat commanders became acquainted with the principles of preventive psychiatry. The comparison of psychiatric rates with the incidence of battle casualties (KIA, WIA, MIA), diseases and non-battle

injury including frostbite and self-inflicted wounds aroused interest as to reasons for differences among various large divisional components. The Commanding General, 24th Infantry Division, instructed MAJ W. Hausman (division psychiatrist) to visit the three regimental commanders to discuss conditions which could explain variations of psychiatric rates in the three regiments. MAJ Hausman was impressed by the regimental commander with the lowest neuropsychiatric rate who personally screened and observed the functioning of assigned officers.^{2(pp70-71)}

MAAJ Clarence Miller, 3rd Infantry Division Psychiatrist, was returned to the ZI in February 1951. He was replaced by CPT Clay Barritt, the assistant division psychiatrist (one year civilian psychiatry residency under Army auspices). CPT Barritt demonstrated an ability to motivate and work with line and medical officers which made him a popular figure in his division.

MAJ Wilmer Betts, 7th Infantry Division Psychiatrist, studied self-inflicted wounds (SIWs). He found that about 50% of cases came from new divisional replacements. This survey, supported by the division surgeon, influenced the Division Commander to establish battle indoctrination for infantry replacements. The investigation by MAJ Betts made it logical to conclude that relative unfamiliarity with weapons plus numbing cold permits some persons to accede to more or less unconscious wishes for accidental injury and medical evacuation. The institution of a 7- to 10-day training period in the 7th Infantry Division produced decreases of SIWs. It proved to have further beneficial effects of giving the newcomer more self-confidence as battle tactics were learned under experienced combat personnel. Under these training conditions insecure replacements were especially motivated to absorb imparted knowledge when frankly told that the instruction was akin to life insurance. In the process of battle indoctrination the new infantrymen came to appreciate group identification when taught that one could best survive as a team member.

The training period also demonstrated that combat leaders were concerned with health and safety of personnel. All in all the preliminary instruction

for the newcomer was a pertinent and valuable morale factor and represented a major improvement over placing new and tremulous recruits into battle with no alleviation of inevitable anxiety. The success of the training program as publicized in a Sunday Supplement of the Stars and Stripes, Far East Command edition, spurred other divisions to adopt similar training.^{2(pp71-72)}

From both CPT Stimson, 1st Cavalry Division Psychiatrist, and MAJ Krause, 25th Infantry Division Psychiatrist came information that over half of their psychiatric casualties had 8 to 9 months of combat beginning with the early fighting in July and August 1950. These patients were designated the "Old Sergeant Syndrome" as their manifestations seemed identical with the syndrome described in World War II. One can argue whether there were sufficient combat days in number and severity endured in Korea as in World War II; yet, there was the same clinical picture of the previously excellent soldier often becoming promoted to a noncommissioned officer who gradually became ineffective in battle with or without accompanying guilt. However, with the beginning of rotation in April 1951 such cases were removed from Korea.^{2(p72),3}

In all combat divisions the division psychiatrist made the holding platoon of the clearing company the permanent base of operations. Psychiatric cases were sent to this platoon for evaluation or treatment. The holding platoon was located in a rear position relative to the other two clearing platoons which moved according to the needs of the tactical situation. Patients with mild organic disease were also treated at the holding platoon to which two general medical officers were assigned. The presence of other medical officers in the treatment platoon obviated the need for a professionally trained assistant division psychiatrist. In actual practice it was not difficult to orient one or more of these young medical officers in utilizing the relatively simple physical and psychological measures employed at this level for psychiatric casualties. The division psychiatrist was seldom absent for more than a 24-hour period so that all evaluations and major decisions were made by the division psychiatrist. The "assistant division

psychiatrist" was mainly concerned with initiating or continuing routine treatment.

Each division psychiatrist had several enlisted assistants with more or less psychiatric experience. Their services were invaluable in the management and observation of patients. They were also useful in obtaining history data and gathering information for routine reports. The chief enlisted assistant of CPT Barritt (3rd Infantry Division Psychiatrist) was a former bartender with no psychiatric experience but who possessed a keen intuitive ability in understanding and managing mental disorders. Rarely were there available trained social workers or clinical psychologists who were utilized mainly by psychiatry at the Army level.

A frequent complaint of division psychiatrists involved difficulties in obtaining transportation for trips to visit divisional units. This was a chronic problem in combat areas where it seemed that every staff officer needed a personal vehicle. Actually necessary visits by division psychiatrists were only delayed rather than blocked; and, although it required pleading, ingenuity, and cooperation, visits by division psychiatrists were accomplished. Naturally, it would have been more convenient and would have facilitated the work of the division psychiatrist to have a jeep similar to the transportation advantages of division chaplains.^{2(pp73-74)}

New Informal Theater Policy

During March 1951, an informal Far East Command Theater policy was gradually established that gave the division psychiatrist control over decisions for return to combat duty of psychiatric casualties who originated from combat personnel of his division. The policy was based upon experience that the division psychiatrist could more correctly estimate the potential of such casualties to perform combat duties than rear colleagues. When the division psychiatrist determined that a psychiatric casualty was temporarily disabled for combat, the initials DSB (Don't Send Back) were added to the

diagnosis of "Combat Exhaustion" on the Emergency Medical Tag. This decision was honored by psychiatrists at the Army level. Division psychiatrists were enjoined never to predicate the decision of the receiving psychiatrist as to fitness for non-combat duty in Korea or Japan by avoiding such a recommendation either directly to the patient or on the medical record. In such cases decisions for combat duty avoided iatrogenic trauma to patients who were not promised duty in Japan or evacuation to the ZI, thus allowing receiving psychiatrists to make their own disposition.

Division psychiatrists did not abuse their control over criteria for assignment to combat duty as uniformly they were motivated to maintain as many personnel as practicable on duty within the division. To further this goal division psychiatrists were active in obtaining reassignment within the division for battle-weary riflemen or other neurotically handicapped persons who could be effectively utilized at less strenuous positions in regimental and division headquarters or the service units of quartermaster, ordinance, and the like. The author has a distinct recollection that MAJ Hausman, 24th Infantry Division Psychiatrist, initiated the DSB technique.^{2(pp74-75)}

Administrative Discharges

Another aspect of informal psychiatric disposition involved personnel with so-called personality or behavior disorders who in peacetime received administrative discharges under AR 615-369⁴ and AR 615-368.⁵ Experiences in World War II and the Korean War indicated that few cases could be discharged under AR 615-369 in a combat unit because first, there was little time for administrative procedures and second, such a general discharge under honorable conditions would in the combat environment be construed as a reward for ineffectiveness with a consequent negative impact upon morale. Moreover in wartime with increased situational needs persons who fall under AR 615-369 can be profitably employed in non-combat assignments since their personality defects were not so severe as to preclude functioning under less stressful

conditions.

It was agreed that the division psychiatrist was to medically evacuate mild personality problems who could not be reassigned within the division. The next psychiatric echelon would then reprofile the evacuee and recommend a rear assignment. By this procedure, it was demonstrated that the bulk of such cases could and did function effectively. Even enuretics became useful rear soldiers when it was made clear that the problem was laundry facilities of which there was no dearth in Korea or Japan. Generally the enuretic was considerably less bothered by his uncomfortable habit when reassigned out of combat. In time discharge by AR 615-369 became rare in the entire Far East Command. Such a gain producing reward was impractical in an overseas wartime theatre. AR 615-369 was only utilized in severe instances of inadequate personality where it was clearly evident that marked ineffectiveness in military service duplicated a borderline civilian adjustment and the person was literally incapable of being motivated toward effective work of any kind.

Individuals with pathological personalities who belonged in the category of AR 615-368 for undesirable discharge were not evacuated through medical channels but were handled by administrative and disciplinary measures within the division. Such cases included narcotic and alcohol addicts, habitual shirkers, antisocial personalities, and chronic disciplinary problems. This policy was based on the assumption that such persons cannot be rehabilitated by reassignment. In actual practice, infantry divisions had few cases when in the combat zone. There was little opportunity for usual disciplinary disorders and AWOL was a serious offense at this time. Alcohol and drugs were scarce and addiction much less of a problem. In one infantry division (25th Infantry Division) only 12 AR 615-368 dispositions were made during 1 year of combat.

The Noneffective Combat Officer

The disposition of noneffective combat officers was resolved during

March 1951. Previously officers who demonstrated unsuitability as combat leaders at the company or battalion level, for whatever reason, were either evacuated through medical channels or referred for administrative action under AR 605-200.⁶ Neither method proved to be effective. On the one hand combat units did not have the time or administrative ability to cope successfully with the unwieldy process of AR 605-200. On the other hand medical evacuation was an obvious gain for poor duty performance. As a result Eighth Army in early March 1951 established a permanent 605-200 Board at the main Army Headquarters under direct supervision of the Eighth Army Judge Advocate General to process all cases that arose in Eighth Army. This action promptly removed the administrative burden from combat units who were then more willing to recommend this procedure rather than press medical officers to use medical evacuation. Because of more expert guidance and accumulated experience, the permanent 605-200 Board was able to readily accomplish the procedure assisted by prompt medical or psychiatric consultation as needed.

The utilization of the permanent Board proved to be an effective solution to this difficult problem. After 6 months of operation, 45 cases had been processed under AR 605-200 with 13 cases pending approval from Washington, DC. In this regard was demonstrated a major problem as final action from Department of the Army required about 3 months during which the individual concerned was useless to himself or others. During wartime it seems advisable to permit final action by the overseas Army or Theater Headquarters involved or allow return of the already boarded officer to the ZI to await final decision of Department of the Army.^{2(pp74-78)}

PSYCHIATRY AT THE ARMY LEVEL

In the early phase of this period, the 4th Field Hospital at Taegu with the psychiatric team of CPTs Kolansky and Cole continued to be the major psychiatric center of Eighth Army. There were no special changes in the clinical syndromes of psychiatric casualties at this time except a

proportional decrease of patients with free floating anxiety in favor of those with somatic complaints. Headache was most common followed by backache, fatigability, urinary frequency, and gastrointestinal disorders. Physical hardships from cold and inclement weather coupled with monotonous diet seemed almost as stressful to the soldier as combat trauma. Indeed battle casualties (KIA and admissions for WIA) during this period (January-April 1951) were decreased whereas admissions for disease and non-battle injury including frostbite were increased; also psychiatric casualties slowly decreased.

Thus mild injuries, disease and diagnostic problems comprised a high proportion of evacuees from combat areas. The trend toward treatment and disposition of such cases at the Army level (2nd echelon) rather than evacuation to Japan was especially fostered during this period. COL Hanson, the commanding officer (CO) of the 4th Field Hospital, strongly encouraged the professional staff toward treatment. He constantly improved and expanded the facilities of the hospital toward this end. It was his characteristic boast that the 4th Field Hospital had "beds unlimited" so that space requirements did not deter the hospital from holding patients for treatment. The salvage of men for duty was also stimulated by a directive from General Ridgeway, who enjoined the Army Medical Service to make all possible efforts toward prompt rehabilitation and prevention of unnecessary hospitalization or evacuation.^{7(p79)} In addition to the treatment of psychiatric casualties, CPTs Kolansky and Cole received a number of inpatients and outpatients from the many service units of Eighth Army. The main Eighth Army Headquarters was also located in Taegu, thus placing the psychiatric center of the 4th Field Hospital in a strategic position to give advice and consultation to the various administrative and medico-legal problems commonly encountered in a large headquarters.

From the beginning, CPT Kolansky established an excellent relationship with COL Silvers, the Judge Advocate General of Eighth Army. COL Silvers was pleased with the comprehensive reports that he received relative to referred disciplinary problems. He came to appreciate the psychiatric position which

insisted on administrative handling of ineffective officers and men rather than abusing medical evacuation channels.

In contrast to the policy of Eighth Army Headquarters was the stubborn refusal of 2nd Logistical Command (Pusan, Korea) to alter their stand that courts-martial was the proper method of elimination for the behavioral problems of enlisted personnel rather than administrative discharge. It was their fear that employment of administrative discharges would result in a wholesale loss of manpower. At best they agreed to consider a limited number of cases referred by local psychiatrists. 1LT (later CPT) Richard Conde (1 year civilian psychiatry residency) arrived at the 10th Station Hospital in February 1951 to initiate another psychiatric unit in Pusan. This was a welcome relief to overworked CPT Steve May whose psychiatric section of the 3rd Station Hospital (previously the 8054th Evacuation Hospital) was kept busy with consultations and referred patients from local organizations. 1LT Conde received the strong support of COL John Baxter, the CO of the 10th Station Hospital, who, like COL Hanson, was convinced of the need to hold patients for treatment and return to duty, rather than accenting the number of patients passing through the hospital. 1LT Conde combined forces with the orthopedic section in the treatment and evaluation of patients with backache and, by the use of hypnosis or pentothal interviews, demonstrated psychological causation in most cases with improvement.^{7(pp80-81)}

In the Prisoner of War Hospital for captured North Korean prisoners, Dr. Jun Doo Nahm lived up to expectations as he steadily enlarged the scope of the psychiatric section and demonstrated rare tact and ability to work with Korean psychiatric cases. All of his cases were carefully evaluated. Because Dr. Jun's professional training was mainly in descriptive psychiatry, considerable attention was paid to diagnosis and prognosis. But his approach to patients was one of concern and help. An ECT machine was obtained to be used mainly for psychotic disorders.

The 121st Evacuation Hospital after withdrawal from northeast Korea in late December 1950, was placed near Pusan for staging. In late January 1951

the hospital became operational at Toxond-Dong, about 20 miles from Taegu. Their site was a frozen rice paddy. Rarely has the author seen hospital personnel in such poor spirits. They were cold, miserable, living in tents, and off the main channels of evacuation. There was not even the stimulus of hard work which usually acts as a tonic to medical personnel. In late February 1951 the hospital was moved to Taejon. Morale promptly improved as all became occupied in establishing and operating a winterized hospital using the existing station hospital buildings as a nucleus. CPT Glasscock, the psychiatrist, maintained the psychiatric section at a high peak of interest. Initially, he received few patients in this location because conditions of the airfield at Taejon did not permit its frequent utilization and mainly mild surgical and medical cases evacuated by train were received. In late March 1951 the hospital moved to Yongdongpo near Seoul and in early April 1951 it was established in Seoul. Here, the 121st Evacuation Hospital was in the most favorable location to receive casualties from the combat area. The psychiatric section soon became quite active and at the close of this period an addition of another psychiatrist was contemplated.^{7(pp81-83)}

BASE SECTION PSYCHIATRY IN JAPAN AND OKINAWA

This phase saw further progress in the organization and development of psychiatry in Japan. One change was in the air evacuation of patients from Korea. The usual policy had been to evacuate the majority of cases by air to southern Japan from which most patients were transhipped by air or rail to hospital centers around Tokyo and Osaka. This method involved considerable duplication of handling and hospitalization in Japan which required additional personnel and delayed definitive treatment.

For sometime BG S. Hays, Surgeon, Japan Logistical Command, had endeavored to have air evacuation from Korea routed directly to the various hospital centers in Japan, but apparently there were insufficient planes for

this purpose. But in January 1951 direct evacuation as proposed was placed in operation. Each of the hospital centers in the Tokyo and Osaka areas were to receive 40% of the casualties from Korea with 20% sent to medical facilities in south Japan (Fukuoka area). Thus was created the then well known "40-40-20" distribution of evacuees from Korea based upon the number and types of hospital facilities in various areas of Japan.^{8(p84)}

From a psychiatric standpoint, the changes in air evacuation was fortunate because the three psychiatric centers were strategically located along the 40-40-20 axis, thus completely obviating the transfer of psychiatric patients within Japan. The location of the two convalescent hospitals near Tokyo and Osaka allowed for the triage of non-psychotic psychiatric casualties directly to the convalescent hospital, thus bypassing fixed hospitals in Tokyo and Osaka for a more realistic treatment environment. However, psychotic, neurological, or other severely ill neuropsychiatric patients were sent to fixed hospital facilities.^{8(pp84-85)}

The greater effectiveness of a convalescent hospital type environment over that of a fixed general hospital, in the treatment of non-psychotic psychiatric patients became quite evident in the early part of this period. As time passed, convalescent psychiatry was steadily exploited as indicated by accumulated evidence to insure a growing belief that only severe mental reactions, as psychoses or neurological disabilities required the facilities of a fixed hospital. The minor mental reactions, (combat psychiatric casualties) not only did not need to be in the "good beds" of a general hospital, but such accommodations served as a deterrent to recovery by increasing gain in illness through providing an artificial and suggestible atmosphere that militated against return to even non-hazardous daily tasks. Fortunately the two assigned psychiatrists, 1LT Francis Hoffman, at Nara Convalescent Hospital (near Osaka) and LTjg Richard Blacher, his U.S. Navy counterpart at Omiya Convalescent Hospital (near Tokyo), were enthusiastic young therapists. Both developed objective methods of brief treatment, learned to deal realistically with gain in illness complications, used

abreactive techniques of hypnosis and barbiturate interviews, and fully utilized the daily activities of the convalescent hospital to discourage tendencies toward neurotic helplessness.

At Omiya, Dr. Blacher treated about 350 patients during this period and performed 75 hypnotic and barbiturate interviews. The great majority of this caseload was returned to non-combat duty (90%). The remainder were transferred to the 361st Station Hospital because of psychotic manifestations or organic neurological disabilities. Similar results were obtained at the Nara Convalescent Hospital except that a larger percentage was returned to combat duty. The author believed that the reason for the difference was that the Osaka triage was more successful in sending patients directly to Nara Convalescent Hospital; whereas, in Tokyo it seemed almost impossible to prevent similar patients from being first sent to the 361st Station Hospital where 3.5 days were required to effect their transfer to Omiya Convalescent Hospital. Apparently even this brief period at a general type hospital was sufficient to produce a fixation of symptoms.^{8(pp85-86)}

Limited Duty Assignment

The many difficulties inherent in the reassignment of reprofiled (Limited Service) personnel were clarified during this period, also through the efforts of BG S. Hays, Surgeon, Japan Logistical Command. It will be recalled that in the early months of the Korean War, (July, August, September 1950) there was an improvised theater (FEC) policy that covered the return to duty of patients whose physical or mental defects permitted only a limited type service. But "Limited Service" had been deleted by Army Regulations following World War II. Because hospitals in Japan were still under the control of Eighth Army during this time, the Eighth Army Surgeon gave verbal permission to return suitable cases to limited type duty. The G-1 (Personnel) Section of GHQ FEC promptly changed this designation to "general service with waiver for duty in Japan only" to be accompanied by an appropriate change of

the physical profile on a temporary basis not to exceed 90 days. The geographical limitation to Japan was not a medical recommendation but a G-1 stipulation for the purpose of filling depleted service requirements in Japan.

The need for a limited service category is a virtual necessity in a wartime overseas theatre, otherwise large numbers of individuals would be medically returned to the ZI who were capable of performing service but not combat type duty. This procedure operated satisfactorily so long as there were sufficient vacancies in Japan. However, in January 1951, it became increasingly difficult to find non-combat assignments in Japan.^{8(pp16, 86)}

The entire problem of limited assignment was brought to a head by the following circumstances. In latter January 1951 GHQ FEC ordered the 34th Regimental Combat Team (RCT) reconstituted and put in combat readiness. This unit, previously a part of the 24th Infantry Division, had been withdrawn from Korea after severe losses in July and August 1950. There were no "pipeline" replacements for the project. The G-1 Section of GHQ FEC directed the utilization of recently reprofiled hospital returnees waiting at the Japan Replacement Training Center (JRTC) for limited assignment.

Due to an apparent misunderstanding the JRTC officials assigned all reprofiled persons to the 34th RCT, regardless of physical or mental defect. Replacements numbered about 1500, and included mainly individuals improved from frostbite, wounds, injuries, and disease. Former psychiatric casualties were about 1/6 (250) of the total group. The CO of the 34th RCT was informed that his training mission should be construed as a "sense of urgency." Accordingly he began a vigorous program designed to reach efficiency in several weeks. Curiously in none of the above arrangements was medical advice sought or obtained from either the medical section of GHQ FEC or the Surgeon, Japan Logistical Command.

The effects of strenuous battle training upon recent reprofilees was immediate, as sick call became inundated by hundreds of complaining and bitterly protesting soldiers who felt that promises made to them were broken and their mainly physical condition made it impossible to perform such duty.

BG Hays was made promptly aware of the problem from dispensaries and hospitals near Zama, the training area of the 34th RCT. He called for a general conference to reach a reasonable solution of the Zama situation. The meeting was attended by theatre medical consultants to the Far East Command (medical section of GHQ) including the author, representatives from G-1 and G-3 [operations] GHQ, General Hays and members of his staff and ranking officers of the 34th RCT. In the ensuing discussion it became obvious that there was confusion in use of the term non-combat duty, doubt as to accuracy of medical recommendations, and difficulties in finding suitable assignments for non-combat personnel in Japan. It was decided that a team of medical specialists would review all reprofiled assignments to the 34th RCT. It was also agreed to reexamine existing directives to prevent similar future difficulties.^{8(pp86-88)}

The medical team found that three-fourths of the reprofiled members of the 34th RCT were unfit for continuation of battle training. The remainder were permitted to continue with the unit, but with a decreased intensity of training. A medical and administrative group under the supervision of BG Hays brought forth the following changes in the utilization of limited duty personnel that were in the main, accepted and incorporated in directives of GHQ and Japan Logistical Command:

- (1) The limitation "for Japan only" was deleted from recommendations for assignment. This increased opportunities in the use of non-combat personnel for vacancies in rear Korea and Okinawa.
- (2) Reexamination was made mandatory for all reprofilees at the expiration of temporary disability. It should be realized that raising physical profiles of hospital returnees was necessarily temporary (up to 90 days) since Army regulations did not provide authority for permanent limited service except under special circumstances. Individuals found fit

for full duty were made eligible for combat assignment. Those still unable to perform full duty had their status continued for another period of one to three months. This procedure served to offset the ever increasing number of limited personnel. All previous reprofilees in Japan were reevaluated during February and March 1951. A surprising result was obtained from those in the psychiatric category when 30% to 50% were judged to be fit for full duty by many examiners in various areas of Japan. Although criteria employed for the determination of full duty were not uniform, psychiatrists were instructed to consider individuals fit for combat when free of overt anxiety or its somatic displacements, nightmares and insomnia, and when capable of considering return to combat duty without a recurrence of disabling symptoms. Examiners reported that many psychiatric reprofiles welcomed a full duty decision, expressing a desire to prove themselves and avoid feelings of inferiority that had been present since removal from combat. This formal process of reclaiming psychiatric casualties after several months of non-combat duty was a new practice in military psychiatry. Unfortunately no follow-up studies were performed to determine effectiveness after restoration to combat duty. However, on repeated questioning of division psychiatrists in later months, the author found it was rare to find a history of restoration to combat duty among their cases. Perhaps this apparent favorable result was due to rotation that became fully operational in May 1951 and gradually removed the personnel restored to combat duty. Despite the absence of more exact information as to effectiveness, there is sufficient data to indicate that such a reclaiming process as so stated is of

much benefit and should be given further trials in future wars. [FDJ: Israeli experience with psychiatric casualties of the 1973 war who were returned to combat duty in the 1982 Lebanon War showed this same lack of increased psychiatric breakdown.] There are powerful forces which impel psychiatric casualties to return to combat. They are discernible in battle dreams and irritability of the psychiatric casualty who constantly returns to the traumatic situation that he was unable to master. When forward psychiatry operates effectively, salvageable psychiatric casualties were usually returned to duty at division or army level. But when circumstances did not permit efficient combat psychiatry as occurred early in the Korean War, many reclaimable psychiatric cases were rapidly evacuated and placed in non-combat assignments.

- (3) Hospitals were enjoined to give special consideration to accuracy in reprofiling and required to create a special board of senior medical officers (Chiefs of Service) to review and approve all profile changes made by members of the medical staff. It was further stipulated that the physical or mental limitations stated on the individual disposition form be in understandable lay terminology in order that proper placement was facilitated.^{8(pp88-90)}

Arrival of Psychiatric Assets in Theater

279th General Hospital

A major event during this period, was the arrival in Japan of three numbered general hospitals. The 279th General Hospital became operational in early March 1951 at Camp Sakai near Osaka; the 382nd General Hospital was established also near Osaka at Konoka Barracks and began receiving patients in

latter March 1951. The 343rd General Hospital was placed on a standby basis at Camp Drew, 50 miles from Tokyo, and did not become operational until 1 October 1951. The pre-existing psychiatric facilities in Japan were adequate for current and future foreseeable needs. Accordingly it was proposed and accepted by BG Hays that the three new general hospitals delete their planned psychiatric services except for consultative functions. The personnel thus made available would be absorbed in other psychiatric assignments as needed.

The 279th General Hospital arrived with a complete complement of psychiatric personnel as follows:

MAJ Marvin Lathrum	board certified psychiatrist, civilian psychiatric training
CPT James Reilly	2 1/2 years civilian neurology residency under Army auspices
1LT Otto Thaler	6 months civilian psychiatry residency
MAJ Susan Stimson	psychiatric social worker
1LT George Humiston	clinical psychologist

A full quota of enlisted neuropsychiatric ward technicians, psychological assistants, and social work assistants, including six nurses with special psychiatric training, was available.

Arrangements were made to utilize the psychiatric staff of the 279th as follows: Their major function was to provide psychiatric consultative services for the entire Osaka-Kobe-Kyoto region. More specifically MAJ Lathrum and his staff became responsible for consultations from the 8th Section Hospital at Kobe and the 35th Section Hospital at Kyoto besides referrals from his own hospital and the 382nd General Hospital. It was agreed that MAJ Lathrum was to maintain an open neuropsychiatry ward for the diagnosis and treatment of referred patients considered to warrant further study or recoverable by brief psychotherapy. All closed ward patients were to be transferred to Osaka Army Hospital that had closed ward facilities and ECT apparatus. MAJ Lathrum found it convenient to visit one day each at Kobe and

Kyoto on a regularly scheduled basis. This avoided travel by patients, enabled MAJ Lathrum to become familiar with local problems, and allowed him to furnish written reports as well as to be available to discuss findings in appropriate cases with referring line or medical officers. Generally he was accompanied by MAJ Stimson on these visits. The 279th General Hospital received no patients directly from Korea as they were triaged directly to Nara Convalescent or Osaka Army Hospitals. These various functions allowed for the effective utilization of MAJ Lathrum and some specialized personnel. The remainder were absorbed by other psychiatric units, mostly in Japan.

382nd General Hospital

The following officer personnel were included in the psychiatric service:

CPT Avrohm Jacobson	completed civilian psychiatry residency and board certified
CPT Pust	2 years experience with chronic mental patients in a VA Hospital
CPT Dunaef	2 years civilian psychiatry residency under Army auspices
1LT Gordon McKay	psychiatric social worker
1LT Philip Barenberg	clinical psychologist

CPT Jacobson was delayed, arriving in the theater in late April 1951. He was sent to the Nara Convalescent Hospital to aid 1LT Hoffman and become familiar with this type of treatment. CPT Dunaef and 1LT Barenberg were sent to the Neuropsychiatry Service of the 141st General Hospital in early April 1951. CPT Pust was permitted to continue his work as an anesthetist on the surgical service of the 382nd General Hospital. He was not particularly interested in psychiatry. 1Lt McKay was eventually transferred to the 361st Station Hospital in Tokyo.

118th Station Hospital

With decrease of the casualty flow through southern Japan after implementing the 40-40-20 ratio of patient distribution from Korea to Japan, the 118th Station Hospital and the 141st General Hospital received relatively few psychiatric admissions; but, the 118th Station Hospital, steadily increased its outpatient function. CPT Allerton of the 118th Station Hospital assisted by 1LT Pamela Robertson (psychiatric social worker) continued to maintain a small number of inpatients, but most of CPT Allerton's caseload comprised evaluation and treatment of referred outpatients. In the course of time, CPT Allerton could not fail to note the relative frequency of referrals from nearby units. This led to a discussion with BG Hays, Surgeon, Japan Logistical Command to determine what channels, if any, could be used to transmit such information. It was evident that while the frequency of disciplinary and psychiatric disorders fall in the realm of preventive psychiatry, any remedial action was the very essence of command. BG Hays informally transmitted information gathered on one organization which was investigated by General Clark, the Commanding General of the Southwest Base Command that included southern Japan, who found evidences of poor leadership with mismanagement and lowered unit morale. Thus BG Hays demonstrated that the channels required should be comparable to those employed with the bimonthly division psychiatric reports which are routinely sent to the Commanding Officer of each combat Division through the Division Surgeon.

141st General Hospital

In early March 1951 LTC H. Wilkinson, Chief of the Neuropsychiatry Service, was medically evacuated to the ZI. He was replaced by MAJ Henry Segal from Tokyo Army Hospital who reorganized and further developed the Neuropsychiatry Service. Plans were made and approved to rebuild the closed facilities. ECT apparatus was obtained and placed in operation.

Osaka Army Hospital

The Neuropsychiatry Service of Osaka Army Hospital became a smoothly functioning team under LTC Philip Smith. It was further strengthened by the addition of 1LT F. Hammer, clinical psychologist. A study of self-inflicted wounds (SIWs) was begun at this time to determine if any specific personality traits or dynamic mechanisms could be demonstrated.

361st Station Hospital

The Neuropsychiatry Service of the 361st Station Hospital continued to function as the major center for psychiatry and neurology in the Tokyo-Yokohama area. However, the policy of decentralization had steadily decreased the inpatient census until it remained fairly constant at about 150 psychiatric and neurological patients of all types including prisoners for pre-trial examination. More than half the patients came from local sources. New arrivals to the Neuropsychiatry Service, 361st Station Hospital included:

1LT L. Laufer	2 years civilian psychiatry residency
CPT James Rafferty	1 year civilian psychiatry residency under Army auspices
MAJ Philip Steckler	board certified psychiatrist, completed 3 years civilian psychiatry residence and necessary professional experience
LTjg Mariner	enlarged the scope of the psychiatric outpatient and consultation service at the 155th Station Hospital Yokohama

In February 1951, he was joined by LTjg Austin (1 year civilian neurology residency) who, soon became fully occupied with neurological referrals both inpatient and outpatient. An account of their experience can be found in the Symposium of Military Medicine in the Far East Command (FEC) published as a Supplemental Issue of the Surgeon's Circular FEC, September 1951.

CPT James Corbett (2 1/2 years civilian psychiatry residency) replaced MAJ Segal as psychiatric consultant at Tokyo Army Hospital. Also at Tokyo

Army Hospital, CPT Philip Dodge (1 year civilian neurology residency under Army auspices) worked with both the neurosurgical and medical services as neurology consultant. He organized weekly evening seminars on neurological topics which was given strong support by LTC William Caveness (board certified neurologist), Chief of Neurology US Naval Hospital at Yokosuka near Tokyo. The evening seminars were well attended by neuropsychiatry specialists from the Tokyo - Yokohama area.^{8(pp90-94)}

40th and 45th Infantry Divisions (National Guard)

The 40th and 45th Infantry Divisions (National Guard) arrived in Japan during March and April 1951. The 45th Infantry Division from Oklahoma was sent to Hokkaido, the northern island of Japan, and the 40th Infantry Division from California to the northern area of Honshu, the main Japanese island. Both divisions had as their mission the defense of Japan, and both began active training programs calculated to reach combat readiness as soon as possible. Each division arrived with a psychiatrist. In the 45th Infantry Division MAJ H. Witten (3 years civilian psychiatry residency and board eligible) was properly assigned as the division psychiatrist and prepared to function as such. It was arranged that MAJ Witten would also act as psychiatric consultant to the 161st Station Hospital in Sapporo, Hokkaido, the hospital support for the division. The 40th Infantry Division refused to assign CPT Bramwell (2 years civilian psychiatry residency) as division psychiatrist because of a shortage of medical officers and their insistence that he was needed as the clearing company commander. It was agreed that CPT Bramwell would be released to serve as the division psychiatrist when additional medical officers were assigned to the division; but, this did not occur until August 1951.

Here was another instance of the misuse of division psychiatrists either due to ignorance of their functions or an inability to appreciate the need for all efforts to prevent loss of manpower. The contention of the 40th Infantry Division Surgeon that he lacked sufficient medical officers was technically

correct. But of the 15 medical officers in the division that were available, four (the division surgeon, the medical inspector, the CO of the Medical Battalion, and the clearing company commander) were utilized in mainly administrative duties. Yet the largest loss from the division at this time came from persons hospitalized for anxiety or vague somatic complaints; thus, it seemed unrealistic at such a time to be without a division psychiatrist while four medical officers were not professionally utilized. The author's suggestion that the CO of the Medical Battalion who had few professional duties also act as the clearing company commander fell on deaf ears.^{8(pp94-95)}

Psychiatric Problems on Okinawa

Psychiatric problems on Okinawa increased to troublesome proportions during this period. The early phase of the Korean War saw a depletion of the Okinawan garrison for services in Korea and a subsequent decrease in the psychiatric caseload. 1LT Daniel Casriel (8 months civilian psychiatry residency), replaced CPT Clements (1 1/2 years Army psychiatry residency) who was returned to the ZI in November 1950 to complete residency training. Psychiatric consultations during this time were less than 100 per month with a small inpatient census of 10-15 per month. 1LT Casriel was assisted by a civilian clinical psychologist and several enlisted social workers.

In December 1950 and January 1951 there began a rise in psychiatric consultations as the strength in Okinawa was increased in both ground and air elements. As the winter months brought its discouraging tide of battle and continuation of the lengthened tour of duty in Okinawa, there ensued inevitable loss of morale that occurs when military personnel stationed on an island do not have an obvious mission or stated length of time to serve. The result was a sharp upswing in disciplinary problems, psychiatric referrals, and suicidal attempts.

A visit to Okinawa by the author in early April 1951 confirmed the impression of typical irritability and low morale common in an island setting

with little effort made to utilize recreational, social, and other outlets that were available. Despite the increase of suicidal attempts, there had been no fatalities from this source since the onset of the Korean War. In the author's opinion, this fact demonstrated such attempts were not the result of serious intrapsychic conflict but rather represented anger against the environment with an effort to influence the outside world. The attitude of many on Okinawa that they were neglected, unappreciated, and not given due consideration, was even shared by senior officers. Any attempt to make favorable comparisons of their situation with those fighting or living in Korea, brought forth angry outbursts that displayed an oversensitivity toward any argument that seemed to be against their right to complain and feel unhappy. It was clear that while living conditions on Okinawa were not elegant and there were decreased opportunities for recreational and social outlets, the major difficulty was the need for a definitely stated tour of duty.

1LT Laufer (2 years civilian psychiatry residency) was sent to Okinawa to join with 1LT Casriel, so as to enlarge the psychiatric facilities required for the increased patient load. An enlisted psychologist was transferred to Okinawa from the 361st Station Hospital to replace the civilian psychologist who had returned to the ZI. It was recommended that certain behavior and disciplinary problems characterized by restlessness and aggression in persons with a relatively good military record prior to Okinawa be transferred to the replacement center in Japan for shipment to combat units in Korea. This procedure, which became known as "Operation Vital," functioned quite effectively to salvage worthwhile soldiers who found it difficult to tolerate monotony and welcomed a change that gave an opportunity to externalize aggression.

It was believed that morale in Okinawa was certain to improve in the future as the reestablishment of a stated length of a tour of duty was expected. Dependent travel had resumed in April 1951 and was to continue in larger increments since considerable housing construction was nearing

completion. In general the building program was making good progress with a reasonable expectation of providing better barracks, roads, and recreational projects.^{8(pp96-97)}

Discharge of Undesirable Personnel

The elimination of undesirable personnel by the provision of AR 615-368 came up for considerable discussion during this period. There were many inconsistencies in the use of this regulation in Japan as various local headquarters utilized individual interpretations relative to what constituted proper criteria for administrative discharge from the service. In some instances, as in the 2nd Logistical Command in Korea, no cases were approved for discharge; court-martial was deemed the logical method of elimination. They feared that undesirable discharge by AR 615-368 would result in a wholesale loss of manpower. In other instances AR 615-368 was used freely as a punitive measure. The entire question was taken up with BG Hays, who submitted a more uniform procedural data to MG Walter Weibel, the Commanding General (CG) of Japan Logistical Command. This resulted in a well written directive on the subject by Japan Logistical Command Headquarters, to its subsidiary branches. In time, there was definite improvement as indicated by a decrease of referrals for alcohol addiction, chronic behavior disorders, and various other pathological personalities who were a burden to their units and not amenable to any type of punishment or treatment.^{8(pp97-98)}

In the above connection, the question of narcotic addiction will be mentioned. Before the Korean War, narcotic addicts were well known to be relatively common, particularly among American troops based in port cities of Kobe and Yokohama in Japan, and also Pusan, Korea. As in civilian life this problem was difficult to control, especially so in the Far East where opiate drugs were cheap and easy to obtain. Previous attempts to solve narcotic addiction by lectures to the troops, unannounced inspections for drugs, and undercover investigations by the Central Intelligence Division (CID) had not

been successful. At this time it was stated that there had been no increase in narcotic addiction since the onset of hostilities in Korea. This statement was later found to be erroneous.

Also, at this time, it seemed logical to conclude that the prompt removal of confirmed narcotic addicts by AR 615-368 would decrease the extent of the problem and prevent to some degree the contamination of susceptible soldiers. Further, it was argued that action should be taken whenever the diagnosis of narcotic addiction could be made by the psychiatrist on the basis of withdrawal symptoms, the presence of typical venous puncture marks, and a characteristic history in an effort to present evidence to warrant trial by court-martial.

However later experiences and investigations indicated that most of the above state characteristic manifestations of narcotic addiction were found to be incorrect as follows:

- (1) The well known withdrawal symptoms seldom occurred when confirmed users were held in locked wards of a psychiatric service. Also, the lack of withdrawal symptoms was found related to the relative youth of subjects and the low dosage of opiates involved. Civilian experience with teenage addicts demonstrated that little or no distress was exhibited during drug withdrawal.
- (2) Moreover there was some evidence that the withdrawal syndrome was a learned process compounded out of physical discomfort from physiological dependence and anxiety from psychological dependence. Thus, teenage users at the Federal Narcotic Hospital in Lexington, Kentucky had severe withdrawal symptoms in contrast to the mild or no distress displayed by similar youthful offenders incarcerated in hospitals such as Bellevue in New York City. Presumably association with confirmed and older offenders at the federal institution may have influenced the newcomers to

exhibit a heightened response to drug withdrawal.

- (3) Experience with physical inspections indicated that needle scars must be looked for not only in the forearms, but also in the feet, legs, buttocks, neck and abdomen. Random and well distributed needle scars could readily be explained away by suspects who rarely exhibited weight loss or physical stigmata that characterizes confirmed and older addicts. [FDJ: Furthermore a habit can be maintained by nasal inhalation (snorting) heroin, the preferred route during the subsequent Vietnam War.]

In general, psychiatry in the Far East Command did not foster or favor punitive discharges either by AR 615-368 or by courts-martial. Such a discharge only further handicapped the antisocial or disciplinary problem in civilian life. Various efforts were made including transfer of narcotic addicts from port cities to remove them from supply sources after complete withdrawal was accomplished.

It was further proposed that senior noncommissioned officers of port companies serve as "vigilantes" in protecting their men against known suppliers of narcotic drugs to their organizations. Also proposed was the selective reassignment of completely withdrawn addicts to combat units where opiate supplies were as yet unknown. However none of the above noted later proposals were placed into operation during the author's tour of duty in the Far East Command which ended 13 September 1951.^{8(pp98-99)}

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Chapter 10

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Chapter 11

TRUCE NEGOTIATIONS AND LIMITED OFFENSIVES BY THE UNITED NATIONS

(10 July 1951 - 1 October 1951)

By Albert J. Glass, MD, FAPA

The beginning of truce talks in July 1951 continued for several weeks the lull in ground activity that began in latter June 1951. Soon it became apparent that optimism regarding an early end to the Korean fighting was not warranted.

Limited United Nations' Offensive Actions

Offensive moves by United Nations' forces began in latter July 1951 and were periodically renewed in August and September 1951, when severe combat produced a large number of battle casualties. The attacks were aimed toward improvement of United Nations' positions, particularly in the east central sector in order to obtain a shorter and more defensible battle line. These efforts were largely successful, but the capture of stubbornly defended hill masses was a slow and painful process. Although patrol actions and limited engagements took place in the western area, the units in the east central zone, particularly the 2nd Infantry Division, the 1st Marine Division, and to a lesser extent, the 7th Infantry Division, and the 24th Infantry Division, bore the brunt of offensive combat during the period.

The Psychiatric Rate

The psychiatric rate was only slightly elevated in response to increased battle casualties. This was especially true in September 1951 when the psychiatric rate rose to 36/1,000/year from the August 1951 rate of

32/1,000/year despite an increase of battle casualties from 68/1,000/year in August to 227/1,000/year in September.

Influence Of Rotation

Perhaps the principal reason for the continued relatively low incidence of psychiatric admissions was the influence of rotation. For this reason any adverse reaction from the pessimistic progress of the peace talks was not evident. Relief from combat had become an individual affair obtainable by the person regardless of the outcome of negotiations. Rotation became the chief topic of conversation among troops in Korea; for, upon it depended their hopes and dreams. As practiced in the Korean War, it was a new phenomenon for American combat forces.

While rotation was a mighty step forward in preventive psychiatry and already has proved its value, there were inevitable and undesirable by products. The most pertinent defect of rotation, aside from logistical problems inherent in such a mass replacement of personnel, lies in the disruption of the sustaining power of group identification that occurred when the combat veteran was notified or became aware that soon he will rotate home. The increase of tension that followed was well known. Such a person has been aptly named the "short timer."

The "short timer" has shifted his thoughts and feelings away from the group; and, often for the first time, battle fear became unbearable as now all of his love was returned to the self. Emotionally at least the "short timer" was disengaged from his buddies and only concerned about himself. The subsequent rise in anxiety produced in some an inability to function and mental breakdown. In most, tension noticeably increased in the last few days of combat as if it were now dangerous to tempt fate. One could often hear stories, undoubtedly exaggerated, of the unlucky person who was killed the day before being scheduled to leave on rotation.

Others of the group readily identified with the "short timer" as

demonstrated by spontaneous actions of units in sending rotatees to rear safe positions or insuring relief from patrol or similar hazardous duties. The "short timer" often had mixed feelings about leaving as ties to buddies did not loosen so easily. However it was rare for one to give up the rotation opportunity as such behavior would be regarded as queer or unusual by the group. An excellent description of combat rotation problems by the 25th Infantry Division psychiatrist, MAJ Krause, can be found in Appendix I. (Here the "short timer" was labeled the "short timer's attitude".)

Perhaps the most effective form of rotation would be removal of entire combat units or at least its older or original members. However, such a process would be most difficult to accomplish from a logistical standpoint.

Misassignment Of Limited Service Personnel

The misassignment of reprofiled (limited service) personnel to combat units was satisfactorily corrected in late July 1951. An Eighth Army circular (see Appendix II), clearly set forth the utilization of limited type personnel by service units and enjoined against return to their original combat unit. This directive also made official in Korea a policy of mandatory periodic reevaluations of personnel classified as "general service with waiver," identical with the procedure in Japan. Individuals found fit for full duty were available for reassignment to combat units. Subsequent follow-up surveys with division surgeons and psychiatrists in August and September 1951 confirmed that the policies laid down in the Eighth Army directive were being carried out.

2nd Infantry Division Psychiatry

The 2nd Infantry Division had taken a major share of the uphill offensive fighting. As a result, MAJ Bolocan was perhaps the most busy of the division psychiatrists during this period. He collaborated with Brigadier

General (BG) Bootner, the assistant division commander, in establishing an intradivisional training program for replacements that was probably the most comprehensive effort of this type. A copy of the 2nd Infantry Division training memorandum is included as Appendix III. The report of MAJ Bolocan that led to the adoption of the replacement training program is listed as Appendix IV.

Combat Psychiatry For Battalion Surgeons

Periodic visits by division psychiatrists to Battalion Aid Stations strongly encouraged and influenced battalion surgeons to participate in the evaluation and treatment of combat exhaustion. More and more the first echelon of psychiatric treatment became the battalion aid station and the collecting station in suitable cases, particularly in secure tactical situations. To further this program CPT Glasscock, the 3rd Infantry Division Psychiatrist, distributed a divisional memorandum, a copy of which is included as Appendix V.

Rotation Of Psychiatrists

In latter July 1951 among the first medical officers rotated to the ZI were the following two division psychiatrists: CPT Paul Stimson, veteran psychiatrist of the 1st Cavalry Division, had served continuously with his division since latter August 1950. He was one of the pioneers of combat psychiatry in the Korean War. His well-deserved promotion to major was approved while he was in Japan awaiting shipment home. CPT R. Cole became the 1st Cavalry Division Psychiatrist by volunteering for this position from Japan. MAJ W. Krause was the second division psychiatrist to earn rotation. He had been in Korea since 7 July 1950, but with the 25th Infantry Division since October 1950. He was replaced by CPT (later MAJ) Robert Yoder (3 years civilian psychiatry residency), formerly assigned to the United States Air

Force Hospital at Nagoya Japan. Both incoming division psychiatrists were oriented by their predecessors and had no difficulties in maintaining the high level of the two psychiatric programs.

In mid-September 1951, MAJ T. Glasscock (1 year civilian psychiatry residency), 3rd Infantry Division Psychiatrist, was returned to the ZI to resume residency training. He was replaced by CPT Dermott Smith who also volunteered for a divisional post from Japan.¹

PSYCHIATRY AT THE ARMY LEVEL

121st Evacuation Hospital

The 121st Evacuation Hospital continued to serve as the principal psychiatric center of Eighth Army throughout this period. The psychiatric service had developed excellent physical facilities sufficient to care for 100 patients. MAJ Segal, head of the service who replaced 1LT Jensen, began reorganizing the Neuropsychiatric Service. He was given invaluable support by MAJ Ralph Morgan, psychiatric social worker, who arrived in early August 1951.

His assignment was facilitated by COL Page, the new Eighth Army Surgeon. MAJ Morgan took over most administrative details, assisted in consultations, oriented new admissions, began group therapy sessions, and supervised the recreational program. An enlisted clinical psychologist joined the service in late August 1951, and another psychiatrist, 1LT Alan Clarke, (1 year civilian psychiatry residency) was added in September 1951. The gradual shift of Eighth Army Headquarters from Taegu to Seoul brought the psychiatric staff in greater contact with administrative and medico-legal problems that required psychiatric consultation.

The Psychiatric Team

Experiences in the utilization of psychiatrists at Army level in Korea

had consistently demonstrated the value of the psychiatric team. Such a professional team functions in a similar manner to a surgical team. The small group of trained personnel could be moved to any medical facility that was strategically located to receive casualties, be it a separate clearing company, field hospital, or evacuation hospital. When there was continued static warfare as in World War I or a large production of psychiatric casualties as occurred in the European Theater of Operations (ETO) of World War II, a separate psychiatric unit may be preferable. In Korea, with its many tactical reverses, difficult transportation problems, and at times dangerous rear areas, especially in the first year of the Korean War, it was necessary to have alternate or reserve treatment capabilities. The psychiatric team could begin functioning almost immediately in any unit that provided housekeeping facilities. Eighth Army accepted the elastic use of psychiatric personnel and agreed to utilize MAJ Morgan and a psychiatrist of the 121st Evacuation Hospital as the psychiatric team that would be moved in the event the 121st Evacuation Hospital was dislocated or psychiatric casualties became large at another hospital.

Professional Medical Consultants at the Army Level

COL Paige, Surgeon Eighth Army, appeared to be more receptive than his predecessor to the acceptance of professional consultants on his staff. In September 1951 he agreed to an Eighth Army Surgical Consultant and indicated that perhaps consultants in medicine and psychiatry would be included in the near future.

11th Evacuation Hospital

In mid-September 1951 the 11th Evacuation Hospital moved forward from Chungju to above Wonju. The new site was conveniently located for air and

rail transportation so that the hospital was in position to play a more active role by receiving casualties directly from forward units. CPT Levy, the assigned psychiatrist, had previously only a small caseload but the future might make this unit of larger importance as a psychiatric center.

4th Field Hospital

The 4th Field Hospital in Taegu had become a relatively minor medical facility with a low patient census. Thus the psychiatric section headed by CPT Corbett was relatively inactive.

Pusan Area

The Pusan area remained important as a major communication zone, a port facility, and a reserve hospital center for battle casualties. In September 1951 COL Paige, Surgeon Eighth Army, agreed to a consolidation of the psychiatric section of the 3rd and 10th Station Hospitals.

Discharge by AR 615-368 Versus Courts-Martial

A final effort was made in September 1951 to influence 2nd Logistical Command (Pusan area) to alter their opposition toward discharge by AR 615-368² in appropriate cases rather than discharge by courts-martial. A conference was held with Brigadier General (BG) Yount, the Commanding General, 2nd Logistical Command. In this meeting the author was supported by five senior medical officers from the Pusan area and the Medical Section, GHQ, FEC. A thorough airing of conflicting viewpoints occurred between the Chief of Staff 2nd, Logistical Command and the author. The conference ended with BG Yount's decision that undesirable individuals in the 2nd Logistical Command would be eliminated by AR 615-368.

It was further arranged that copies of the psychiatrist's recommendations for such a discharge be sent directly to BG Yount's headquarters to insure that action would be taken. Apparently this meeting brought results as follow-up information by reliable sources found that by early December 1951 13 cases had been processed and discharged by AR 615-368 in the Pusan area.³

BASE SECTION PSYCHIATRY

There was no essential change in the organization and operational procedures of psychiatry in Japan during this period. The decentralization policy for psychiatric patients along with an emphasis on outpatient and convalescent type therapy for minor reactions was by this time a well established development. Major mental disorders, neurological cases, and diagnostic problems were hospitalized at one of three well-staffed neuropsychiatric centers, each equipped with closed ward facilities, ECT apparatus and an EEG machine.

Visit by Colonel Caldwell

COL John Caldwell, Chief of the Psychiatry and Neurology Consultant Division, Office of the US Surgeon General, visited the theater in latter July 1951. He made a comprehensive tour of psychiatric units in Korea and Japan. COL Caldwell offered valuable suggestions on psychiatric policies, personnel, and organization.

Important Changes in Rotation

Two important improvements were made in the reassignment of limited duty personnel in late July 1951. The first and most important change was brought about by a GHQ FEC request for an extra rotation quota in order that some of

the combat personnel reprofiled to non-combat duty, because of wounds or disease, could be returned home. The request was granted in part. Authority was given for a rotation quota of up to 200 reprofiled Korean veterans per month, who could not be effectively utilized in the Far East Command (FEC). A conference with the G-1 and AG sections of GHQ produced agreement that selections for the additional quota be made at the Japan Replacement Training Center that served as the funnel through which all hospital returnees designated "general service with waiver" were concentrated. It was further agreed that LTC Buhrig, the capable surgeon of the Japan Replacement Training Center, would make the actual selections based upon length of combat service in Korea, the number and severity of battle wounds incurred, and the total length of service in the FEC that must include combat. Only the most deserving Korean combat veterans would be chosen for return to the ZI under this additional quota. The rotation of limited service personnel began 1 August 1951. Two months of operation proved that the above criteria for selection could be carried out in a practical manner. It operated to prevent return to Korea of non-combat personnel who were sufficiently high in rotation eligibility so that a new assignment would have been only temporary. At the same time it lessened the assignment problems in Korea for non-combat positions.

The second and relatively minor change arose out of the need to assign certain limited personnel specifically in Japan rather than Korea. Individuals in this category included epilepsy controlled by medication, tension states in persons of marked passive personality, and injuries or organic disease that were improved but required routine treatment or evaluation. Arrangements were made with the AG (Adjutant General) of GHQ to permit up to 25 so-called convalescent assignments per month. The selection of cases would again be determined by LTC Buhrig at the Japan Replacement Training Center upon the request of the particular professional service in which the individual was hospitalized. The procedure also operated successfully in that greater elasticity in assignment for special cases was

provided.

New Arrivals to the Theater

New arrivals to the Far East Command in later July and August 1951 were:

1LT T. Sclhaug	7 months civilian psychiatry residency
CPT William Lorton	1.5 years civilian psychiatry residency
1LT Frank Norbury	1 year civilian psychiatry residency

In September 1951, the following professional neuropsychiatric personnel arrived in the theater:

CPT Samuel Bullock	3 years civilian psychiatry residency
CPT Rhead	2 years civilian psychiatry residency
1LT Thorndike Troop	1 year civilian psychiatry residency
1LT Walter Easterling	1 year civilian psychiatry residency
1LT Bernard Hanson	1 year civilian psychiatry residency
1LT Francis Vazuka	1 year civilian neurology residency

In addition, CPT Harold Collings MC (Medical Corps) RA (Regular Army) was transferred to the 361st Station Hospital both to initiate training in neurology, that he requested, and to aid CPT Reilly in the large neurological caseload at the 361st Station Hospital.

The usual indoctrination lectures by the author and other senior medical officers were held with both groups of incoming psychiatrists and neurologists at the 361st Hospital in Tokyo. With addition of the September 1951 arrivals the theater was in an excellent position insofar as the availability of psychiatrists was concerned.

Changes of Assignment

Assignment changes of neuropsychiatry personnel in Japan during this period were as follows:

In July 1951 1LT Gordon McKay, psychiatric social worker was transferred from the 382nd GH to the 361st Hospital to replace Major Morgan.

In August 1951 1LT George Humiston, clinical psychologist, was transferred from the 279th General Hospital to Okinawa. 1LT Pamela Robertson, psychiatric social worker, from the 118th Station Hospital, was assigned to the 361st Hospital in Tokyo. Also in August 1951 CPT Lorton was sent to Nara Convalescent Hospital to understudy 1LT Hoffman and perhaps serve as his replacement in the event 1LT Hoffman was transferred to Korea. At the same time 1LT Sclhaug was assigned to Omiya Convalescent Hospital for training with CPT Dermott Smith. MAJ Lucinda DeAguiar was given a 30 day compassionate leave in August 1951.

In September 1951 1LT Sclhaug replaced CPT Smith, who became the 3rd Infantry Division Psychiatrist. Also in September 1951, 1LT Vazuka was assigned as neurologist to the Neuropsychiatric Service of Osaka Army Hospital, a position that had been vacant since July 1951. In this month also CPT Rhead was sent to the Neuropsychiatric Service of the 141st General Hospital.

Change of Theater Consultant in Psychiatry

On 19 August 1951 COL Donald Peterson arrived in the FEC to assume the position of Theater Consultant in Psychiatry. COL Peterson and the author made a complete tour of psychiatric facilities in Korea so that he could obtain a first hand acquaintance with the various psychiatrists and their special situations. A similar tour was made of most psychiatric facilities in Japan. COL Peterson also collaborated in the indoctrination talks for incoming personnel at the 361st Station Hospital. In general it was the

author's belief that COL Peterson became well oriented on the various neuropsychiatric problems in the Far East Command. The author left the FEC on 10 October 1951.

This concludes the history of psychiatry in the Korean War up to this author's departure. An integral part of this review not previously mentioned was the splendid cooperation and strong support given the psychiatric program by various members of the medical sections of GHQ FEC, Japan Logistical Command, and Eighth Army.³¹⁴

[FDJ: This ends COL Albert Glass's contribution to this volume except for appendiceal material. When COL Glass arrived at Far East Command, psychiatry was in disarray with combat stress casualties erroneously being evacuated out of country and often back to CONUS. This is reminiscent of the disastrous policies in the beginning of World War II in North Africa in which stress casualties became psychiatric cripples by being evacuated out of combat to languish in VA hospitals in the United States.

COL Glass quickly established correct policies for treating stress casualties with steadily increasing numbers of casualties being returned to combat or non-combat duty reaching 80-90% in the latter months of COL Glass's tour. Following COL Glass's rotation, COL Donald Peterson was theater Neuropsychiatry Consultant until the war ended. Both he and COL Glass were later Psychiatry and Neurology Consultant to the Army Surgeon General. MAJ (later COL) Ralph Morgan became the Social Work Consultant to the Army Surgeon General and CPT (later COL) William Hamill specialized in neurology and as a reservist served as Neurology Consultant to the Army Surgeon General.

COL Glass achieved fame in the military and civilian psychiatric community. He edited the two-volume definitive history of military psychiatry in World War II and was working on this history of military psychiatry in the Korean War when he died suddenly at his desk.]

Chapter 12
MILITARY PSYCHIATRY AFTER THE FIRST YEAR OF THE KOREAN WAR

By Franklin D. Jones, MD, FAPA

The United States had been engaging in a massive demobilization at the end of World War II. The Army was reduced from 89 divisions and 8 million men in 1945 to 10 divisions and 591,000 men in 1950.^{1(p540)} When the North Koreans crossed the 38th parallel to invade South Korea on Sunday, 25 June 1950, the United States had only a small advisory group in the entire country. The United States was able to gain support from the United Nations to counter the North Korean aggression since the Soviet Union had refused to participate in the United Nations because of its refusal to seat Communist China in place of the defeated Nationalist Chinese.

Chartered in San Francisco in 1950 with 50 member states, the United Nations had been unable to take action against communist aggression previously because of the veto power accorded to the Soviet Union (as well as the United States, the United Kingdom, France, and China). This absence allowed the United Nations to pass a resolution supporting military action in Korea.

In early battles the Republic of Korea (ROK) forces were crushed followed by the defeat and retreat of a hastily assembled and undersupported group of 540 Americans (Task Force Smith) dispatched from elements of the 24th Infantry Division in Japan. Three later American delaying actions with larger forces failed and by August 1950 United Nations forces were reduced to a small foothold in the southernmost part of Korea (Pusan perimeter). General MacArthur placed ground troops in the Eighth Army under the command of General Walton Walker. On 15 September 1950 General MacArthur counterattacked at the Incho'on harbour in an amphibious maneuver that ultimately cut off most of the North Korean forces in the South and resulted in their deaths or capture. About 30,000 North Korean troops were able, however, to escape to the north.

The United Nations forces then drove north until the North Koreans eventually took refuge in Manchuria. On 25 October 1950, United Nations forces found themselves fighting Chinese forces at the town of Ch'osan. By 24 November 1950 it was known that United Nations forces were facing 300,000 well-armed Chinese troops. A retreat was ordered to avoid envelopment and eventually the Chinese drove the United Nations forces back once again to south of the 38th parallel. The floating bridges over the nearly frozen Han River were blown and Seoul was left to the advancing Chinese forces. Not only Seoul, with a third of the South Korean population, but also the important Kimpo Airport and Inchon harbor were lost. Ridgeway established a firm defensive line in mid-January running due east from Pyongyang 75 miles south of the 38th parallel to the coast about 40 miles south of the parallel.

By mid-January 1951 United Nations forces under command of General Matthew Ridgway (General Walton Walker had been killed 2 days before Christmas in a motor vehicle accident) began a cautious drive north and recaptured Seoul by mid-March 1951. During this time there had been a great deal of political maneuvering in the United Nations and a call for a ceasefire and the removal of all foreign troops from Korea. This was rejected by China.

MacArthur continued to demand a policy of victory in Korea and unification of the country. He called for blockading the Chinese mainland and opening a second front with the Chinese Nationalists. Finally he made these suggestions in a public setting despite President Truman's patient explanation to him of the risks of Soviet intervention in Europe if such a policy were initiated. President Truman had little recourse but to recall General MacArthur, which he did on 11 April 1951 and named General Ridgway as his successor. Ridgway's forces included units from 15 nations, all less than brigade size, except American, ROK, British and Turkish units. Lin Piao, the Chinese commander, had 485,000 men in 21 Chinese and 12 North Korean divisions.

When Ridgway stabilized his line in mid-January, he had 365,000 men in 3 American and 3 ROK corps. The air situation had improved with the arrival

of F104 Sabres which quickly established superiority over the Russian Mig15s flown by the Chinese (and probably by some Soviet volunteers).

STALEMATE AND NEGOTIATIONS

The war entered a period of stalemate with small exchanges of territory between opposing forces. In the ensuing year each side advanced and retreated but with little improvement in tactical situation for either. By the end of 1951, General Peng, who had replaced Lin Piao, had 1,200,000 men of which 270,000 were deployed in the front line. General Mark Clark, who replaced Ridgway in May 1952, had 768,000 men in Korea.

Two years after the North Korean invasion, peace negotiations began but the fighting continued. Negotiations and fighting dragged on for another year until 27 July 1953 when an armistice was signed. In May 1953 an initial exchange of prisoners (Operation Little Switch) had occurred and after the armistice a large number of prisoners of war (POWs) were exchanged (Operation Big Switch). In general the first ones released had been those who cooperated most and in some cases collaborated with the enemy.² Following COL Albert Glass, COL Donald Peterson was FEC Neuropsychiatry Consultant from September 1951 until the end of the war in 1953. Neuropsychiatry Consultants to the 8th Army in Korea were, in order: COL Harold D. Whitten (1951-July 1952), COL Paul Yessler (July 1952-July 1953) and COL James Green (July 1953-July 1954). COL Green replaced COL Yessler 3 days before the Armistice (27 July 1953). The replacement for an outgoing physician was called his "turtle" for obvious reasons.

Paul Yessler and Henry Segal had examined the released POWs at Operation Little Switch and after the armistice they examined the POWs from Operation Big Switch. COL Yessler did some of these interviews in Japan and on a 2-week voyage to California.

Dr. William Mayer was also on a ship transporting the POWs and he gained a great deal of attention by reporting on the degree to which some soldiers

collaborated. Dr. Mayer felt that the American soldiers lacked willpower due to overindulgent mothering. He felt that this caused them to collaborate but also made them prone to die more readily in harsh circumstances due to "giveupitis."³ A U.S. Army White Paper rebutted Mayer's assertions and revealed that most of the communist propaganda was accepted by only a small number of POWs, mainly among minority groups who had experienced discrimination due to their race or ethnicity.

The 37 months of fighting had produced 550,000 United Nations casualties including almost 95,000 dead. American losses numbered 142,091 of whom 33,629 were killed, 103,284 wounded and 5,178 missing or captured. The bulk of casualties occurred during the first year of the war. The estimate of enemy casualties, including prisoners, exceeded 1,500,000, of which 900,000, almost two thirds, were Chinese.

In the Korean War, three fairly distinct phases are reflected in the varying types of casualties reported. The mid- to high-intensity combat from June 1950 until November 1951 was reflected in traditional anxiety-fatigue casualties and in the highest rate of combat stress casualties of the war, 209/1,000/year in July 1950.⁴ Most of the troops were divisional with only a small number being less exposed to combat. This was followed by a period of static warfare with maintenance of defensive lines until July 1953 when an armistice was signed. The gradual but progressive build-up of rear area support troops was associated with increasing numbers of characterological problems.

Norbury⁵ reported that during active combat periods anxiety and panic cases were seen, while during quiescent periods with less artillery fire the cases were predominantly characterological. Following the armistice obviously few acute combat stress casualties were seen. The major difference in overall casualties other than surgical before and after the armistice was a 50% increase in the rate of venereal disease among divisional troops.

Commenting on the observation that psychiatric casualties continued to present in significant numbers following the June 1953 Armistice of the Korean

War, Marren⁶ gives a clear picture of the reasons:

The terrors of battle are obvious in their potentialities for producing psychic trauma, but troops removed from the rigors and stresses of actual combat by the Korean armistice, and their replacements, continued to have psychiatric disabilities, sometimes approximating the rate sustained in combat, as in the psychoses. Other stresses relegated to the background or ignored in combat are reinforced in the postcombat period when time for meditation, rumination, and fantasy increases the cathexis caused by such stresses, thereby producing symptoms. Absence of gratifications, boredom, segregation from the opposite sex, monotony, apparently meaningless activity, lack of purpose, lessened chances for promotion, fears of renewal of combat, and concern about one's chances in and fitness for combat are psychologic stresses that tend to recrudesce and to receive inappropriate emphasis in an Army in a position of stalemate...Sympathy of the home folks with their men in battle often spares the soldier from the problems at home. The soldier in an occupation Army has no such immunity...Domestic problems at home are often reflected in behavior problems in soldiers, particularly those of immature personality or with character defects.^{6(pp719-720)}

The main result of the Korean War was that NATO was greatly strengthened. In June 1950 NATO was virtually without power but in 1953 NATO could call on 50 divisions and strong air and naval contingents. Also both the United States and the Soviet Union had become thermonuclear powers, the United States having exploded a hydrogen bomb in 1952 and the Soviet Union in August 1953. Furthermore, the despot, Stalin, was dead and there was some thawing of East-West relations.

PSYCHIATRIC LESSONS OF THE KOREAN WAR

Just as in the initial battles of World War II, provisions had not been made for psychiatric casualties in the early months of the Korean War. As a result they were evacuated from the combat zone. Due largely to the efforts of COL Albert J. Glass, a veteran of World War II, who was assigned as Theater Neuropsychiatry Consultant, the U.S. Army combat psychiatric treatment program was soon in effect and generally functioning well.⁷ Since only 5 years had elapsed, the lessons of World War II were still well known and the principles learned during that war were applied appropriately. Combat stress casualties were treated forward, usually by battalion surgeons and sometimes by an experienced aidman or even the soldiers' "buddies," and returned to duty. Psychiatric casualties accounted for only about 5% of medical out-of-country evacuations, and some of these (treated in Japan) were returned to the combat zone. To prevent the "old sergeant syndrome," a rotation system was in effect (9 months in combat or 13 months in support units). In addition, attempts were made to rest individuals ("R and R" or rest and recreation) and, if tactically possible, whole units. Marshall⁸ warned of the dangers to unit cohesion of rotating individuals, but this lesson was not to be learned until the Vietnam War.

These procedures appear to have been quite effective with two possible exceptions. One was the development of frostbite as an evacuation syndrome. This condition, which was the first psychiatric condition described in the British literature during World War I,⁹ was almost completely preventable, yet accounted for significant numbers of ineffectives.

The other problem was an unrecognized portent of the psychiatric problems of rear-area support troops. As the war progressed, American support troops increased in number until they greatly outnumbered combat troops. These support troops were seldom in life-endangering situations. Their psychological stresses were related more to separation from home and friends,

social and sometimes physical deprivations, and boredom. Paradoxically, support troops who may have avoided the stress of combat, according to a combat veteran and military historian, were deprived of the enhancement of self-esteem provided by such exposure.¹⁰ To an extent the situation resembled that of the nostalgic soldiers of prior centuries. In these circumstances the soldier sought relief in alcohol abuse (and, in coastal areas, in drug abuse)¹¹ and sexual stimulation. These often resulted in disciplinary infractions. Except for attempts to prevent venereal diseases, these problems were scarcely noticed at the time, a lesson not learned.

The Korean War revealed that the appropriate use of the principles of combat psychiatry could result in the return to battle of up to 90% of combat psychiatric casualties; however, there was a failure to recognize the types of casualties that can occur among rear-echelon soldiers. These "garrison casualties" later became the predominant psychiatric casualties of the Vietnam War.¹² Vietnam and the Arab-Israeli wars revealed limitations to the traditional principles of combat psychiatry.

Chapter 12

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Chapter 13
MILITARY PSYCHIATRY IN THE INTERVAL BETWEEN
THE KOREAN WAR AND THE VIETNAM WAR (1953-1961)

By Franklin D. Jones, MD, FAPA

FROM COMBAT TO COMMUNITY PSYCHIATRY

The continued conscription of young men after World War II and after the Korean War resulted in large numbers of unhappy soldiers who would much prefer to follow other pursuits. The U.S. Army Mental Hygiene Consultation Service became the preferred method of managing them.

Military Versus Civilian Psychiatric Practices

The military approach to psychiatric casualties is quite different, and for good reasons, from that of traditional office-based psychiatric practice; however, it may be quite similar to some forms of community programs which are founded on principles discovered in the military. The basic understanding of pathology, treatment practices, and theoretical considerations are the same in civilian and military practice. It is in application that the variance may be greatest.

Some of the reasons for the differences are based in part upon the population involved. The military population is a healthy one. Chronic and debilitating diseases have been eliminated to a considerable degree by selection and disposition of those who are severely unhealthy both mentally and physically. The population also is young and still predominantly masculine. A minimum of a moderate degree of intelligence is assured and outside of combat the environment provides for good health.

However, probably the most important reason for differences is that

psychiatry in the military setting functions in terms of the needs of the service; that is, military psychiatry is unique because the mission of the military is unique.

Obviously it will be rare that the civilian psychiatric casualty has been exposed to the kind of conflict experienced by a combat soldier. Examples of persons exposed to hazardous occupations do come to mind--policemen, firemen, flyers, and so forth--but these are rare and do not involve legal or psychological stigmas as with the soldier.

The better analogy is the marriage partner, teacher, therapist (as in "professional burnout" syndrome), parent, supervisor or other person who has responsibilities to a group or another person and who becomes demoralized in discharging those responsibilities. Many of such persons will be given labels such as "adjustment reaction" or "depression" or "anxiety neurosis" depending on presenting symptoms and therapeutic school. This listing does not include "organic" mental illnesses such as schizophrenia and biological depressions but conditions emanating primarily from psychological antecedents, usually generated by crisis situations, although these ideas can be usefully applied even in those "organic" conditions.

The comparability to be emphasized is in the acceptance of a medical label as the solution to one's problems of living and one's inability to cope with them. This is not limited to psychiatric patients; in fact, it may be more common in other conditions--chronic low back and tension headache syndromes come to mind as frequent ailments prone to result in one's escape from the daily fray of work. Such "organic" conditions don't even carry the psychiatric stigma, making them even more desirable as avenues of escape. As will become clear such persons are not malingering or consciously ineffective.

Rather for them the short term rewards of the invalid or medical label outweigh the long term rewards of mastery of the situation.

Bushard¹ has chronicled the empirical development of Army community psychiatric services (the Mental Hygiene Consultation Service) during the decade following World War II. Cold War tensions had resulted in the

continued need for drafted soldiers, many of whom preferred to be civilians. The early psychiatric services were little other than struggling out-patient clinics which were totally overwhelmed by the problems presented to them of large numbers of disaffected troops. Applying the usual psychiatric treatment techniques growing out of psychoanalytic theory in this situation produced results which were frequently discouraging. The usual conclusion was that, in view of the disparity between large referral load and psychotherapeutic talent available, little could be offered. Considering the large case load and the brief period of the patient's stay on post, traditional psychotherapy was not feasible. Dire predictions about the future of individuals examined were frequently offered.

After several years, a review of the situation led to several consistent observations:

1. Extensive and intensive work-ups did not really contribute a great deal of helpful information. Insofar as the psychotherapeutic result was concerned, frequently a brief interview would have been as valuable as the remarkably thorough study conducted.
2. Psychiatric and psychological data did not reliably predict future performance. Although in-depth examinations frequently revealed highly disturbed and distressed individuals, prognostications based on these findings were not a reliable basis for predicting either actual job performance or the future of the symptomatology.

Information derived from actual observation of the patient at work and study of the actual nature of, rather than his verbalizations about, his relations with others were a far more valid basis for predicting the outcome of his problem. Army mental professionals tend to over-emphasize pathology and overpredict failure.² It was observed that persons with more serious psychiatric disease, such as schizophrenia, frequently continued to function in the field without coming to psychiatric attention.

3. The immediate determinants of the psychological reaction were usually clearly evident. For example, Private Jones got a "Dear John" letter from his high school sweetheart and cut his wrist.
4. The disability would be described by the soldier as of a more global nature than one ordinarily encounters. The number of things the patient "could not do" seemed to pervade a wider segment of his function than one was accustomed to find in other practice. Anxiety, anger and other affective responses appeared to be related more clearly to the problems involved in mastery of the immediate situation than to infantile and oedipal experiences.

There was an almost universal and nearly magical conviction that escape from the reality situation was the answer. Rarely did one encounter the attitude that success or mastery was the desired end point, as it might be, for example, in marriage, career, and parenthood. It was not seen as an important aspect of growing up.
5. There was a predominant use of the mechanism of rationalization. One might explain his discomfort on the basis of intolerance of military profanity, or on rejection of the use of force in human relations, or on the basis of concern for sick parents. These were usually recognized as transparent devices. In the absence of such rationalization, there was frequently a willingness to admit to weakness, unpatriotism and being simply no good as an explanation for giving up. Such persons were influenced very little by competitiveness and group spirit.
6. Even when it was available, traditional psychotherapy had little impact. The psychotherapeutic interpretation, however clever, was lost; the urge of the patient toward health, if that involved staying in the military, was minimal. To address one's efforts at the classical psychiatric syndromes was simply not feasible and had little value. If this were done, the mass of referral load went untreated and the patient would often be abandoned either to

punitive measures or conversely to environmental manipulation which would tend to make for the continuation of the symptom.

Concurrence and Commitment

Eventually a view of the soldier emerged in which he is seen as part of an interactional set with his environment. The dynamics involved relate not so much to oedipal traumas and disturbed biochemistry as disturbed homeostasis in the soldier's social ecology. Adaptability was seen to relate to supports and circumstances which tend to prevent or strengthen the illness role. Depending on the balance achieved one may see increased or decreased rates of ineffectiveness as measured by AWOL, venereal disease, sick call and disciplinary action rates.

Bushard¹ used the concepts of *concurrence* and *commitment* to explain both the soldier's problems in adapting and their solution:

By concurrence we mean that aspect of internal psychological operations which looks to the incoming sense data for evidence that one's behavioral negotiations with the environment are leading to goal achievement, instinctual gratification and successful social inter-action.^{1(p436)}

It is easy to translate this concept into behavioral terms involving positive social reinforcement; in fact, research projects for treating delinquent soldiers used such translation.^{3,4}

One saw the soldier seek concurrence as he looked for the support of his Chaplain, his Inspector General, his family, his legislators or anyone else who might agree that the proper solution of his discomfort was a specific change such as return to his home. Seeking support from more official sources, he had usually either abandoned his immediate colleagues, or failed to obtain a comfort-giving concurrence from them.

If he did allow himself to see his sameness with those about him as opposed to his difference, he would begin to sense a diminution in anxiety level, an increased capacity to function, a waning of his conception that he could not succeed and that escape was the answer. He might continue to have his problems, but he was at least functioning at something approaching a level of mastery.

In the concept of commitment, Bushard described

that emotional and behavioral set by which the individual addresses himself to the mastery of the problem at hand. It involves his maintaining his attention to it at an intensity which results in the mobilization of his physical and psychological resources in the direction of achieving this goal as opposed to or differentiated from others.^{1(p437)}

The inductee who had failed to make provision for the needs of his dependents, and who did not find some source of pleasure and relaxation within the military had failed to establish a situation propitious for his efforts to succeed. Having failed to commit himself through a realistic appraisal of the situation, he was so distracted, worried and preoccupied, or found life so dull that no one could conceive of success in any undertaking.

Life is full of examples of lack of commitment. It is absent in the student who watches television rather than doing homework, in the worker who does not get enough sleep, in the adolescent who quits school altogether. Failure of commitment in other situations such as work, schools, and family responsibilities is a frequent finding in people who fail to commit themselves to military service as an accepted responsibility.

Applicability of Principles to Non-Combat Settings

In summary the practice of military psychiatry in combat and garrison

settings although developed empirically in the two settings can be shown to have a number of similarities, particularly when one is handling acute adjustment disorders. These practices can be seen to include various elements of the proximity, immediacy, simplicity, expectancy and centrality elements of combat psychiatry. These will be discussed separately.

Centrality

In the combat setting centrality refers to having a casualty evaluated prior to departure from the combat zone, but in the non-combat setting it is better seen as an aspect of what Glass⁵ has referred to as "related echelon psychiatry." This is traced back to Salmon's⁶ provision of a first echelon division psychiatrist supported by a second echelon special base hospital. The comparability with a community mental health center and the hospital to which it refers patients should be obvious. A further refinement found in an increasing number of mental health settings is the provision of partial hospitalization or interposition of an echelon between outpatient and inpatient status.

Proximity and Immediacy

In initially treating the disaffected soldier, it is often more important to know what his unit is, who his commander, and how long he has been in the service than it is to know who he is, where he came from, and what his specific symptoms are. This kind of information can only be obtained by an intense familiarity with the involved community. Attempts are made to avoid hospitalization and prevent the patient from being taken for any significant period of time from actual, if impaired, participation in his work. He is seen immediately on the day of referral, delay tending to consolidate the problem. Physical separation of the patient from the scene of his difficulties will cause him to indulge in the hope of not having to return which usually increases his symptom in a manner making return to work less possible with the increasing distance in time or space between him and his

group (immediacy and proximity).

Simplicity

As mentioned earlier this crisis-generated patient seldom requires more than simple supportive psychotherapy. This usually involves some degree of catharsis and a great deal of clarification. Other significant members may be brought in for consultation if they are supervisors or for additional support if they are peers or relatives. Medication with these patients is usually not indicated.

Expectancy

These maneuvers alone will begin to create the expectancy that the patient will continue performing, however, other procedures will enhance this expectancy. Interviewing is restricted to the situation and most efforts are directed at keeping the patient in the fray where his own innate adaptive talent may come to his aid. This is indicated more nonverbally by returning him rapidly to work than in any verbal manner. Psychiatric labels are to be avoided if possible. Follow-up is of extreme importance and should be at the working level rather than at the clinic. Here it is possible to assess the manner of the patient's effort, the degree of his success, the limitations which are insuperable. By one's working with the supervisor, work restrictions or other changes may be recommended and assignment limitations implemented.

When adaptation to the unit is impossible, the therapist may recommend changes. This is seen as a therapeutic environmental manipulation and should be under circumstances and by means which encourage the least possible persistence of chronic symptomatology, yet does not encourage others to follow suit. All of this is directed at resolving anxiety through implementing the patient's use of his own skills, the treating of anxiety as a normal phenomenon rather than as a pathological one, the dealing with it in such a way as to imply that success is possible.

Did these interventions in fact succeed? In 1951, just before the wide-scale use of these methods, the rate of troop admissions for all psychiatric disease was 24/1,000/year. By 1965 and roughly since, the rate dropped to 5/1,000/year (about twice the rate of psychosis). The number of outpatient visits in 1951 was 107/1,000/year⁷ and in 1965, 305/1,000/year.⁸

THE COLD WAR AND PROXY WARS

After the fall of the Axis Powers in 1945 Soviet troops invaded most of the Eastern European countries that had been conquered by Germany. In early 1946 Winston Churchill in Fulton, Missouri warned that the Soviet Union was lowering an "iron curtain" across the European continent with Soviet domination of East Germany, Poland, Hungary, Rumania, Bulgaria, Yugoslavia and Albania.⁹ At the same time communists were supporting an insurrection in Greece and in the Near East the Soviet Union was in firm control of Iran with occupying forces and was attempting to intimidate Turkey. In the Far East Soviet Forces were occupying Korea above the 38th parallel and supporting communist insurrections in China and Malaya.

The United States responded to this aggression with the Truman Doctrine of material and monetary support to Greece and Turkey but later the Doctrine was expanded to confront communist aggression worldwide. General Marshall, who became Secretary of State in January 1947, proposed a \$16 billion program to rebuild the shattered economies of Western Europe. The communists refused to participate, claiming this was an "instrument of American imperialism" and in October 1947 organized the Cominform, a committee to coordinate the activities of the communist parties in Europe to counter the Marshall Plan. Congress had initially balked at this massive amount of economic aid but appropriated funds in April 1948 when the Soviet Union engineered a *coup d'etat* that placed a communist government in power in Czechoslovakia.

The Soviet Union did not fully demobilize after World War II but kept 4 million men under arms, continued its armaments industry at full capacity and

rearmed its satellite countries. In June 1948 the Soviets established the Berlin Blockade of the corridor from West Germany to Berlin through East Germany. The United States and its European allies responded with the Berlin Airlift and a blockade of parts of East Germany. By May 1949 the Blockade was recognized as a failure and was discontinued. In April 1949 the United States joined the North Atlantic Treaty Organization (NATO) pledging collective security with ten European allies and Canada.

In Asia the Soviet Union turned over occupied Manchuria to Mao Tse Tung and supported his insurrection which was ultimately successful in driving the Kuomintang government of Chiang Kai Shek to Taiwan (Formosa) in December 1949.

The divided Korean peninsula was to have been reunited in national elections shortly after the War; however, the Soviets declared such elections illegal and refused to allow them in North Korea. The United Nations sponsored elections in the South and in August 1948 it became the Republic of Korea. The Soviets countered by installing the communist Democratic People's Republic in the North.

The Soviets had exploded an atomic bomb in Siberia in late summer 1949, several years earlier than expected due to gaining information through espionage. In February 1950 the Soviet Union and China signed a treaty of mutual assistance. These two facts would eventually lead to a stalemate in the Korean War.

Chapter 13

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Chapter 14
MILITARY PSYCHIATRY IN VIETNAM (1961-1975)
by Franklin Jones, MD FAPA

INTRODUCTION

America's longest war, Vietnam, (1961-1973) can best be viewed from a psychiatric perspective as encompassing three phases: an advisory period with few combatants and almost no psychiatric casualties; a build-up period with large numbers of combatants but few psychiatric casualties; and a withdrawal period in which relatively large numbers of psychiatric casualties took forms other than traditional combat fatigue symptomatology.

During the initial phases of the buildup in Vietnam, the psychiatric program was fully in place with abundant mental health resources and psychiatrists fairly conversant with the principles of combat psychiatry. Combat stress casualties, however, failed to materialize. Throughout the entire conflict, even with a liberal definition of combat fatigue, less than 5% of casualties (and nearer to 2%) were placed in this category.¹ The Vietnam War produced a number of paradoxes in terms of the traditional understanding of psychiatric casualties. Most spectacular was the low rate of identified psychiatric casualties generally and, in particular, the relative absence of the transient anxiety states currently termed combat fatigue or combat reaction. Table 12, taken from statistics compiled by Neel,² reveals that the Vietnam War was unusual in that the psychiatric casualty rate did not vary directly with the wounded-in-action rate. Despite the decline of the wounded-in-action rate by more than half in 1970 compared with the high in 1968, the neuropsychiatric casualty rate in 1970 was almost double the 1968 rate. In other words, wounded-in-action and neuropsychiatric casualty rates showed an inverse relationship that was unique to the Vietnam War until the 1982 Israeli Invasion of Lebanon.

Insert Table 12: Vietnam Casualties

This was contrary to prior experience and expectations. For example, Dattel,³ in reviewing neuropsychiatric rates since 1915, showed that in the U.S. Army the rates had previously peaked coincidentally with combat intensity (1918, 1943, and 1951) but in the Vietnam War they peaked after the war was over (1973), as seen in Figure 3.

Insert Figure 3: Incidence of Army Neuropsychiatric Disorders

In one study of combat psychiatric casualties in Vietnam⁴ during the first 6 months of 1966, less than 5% of cases were labeled "combat exhaustion." Most cases presented with behavioral or somatic complaints. This initially (1965-67) low incidence of neuropsychiatric cases in Vietnam was posited by Jones⁵ to reflect the low incidence of combat fatigue in Vietnam compared to other wars. This low incidence of combat fatigue was in turn attributed to the 12-month rotation policy, the absence of heavy and prolonged artillery barrages, and the use of seasoned and motivated troops. Since the rate of psychiatric cases did not increase with increased utilization of drafted troops in 1966 as compared to 1965, the latter consideration seems less important.

Other explanations of the low incidence of psychiatric cases included thorough training of troops, troops' confidence in their weapons and means of mobility, helicopter evacuation of wounded, early treatment of psychiatric casualties in an atmosphere of strong expectation of rapid return to duty, and a type of combat which consisted largely of brief skirmishes followed by rests in a secure base camp. Fatigue and anxiety did not have a chance to build up.¹

Huffman⁶ suggested that a factor in the low incidence of psychiatric cases was the effectiveness of stateside psychiatric screening of troops being

sent to Vietnam. This possibly affected in a sporadic way the initial deployment of troops since some company level commanders did attempt to eliminate "oddballs" from their units in anticipation of future ineffectiveness; however, no organized screening program beyond basic combat and advanced individual training was in effect.

In an interesting sociological and psychodynamic analysis of 1,200 Marine and Naval personnel serving in the Vietnam combat zone, Renner⁷ suggested that the true picture was not one of diminished psychiatric casualties but rather of hidden casualties manifested in various character and behavior disorders (CBDs). These CBDs were "hidden" in the sense that they did not present with classical fatigue or anxiety symptoms but rather with substance abuse and disciplinary infractions. Renner developed evidence supporting an explanation of CBD based on a general alienation of the soldier from the goals of the military unit. He contrasted support units with combat units noting that the former faced less external danger, allowing greater expression of the basic alienation which he regarded as present among virtually all American troops in Vietnam. He attributed this alienation to the lack of group cohesiveness largely resulting from the policy of rotating individuals and disillusionment with the war after 12 months.

The result was that the prime motivators of behavior became personal survival, revenge for the deaths of friends, and enjoyment of unleashing aggression. These in turn produced not only disordered behavior reflected in increased character and behavioral disorder (CBD) rates but also feelings of guilt and depression. Alienation from the unit and the Army led to the formation of regressive alternative groups based on race, alcohol or drug consumption, delinquent and hedonistic behavior and countercultural life styles.

A second paradox in the Vietnam War was the development of greatly increased rates of psychosis in Army troops as seen in Figure 4. Dattel³ showed that this was a worldwide phenomenon of all active duty personnel, but especially of Army troops (refer back to Figure 3). Like the total

neuropsychiatric incidence rate previously mentioned, the psychosis rate also peaked after active combat. Previous experience had shown only minor increases in the psychosis rate during wartime. In both combat and non-combat situations the psychosis rate had remained stable at around two or three per thousand troops per year.^{8(pp1004-1026)}

**Insert Figure 4: Psychosis & Evacuation Rates
US Army, Vietnam**

Hayes⁹ suggested two hypotheses to explain the increase in psychoses. One was the increased precipitation of schizophrenia and other psychotic reactions in predisposed persons by their use of psychoactive drugs. The other was the tendency of recently trained psychiatrists to classify borderline symptomatology as latent schizophrenia, while more experienced psychiatrists would have chosen a different nosologic category (presumably character and behavior disorders).

Jones and Johnson¹ suggested that the doubling of the psychosis rate in the U.S. Army Vietnam (USARV) troops in 1969 was due not to drug precipitation of schizophrenia or styles of diagnosis per se but rather due to the influence of drugs in confusing the diagnosis. Holloway¹⁰ showed that large scale abuse of drugs other than marijuana and alcohol began about 1968. About 5% of departing soldiers were excreting detectable heroin products in the summer of 1971; however, this fell to about 3% when the screening became publicized. Soldiers frequently took potent hallucinogens as well as marijuana and heroin.

Furthermore, Jones and Johnson¹ showed that out-of-country evacuations were essentially reserved for psychotics until the beginning of 1971 (Figure 4) but with the advent of emphasis on drug abuse identification and rehabilitation, often by detoxification and evacuation to stateside rehabilitation programs, an alternative diagnosis was available. Finding a new diagnostic category for soldiers who just did not belong in a combat zone, namely, drug dependence, the evacuating psychiatrists quit using the

schizophrenia label. This is reflected in the decline in psychosis back to about the 2/1,000/year level. Also, fluctuation began to increase due to the smaller samples.

In other overseas areas the Army policy of not evacuating persons with character and behavior disorders (CBDs), including drug dependence, still held; therefore, the psychiatrist seeing a patient who did not belong overseas might label him with a psychosis, especially if the patient described perceptual distortions and unusual experiences. Such a psychiatrist might be applying a broad categorization of schizophrenia as Hayes suggests.

Because Air Force and Navy psychiatrists have generally had more latitude in being permitted to evacuate patients with CBD than have Army psychiatrists, one would expect their rates of psychosis to be lower, and Figure 5 reflects this. This may explain the discrepancy between Datel's worldwide psychosis rate with diagnoses by Navy, Air Force, and Army psychiatrists (refer back to Figure 3) and Jones and Johnson's Vietnam psychosis rate with diagnoses by Army psychiatrists only (refer to Figure 4).

Insert Figure 5: Neuropsychiatric Casualties, All Services

WAR INTENSITY AND COMBAT STRESS CASUALTIES

The epidemiology of psychiatric casualties among troops in battle has been examined in numerous studies since World War I.^{1,11-17} Such studies tended to emphasize the psychiatric casualties which resulted from battlefield stress even though casualties resulting from less dramatic causes had been recognized since World War I. These less dramatic casualties presented with problems of alcohol and drug abuse, disciplinary infractions, venereal diseases, and "self-inflicted" medical disorders (for example, malaria from failure to use prophylaxis). Not until the Vietnam War were these casualties recognized as potentially serious causes of ineffectiveness.

While the casualties which occur during actual engagement with the enemy

may present the traditional picture of battle fatigue (anxiety, fatigue, hysterical syndromes, etc.), the majority of neuropsychiatric cases in low-intensity combat present a picture similar to those which occur among rear-echelon troops in wartime and among garrison troops during peacetime (venereal diseases, alcohol and drug abuse, and disciplinary problems, often related to personality disorders). It is not surprising then that various authors have called such casualties "guerrilla neurosis,"¹⁸ "garrison casualties,"¹⁹ "disorders of loneliness,"⁵ and "nostalgic casualties."^{20, 21}

Jones²² studied the features distinguishing psychiatric casualties among combat troops from those among combat-support troops in Vietnam. ["Combat support" in this context refers to soldiers whose primary mission is not to fight the enemy but to assist those doing the fighting.] He concluded that such "garrison casualties" were found particularly among rear-echelon elements in the Vietnam War, a conflict in which each combat soldier was supported by about eight non-combat-arms troops. Such troops characteristically present with "nostalgic" disorders related to separation from family and friends, boredom, social and sometimes physical deprivation. Considering their source, Jones⁵ had previously labeled these casualties as suffering from "disorders of loneliness"; however, since before the Napoleonic Wars, such disorders have been termed "nostalgia." Obviously such disorders can and do occur in combat troops as well.

NOSTALGIA

Resurrection of a Concept

Nostalgia was a medical concept recognized even before 1678, when the Swiss physician Hofer created this term to describe soldiers previously labeled as suffering from "Das Heimweh" or homesickness.²³ Earlier in the 17th century soldiers in the Spanish Army of Flanders were stated to suffer from "mal de corazon" ("illness of the heart"), and Swiss mercenaries in

France were said to suffer from "maladie du pays" ("homesickness"). Since the majority of such soldiers were mercenaries uprooted by financial exigencies from their farms in Switzerland, these soldiers were often described as suffering from "the Swiss disease." The critical variable was service, often involuntary, far from one's country, family, and friends. By the middle of the 18th century, nostalgia was a well-defined nosologic entity recognized as afflicting not just Swiss but potentially any soldier displaced from his milieu of origin, and generally was considered to be a mental disorder.

The symptomatology associated with nostalgia was consistently that compatible with modern descriptions of depression with complaints, for example, of "moroseness, insomnia, anorexia, and asthenia" in a report by Sauvages in 1768, as described by Rosen.²⁴ Even this early there were observations that nostalgia might be feigned as a method of avoiding duty. A French physician, De Meyserey, who published a treatise on military medicine in 1754, observed that war and its dangers always produced a fruitful crop of malingerers who must be discriminated from soldiers with "true nostalgia."

During the American Civil War, Calhoun, reviewed in Deutsch,²⁵ ascribed a relationship between nostalgia and the recruiting methods of the Union Army which could have parallels with the "nostalgic casualties" of the Vietnam War.

Calhoun described initially enthusiastic soldiers who had expected an early end to the conflict and who became disenchanted as the war dragged on. The statistics on desertion, draft dodging, and similar attempts to avoid duty were not much different during WW II, a more popular war, and the Vietnam War (in fact they were generally lower during Vietnam than World War II). This suggests that the disenchantment toward the end of the war in Vietnam may not have been as important a factor in generating nostalgic casualties as the loss of unit cohesion.²⁷ Table 13 reveals factors influencing nostalgic casualties.

**Insert Table 13: Factors and Characteristics of
Nostalgic Cases**

Nostalgic casualties occur in soldiers separated from their home environment with attendant loss of social reinforcement. Rosen²⁴ has pointed out that one need not be a soldier for this to occur and that displaced persons and other groups often suffer from this "forgotten" psychological disorder. Situations such as the fighting of an unpopular war of indefinite duration are likely to increase these casualties, particularly in the absence of strong cohesive forces which usually develop from shared hardship and danger. Hence Calhoun²⁷ cited battle action as a curative factor in nostalgia:

Their thoughts were turned from home, and they felt they were men and soldiers, peers of the veterans with whom they associated; and from that day to this there has been but little or no sickness, and but one or two deaths...When men have passed through the baptism of fire together, they feel they have something in common.

They have a common name, a common fame, and a common interest which diverts their thoughts away from home. ^{27(p376)}

Based on the recollections of Civil War veterans, Stephen Crane's *The Red Badge of Courage*²⁸ eloquently described the development of cohesive bonds in response to the horrors of battle:

There was a consciousness always of the presence of his comrades about him. He felt the subtle battle brotherhood, more potent even than the cause for which they were fighting. It was a mysterious fraternity born of the smoke and danger of death. ^{28(p31)}

Unit cohesion is group and self-preservative behavior which evolves from shared danger in an almost impersonal manner despite its very personal nature. This group cohesion evolves in almost any situation of shared hardship or danger. Belenky and Kaufman²⁹ found that vigorous training involving some

danger produced cohesion in air assault trainees. In combat situations, cohesion needs little encouragement to flourish. Recognizing this, one company commander, when asked about cohesion in his unit in West Germany, commented, "I train my men to be skilled soldiers; I'll rely on the enemy to make them cohesive." Such a *laissez-faire* attitude ignores the possibility that non-cohesive units may disintegrate in high-stress combat before cohesive bonds can develop.

Low-intensity warfare, often characterized by long periods of idleness without the shared experience of cohesion-building danger, should produce more nostalgic casualties. This situation probably also accounts for the higher incidence of such casualties among support than combat troops.²²

During World War I conditions of battle did not lend themselves to producing large numbers of nostalgic casualties; however, following the Armistice, the Third Army, which remained as an Army of Occupation, was in a garrison-type role. The casualties in this situation began to approximate those seen in low-intensity warfare. For example, from December 1918 to June 1919 at the hospitals at Coblenz and Trier, 1,022 psychiatric cases were evaluated.^{30(pp423-428)} In this garrison setting, the largest groups of casualties were those diagnosed as "defect" (presumably retarded) and "psychopathy" (36.8%). When these are added to alcoholism and drug states (6.8%), they account for nearly half of the psychiatric morbidity, and over half if epilepsy is excluded. There were many disciplinary problems in this occupation group. An attempt was made by commanders and medical officers to eliminate "misfits--defectives and psychopaths" which may have accounted for the identification of a relatively high number of mentally retarded and epilepsy patients; however, "Had not many been evacuated through other channels (replacement depots) the figures would be even higher."^{30(p426)} [In a curious parallel with World War I, in the Vietnam War an attempt was made to utilize lower functioning (though not retarded) men as soldiers in the U.S. Army, the so-called "MacNamara's 100,000." Such soldiers performed more poorly as a group than normally selected soldiers but some were superior. The

results were satisfactory enough that the 100,000 was increased to about one-third of a million].

At a time during World War I when the military population in France of American soldiers averaged 200,000 persons, the incidence of hospitalized "psychopathic states" was 5 per 1,000, comparable with the overall rate for "character and behavior disorders" in overseas areas in World War II of about 4 per 1,000.³¹ However, since diagnostic practices in World War I and World War II differed markedly, true comparability may not exist. The difference in types of casualties in garrison settings was observed by Salmon and Fenton,^{30(p287)} who commented that the cessation of hostilities did not reduce the need for psychiatric beds:

A number of more recent cases showed simple depression... An intense longing for home was characteristic of this condition. It resembled a set of reactions to which the term "nostalgia" used to be applied and is common in all military expeditions when a period of intense activity is succeeded by an uneventful one.^{30(p287)}

About half of the American psychiatric casualties of World War II were unrelated to combat and actually occurred during stateside service.³¹ During World War II "homesickness" was listed as a factor in the breakdown of 20% of psychiatric casualties among American forces.³² At that time, however, the relationship of these homesick casualties to combat situations was not explored.

In the Korean War, as already discussed above, the phases are reflected in the varying types of casualties reported, traditional anxiety-fatigue casualties during intense fighting (the highest rate of combat stress casualties of the war), and a period of static warfare with characterological casualties.

The characterological problems in Indochina and Algeria¹⁸ among French

soldiers were seen in the generally low-intensity campaigns. Since there is a several hundred year history of colonial wars and occupation forces for many European countries, it is surprising that reports of these casualties are sparse. It seems plausible that these were simply not considered medical, particularly psychiatric, problems but rather moral issues similar to earlier consideration of active combat stress breakdown as cowardice or lack of moral fiber. In the French Indochina War (1945-1954), such character disorders were reportedly responsible for a high number of evacuations, but no statistics are available.

Crocq and colleagues¹⁸ studied French psychiatric casualties of the Algerian War. They used statistics compiled by LeFebvre and colleagues for 1280 cases of mental disorders at the military hospital at Constantine who were then evacuated to France between 1 July 1958 and 1 July 1962 (second half of the 1954-1962 Algerian War). Diagnostically, 19.7% of the total cases were character disorders, and another 14.5% were organic psychoses, predominantly from alcoholism. Only 20% of all cases were related to a triggering event during combat. Functional psychoses accounted for 36.7% of cases with about half of these being schizophrenia (224 of 464 cases). The remainder were mentally retarded (14.5%) and neurotic conditions (14.6%). Because these are evacuation statistics, they only indicate in a general way relative prevalence because characterological problems usually are not handled by medical evacuation.

It is unfortunate that actual behaviors cannot be examined to determine the comparability of problem behaviors among soldiers of this war and the Vietnam War; however, there is a strong suggestion of comparability in that only a small fraction of alcohol abusers will develop brain syndromes. The relatively high percentage of such cases among the French suggests that this type of substance abuse was widespread.

For the United States, Vietnam represented the epitome of a conflict in which nostalgic casualties occurred. During the early years of the war the psychiatric casualty rate of about 12/1,000/year was lower even than that in

non-combat overseas areas (Europe and Korea) at the same time.¹ The average psychiatric evacuation rate during the first year of the war was 1.8/1,000/year, lower than that from Army posts in the United States. The most intense fighting occurred in 1968 to 1969, with half of those killed in action killed during this period. In June 1968, 1,200 were killed, close to the peak number. As the war dragged on and the American presence took on many of the characteristics of an occupation force, characterological problems began to surface. Racial incidents began to occur, beginning in the rear areas. Psychiatric problems initially took primarily the form of alcohol and drug abuse but later, as the unpopularity of the war intensified, disciplinary problems approaching the magnitude of mutiny in some cases occurred.

President Nixon announced the withdrawal plans on 9 June 1969. Fragging incidents increased from 0.3/1,000/year in 1969 to 1.7/1,000/year in 1971.³³ Psychiatric evacuations rose from 4.4/1,000/year (4% of all evacuations) to 129/1,000/year (60% of evacuations) in April 1972. Several authors have described these casualties and factors in their causation.^{1, 7, 34-36}

These problems were further aggravated by the "Vietnamization" policy in which American soldiers were increasingly relegated to garrison settings and roles in the later phases of the conflict. The subsequent drug abuse epidemic may have played a decisive role in the premature withdrawal of American troops and the ultimate loss of the war. The "garrison NP casualties" in fact accounted for most of the consumption of mental health resources during the Vietnam War. When a policy of medically evacuating soldiers if they were found to have heroin breakdown products in their urine went into effect, heroin abuse became an "evacuation syndrome."

Marlowe³⁷ pointed out that Vietnam was aberrant compared with World War II and most of the Korean War in that

[T]he soldier's future was as much controlled by the calendar (DEROS) [date of expected return from overseas station] as by the outcome of combat with the enemy. The Vietnam war was

particularly aberrant in that the enemy lacked a significant capacity in weapons of indirect fire, thus providing a battlefield ecology that was substantively different both from the past and the anticipated future.^{37(p1)}

This battlefield ecology, however, was not new to other nations: The French forces preceding the United States in Vietnam fought a similar war until the decisive defeat at Dienbienphu where they were beaten by indirect fire weapons - artillery. The author contends that the casualties of such low-intensity, intermittent campaigns are similar to nostalgic casualties of the American Civil War and of prior wars.

The Israeli Invasion of Lebanon (June 1982) is an excellent example of the problems of a war unpopular at home. While the 1973 Arab-Israeli War has been used as an exemplar of modern, high-intensity combat and Vietnam as an exemplar of low-intensity combat, Lebanon had elements of both. There were roughly two weeks of intense combat in early and late June with the remainder of the war being more of a static situation with Israel as an occupying force. The result in terms of casualties is revealing (refer back to Table 3), showing casualties similar to those during the intense battles of World War I, World War II, and the 1973 War but also symptoms of estrangement and delayed stress casualties found in Vietnam. Belenky¹⁷ revealed that about two-thirds of the psychiatric casualties from the Lebanon War presented during the post-combat period as chronic and delayed post-traumatic stress disorder (PTSD) cases.

Precipitants of Nostalgic Casualties

Psychiatric casualties occurring in actual combat are qualitatively different from those occurring in soldiers less exposed to combat. Billings³⁸ reported that 28% of all medical evacuees from the South Pacific Command during World War II were sent to the Zone of the Interior because of

personality disorders during 1943. Billings also described the stresses and personality symptoms of combat and combat-support troops. Writing of the men sent to the South Pacific during World War II and subsequently diagnosed as personality disorders, Billings believed that certain characteristics of Americans helped produce this outcome. He recorded as follows:

Men...were products of our sociology and ideology. Individualism; the belief in a freedom for all men to compete on an equal basis; the tendency for the American to need tangible evidences of success at frequent intervals; the inclination to be too dependent on others for distraction, recreation, and maintenance of interest; the assumption that American business philosophy is a matter of "not what you do but what you are caught doing," with the unconscious realization that the one who does not or cannot do the job gets the benefits and escapes unpleasantness whereas the one who accomplishes the task only faces more work or loses his life--all stood out as dynamic factors in breakdowns in morale, occurrence of resentment reactions, aggressive tendencies, and hurt feelings. These in turn placed certain personalities in considerable jeopardy of psychiatric disability when they were subjected to special circumstances.^{38(pp479-480)}

Billings describes such "special circumstances" as a variety of precipitants for combat and "service" (support) troops. These included the following:

For Combat Troops^{38(pp480-481)}

1. Facing impending danger, especially for a period of time without specific happenings to break the tension or circumstances permitting the venting of physical effort. For example, remaining alert for a prolonged period of time in a concealed position or foxhole, subjected

to the full effects of loneliness and jungle sounds; being pinned down by artillery or heavy mortar fire; or being caught in the open by strafing from the air, especially when immobilized by impediments or terrain.

2. Subjection to heavy artillery fire....
3. Occurrences of a lull, following a period of danger, which allowed for cogitation and a fuller intellectual realization of what was and might be experienced....
4. Occurrence of transitory, psychobiological disorganization in a particularly susceptible personality when subjected to fear-inducing circumstances.
5. Prolonged patrol and reconnaissance work in enemy-controlled jungle.
6. Promotion, in the field, to positions of great responsibility.
7. Grief over loss of "buddies," or loss of a tactical position taking the form of self-condemnatory thinking.
8. Inadvertent evacuation to a position of safety with that [cogitation] noted in paragraph 3 resulting....
9. Loss of confidence in leaders....
10. Mass psychological reactions.
11. "Snow jobs" or tall tales told often by the veteran combat soldier to the new replacement at, or before, a critical time.
12. Unwarranted or unexplained evacuation or transfer of psychiatric and minor medical and surgical casualties ... resulting in loss of the individual's security in his bodily or personality integrity, loss of identification with his unit, diminished esprit de corps, decreased desire or feeling of need to continue fighting--all being replaced by a conscious or "subconscious" appreciation that it might be possible to return home and thereby honorably escape further danger.
13. Ill-considered or poorly-timed statements to troops by visiting high-ranking officers which lead to misinterpretation of policy, or promote loss of confidence in the administration.

14. Repeated dress parades for visiting dignitaries when the combat team is staging for a forthcoming operation.

For Both Combat and Service Troops^{38(pp481-483)}

1. Hypochloremia, dehydration, fatigue, and subclinical or clinical illness decreasing the efficiency and smooth psychobiological functioning of the individual, thereby often setting the stage for insecurity, tension, and anxiety with personally alarming symptomatology.
2. Enemy propaganda....
3. Rumors stemming from isolation, ignorance of facts, and inactivity.
4. Postponement of the promotion of enlisted men and officers, and the filling of position vacancies with new men in grade or rank.
5. Ill-advised promotion of men and officers to responsibility beyond their ability....
6. Discrepancy between War Department and politically announced policy and plans for rotation and redeployment of overseas personnel....
7. Knowledge of the unfair discrepancy in remuneration to and appreciation for the individual in military service and the one in the merchant marine and industry....
8. Seeming ignorance of the average commander and the officer in personnel work either of War Department policy or of how to comply therewith in regard to proper assignment and readjustment of military personnel.
9. Poor leadership, especially of high-ranking officers, as evident in the officer looking after his personal comfort and safety before acquiring them for his command....
10. Apparent "empire building" of general officers....
11. Work or combat under adverse conditions prolonged to the breaking point of the "average" man.
12. Failure to expedite the elimination from a unit of ineffectuals....
13. Disturbing news from home, such as of a wife's infidelity, business reverses, deaths, illness, and encouragement to forego continuance of

further military responsibility.

Soldiers less exposed to combat and presenting with personality problems may be called "nostalgic casualties." Huffman⁶ in Vietnam reported that only 48 of 610 soldiers (8%) seen in 1965 to 1966 suffered combat-related stress, while Jones²² found combat-related stress in 18 of 47 soldiers (38%) seen in a similar hospital setting (September-December 1966). These 18 cases, however, were given character and behavior disorder diagnoses. As the 25th Division psychiatrist, Jones⁵ from March through October 1966 saw approximately 500 patients of whom about one-third were awaiting legal or administrative action.

Of the remaining two-thirds, almost all were diagnosed as character and behavior disorders including situational fright reactions. The term "combat fatigue" was misleading to the novice psychiatrist with its implication of prolonged combat and cumulative fatigue. In retrospect some of these cases would more appropriately have been so diagnosed; however, the treatment approach was the same: rest, reassurance, and return to his unit.

The term "nostalgic casualty," like "combat stress reaction (CSR)," is an intentionally vague term describing a variety of dysfunctional behaviors, the management of which requires interventions much like those for managing combat fatigue. Army Field Manual 8-51³⁹ terms these casualties "misconduct combat stress reactions"; however, the term suggests that disciplinary action may be indicated and this is not a profitable approach. These dysfunctional behaviors often cluster in patterns forming syndromes. Such syndromes typically have many overlapping behaviors; however, it is useful to divide them into the categories of substance abuse, sexual problems, and indiscipline.

Types of Nostalgic Casualties

Substance Abuse

During the American Civil War the liberal use of opium caused widespread

dependence called the "soldier's disease."⁴⁰ In low-intensity combat and garrison settings in which the risks of being intoxicated are not as great as in higher intensity combat, substance abuse flourishes.

Froede and Stahl⁴¹ evaluated the 174 cases of fatal narcotism retrieved from over 1.3 million surgical and autopsy cases sent to the Armed Forces Institute of Pathology from 1918 through the first six months of 1970. Although the data were incomplete, some interesting trends were observed which strengthen the observation that drug abuse is associated with low-intensity combat situations in geographical areas in which abuse substances are available (about two-thirds of the deaths occurred in the Far East). In terms of combat intensity, the majority of cases in World War II, Korea, and Vietnam occurred in the closing years of the wars and in the post-war periods when fighting had diminished and large numbers of troops were serving in support roles. Their findings are supported by Baker's⁴² estimate that there were 75 opiate deaths in Vietnam from 1 August through 18 October 1970, 11 confirmed by autopsy and 64 suspected.

Alcohol was the first substance of abuse in Vietnam. Huffman⁶ reported that of his 610 patients seen early in the war, 113 (18.5%) suffered from severe problems associated with alcoholic intoxication but there were only 5 cases of unquestionable non-alcohol substance abuse. As the war progressed, marijuana came to be preferred because of the absence of a "hangover." Roffman and Sapol⁴³ reported that in an anonymous questionnaire given to soldiers departing Vietnam in 1967, 29% admitted using marijuana during their tour. Similarly, a survey of 5,000 enlisted men at Fort Sill, Oklahoma who had not served in Vietnam from January through April 1969 revealed that 29% admitted to using drugs sometime in their lives, 83% of the users identifying marijuana.⁴⁴ In the early years of the Vietnam War marijuana users apparently were reflecting the experiences of their stateside cohorts, but this began to change. In a review of studies of drug abuse in Vietnam, Stanton⁴⁵ found that from 1967 to 1971 the proportions of enlisted men who used marijuana "heavily" (20 or more times) in Vietnam increased from 7% to 34% while the proportion of

"habitual" users (200+ times) *entering* Vietnam remained at 7% to 8% for the years 1968 through 1970 and the proportion of habitual users *in* Vietnam stabilized at 17% to 18% between 1969 and 1971. Thus, about 9% to 10% of the lower grades of enlisted men first *became* habitual smokers (daily usage) in Vietnam.

Heroin abuse became significant in early 1970 when 90% to 96% pure heroin derived from the "golden triangle" of Thailand, Burma, and Laos became available countrywide. This pure heroin was so cheap that a significant "habit" could be maintained for \$8. to \$10. a day.⁴⁵ The preferred route was "snorting" through the nostrils or smoking. Of the 18% who injected at all, this was only occasionally. At a peak in October 1971, perhaps 44% of all lower ranking enlisted men (E-1 to E-4) were using heroin and half of these may have been addicted.⁴⁶ Like venereal disease rates, drug abuse rates tend to increase when there are lulls in combat or when exposure to combat is decreased.

Heroin reportedly displaced cannabis because it had no characteristic strong odor allowing detection, made time seem to go faster rather than slower as with marijuana and was compact and easily transportable. However, McCoy⁴⁷ argues that heroin did not so much replace marijuana as augment its use and that the real reason for the heroin epidemic was enormous profits that South Vietnamese officials could make by selling it to Americans.

These findings must be considered in the light of a nationwide epidemic of drug abuse in American youths at that time. Drug and alcohol abuse were so prevalent in troops stationed in Europe that special programs had to be inaugurated.⁴⁸⁻⁵⁰ The biggest difference between drug abuse in Vietnam and in Europe and the United States was the ready availability of very pure, inexpensive heroin in Vietnam.⁵¹ Treatment of substance abusers has varied considerably over time. Early approaches were to consider such casualties problems of a moral nature and later of a character defect with punishment as the primary intervention. It was only when such losses of manpower became significant in the Vietnam War that a non-punitive, therapeutic approach was

undertaken. By 1971 more soldiers were being evacuated from Vietnam for drug use than for war wounds.⁴⁵ The Army had adopted a country-wide voluntary treatment program in Vietnam in October 1969 aimed primarily at marijuana abusers. This was patterned on an amnesty program developed in the Fourth Infantry Division in May 1969. Army regulations tended to be slow in changing to accommodate the therapeutic perspective, sometimes resulting in paradoxical punishment of recovered abusers.⁵²

The main lessons from the American experience in managing substance abuse in Vietnam are that treatment should be in-country to prevent an evacuation syndrome and that the factors which prevent breakdown in general--cohesion, effective leadership, and good morale--may protect soldiers from substance abuse. For example, the Australians serving in Vietnam did not have significant personnel losses from substance abuse.^{53, 54} Their forces were based on a regimental system with unit rather than individual rotations, and officers and troops had usually served together for long periods of time. This may have produced greater unit cohesion, a crucial difference from American troops which protected Australian troops from developing nostalgic problems of substance abuse and indiscipline.

Sexual Problems

The most common nostalgic behavior coming to medical attention is sexual intercourse with prostitutes leading to venereal diseases. Officers were not immune. Furthermore, the availability of antibiotics in Vietnam (and Korea) without prescription may have hastened the development of resistant strains of gonorrhea which have been reported since the Vietnam War.

Low-intensity wars frequently show an increased incidence of drug abuse and sexual disorders. Occasional incidents have come to the attention of military authorities involving homosexuals and have been used to vindicate the military policy of eliminating homosexuals from the service; however, a study of homosexual college students who served in World War II revealed that the great majority served adequately and some with distinction.⁵⁵

Sexually transmitted diseases (venereal diseases or VD) have been a major cause of lost soldier strength in wars of the Twentieth Century. While modern medicine has markedly reduced the time lost and complications of venereal diseases, it has not reduced the infection rates as shown by Rothberg⁵⁶ in Table 14.

**Insert Table 14: Annual Admission Rates of
Selected Diseases by Year and Area**

Although the VD rate of the American Expeditionary Forces (AEF) in World War I was a relatively low 34.3/1,000/year,⁵⁷ there were over 6.8 million lost man days and 10,000 discharges.⁵⁸ Each case resulted in over a month of lost duty time (from 1929-1939, lost days per case ranged from 38 to 50).⁵⁸ By the time of the Vietnam War, nine out of ten cases were for gonorrhea (lymphogranuloma venereum, chancroid, and syphilis accounted for most of the rest), and lost duty time averaged only a few hours per case. Deller and colleagues⁵⁸ echo Jones'²² observation that rates were greatest in support troops with little combat exposure, and they add that such troops were most often near population centers. The peak incidence of nearly 700/1,000/year occurred in the period January to June 1972 when almost all American troops were in support roles in accordance with the "Vietnamization plan" of using Viet forces in combat.

Prevention through education is a valid approach to VD even though some soldiers will risk infection no matter what the threat. Prevention should not be directed at preventing sexual intercourse which is an unrealistic goal but toward the use of condoms which should be made readily available. Studies revealing that 50% of all prostitutes who have been randomly tested in the United States carry the HIV (human immunodeficiency virus) antibody⁵⁹ suggest that this retrovirus, which may cause the currently incurable and usually fatal acquired immunodeficiency syndrome (AIDS), may be a problem in future wars. In battlefield conditions, soldiers may have to donate blood to each

other, and the presence of a soldier who is HIV positive could prove hazardous to not only the health but also the morale of troops. Currently soldiers are routinely tested for HIV prior to enlistment and deployment.

Although unlikely to have immediate effects on combat efficiency, the HIV virus poses severe problems in long-term prevention. Many of the world social tensions and ongoing wars are occurring in Africa, where the HIV infection is reaching epidemic proportions. Unlike in the United States, where the populations at risk are mainly homosexuals and intravenous drug abusers and their consorts, the spread of HIV in Africa is primarily through heterosexual intercourse. In South America, another politically troubled area with communist insurgencies in several countries, AIDS is emerging as a difficult public health problem. Since urban areas in these third-world countries are being hit hardest by AIDS, there is concern that the professional and leadership classes of African, and to a lesser extent South American, countries could experience severe setbacks in goals of industrialization and democratic reforms. Internal unrest in Latin America frequently has led to American military deployment beginning before 1900. The mid-1990s have found American forces in Somalia, Haiti, and Bosnia.

Indiscipline

Indiscipline is a psychiatric issue in the sense that socio-psychological factors play a paramount role in its emergence. Furthermore, indiscipline and psychiatric breakdown merge almost imperceptibly as evacuation syndromes. For example, failure to take preventive hygiene measures in Korea allowed the development of frostbite in some cases. Similarly, failure to take the prophylactic chloroquine-primaquine pill in Vietnam allowed the infestation of malarial protozoans. In both cases, indiscipline rendered the soldiers unfit for duty.

Indiscipline may range from relatively minor acts of omission to commission of serious acts of disobedience (mutiny) and even to murder ("fragging"). In an analysis and historical review, Rose⁶⁰ indicated that

combat refusal has been a relatively frequent occurrence in most significant wars for which we have adequate data. The military has often colluded with the perpetrators in hiding the true nature of collective disobedience (mutiny) by using various euphemistic phrases ("unrest ... incident ... affair ... collective protest ... insubordination ... strike ... disaffection").^{60(p562)} Rose indicates that there are compelling reasons for command to do this: "...mutiny is the antithesis of discipline"^{60(p562)} and a commander who "allows" a mutiny to occur jeopardizes his career and those of his "commanding officers up and down the line."^{60(p563)}

Most indiscipline, of course, is more subtle than combat refusal and does not appear to be related to it. However, unavailability for combat is a frequent consequence of indiscipline. The main role of the psychiatrist is in prevention since the same conditions that give rise to neuropsychiatric casualties may produce indiscipline as another evacuation syndrome.

Early in the Vietnam War the majority of American soldiers were volunteers who served together prior to deployment to Vietnam. Morale was generally high. In the later phases of the war an unpopular officer or non-commissioned officer (NCO) would have been a likely "fragging victim" (killed or injured by a fragmentation grenade thrown by a fellow American).

Linden⁶¹ reported that there was a progressive rise in the number of courts martial for insubordination and assaults (including murder) on officers and senior NCOs during the Vietnam War. He attributed these incidents to disaffection and poor morale because the war was increasingly seen as useless by the soldiers who were unwilling to risk their lives in a lost cause. The specificity of circumstances and the importance of leadership surrounding that form of indiscipline called combat refusal is often seen.

Indiscipline is not limited to subordinate ranks. Perhaps the most notorious example of collective indiscipline during the Vietnam War occurred in the My Lai incident.

Case Study: Lieutenant Calley

[Although the author was one of three Army psychiatrists who examined First Lieutenant William Calley and testified at his court martial, the information given in this case comes from public records of the trial.] Calley testified that he had been ordered to go to My Lai and "kill the enemy"; however, the major who had allegedly given the order was killed before the trial began. Several factors are important in understanding this incident. First, prior to assignment in Vietnam, Calley was stationed in Hawaii where he was exposed to numerous "after action" and "lessons learned" reports coming from Vietnam. Many of these emphasized the dangers from civilians who were secretly Viet Cong. Many reports included descriptions of Vietnamese women and children unexpectedly killing and wounding Americans with grenades and satchel bombs. Secondly, Calley identified strongly with his men and was quite upset when his company incurred large numbers of casualties in the My Lai region (thought to be pro-Viet Cong) not long before the killings in My Lai. He was even more upset because he had been away when this occurred. Finally, Calley tended to see things in a black or white, all-or-none fashion. If the enemy included women and children and the enemy were supposed to be killed, so be it. 1LT Calley was convicted of having ordered and participated in the killing of about two dozen Vietnamese men, women, and children. Evidence in the Peers Investigation Report suggested that over a hundred persons were in fact killed. One soldier in the unit may have disobeyed orders to kill the villagers by a self-inflicted wound to his leg; his "indiscipline" prevented worse indiscipline on his part.

Comment: This form of indiscipline in which not only military but also international rules for handling prisoners are disregarded

may be more common in low-intensity wars. Following the recapture (by American and South Vietnamese forces) of Hue during the Viet Cong and North Vietnamese Tet Offensive, a mass grave was found containing the bodies of about one thousand men, women, and children presumably slaughtered by the North Vietnamese. Similarly, torture and killing of POWs occurred in the French-Algerian War, in the guerrilla warfare in Central (El Salvador and Nicaragua) and South America (Argentina), and in 1995 reports of POWs in the former Yugoslavia.

Indiscipline by a high-ranking officer occurred in the 1982 Israel-Lebanon War when Colonel Eli Geva (commander of the Israeli tank force outside Beirut) refused to lead his troops into Beirut which he expected to entail killing civilians. Geva urged that Beirut not be attacked and asked to be demoted to tank crew member if the city were attacked. Rapid decisive action (Geva's prompt removal and isolation from other military personnel) coupled with the decision to launch a more discriminating attack that would minimize civilian casualties prevented other commanders from following suit.⁶² Calley was criticized for showing too little concern for civilians, Geva for showing too much.

Post-traumatic Stress Disorders

To the heterogeneous syndromes found in low-intensity wars which have been labelled "nostalgic casualties" should be added chronic and delayed post-traumatic stress disorders (chronic and delayed PTSD). PTSD is usually and appropriately thought of in the context of acute overwhelming stress; however, the frequent morale problems of low-intensity, ambiguous wars may carry over into the post-war lives of the former combatants.

The current discontents of these war veterans may find expression in the reappearance or new appearance of symptoms associated with combat: anxiety and fears, automatic hyperactivity, re-living of psychologically traumatic events,

and a variety of other malaises. Such symptoms often follow service in wars of high intensity as well, particularly when the outcome was unsatisfactory or there is psychological or financial gain from such symptoms. This was seen, for example, in the large numbers of German veterans of World War I who developed chronic war neuroses (many of whom would now be labelled chronic PTSD) compared with the small numbers of such cases following World War II.⁶³

In both cases Germany lost the war but one difference was that after World War II veterans were not given pensions for neurotic (non-psychotic or non-organic) conditions due to the experience of German psychiatrists who knew of the World War I findings, and due to the general opprobrium earned by the military because of Nazi atrocities.

Post-traumatic stress disorders evolved from the Freudian concept of "traumatic neurosis" and technically may be part of the combat stress disorders spectrum, either of the acute, chronic, or delayed type. The chronic and delayed forms of PTSD have assumed considerable importance as sequelae of combat in Vietnam and in the 1982 Israeli-Lebanon War. PTSD and its relationship to combat is explored at length elsewhere.⁶⁴ Here it is important to recognize that PTSD symptoms can follow any serious psychological trauma, such as exposure to combat, accidents, torture, disasters, criminal assault and exposure to atrocities or to the sequelae of such extraordinary events. Prisoners of war exposed to harsh treatment are particularly prone to develop PTSD. In their acute presentation these symptoms, which include subsets of a large variety of affective, cognitive, perceptual, emotional and behavioral responses which are relatively normal responses to gross psychological trauma. If persistent, however, they develop a life of their own and may be maintained by inadvertent reinforcement. Early intervention and later avoidance of positive reinforcement (which may be subtle) for such symptoms is a critical preventive measure.

TREATMENT OF LOW-INTENSITY COMBAT STRESS DISORDERS

Although successful treatments for low-intensity combat stress casualties were developed as early as the Napoleonic Wars, circumstances can prevent the application of remedies. For example, during the Vietnam War the 1-year rotation policy, ostensibly for the purpose of preventing psychiatric casualties due to cumulative stress, the policy of rotating commanders out of combat units after 6 (and later only 3) months in order to give more officers combat experience, and the policy of individual replacement of losses rather than unit replacements all interacted to impair unit cohesion which might have prevented some of the nostalgic casualties.

Treatment of chronic PTSD may be summarized as the appropriate treatment of acute PTSD following combat psychiatric principles, not reinforcing symptoms associated with chronic and delayed PTSD, use of evocative therapies emphasizing correcting current maladaptive behaviors and judicious use of pharmacotherapy in some cases.

A critical component of treating chronic PTSD is determining associated conditions, especially drug and alcohol abuse, and treating them as well. The use of a relaxation technique such as one of those described by Benson⁶⁵ can be critical in managing anxiety symptoms without resorting to medications or may be adjunctive to their use.

Vietnam revealed the limits of World War II type psychiatric treatment policy in a low-intensity, prolonged, unpopular conflict. Such conflicts, if they cannot be avoided, must be approached with primary prevention as the focus. Career soldiers with strong unit cohesion will not endanger themselves, their fellows, or their careers by abusing alcohol or drugs. When casualties do occur, the Larrey treatment for nostalgia can be used as a model.²⁴ Baron Larrey, a French physician of the Napoleonic Wars, prescribed vigorous exercise, patriotic music and association with soldiers of the line to treat nostalgia.

EFFECTS OF THE VIETNAM WAR ON AMERICAN PSYCHIATRY

Like the stalemated latter half of the Korean War, the Vietnam War became controversial and unpopular after the Tet (Chinese New Year) Viet Cong offensive of January 1968. Although this was the defeat of a last gasp attempt by the South Vietnamese rebels to overcome repeated losses in the field which resulted in the virtual destruction of the rebel forces, it proved to be a brilliant political victory by its encouragement of the peace faction of the American population. Antiwar protesters redoubled their efforts and draft resisters increasingly gained media attention. Some physicians in the military refused to contribute to the war effort and faced courts martial. Some soldiers returning from overseas duty were reviled and even attacked.

The rifts in society were reflected in organized American psychiatry in which resolutions were proposed (and passed in some organizations) requesting the ouster of military psychiatrists from organized psychiatry. Camp²⁶ has argued that military psychiatrists were abandoned by organized psychiatry and left to handle ethical dilemmas on their own. The Vietnam War resulted in the end of military conscription and a great hesitancy of politicians to engage in overt foreign adventures (and perhaps encouraged covert operations which sometimes ran afoul of the law). It took almost a generation for military service to again become respectable.

Chapter 14

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Chapter 16

COMBAT AND MILITARY PSYCHIATRY IN THE FUTURE

Franklin Jones, MD, FAPA

FUTURE COMBAT

Future wars may differ drastically from previous wars. Although the former Soviet nation states are mostly considered allies or at least neutral to the NATO allies and NATO has overwhelming military superiority, conflicts with nations that have advanced military technology are possible. This was demonstrated in the Persian Gulf War in which Iraq launched advanced missile systems resulting in military and civilian casualties and posed the potential risk of mass casualties.

Future wars that pose the risk of use of weapons of massive destruction (chemical, biological, or radiation weapons) will require dispersion and mobility of allied forces. Furthermore a technologically advanced enemy may possess sensors capable of detecting aggregations of materials and personnel.

This scenario would severely erode the traditional principles of combat psychiatry.

Combat psychiatric treatment requires a safe setting near the battle area in which mental health personnel can render simple supportive treatment followed by return of the casualty to his own unit. The ability to target aggregations of personnel and equipment will mean that treatment settings may be far from the battlefield. The dispersion and mobility of tactical units will make it very difficult to return casualties to their own units.

Despite strenuous efforts of prevention including strengthening unit cohesion, avoiding physiological deficits and optimizing personality variables, psychiatric casualties will occur. Treatment of these casualties requires development of new principles of management. Combatants will need to

recognize combat stress reactions in themselves and their comrades and take remedial action. This may be as simple as arranging for nutritional and sleep replenishment. It may include reassurance from a squad leader, commander or medical aidman. It is possible that a rapid-acting, non-sedating, non-addictive anti-anxiety drug may be developed to treat soldiers on the battlefield.

Currently buspirone, an azapirone with partial serotonin agonist actions, is a non-sedating, non-addicting anxiolytic; however, it has an approximately 10-day latency prior to its therapeutic effects. Furthermore, buspirone's activating effects may not be desirable and may interfere with sleep. It may prove useful in returning refractory cases to duty. The notion that medicated soldiers would lack compassion and would release inappropriate aggression has little basis in fact or theory.

If a combat stress casualty is evacuated and cannot be returned to his or her own unit, it may be possible to incorporate him into a newly created unit of such casualties. This may be necessary anyway if units are markedly degraded in mass casualty actions. Creating such units would be a formidable but accomplishable task utilizing known techniques to create cohesion and morale; however, it would probably require several weeks of intensive work with mental health professionals.

FUTURE ROLES OF THE MILITARY

While defense of the nation through readiness for combat is the *raison d'etre* of a military, many other roles have been played in the past and will be played in the future. These roles have included peace keeping (currently occurring in the Sinai and Macedonia) often with other United Nations Forces, refugee management and relocation (as occurred in the influx of Cuban marielitas [from Mariel, the port of departure] and is currently occurring with Haitians and Bosnians), rescue operations (as occurred in Grenada and is occurring in Somalia), large-scale rioting (as occurred in Chicago,

Washington, D.C. and Los Angeles), assistance in disasters as occurred with Hurricanes Hugo and Andrew and with the 1993 Mississippi flooding), and intercession of drug trafficking (as occurred in South America and is a cooperative effort with the Justice and Treasury Departments). Recently military forces have taken a pro-active stance interdicting commercial refugees from Haiti and China.

The Army maintains a special unit, Delta Force, at Fort Bragg, North Carolina to combat terrorists. The need for such a unit was recognized with the dismal failure of a combined services attempt to rescue the 52 hostages in Iran. Since Islamic terrorists have recently targeted the Federal Bureau of Investigation (FBI) and the World Trade Center in New York City, there will likely be an increased role in countering or responding to such threats.

New roles for the military may include resocialization of offenders of the criminal justice system. Experimental programs based on basic training approaches and run by former military personnel are being tried by some jurisdictions. It is reasonable to expect that the military itself could assume such responsibilities if not engaged in other pressing activities.

SOME FINAL REMARKS

This history of warfare reveals certain recurring themes concerning soldiers who persevere in combat versus those who break down in combat. Both groups are often quite similar as individuals (and may even be the same individuals); however, their social situations are markedly different. The social situations consist of a matrix of factors which determine whether the soldier excels or breaks down.

Thus, in adapting to combat, as in all survival-relevant activities, humans respond holistically. Their physical, intrapsychic, and social states form this matrix of factors which influences their responses to environmental danger. In combat, deep urgings for individual survival often conflict with socially conditioned expectations, requirements, and desires for "soldierly

conduct" which have been embodied in ideals such as patriotism, discipline, loyalty to comrades and identification with the leader.

To prevent combat breakdown the presence of mission-oriented small group cohesion is essential. Cohesion is fostered by good leadership and by having soldiers train, live and experience stress together. Further preventive measures include adequate rest, sleep, and nutrition so that chronic or acute fatigue does not develop. Rest from battle should ideally occur through small group rotation so that group support is continuous. Commanders should be open and honest with their subordinates to build trust and vertical cohesion and to enhance the soldier's understanding of the importance of his or her contribution to the unit mission and the national interest. The soldier must believe that the entire society supports him or her in suffering privations and sacrifices.

Factors which foster psychiatric breakdown are the negatives of the preventive factors: poor leadership, cohesion and training, inadequate social support, and the buildup of fatigue. Factors which emphasize perceptions of individual or collective vulnerability increase the probability of psychiatric breakdown. This accounts for the strong relationship between intensity of combat (as measured by wounded and killed in action) and numbers of stress casualties. It also accounts for the observation that death of a comrade was the most common precipitant of breakdown during World War II. A feeling of helplessness in controlling one's fate also exacerbates stress and weakens resistance. This is seen in the increased stress casualties which occur in circumstances of indirect fire such as artillery or bombing barrages, or gas attacks compared with the direct fire situation (even though the wounded and killed rate may be the same or higher than under indirect fire).

After a soldier has become a psychiatric casualty, it is important to restore as many positive factors as possible: rest, sleep and nutrition. Bonds to the unit are kept intact with expectation of return to the unit, hence the importance of treating as far forward and as quickly as possible. Treatment must be kept simple to emphasize the normality of the soldier's

experience rather than give an imputation of mental illness. In garrison or rear-echelon settings prevention is even more important since the disorders which occur (alcohol and drug abuse, character disorders, and sexual problems) are even more difficult to treat than combat stress disorders. In rear-echelon settings attention should be paid to discipline, morale-enhancing activities, and recognition of the critical role played by support troops. Communication between support troops and those they support should be encouraged. Temporary assignment to combat units should be available. Infractions should be dealt with through forward rather than rearward evacuation to minimize secondary gain from misbehavior.

Prevention of combat stress casualties is primarily a command responsibility but the medical person, through consultation with command and avoidance of medical "evacuation syndromes," plays a critical role in this endeavor. The psychiatric lessons of war can profitably be applied to military communities during peacetime and to civilian communities.