American Handbook of Psychiatry

MENTAL HEALTH PROGRAMS IN THE ARMED FORCES

Albert J. Glass

MENTAL HEALTH PROGRAMS IN THE ARMED FORCES

Albert J. Glass

e-Book 2015 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 2* edited by Silvano Arieti, Gerald Caplan

Table of Contents

MENTAL HEALTH PROGRAMS IN THE ARMED FORCES

To appreciate the unique contributions of military psychiatry, it is necessary to recognize its origin and development as a logical extension of military medicine. Military medicine was born of a necessity to conserve personnel, particularly in combat operations. Experiences of past warfare had repeatedly demonstrated a marked attrition of military manpower, of far greater magnitude than battle losses from infectious diseases, climate extremes, and other nonbattle injury and disease. Minimizing losses from combat causes was also important, for even relatively minor battle injuries could and did result in a large loss of trained manpower. Clearly, wars could be won or lost dependent on the ability "to conserve the fighting strength."[1]

Not until the latter half of the last century did advances in medicine make available an increasing technical capability of safeguarding military personnel from externally induced disease and injury. Thus, military medicine was fated to pioneer in the development of preventive and treatment techniques for disease and injury of environmental origin. It was therefore inevitable for military psychiatry to be created as a branch of military medicine in order to curtail manpower losses from mental disorders, when it became evident that such casualties were of situational or environmental origin.

Military Psychiatry Before World War I

Prior to World War I, mental disorders in military personnel, as in civil life, were restricted to severe or bizarre conditions of psychotic proportions. Because of the low incidence of mental illness as then defined, which was ascribed to internal pathology rather than environmental causes, there was little interest or concern for these problems by the expanding activities of military medicine. Such cases were either discharged from the service or transferred to the Government Hospital for the Insane in Washington, D.C. (now St. Elizabeth's Hospital).

Situational causation of mental illness in military personnel was clearly demonstrated during the Civil War by the prevalent syndrome of nostalgia, which was characterized as a "mild type of insanity caused by disappointment and a continuous longing for home." However, psychiatric sophistication at that time was insufficient to grasp the concept of a situationally induced mental disorder. Instead, emphasis was placed on the innate vulnerability of youthful personnel as the cause for nostalgia. In the Russo-Japanese War (1904-1906), when mental disorders of combat troops were first treated by psychiatric specialists, their somewhat increased frequency was attributed to exposure to high explosives. However, these observations excited little comment.

World War I

From reports of the early fighting on the Western front in 1914, a new psychiatric disorder appeared that was of such frequency as to constitute a major loss of military manpower. Warfare had reached new heights of destruction and terror, and these new mental disorders seemed clearly to be of environmental origin. However, it was necessary that failure in the combat role be manifested by symptoms or behavior acceptable to the reference group and its leaders as constituting an inability rather than an unwillingness to function in battle. Similar but less frequent adaptive failure in previous wars was usually regarded as evidence of weakness and characterized as cowardice or other expressions of moral condemnation. Thus, initially, psychiatric casualties of World War I seemed to be a direct result of enemy shelling, hence the terminology of shell shock. By 1915-1916 the Allied medical services clearly recognized shell shock to be a psychological disorder, and terminology of the "war neuroses" came into common usage. But by this time, psychiatric casualties had achieved legitimacy as a disease and thus an inability to function in battle.

The 1914 shell shock cases from Allied combat troops were evacuated to the remote rear where they quickly overtaxed existing civil and military medical facilities. Later, special neuropsychiatric hospitals were established; but in rear facilities almost all shell shock casualties remained unimproved and refractory to treatment. After many months, neuropsychiatric hospitals for the war neuroses were established in the zone of active military

operations. The better results obtained in advanced positions prompted a further extension of treatment nearer the front in British casualty clearing stations and similar forward posts of the French medical services. In 1916 Allied psychiatrists and neurologists reported that a majority of the war neuroses could be returned to combat duty by forward treatment. With further experiences, the British and French medical services showed conclusively that the war neuroses improved more rapidly when treated in permanent hospitals near the front than at the base, better in clearing stations than even at advanced base hospitals, and better still when encouragement, rest, persuasion, and suggestion could be given in the combat organization itself.

Upon entry of the United States in World War I (April 1917), Major Thomas Salmon, the chief psychiatrist of the American expeditionary forces, and his associates, fully aware of the British and French experiences, gradually established a network of services for the war neuroses. The three-echeloned system that became fully operational during the last several months of the war included:

1. Divisional psychiatric facilities, which held shell shock disorders for three to five days of rest, suggestions, and other psychotherapeutic measures under supervision of the division psychiatrist.

2. Neurological hospitals, which received refractory cases from

nearby divisional facilities and had a treatment capability of several weeks.

3. A special psychiatric base hospital located in the advanced communication zone, which provided prolonged treatment for the most resistant of the war neuroses in order to prevent chronicity and evacuation to the United States.

An important aspect of treatment at all levels was noted by Salmon and Fenton as "an intangible and mysterious influence termed 'atmosphere.' " Perhaps this observation was the first direct reference to the environment of treatment, which included those feelings and attitudes of all medical personnel who came in contact with the war neuroses and sought to provide an urge or incentive for return to duty.

In retrospect, military psychiatry in World War I provided much of the conceptual framework on which has been based the current community mental health movement. Major contributions in this regard can be subsumed as follows:

1. Repeated demonstrations showed that situational stress and strain can produce mental disorder in so-called normal personnel as well as in those of neurotic predisposition. Previously, mental illness had been regarded as originating almost exclusively from physical and/or psychological abnormalities within the individual.

2. The development of treatment at the site of origin was a logical consequence of recognition that the war neuroses were caused by situational circumstances. It made possible a therapeutic rationale of prompt intervention measures with the objective of adjustment to the combat situation rather than evacuation to remote hospitalization with fixation of failure and symptoms of chronic disability. In time, the importance of location in the treatment of mental disorders has become a basic principle of the community delivery of services.

3. A network of supportive treatment facilities for the war neuroses from forward to rear areas was established by the American expeditionary forces. Only recently has the value of such a comprehensive network of services for mild to severe mental disorders become appreciated; it is in various stages of implementation as a linkage of community services with supportive state facilities.

4. Probably for the first time, the environment of treatment including its location, physical facilities, and the attitudes and behavior of treatment personnel was utilized as a therapeutic instrument. Later, this concept formed the basis for various types of milieu therapy and in military psychiatry became the principle of expectancy for return to duty.

Post-World War I

With the end of hostilities, the contributions of military psychiatry were largely disregarded. Psychiatry at this time was not prepared to grasp the significance of social or situational determinants of mental disorder or the importance of location and therapeutic atmosphere in its treatment. Moreover, extensive clinical experience with the persistent residual syndromes of the war neuroses in the postwar years created a widespread belief that these problems originated mainly from persons who were vulnerable to situational stress by reason of neurotic predisposition. The limited ability to cope with combat was deemed the result of faulty personality development and thus conformed to the psychoanalytic model of the psychoneuroses and was so generally diagnosed.

Military psychiatry after World War I became a permanent component of U.S. military medicine. Psychiatric units of open and closed wards with outpatient services were provided as sections under the medical services at all U.S. Army general hospitals. The practice of military psychiatry at these large Army hospitals was similar to that of civil mental facilities. But neither locally based treatment nor other concepts of social psychiatry as elaborated by the American expeditionary forces survived after World War I. Curiously, during the period it was generally believed that the major lesson learned by military psychiatry in World War I was the importance of psychiatric screening at induction to remove vulnerable candidates for service and thus prevent the emotional breakdown of troops in peace or war. Yet none of the

experiences of World War I indicated that studies were conducted or observations made on the validity of psychiatric screening.

World War II

Because of the above-stated circumstances and other problems of need and expediency during the early phases of World War II, the contributions of military psychiatry of World War I were completely ignored. Instead, reliance was placed on psychiatric screening. The subsequent failure of the psychiatric screening program has been well documented.* As a result, there was little preparation for the management of psychiatric disorders, combat or otherwise. With expanding mobilization and the onset of hostilities, a high incidence of mental disorders soon overwhelmed existing medical facilities. The major available diagnostic category for these mainly situationally induced mental disorders was psychoneurosis with its implication of unresolved internal conflict from which symptoms were unconsciously derived. The newly built cantonment hospitals of World War II were soon filled with refractory symptomatic disorders in which psychological problems were a major component. The only resolution to this mounting caseload was medical discharge for psychoneurosis. Thus, mental illness became the major cause of manpower loss in the U.S. Army. As in World War I, combat psychiatric casualties were evacuated hundreds of miles to distant medical facilities where few could be restored to combat duty. Again, terminology for

these cases was “psychoneurosis.” With such labeling and its connotation of individual weakness, it was difficult for psychiatric casualties to be accepted by the combat group and its leaders as being the result of battle conditions; rather, they were considered the result of failure in induction screening.

Because of the above-stated events, efforts were made by individual psychiatrists and later by coordinated programs to establish locally based or forward treatment services. However, more than two years elapsed in World War II before sufficient organizational and operational capability was developed to deal adequately with the large incidence of wartime mental disorders. These changes occurred during 1943 and 1944, first in training bases in the United States and later in overseas combat theaters.

Extramural psychiatric units termed “consultation services” were gradually established at each of the training camps to provide outpatient treatment for symptom disorders and participate in the orientation of trainees. Later, psychiatric personnel included the function of consultation to trainer personnel in influencing decisions relative to facilitating the adjustment of trainees. By firsthand observation, psychiatrists of the consultation services became aware of the problems of trainees in dealing with separation from families and loved ones, lack of privacy, regimentation, unaccustomed physical activity, and other deprivations and changes incidental to the transition from civil to military life, t This function of

consultation is perhaps the earliest demonstration of the utilization of indirect psychiatric services, which has now become an essential component of the community mental health approach to prevention.

During the later phases of the Tunisia campaign (March 1943), successful attempts were made to reestablish the World War I forward treatment for psychiatric casualties. Soon thereafter, a new terminology for psychiatric casualties was adopted. By directive, all psychiatric disorders in the combat zone were ordered to be designated as exhaustion regardless of manifestations. Other and more definitive diagnoses were permitted in rear medical facilities. With the acceptance of exhaustion, manifestations of combat psychiatric breakdown became less florid or dramatic. Psychiatric casualties did not need to portray "psycho" to communicate inability to function in battle. Beginning in March 1944, a three-echeloned system of services similar to that of World War I was implemented. The prolonged and diversified experiences of military psychiatry in World War II refined and elaborated on the accomplishments of World War I psychiatry as follows.

1. Causation. Perhaps the most significant contribution of World War II psychiatry was recognition of the sustaining influence of the small combat group or particular members thereof, termed "group identification," "the buddy system," or "leadership," which was also operative in noncombat situations. World War II clearly showed that interpersonal relationships and

other situational circumstances were at least as important as personality configuration or individual assets and liabilities in the effectiveness of coping behavior. The frequency of psychiatric disorders seemed to be more related to the characteristics of the group than the character traits of the individual.

2. Treatment. During World War I and World War II, it was apparent that forward and early treatment afforded the opportunity of providing prompt relief for fatigue, loss of sleep, hunger, and other temporary physiological deficits. However, it was not until recognition of the sustaining influences of group and interpersonal relationships that the significance of treatment near or at the site of situational origin of psychiatric disorders was fully appreciated. Proximity of treatment maintained relationships and emotional investment in the core group. There existed in psychiatric casualties under conditions of forward treatment varying degrees of motivation to rejoin the combat group, which was heightened by improvement in physical well-being from recuperative measures of sleep, food, and the like. Also treatment in the combat zone provided an atmosphere of expectancy for improvement and return to duty. Forward location and brief simplified treatment clearly communicated to both patients and treatment personnel that psychiatric casualties constituted only a temporary inability to function. Conversely, removal of psychiatric disorders to distant medical facilities weakened emotional ties with the combat group with implications of failure, for which continuation of the sick role was the only

honorable explanation.

3. Diagnosis. An important but as yet only a potential contribution of military psychiatry concerns the influence of diagnosis. World War I and World War II demonstrated that a definitive diagnosis in an early and fluid phase of a mental disorder can adversely affect the individuals so involved as well as exert a negative expectancy by treatment personnel toward improvement or recovery. Practically all available psychiatric diagnoses indicate the existence of organic or intrapsychic pathology, such as character and personality disorder, neurosis, psychosis, and brain damage. As yet, there is little usage of diagnostic designation for failure of adaptation, which would include both external and internal determinants of behavior. Even the addition of reaction to the usual diagnostic categories in World War II has been recently abandoned. For the above reasons, it is suggested that civil psychiatry would be as equally benefited as has been military psychiatry in avoiding the early use of definitive diagnoses, which place emphasis mainly on the liabilities of individuals and negate the setting in which failure of adjustment occurred. In the initial stages of patient contact, it would seem reasonable to utilize a general descriptive label and permit later events to determine the need for a more definitive diagnostic categorization.

Post-World War II

Following cessation of hostilities, military psychiatry maintained a coequal status with medicine and surgery achieved in World War II. With other branches of military medicine, specialty medical training in psychiatry was instituted. Curiously, during the early postwar years, as following World War I, military psychiatry, like civil psychiatry, ignored the lessons of wartime experiences. Instead, attention was focused on the then prevalent psychoanalytic concepts and practice. At this time, there was a major need to explain symptoms and behavior on a dynamic rather than descriptive basis. The emerging field of social or community psychiatry had no conceptual frame of reference or special language. In contrast, psychoanalysis had a unified theory, considerable historical background, much literature, and a special vocabulary for expression and communication. At this time, military psychiatry in its training and practice emulated the expanding departments of psychiatry of the various medical schools. The wartime consultative services were largely discarded.

Korean War

After the abrupt onset of the Korean War on June 25, 1950, U.S. Army psychiatry moved rapidly to establish the World War II system of mental health services both at home and overseas. A three-echeloned network of services for psychiatric casualties was in operation during the early fall of 1950. The ineffective psychiatric screening of World War II was abandoned. A

rotation policy of nine to twelve months in the combat zone, which had been unsuccessfully urged in World War II, was instituted after the first year of the Korean War. Mental hygiene consultation services were established at all major army bases in the United States. These units, utilizing psychiatrists, psychologists, social workers, and enlisted technicians, provided an expanded and flexible capability in furnishing direct care for referred problems and indirect consultation services for supervisory personnel.

As a result of the prompt implementation of the psychiatric lessons learned in World War II, during the initial year of severe combat in the Korean War the frequency of psychiatric disorders was less than one-half of the high incidence in World War II. Thereafter, a steady decline of the psychiatric rate occurred, which during the last year of the Korean War reached almost to previous peacetime levels.

Developments since the Korean War

During and following the Korean War, there has evolved an increasing application of social psychiatry principles in the practices of military psychiatry. This trend and its momentum were considerably influenced by the training and research activities of the neuropsychiatry division, which was established in 1951 and headed by David McK. Rioch. In this regard, symposia held at the Walter Reed Institute of Research in 1953 and 1957

brought together emerging civil and military concepts and experiences in social psychiatry and provided a needed body of theory and operational framework of reference for expansion in this area.

From the beginning of this era, emphasis in military psychiatry has been placed upon the activities of locally based mental health facilities, both in the field, at the division level, and on posts and bases, by Mental Hygiene Consultation Services (MHCS). These forward-level psychiatric units explored new approaches and developed innovative techniques in providing direct and indirect mental health services. Thus, over time, there have been incorporated into the regular operations of military psychiatry changes in the direction of social or community psychiatry as follows: (1) organizational flexibility and (2) field service program.

1. Organizational flexibility. An early basic change discarded traditional clinic procedure in which each referral was subjected to multiple examinations, including social history, psychological testing, and psychiatric evaluation, from which diagnoses and decisions for treatment or disposition were derived. Inevitably, such a time-consuming ritualistic arrangement produced long waiting lists and little flexibility in the utilization of personnel. In its place, a screening or triage function was assigned to an experienced social worker, who in the initial interview evaluated presenting problems with prompt referral to the appropriate staff member. Waiting lists were

abolished and routine psychological testing eliminated in favor of specific requests for such services, and psychiatrists were utilized mainly in consultation and supervision. All professional staff members were made available for evaluation and treatment with a free interchange of consultation. With achievement of organizational flexibility, the role of enlisted personnel changed from reception and clerical duties to active involvement and interaction with patients. Enlisted personnel became utilized in intake evaluation, the obtaining of collateral information, and counseling, dependent on training and experience. It was soon noted that enlisted specialists could readily obtain realistic accounts of situational problems and render effective counseling services. Enlisted staff members proved to be enthusiastic workers with considerable understanding of and empathy with the difficulties of fellow enlisted men. This more flexible organization and availability of staff permitted local military mental health services to make further advances.

2. Field service program. With time, it became apparent that more satisfactory results could be obtained when the location of evaluation and treatment was displaced from clinic facilities to the unit from which referral was made. In the field service program, an enlisted specialist responded to requests for mental health services by proceeding to the referring organization. Interviews were conducted with the subject and significant other persons in barracks, dayrooms, or offices. Experience demonstrated

that more valid data could be obtained within the unit, from both the individual concerned and collateral information. Referring units came to appreciate that the objective of mental health services was adjustment rather than removal. The field service program was conducted almost entirely by enlisted specialists with back-up supervision usually by social work officers. In this program, the enlisted specialist always had the option of promptly bringing subjects to the clinic. His instructions were to deal with problems unless unable to communicate with the referred soldier or understand his situation. In time, 50 percent of referrals to the psychiatric unit for services were handled by the field service program.

It is pertinent to review the development of the enlisted specialist in mental health services. During World War II, enlisted personnel with usually little or no previous training were made available through on-the-job experience to assist psychiatrists and nurses (also to some extent, social workers and psychologists) in order to expand the services of these scarce professionals. After the war, formal training programs were instituted to train enlisted specialists as neuropsychiatric technicians to work in psychiatric inpatient services and as social work and psychology technicians for clinic or divisional mental health services. In addition, even larger numbers of enlisted specialists were made available through on-the-job training by the various mental health facilities. More recently, social work and psychology training have been combined to produce enlisted mental health specialists for

function with field and post psychiatric services. Such enlisted specialists may also be directly obtained from military personnel having bachelor of arts degrees, with graduate work or experience in a related field.

Command Consultation

During this period, there was increasing awareness that the majority of mental disorders in military personnel represented casualties or failures of adjustment in part at least due to circumstances or problems within the referring organization. As indicated previously, experiences in World War II and the Korean War had already demonstrated that the frequency of combat psychiatric casualties was, in addition to the intensity of battle, related to the characteristics of the group and/or its leadership. In this era, similar relationships were observed in the origin of psychiatric disorders from peacetime military activities.

Consistent with the above trend, the more flexible organization of local military mental health facilities following the Korean War made possible a wider utilization of professional and nonprofessional consultants to unit commanders at various levels; thus the term “command consultation.” In this program, consultation services are usually initiated with commanders on the basis of a mutual effort to resolve the particular adjustment difficulties of an individual who was referred to the local mental health facility. After repeated

instances of successful collaboration for specific individuals, a positive consultant-consultee relationship is established, which serves as a channel for more general issues of the command management of personnel. In this area, the consultant often has much to contribute, including epidemiological data, relative to the incidence of various categories of noneffective behavior, such as mental disorder, delinquency, and alcoholism. Soon specific problems are raised, such as screening for certain special schools, alteration of training procedures, and the identification of organizational problems. In essence, psychiatric personnel learn to serve as consultants in personnel management as restricted to conditions under which military personnel live, work, train, and fight. To perform this function, psychiatric personnel must have firsthand knowledge of unit activities as well as direct and collateral information concerning the maladjustment of referred individuals.

Consultation was extended to such post special services as the judge advocate for offenders and the provost marshal in the problems of confinement. Out of these consultation activities, there arose a mutual concern with the problems of the military offender and the correctional process in post stockades and military prisons which led to the development of the stockade screening program.

With study of the correctional program, it became apparent that offenders in the five Army prisons who received sentences and a

dishonorable discharge by general court martial had served one or more previous sentences in local post stockades for lesser offenses. Also the large majority of convictions both in stockades and prisons were for military type offenses, such as AWOL, desertion, and insubordination. Thus, the natural history of most military prisoners was clearly portrayed as nonconformist behavior relative to military rales and discipline which was repetitive and often led to a prison sentence with dishonorable discharge. Intervention at the stockade level appeared to be a logical procedure to prevent extended noneffective behavior.

Accordingly, a program was gradually established on major posts in the United States and overseas that evaluated each admission to the stockade as to assets, liabilities, situational problems, and potential for adjustment in the military service. Local psychiatric personnel from divisions or post mental hygiene consultation services, mainly enlisted specialists and social work officers, accomplished such evaluations within the stockade and thereby became aware of correctional procedures at firsthand. Then followed mutual efforts with judge advocate, provost marshal personnel, and unit commanders to consider the potential of each stockade inmate. By this procedure, changes could be made in assignment, training, or other conditions for the individual offender to aid in adjustment on release with follow-up counseling usually by enlisted specialists. When it became apparent that attitudes and motivation of the stockade prisoner were such as to

preclude effective adjustment in military service, administrative discharge was accomplished by agreement with the unit commander. Under these circumstances, before a record of repeated violations could be accumulated, a discharge under honorable conditions for unsuitability was usually given, which provided a more favorable opportunity for later adjustment in civil life. Within three to four years of the operation of this program, reduction of general prisoners was such that four of five Army prisons were closed, with a marked decline of dishonorable discharges. This utilization of intervention has been extended to correctional programs of all branches of the armed forces.

Vietnam

According to authoritative reports, military psychiatry in the Vietnam conflict achieved its most impressive record in conserving the fighting strength. In its operations, enlisted mental health specialists were utilized for intervention, treatment, and consultation to a greater extent than previously practiced or even envisioned. The dispersed and intermittent nature of combat in Vietnam, with episodic search and destroy missions and perimeter fighting, made necessary a corresponding dispersal of divisional psychiatric services. The eight enlisted specialists in each combat division were assigned in pairs to each of four medical companies, which were distributed to provide medical services over the large area of division operations.

In a combat division of 15,000 to 18,000 men, psychiatric referrals averaged from 100 to 200 per month. Intake evaluations and counseling were performed by enlisted specialists, who conducted follow-up services. Enlisted specialists worked in close association with battalion and company medical officers who prescribed psychotropic and other medication as appropriate and provided for brief hospitalization as indicated. The division psychiatrist and division social worker visited the medical companies regularly for supervision. In addition, radio and landline communication enabled the enlisted specialist to contact these supervisors at any time. The more severe psychiatric problems were transferred to the division psychiatric treatment unit. Consistent with increased responsibility for direct services, enlisted specialists assumed an active role in providing consultation services, particularly for sergeants and junior officers.

As a result of forward divisional mental health services, so few psychiatric disorders had been evacuated to rear medical facilities as to create the impression that psychiatric casualties were rarely produced by the unique nature of combat in Vietnam.

Conclusion

This chapter presents the historical development of military psychiatry in the U.S. Army. Particular emphasis is placed on its evolution into programs

of social psychiatry, utilizing the principles of immediacy, proximity, and expectancy.

Bibliography

Bailey, P., Williams, F. E., and Komora, P. O. "In the United States." In *The Medical Department of the United States Army in the World War.* Vol. 10. *Neuropsychiatry.* Washington, D.C.: U.S. Government Printing Office, 1929.

Bey, D. R., and Smith, W. E. "Mental Health Technicians in Vietnam." *Bulletin of the Menninger Clinic,* 34, no. 6 (1970), 363-371.

Bourne, P. A. "Psychiatric Casualties in Vietnam, Lowest Ever for Combat Zone Troops." *U.S. Medicine,* May 15, 1969.

Glass, A. J. "Observations Upon the Epidemiology of Mental Illness in Troops During Warfare." In Walter Reed Army Medical Center, *Symposium on Preventive and Social Psychiatry.* Washington, D.C.: U.S. Government Printing Office, 1958.

----, Artiss, K., Gibbs, J. J., and Sweeney, V. C. "The Current Status of Army Psychiatry." *American Journal of Psychiatry,* 117 (1962), 675.

----, and Bernucci, R. J. *Neuropsychiatry in World War II.* Vol. 1. *Zone of the Interior.* Washington, D.C.: U.S. Government Printing Office, 1966.

Medical Department, U.S. Army. *Neuropsychiatry in World War II.* Vol. 11. In preparation.

Medical and Surgical History of the War of the Rebellion. Vol. 1. Washington, D.C.: U.S. Government Printing Office, 1870.

Nolan, K. J., and Cooke, E. T. "The Training and Utilization of the Mental Health Paraprofessional Within the Military: The Social Work/Psychology Specialist." *American Journal of Psychiatry,* 127 (1970), 74-79.

Office of the Surgeon General, Department of the Army. *The Mental Health of U.S. Troops in Vietnam Remains Outstanding.* Washington, D.C.: U.S. Government Printing Office, 1968.

Rodeman, C. R. "The Technicians." In A. J. Glass and R. J. Bernucci, eds., *Neuropsychiatry in World War II.* Vol. 1. *Zone of the Interior.* Washington, D.C.: U.S. Government Printing Office, 1966. Pp. 701-707.

Salmon, T. W., and Fenton, N. "In the American Expeditionary Forces." In *The Medical Department of the United States Army in the World War.* Vol. 10. *Neuropsychiatry.* Washington, D.C.: U.S. Government Printing Office, 1929.

Tiffany, W. J., Jr. "Mental Health of Army Troops in Vietnam." *American Journal of Psychiatry,* 123 (1967), 1585-1586.

Notes

1 Motto of U.S. Army Medical Service