

The interwar years saw the development and spread of the concepts and assumptions of depth psychology, particularly of psychoanalytic thought. These contributed in great measure to assumptions about the sources of combat breakdown and symptom generation. They were also combined with eugenics theories to focus attention on screening and preselection as the most effective ways to minimize the number of men who might become psychological casualties in wartime. And they created the foundation for the unsuccessful “selection out procedures” of Selective Service in World War II.

World War I saw the weaving together, both intellectually and emotionally, of the various strands of knowledge, belief, and value about the effects of combat, deployment, fear, and anxiety upon human beings. This concatenation of ideas, often connected as non sequiturs rather than as logical correlates, was significant for the future guidance of medical thought and policy and for the immediate interpretations of postwar problems and symptoms. In a sense, this concatenation was a simple transformation of the long-standing division of the world of men into cowards and the courageous: It reinforced the view that cowardice was the result of biological inferiority.

The United States came out of World War I with a racially or ethnically based view of why “bad things” happened to soldiers in combat. Psychologically based symptoms and ailments (as we saw in the passage from Benton, 1921, in the previous chapter) occurred in people who had “inferior” nervous systems, which were attributed to their racial or ethnic origins. Those at risk had poor nervous systems, were inherently weak, and were intellectually inferior.¹ Such thinking fit in well with the eugenics movement, which had gained wide intellectual and political ascendancy in the United States. Thomas Salmon, who continues to be idolized in military psychiatric circles for his work in developing

¹Based upon the appallingly inadequate and culturally biased Army Alpha and Beta “intelligence” test.

Army Psychiatry, was one of the leaders of the eugenics movement in the United States. He fully believed, as so many others did, that if “weak” people² were removed from the Army, the Army would never again have psychological problems at the levels seen in World War I. The “normal” man with a strong nervous system and reasonably good coping ability was perceived as immune from the stresses of war, while weaker men were susceptible to them.

The rising ascendancy of Freudian and other forms of “depth psychology” in the 1920s and 1930s, while not based on individual physical constitution or race, nevertheless complimented and reinforced the view that those predisposed to psychological breakdown were a vulnerable and detectable group. The members of this group were thought to be vulnerable because of experiences in infancy and/or early childhood. These concepts, however, had been fusing with the more environmentally oriented “psychobiology” of Adolph Meyer and his followers at Johns Hopkins and elsewhere. Meyer’s model focused on the interaction of the psychodynamics of the individual with the effects of events in the environment. Concern with the latter typified the “Mental Hygiene” movement, in which Meyer was a major figure, and its commitment to psychosocial techniques of prevention. Depth psychology and psychobiology were of great importance during World War II. Concern with predisposition was to be dominant at the outbreak of the war. While predisposition contributed to the earlier predispositional model, it also created the foundation for the concept that psychological and behavioral symptoms were the result of mental insult, so that almost anyone could break down in combat.

The most basic principle of the paradigm was to learn to identify and remove from the Army people with “weak nervous systems” or exceptional dysfunctional responses to fear and anxiety. There was very little understanding of how events and the environment could alter the processes of the brain and the body, change human behavior, and produce those real physical and psychological ailments, which are today referred to as stress responses. In this light, past attempts to grapple with the symptoms of shell shock and war neurosis were examined. The quests to define the causes of war neuroses were also undergirded by economic concerns. In the United States, Britain, France, and Germany, large numbers of veterans sought treatment at medical facilities and claimed pensions based upon a wide array of physical and psychological symptoms claimed to be the result of shell shock or combat trauma. The costs were considered staggering and avoidable if proper selection was used.³

²Those deemed “weak” by these tests were mostly blacks, Jews, Southern Europeans, and Slavs.

³See the references to Sullivan, below, and Benton, above.

MIND-BODY DICHOTOMY

In addition to the “psychologization” of Western thinking about the sources of both normal and aberrant behavior,⁴ new approaches were being developed to address the effects of external events upon the internal dynamics of the brain and body. While a number of medical observers during and immediately after World War I hypothesized that combat experiences led to alterations in bodily physiology that sustained both mental and physical symptoms for some soldiers, there was little evidence about how this might have occurred. The “hows” were addressed, albeit in preliminary fashion, by the work of Walter Cannon and Hans Selye.

Walter Cannon⁵ was the first to look experimentally and in-depth at the effects of emotions on the body. Cannon discovered that strong emotions release endocrine secretions (such as epinephrine and norepinephrine) which have major effects on heart rate, blood pressure, etc. The body’s systems respond with significant physiological alterations of normal function as a reflection of strong emotions being generated by external events and experiences. Cannon’s work represented the first true break with the Cartesian mind-body dichotomy that had formed the background of the Western view of human status and behavior. Cannon took the first tentative steps toward understanding the brain as a mechanism by which signals generated by a life experience are converted into internal physiological signals that alter physical bodily states and the effects of which are then fed back to further alter psychological states.

Hans Selye⁶ developed the first cogent approach to the problem of stress. He examined what happened within the body when a subject was faced with highly stressful demands, particularly those that fall under the rubric of the fight-or-flight paradigm. Selye pointed out that the physical responses to stress (i.e., the outpouring of adrenaline and other secretions, the rise in heart rate and blood pressure, and the general bodily preparedness to cope with assault or insult) were evolutionarily necessary for survival and were normal and reasonable when they were directly linked to a threat. Based upon the classical “fright-flight” model, Selye called these responses the “general adaptational syndrome.” Selye noted when such responses continued well after the threat situation had dissipated, the normal stress response becomes abnormal and progresses to chronic distress, with potential long-term detrimental effects.

⁴Which drew on elements as diverse as psychoanalysis and Watsonian behaviorism.

⁵A professor of physiology at Harvard.

⁶Selye began his work in Vienna in the 1930s before moving to Toronto as a refugee from the Nazis.

DIAGNOSIS AND CLASSIFICATION

It is important to note that throughout this period and, in fact, throughout World War II no fixed, universally agreed upon system of diagnosis and classification existed. (One did not exist until the publication of *Diagnostic and Statistical Manual I* by the American Psychiatric Association in 1951 and that certainly did not debut to universal agreement.) Most psychiatric disorders can be classified only based upon symptoms (see for example, Gelder, Gath, and Mayou, 1991). Diagnostic judgments, labels, and allocations were often different from practitioner to practitioner depending upon training, experience, and the “school” of psychiatry with which the physician was identified. Dispositional diagnoses and choices of treatment might not be at all consonant between equally well-trained psychiatrists. As in any scheme of diagnostic classification not based on hard pathophysiological findings, there was wide room for fluidity of choice and difference in judgment.