PSYCHIATRY IN THE ARMY AIR FORCES[1]

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The problems which arise in the Army Air Forces and call for psychiatric help in solving can be divided into three categories:

1. Selection of aviation cadets.
2. Mental hygiene in the ground crew members' training centers, known as the Technical Training Command Basic Training Centers.
3. Care of psychoneuroses which arise in the services and maintenance of personnel.

Selection of Aviation Cadets

The first problem is that of the selection of proper personnel to be trained for pilots, navigators, and bombardiers, which is an intensely interesting and difficult one.

The approach to the problem is from two angles—psychologic and psychiatric. Elaborate psychologic tests are given the candidate which require approximately ten hours to complete, and include tests of learning, interests, mathematical abilities, manual dexterities, coordinative abilities, concentration, etc. From these is gained a comprehensive picture of the candidate's intelligence and interests, as well as his skills and aptitudes. There is a high correlation between the results of these tests and the individual's ability to pass his pre-flight and primary training. The psychiatric examination is known as the A. R. M. A. (Adaptability rating for military aeronautics). It comprises a psychiatric interview in which the examiner attempts to determine the applicant's emotional and temperamental stabilities, or lack of them. The question in the back of the examiner's mind is always this: "Will this man stand up under the stress of combat flying?" Indeed a difficult question to answer! The discussion during the examination deals especially with family and childhood, and a very detailed personal history. This includes accomplishments, adaptability, maturity of ideas, interests and relationships, awareness of the world rather than inner concerns, reactions to major crises and elasticity in the face of them, interest in flying and the translation of this into activities, ability to receive and orient well to a multiplicity of stimuli and a zest for situations which provide these, ability to take punishment and hold on, and fortitude, or, if you like, "guts." Other questions pertinent to the usual psychiatric examination, of course, are included.

If the candidate fails on his A. R. M. A., he is rechecked by a psychiatrist with special experience in this field before his final rejection. Whenever possible, the entire group receives some examination by these psychiatrists. A plan is under way to have the cadet's career during pre-flight and primary training followed with a view to measuring his behaviour during these periods, according to the standards formulated above. This is to see if his actual performance proves that he has these qualities or lacks them. Psychiatric consultants, instructors and flight surgeons will be utilized in this plan, in much the same manner as the psychiatrist now functions with the social worker.

Mental Hygiene in the Basic Training Centers

The second field of interest is the consultation service in the Technical Training Command Basic Training Centers.

This command, as stated previously, receives and trains the ground crews. Inductees are received from the reception centers, and the problems in these training centers are much like those of the army ground forces. These men are processed in the basic training centers, and are then sent to schools for special training as radio operators, armorers, mechanics, photographers, bakers, cooks, medical detachment workers, etc. As these men are received primarily from reception centers, there is bound to be a certain percentage not suited for mili-

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tary life and duties and another group who can rise to meet the demands of the new situation only with special help. The consultation service aims to accomplish this. It helps the newly inducted soldier to make a satisfactory adjustment to his military life and duties and aids in properly classifying him, according to his previous training, capabilities and interests; wherever possible helps reduce or eliminate maladjustments; determines suitability for special training units; recommends for discharge men who, because of mental or emotional factors, will not become good soldiers and properly works up cases in order to arrive at this decision; instructs line officers in the nature of these disturbances and problems; and in general contributes to the post life those elements of knowledge and judgment which are peculiar to the field of psychiatry and which should play an important rôle in the smoother functioning of lives in the close contacts of military service. The organization of the unit is focused around the director, who is a qualified psychiatrist. He is responsible for the functioning of the entire service. It is his responsibility to select, train and supervise the personnel who work in the unit under him. All psychiatric advice and treatment are under his guidance, and his is the final decision in each case after the work of his assistants has been coordinated. The assistants include psychologists, psychiatric social workers, personnel workers, and others with special training and experience in the relationship situation. These assistants are largely obtained from the enlisted personnel of the center, and are trained by the director for these special duties. A single psychiatrist with a corps of fifteen to twenty assistants can take care of the routine requirements of around fifteen thousand men. The customary recommendations are as follows:

a. Counseling with or without the help of the psychiatric social worker.

b. Admission to hospital.

c. Reclassification and reassignment.

d. Psychiatric treatment.

e. Special developmental or corrective programs.

f. Referral to special training unit.

g. Referral to Red Cross for aid in socio-economic problems.

h. Discharge from the army.

The function of the special training unit is the instruction of enlisted men who are not suited to assimilate successfully the regular basic program of training, or who, during the regular course of instruction, show that they need this special training and instruction. The enlisted men who usually comprise a special training unit are chiefly the slow learning (60 per cent), illiterate (20 per cent), non-English speaking (5 per cent), emotionally unstable (7.5 per cent), and physically limited (7.5 per cent). These men are unable to follow the regular program and are a retarding influence on the effective functioning of the teaching program. Their own morale becomes badly disorganized when day after day they are subjected to the frustrating effect of meeting problems which they are unable to solve, while they see others who accomplish this end readily. The hill-billy or the farm-hand is oftentimes overwhelmed by the mass of new stimuli which bombard him and to which he is unable adequately to respond because of their novelty and intensity. Given a longer period of time in which he may gradually adjust himself, he may make a good soldier. But if, at the beginning, he is forced to maintain a pace beyond his adaptive faculties, he may well crumple and become lost to the service. This is true likewise of the foreign-born and the man who is illiterate because of lack of opportunity and not lack of intellectual ability. If such men are given a special course of instruction, they often may be returned later to the course in basic training and have no difficulty in absorbing the training and becoming good soldiers. The statistical results with these two types of problems are very encouraging. More than half of these men are sent on to regular training units, and more than half of the remainder may be reclassified into limited service groups.

Psychoneuroses

The most interesting psychiatric problems of the air forces are those of a clinical nature, encountered among our flyers. This discussion will purposely omit a consideration of the disorders arising among ground crews as they are quite similar to those met with among the ground forces of the army.

Much of our knowledge about neuroses and neurotic reactions arising during opera-

tional flying is derived from the experience of the Royal Air Force, which has been longer and broader than our own.

Neuroses arising among flyers are divided into two main groups. The first group is typical of the neurotic illness encountered in civilian life. Usually, these cases are flyers who deny any trace of neurosis in order to qualify as cadets, but who subsequently give a history of a definitely neurotic nature extending over a long period of time. This frank break is precipitated by the stresses of combat flying, but the characteristics of the illness are typical of those met in civilian life. This group includes psychosomatic disorders and hysteria, more commonly of the anxiety variety, with perhaps mild phobic reactions. Conversion hysterical symptoms are common, chiefly of the ocular variety, but sometimes of a motor nature. Occasionally the men show hypochondriacal preoccupation, but this is more in the nature of an hysterical reaction than a true hypochondria. The unconscious purpose of evading flying dangers and preserving prestige by the device of bodily symptoms is clearly manifest to the trained observer. Clear-cut obsessive compulsive reactions are not rare, appearing in persons who previously were obsessive characters but who now show a clear compulsion neurosis for the first time. Real depressions are rare, though the swings into depressive reactions so common in hysterics are very frequent indeed. These are rather severe and are akin to mild reactive depressions. Psychotic breakdowns are practically absent. The development of character neurotic patterns, such as paranoid reactions, likewise is very rare.

Flying personnel showing such reactions as these of course are lost as flyers. Frequently, however, adequate treatment will restore these men to some useful duty in a less arduous and hazardous type of work. Rest, relief from danger, and surface psychotherapy are indicated.

The other type of neurotic reaction seen is known by a variety of names—"flying fatigue," "flying stress," and so forth, though perhaps the most acceptable name is "fatigue-syndrome." This condition in flying personnel arises chiefly as a result of the continuous and long continued repression and suppression of the normal fear reactions present in all types of operational flying. In a certain number of flyers, sooner or later the ability to master this conflict fails and the individual breaks out into acute anxiety and/or symptom formation. Numerous other factors contribute to this reaction, such as physiological fatigue, anoxia, decompression reactions, loss of sleep and psychologically traumatic experiences.

The types of symptoms seen in this group are largely the hysterical and anxiety reactions, psychosomatic disorders, minor depressive swings, and mild hypochondriacal concerns. Outstanding is the patient's complete loss of zest in flying—and sometimes even desire to fly at all. Characteristic is the nature of the patient's dream life. The flyer is nightly troubled by dreams of flying, accompanied by terror-laden situations and long continuous frustrating experiences, all of which leave him worn out in the morning and completely unfit for his arduous duties. Treatment involves, of course, the early recognition of the state long before it has progressed to any degree of intensity. Rest camps must be provided for these men far enough away from the scene of operations to be free from the tension and danger in an operational area, yet not so far distant as to make the flyer feel he has been evacuated because he has cracked. The flyer must likewise be kept among the men of his own corps. All psychiatrists are aware of the important rôle which identification plays in the growth of children from their infantile neurosis. The strength which they borrow from parents and similar figures by this identification is perhaps the most important factor in their development from neurotic fears to relative stability. The same phenomena are clearly seen in the successful treatment of severe neurotic illnesses. During the process of transition and growth from a neurotic state to a healthier maturity the patient borrows strength by identification with the therapist. In a more general way, esprit de corps serves the same function in war time. The fighter endures the rigors of military life and masters his fears, often by means of the strength he borrows from identification with his leaders and his stronger fellows. The R. A. F. has learned this les-

son well and will have none of their casualties taken care of in other than R. A. F. hospitals. By early and adequate treatment most of these casualties are returned to full flying status and practically all of the remainder salvaged for some important work.

The Flight Surgeon

No discussion of the care and treatment of flyers is complete without a consideration of the functions of the flight surgeon. The chief responsibility of the flight surgeon is the maintenance of his flying personnel. He is primarily and fundamentally a good doctor, and his subsequent training is aimed to fit him to take care of his flyers under all circumstances. This means that he has to be a minor specialist in many fields. This is necessary because the hazards of flying are so great that physical perfection is essential in flyers. For instance, the flight surgeon should be a competent ophthalmologist. It is well known that one of the earliest reactions to anoxia and flying fatigue is the occurrence of ocular defects. Double vision is very apt to manifest itself if any latent tendency whatsoever toward diplopia exists. The loss of distance perception is likewise extremely common under stress. It is therefore incumbent upon the flight surgeon to detect at the earliest possible moment any deviation from the perfect standard of normal vision. One error in a routine landing may mean the loss of many lives and valuable equipment. But more than that, the flight surgeon has to be competent to evaluate disorders in every organ system with at least some of the skill of a specialist in order adequately to determine the fitness of the flyer for flying duty. This situation occurs in many areas of the globe where there are no competent specialists other than himself to determine the fitness of this or that special organ system.

Several special pathologic conditions are due to the hazards of flying, and the flight surgeon must be competent to handle them. A few examples are aerosinusitis, cardiac distress at high altitudes, and reactions to low barometric pressures. Therefore his training consists of intensive courses in ophthalmology, otolaryngology, cardiology, gastroenterology, physiology of high altitude flying, tropical medicine, chemical warfare, military surgery and medicine, neuropsychiatry, and other special subjects.

Psychiatry plays a most important rôle in the fulfillment of a flight surgeon's duty. He cannot function effectively with a tactical unit without an intuitive feeling for, and a reasonably good training in the principles of psychiatry.

Psychiatric casualties are first seen by the flight surgeon, and it is of the utmost importance that he early recognize and wisely determine the treatment for these conditions. The career of the flyer oftentimes hangs on the wisdom of the flight surgeon's procedure at this point. Psychiatric consultants are available to him in combat areas to determine whether leave or relief from actual flying duties is indicated.

Rest camps are being established not too far distant from the scene of combat for flyers who are war weary and in need of rest.

These remarks are a brief summary of the psychiatric problems encountered in the Air Forces, the special means by which some of them have been solved, and methods which are now being evolved for meeting others. This is, in a sense, pioneering work in establishing the effective use of psychiatry in an extremely difficult and far-reaching problem.

THE SERVICES OF THE MILITARY MENTAL HYGIENE UNIT[1]

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It is one of the revealing paradoxes of this war that a plane can be turned out, complete and ready for combat, in a matter of hours, while a flier may have more than a year of training. Blitzkreig is based upon slow, patient preparation. The final outcome of armed conflict is still dependent upon the ability of the individual soldier to function alone and as part of a combat team.

The soldier, so recently a civilian, is called upon to make difficult adjustments at a most unusual tempo and in an atmosphere of authority and discipline which are foreign to everyday life. The loss of individuality, the change in the most detailed habits of life and the hovering imminence of death bring about inevitable problems. It would be strange if some men did not show problems of adjustment as early as the basic training period. Symptomatic behavior, such as drunkenness in barracks or excessive withdrawal or aggression, may be displayed. Such behavior may affect the man alone or, in the case of enuretics, may affect a whole group. Such difficulties are most easily noted and dealt with in the Army Replacement Training Center, where the soldier receives his basic and initial specialized training after assignment from the reception center. All further references in this paper will deal with the services and some of the experiences of the Mental-Hygiene Unit at the Eastern Signal Corps Replacement Training Center, Fort Monmouth, New Jersey. Nearly two years ago, the unit was established by the Commandant of the center, Brigadier General Edgar L. Clewell, to provide mental-hygiene facilities to the command, to institute necessary corrective measures in soldiers having difficulty in meeting military requirements or initiate their discharge. As has been indicated elsewhere,[2] the unit, as an independent agency, is attached to headquarters and functions through the office of the adjutant (S-1), which is the central administrative point of the whole army organization, thus making it possible for the unit to have direct and effective contact with all the organizational units of the command.

The function of the psychiatrist in the Eastern Signal Corps Replacement Training Center is unique in that he is a member of the Commanding General's staff. Thus, he is in a position to bring to bear all the resources of the army in meeting each problem. He is charged with the maintenance of mental health conceived in its larger sense, and for recommendations to insure the soldier's best adjustment. He is clinician and administrator, both within the mental hygiene unit and as its director in its contacts with the rest of the officer staff.

The psychiatrist's task in the army differs from that of the civilian psychiatrist because the army's fundamental emphasis must be upon the essentially normal personality and the degree of usefulness of the individual to the army, rather than upon the individual's ability to adjust, even at a minimal level, in his own environment. The psychiatrist is an officer whose fundamental contribution is to the production of adequately trained, competent fighting men. Consideration of time and function limit the treatment aspects of the mental hygiene unit, while not eliminating them. Discharge from the army, however, must be sought for those whose maladjustments are severe.

A mental hygiene program must be prepared to deal with many different facets of the individual's personality. Intellectual, emotional and social factors may all require understanding in order to provide adequate criteria for diagnosis, treatment and disposition. Use of the coordinated skills of the psychiatrist, psychiatric social worker and psychologist, working as a clinical team forms the most efficient approach to the individual soldier's problem. Such an approach gears itself naturally to the qualita-

[1] Read at the ninety-ninth annual meeting of The American Psychiatric Association, Detroit, Michigan, May 10-13, 1943.

[2] "The Role of the Mental-Hygiene Clinic in a Military Training Center," Capt. Harry L. Freedman, M. C., Mental Hygiene, Vol. XXVII, No. 1, Jan. 1943, pp. 83-121.

tive and quantitative demands of a military setting.

It is the task of the psychiatrist to guide, coordinate and evaluate all the results of the clinical work. He interviews each soldier coming to the unit, no matter what the problem, using the data provided by psychiatric social worker and psychologist. If limited therapy of one or more types is thought advisable, it is done under his guidance. The psychiatrist also takes final responsibility for determining the limits of the soldier's usefulness to the army, where serious question about a man's ability to serve as a soldier has arisen.

In the unit, soldiers are usually interviewed by the psychiatric social worker for preliminary study of their problems. Important in this interview is the fact that the psychiatric social worker himself wears a uniform and represents the army—its requirements and its understanding of the soldier's problem. This is a direct aid to the soldier to discuss his problem with the worker. There are many dynamic factors which operate in this interview. Frequently, it is not the soldier who desires help, but the army which requires that some change be effected in the man's attitude or program.

The mental hygiene unit's philosophy is in no way basically at variance with that of any professional person or mental hygiene clinic. In serving the army, it also aims to serve the individual soldier, sensitively and professionally. It has the task of interpreting the reality of the army setting and the army's demands to the soldier, but it also accepts the responsibility for understanding the interplay between individual and group. Its task is to serve the army by making adequate use of man power. At the same time and as a necessary corollary, it serves the man by placing him where his talents and abilities may be most freely mobilized. Even in the rending experience of discharge, the man can be helped to accept the inevitable and even to use it constructively. Although elaborate therapy is made impossible by the time and functional limits of the army, short therapeutic interviews are used.

In this service, differential diagnosis is of the utmost importance. Should a soldier seem to be so sick as to require prolonged therapy, he is recommended for discharge and returned to community life, where it might still be possible for him to contribute to the war effort and maintain his own mental health. There is the case of the 45-year-old soldier, a neuropsychiatric casualty of the last war. For the past seventeen years, he had been employed as a skilled welder working on naval gun mounts. His induction into the army reactivated his earlier experience and here he became a sick person; because of his attitude toward the war, he disturbed the morale of his company. The return of this man to his civilian occupation, where he could make his contribution, was far more desirable than his continuance in the army.

The criterion in this differential diagnosis is whether or not a man can render service to the army. This is especially important in the milder psychoneurotics. Such individuals frequently have useful skills and, with help, may be an asset in the proper assignment. They are not used of course for combat troops.

In entering the army, men are removed from life situations to which they have become adjusted and in making their transition from civilian life, a number will experience a purely temporary period of maladjustment. This happened in the case of a thirty-year-old lawyer of superior intelligence who found himself cleaning latrines under the supervision of a twenty-two-year old corporal within two weeks of his induction. His general insecurity and emotional maladjustment resulted in insubordination and the necessity to face a court-martial board. Until such men can regain a measure of the security and satisfactions which they had in civilian life, they will need help. A few interviews with the military social worker, under the psychiatrist's supervision, may be sufficient; or a change to a more satisfactory assignment may be all that is required, and an essentially healthy personality finds his place in a new and complicated environment. In some cases, as has been indicated, a short time psychotherapy by the psychiatrist may be helpful.

Following the directives promulgated by command of Brigadier General Edgar L. Clewell, training center soldiers in whose

cases action by the mental hygiene unit appears necessary will be referred thereto by any of the following: staff sections, personnel and classifications officers, school directors, chaplains, regimental, battalion or company commanders, infirmaries and hospital, inspector and intelligence officer.

The director of the mental hygiene unit disposes of the cases referred to him by any one or a combination of the following methods:

(a) Counseling, psychiatric social work and psychological testing.

(b) Reclassification where considered advisable.

(c) Special programs cooperatively developed through contact with staff sections, personnel and classification officers, school directors, chaplains, regimental, battalion and company commanders, infirmaries and hospital, inspector and intelligence officer.

(d) Special psychiatric treatment.

In these categories (a to d inclusive) are included reclassification of actual or potential school failures due to demonstrated inaptitude, extreme dissatisfaction or psychological hazards.

(e) Referral to special training unit for training.

(f) Referral to American Red Cross for aid in home socio-economic problems.

(g) Psychiatric observation at station hospital where deemed necessary.

Fig. 1 represents the chart of the organization and function of the mental hygiene unit.

Whatever the primary service to the army, it is always the aim of the unit to benefit the soldier by the action which is necessary for the good of the army.

One very frequent service is that of evaluating cases of soldiers appearing before courts-martial boards and discharge boards, when a fuller knowledge of their personalities is required for proper disposition. In rendering opinions to the command, the primary consideration is the degree of responsibility which the soldier can be expected to display. A soldier who goes A. W. O. L. because his bride of three months is worried over her pregnancy is of more potential value than the soldier who goes A. W. O. L. when intoxicated.

There are many soldiers whose problems are of such a nature that reclassifications or changes of assignment may be instituted. In this group change in the training program is usually initiated where there is a personality difficulty and is directed toward helping these soldiers to find their place in the army.

A thirty-eight-year old, found to be psychoneurotic, had enlisted as a volunteer officer candidate, wanting to prove his masculinity. He had been assigned to radio operator school in order to qualify technically for the signal corps officer candidate school. Within a short time, he began to run to the infirmary on sick call and was finally referred to the unit when he blew up in a fit of weeping. In the course of several interviews, he decided that being an officer involved too much responsibility and he thought he could be of as much service practicing his former civilian profession in the army. A reassignment was made possible on the advice of the unit.

Four types of assignment have been utilized by the mental hygiene unit. In the first, a change from one training school to another is made either on the basis of a man's inability to perform ably in his present course or because he shows particular aptitude for another course. Second, there are cases where removal from school or assignment to a non-specialist category is necessary because of lack of aptitude or ability. A third type of reassignment, in a few special cases, may result in a soldier's placement on a specific job as part of the permanent cadre of the post. This latter method is used chiefly with men limited either physically, mentally or emotionally and for whom it is felt that shipment into combat duty or even to another post would nullify their value to the service. A fourth group involves the reporting of a soldier to the adjutant general's office because he has a specific skill which, although not applicable to the signal corps, may be of value to some other branch of service.

The increased use of man power by the army involves the induction of men who, in peacetime, would not be considered as able to discharge the duties required for general military service. In particular, there are at present two large groups within this cate-

FUNCTIONAL CHART OF THE MENTAL HYGIENE UNIT
HEADQUARTERS EASTERN SIGNAL CORPS REPLACEMENT TRAINING CENTER
CAMP CHARLES WOOD, FORT MONMOUTH, RED BANK, NEW JERSEY

FIG. 1.

gory now being inducted into the army—the illiterate and non-English speaking soldiers and the physically limited. One of the responsibilities of the mental hygiene unit is the routine re-examination, evaluation and, where necessary, reassignment of soldiers inducted in limited service status. It is also one of the frequent duties of the unit to have a soldier reclassified from general to limited service, particularly for the milder neuropsychiatric conditions.

In handling illiterate and non-English speaking soldiers, the psychologist primarily evaluates the soldier's native intellectual potentialities and the extent of his literacy retardation. The military social worker discusses with the soldier his social and vocational background and the psychiatrist makes the final evaluation and disposition. Soldiers are referred to the special training unit for educational and military training simultaneously, where their functional knowledge of English may be raised to meet the army minimum literacy standards.

Of the 200 soldiers in this category referred to the mental hygiene unit, 42 per cent were found suitable for assignment to the special training unit, 6 per cent qualified as military specialists after direct assignment to training schools, 13 per cent were classified as non-specialist basic soldiers, and discharge was instituted in 12.5 per cent. Of the remainder, 6 per cent were still in specialist schools and 19 per cent were pending.

In the unit's experience with the limited service soldier, 21.4 per cent of 242 such cases were found unsuitable for further service to the army and were discharged. It should be noted, however, that there may be some overlapping in this group of discharged men with the non-English speaking and illiterate, since where there is a combination of literacy handicap with physical limitation, discharge is initiated.

A limited service board of medical officers, with the director of the unit as president, has been established for the RTC. This facilitates and expedites the classification, reclassification and assignment of many soldiers, in terms of the soldier's capacities and abilities, the requirements of the various schools and the rigors of certain assignments. In the unit's experience with the limited service soldier, some were found unsuitable for service to the army and were discharged after trial of duty. This necessitates full use of all the clinical skills of psychiatric case worker, psychologist and psychiatrist.

Frequently, disabilities will crop up during the training period. Under the new pressures of military life, men may aggravate old injuries which have healed and which were not under strain in their civilian capacity. This may require reclassification of men expert in some field. In cases where men have been placed in limited service because of psychoneurosis, the psychiatrist must be especially careful, both in his differential diagnosis and the assignment. The keynote here, as in other cases, is the placement of a man in a position where he can be of greatest service to the army.

In the mental hygiene unit, the American Red Cross fulfills a three-fold function. In the main, it serves as a liaison between the army and the soldier's local community. It obtains social data from the community about the soldier where necessary, gives aid to soldiers with personal and family problems not directly related to the army, and assists with any measures that may aid in the rehabilitation of discharged soldiers.

Several references have been made to the unit's function in cases of discharge. The army provides for discharge in a series of regulations. Those with which the unit is primarily concerned are Section II, Section VIII, and Section X, AR 615-360. Section II provides for certificate of discharge for disability for men either physically or mentally unfit for military service, such as psychotics, severe psychoneurotics, epileptics. Section VIII provides for the discharge of those men who, because of inaptness, undesirable traits of character or habits, are unable to perform satisfactorily in military service. Section X deals with men discharged for the convenience of the Government.

During the last seven months of 1942, of 1089 cases referred to the unit, discharge was initiated in 163 cases. The reasons for discharge and their distribution appear in Table I.

Discharge by certificate of disability is, at present, made on the recommendation of a

board of three medical officers and is a function of the post hospital. The function of the unit in such cases is the early recognition of the symptomatic behavior and the referral to the hospital.

In cases of discharge for inaptitude or undesirable traits of character, the recommendation is, at present, made by a board of three line officers. It has been the policy of this replacement training center to have the director of the mental hygiene unit prepare a report and present it in person to the board. While the interpretive value for these lay officers cannot be over-estimated, it must be emphasized that cases of psychopathic personality or mental deficiency must be so presented as to contain a minimum of technical material and clearly demonstrate that a soldier is of no further military value. It is difficult to speak of "behavior patterns" which result in chronic insubordination, since the army cannot tolerate these because of the need for firm military discipline. Likewise, in the case of psychosomatic complaints, it is a rare layman who will understand that a soldier is not "goldbricking" or malingering. These cases must be presented in very concrete form, drawing freely from illustrative material which is furnished in the field investigation made by the military social worker.

Similarly, in all other cases seen at the unit, a written report is immediately sent direct to the company commander, school director, classification officer and other referring sources for his understanding and disposition of the problem. Such reports have a two-fold purpose: first, they are a medium for transmitting the unit's opinions or recommendations to the proper sources; and second, they become a means for interpreting fundamental principles of a mental hygiene approach for the line officer.

The content of these reports is worded so as to give the line officer the clearest possible explanation of the soldier's problem with a minimum of technical detail. Time and experience have demonstrated that such interpretation, focused directly upon each problem case, is more effective than lectures or theoretical clinical presentation.

TABLE I

REASONS FOR DISCHARGE

		No.	%
Section II:		103	63.3
Psychoses	23—14.1%		
Dementia præcox:			
Simple	7— 4.3%		
Paranoid	9— 5.5%		
Unqualified	2— 1.2%		
Manic-depressive, manic type	1— ..		
Psychosis, undetermined	4— 2.4%		
Psychoneuroses (severe anxiety, hypochondriacal, etc.)	17—10.4%		
Epilepsy	4— 2.5%		
Physical (such as asthma, hernia, sacro-iliac, etc.)	59—36.2%		
Section VIII:		37	22.6
Psychopathic personality	10— 6.1%		
Enuresis	9— 5.5%		
Mental defect	8— 4.9%		
Chronic alcoholism	6— 3.7%		
Homosexuality	4— 2.4%		
Section X (Circular 395):		23	14.1
Limited service (physical) illiterate	8— 4.9%		
Limited service (emotional) illiterate	5— 3.1%		
Limited service (intellectual defect)	10— 6.1%		

CONCLUSION

The experience of the mental hygiene unit has been one of progressive expansion and experiment. Methods and procedures have been developed and created under the pressure of new problems and a greatly increased case load. However, the areas of the unit's responsibilities, as defined by directives promulgated nearly two years ago, have remained fundamentally fixed. It is, of course,

only one of the sections within the command whose ultimate purpose is to achieve the best possible utilization of man power assigned here for training. It is important to emphasize that a psychiatrist in the army is basically seen as another officer. It is neither sufficient nor possible to stand on one's professional or clinical experience, as may be possible in civilian life.

It has been difficult to indicate sufficiently clearly in the body of this report the tremendous debt the unit owes to Brigadier General Edgar L. Clewell and to the line officers of his command. It would be evading the truth to deny that any such clinic must, quite properly, prove itself before being accepted or to deny, either, that there is a certain skepticism of professional ways of thinking and doing. Nevertheless, the mental hygiene unit has found only the most complete cooperation and what measure of success it can report is part of the success of the entire command. It does not mean that the clinic has been unchanged by the impact of the opinions of the command. Rather, there has been a mutual accommodation, based on a genuine desire to work for the army, which has even more important results in store for the future.

The soldier referred to the unit for reclassification, but found to be a schizophrenic, is a spectacular case, it is true, in demonstrating the importance of having such a unit in an army setting. Of greater import, however, is the fact that of 1089 men seen by the unit in the seven months' period from June 1 to December 31, 1942, over 80 per cent were able to continue and complete their training in the replacement training center. This was primarily the result of the careful selectivity of the manifold services which the unit has to offer, both in its personnel and in the resources which it has found available in the army. Such a unit as is described in abbreviated form in this paper can function successfully only if it is an integral part of the command.

That this working relation has been possible is due to the Commanding General's recognition of the need to give special consideration to the types of problems discussed in this report. The keynote of the unit's work has been the use of professionally trained workers, the psychiatric social worker, psychologist and psychiatrist functioning as a clinical team. Some of its methodologies are new to the work of a replacement training center. Many represent ways of meeting problems for which there were no other facilities. None of these methods contradicts or duplicates already established procedures. It is true however that the military psychiatrist and mental hygiene worker have had to adapt their functions in terms of new demands and a new setting, and that more changes will be necessary. Of particular importance has been the liaison provided with the replacement training center's total program in the original directive setting up the clinic. This coordination with all other sections is made possible through the officially defined character of its mission and has enabled the clinic to call upon the widest possible resources.

This report is an outline of the structure and application of professional skills as they have been adapted toward the fulfillment of this replacement training center's mission. It is perhaps not too much to term it a small aspect of the entire democratic approach which has characterized the formation and training of the army. While the responsibility has been accepted for training the best possible soldiers in the best possible army, the rights and personality of the individual soldier have always been respected. Through the mental hygiene unit here described, it is believed that a foundation for service to thousands of American soldiers has been made.

IN MEMORIAM

HUBERT WORK

1860-1942

Dr. Hubert Work was president of this Association for the year 1911-12 when it was called the American Medico-Psychological Association. His presidential address was entitled "The Sociologic Aspect of Insanity and Allied Defects."

Born on a farm in Indiana County, Pennsylvania, July 3, 1860, he attended the local public schools and the Indiana State (Pa.) Normal School, continuing to work on the farm during the summer vacations. He matriculated in the Medical School of the University of Michigan; two years later he entered the University of Pennsylvania and was graduated the following year, 1885, as Doctor of Medicine. He began the practice of medicine in Colorado and in 1896 founded the Woodcroft Hospital for nervous and mental diseases, which he operated for twenty years; then he entered the Army Medical Corps. Dr. Work was commissioned a major, and was assigned by Surgeon General Gorgas to the staff of Provost Marshall General Crowder, where he served as liaison officer between these two branches with direct supervision of the medical features of the draft. He was promoted to the rank of lieutenant-colonel and later was advanced to the grade of colonel in the Medical Reserve Corps.

In addition to his presidency of the American Medico-Psychological Association, he was president of the Colorado State Board of Health and of the Colorado State Medical Society, and in 1921 was president of the American Medical Association.

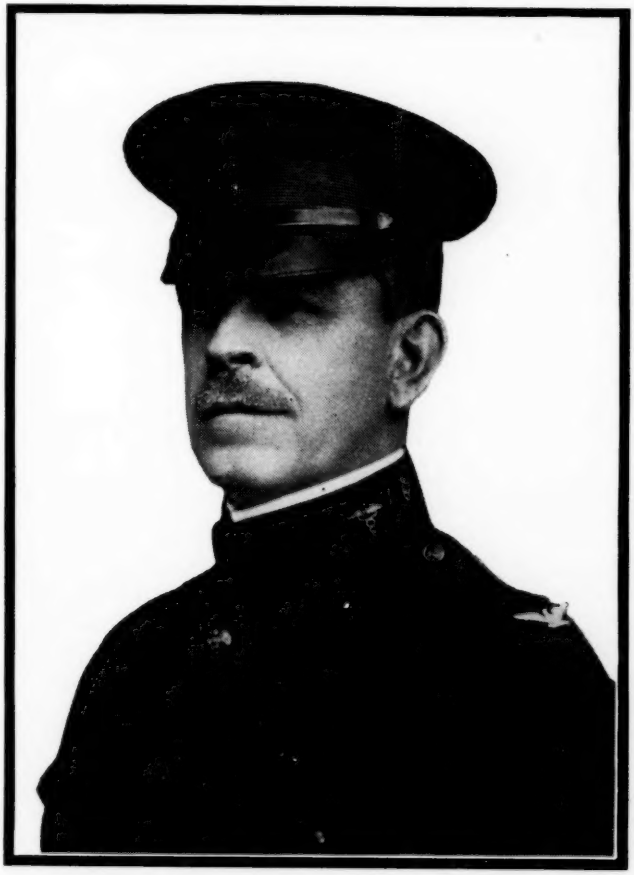
In 1908 Dr. Work was delegate at large from Colorado to the Republican National Convention; in 1912 he was chairman of the Colorado Republican State Central Committee, and from 1913 to 1919 was Republican National Committeeman for Colorado. On March 4, 1921 he was appointed first assistant postmaster general of the United States and a year later he succeeded Mr. Will Hays as Postmaster General. From March 5, 1923 to July 24, 1928 he was Secretary of the Interior, superseding Mr. Albert Fall. During his incumbency St. Elizabeths Hospital was a bureau of the Department of the Interior and among Dr. Work's outstanding services to psychiatry should be mentioned his forthright and able defense of the hospital when it was subjected to serious and unwarranted attack. He resigned as Secretary of the Interior to become chairman of the Republican National Committee (1928-29), and this was his last public post.

Dr. Work married Laura M. Arbuckle of Anderson, Indiana, in 1887. She died in 1924. They had two sons and a daughter: Philip, now a Fellow of this Association; Mrs. Dorcus Bissel; and Robert V. H., deceased. In 1933 Dr. Work married Ethel Reed Gano, who survives him. He died of coronary thrombosis on December 14, 1942, in Denver.

Dr. Work was honored by the following institutions: LL.D., Lincoln Memorial University, 1923, University of Pennsylvania, 1925, University of California, 1927; Sc.D., University of Colorado, 1925.

The American Psychiatric Association has lost a member who was outstanding as a psychiatrist, politician and administrator. His family has lost a loving husband and father and to them we extend our sympathy. An eminent colleague of Dr. Work said of him, "I never knew anyone who was a shrewder judge of men. Distinguished in appearance and bearing, he had unusual intellectual vigor, excellent judgment and a rare combination of affability, wit and reserve."

ROSCOE W. HALL, M. D.



DR. HUBERT WORK.