The Tunisian Campaign, War Neuroses, and the Reorientation of American Psychiatry During World War II

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Warfare has always resulted in extensive loss of life, brutal injuries, and enormous mental strain. It has also inspired, over time, major innovations within medicine.[1,2] During the wars of the twentieth century, psychiatrists came to have a role—despite the ambivalence of military officials—in treating soldiers who had suffered mental breakdowns.[3–6] World War I's high incidence of what was initially called shell shock led to significant treatment innovations and the reconceptualization of mental disorder, although mainstream psychiatry after the war was hardly affected.[7,8] The participation of U.S. psychiatrists in World War II has received less attention from historians but proved to be far more significant for the field of psychiatry itself.[9,10] Before the war, most American psychiatrists believed that mental illness was caused by a relatively stable predisposition related to inheritance, constitution, or early childhood experiences. Within a military context, they therefore concentrated on a preventive approach through the implementation of extensive screening programs intended to exclude inductees predisposed to mental breakdown. During the first major engagements of the U.S. military, however, this approach was proven to be horribly wrong; in some combat regions, the incidence of breakdowns reached more than a third of all wounded. Faced with these results, a cadre of dynamic and psychoanalytic psychiatrists developed and implemented treatment programs near the front lines, working from the revised assumption that extraordinary environmental stresses, rather than predisposition, were the most important etiological factors in war neuroses. The perceived success of these programs increased the self-confidence of psychiatrists and greatly enhanced the public reputation of the discipline after the war. The field of psychiatry grew dramatically in the following decades, moving beyond the locus of psychiatric hospitals and into the broader community, where it has been providing an ever growing range of psychiatric care.

As early as the Russo-Japanese War of 1905, the potential psychiatric effects of war on soldiers were recognized, and some forms of psychiatric treatment were undertaken near the front lines. During World War I, the occurrence of shell shock drew widespread attention to soldiers' emotional responses to the horrors of war. The pioneering work of W. H. R. Rivers in the psychotherapeutic treatment of shell shock in the United Kingdom received widespread medical and also public attention (most recently in the well-known novels of Pat Barker).[11–13] British psychiatrists

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experimented with various treatment methods, including psychotherapy, faradizations, and treatment close to the front lines. Psychiatrists in France, Germany, and Italy also experimented with different methods for treating shell shock.[4,14] In May 1917, the American psychiatrist Thomas Salmon, the medical director of the National Committee for Mental Hygiene and senior psychiatrist to the American Expeditionary Force, observed the various treatment techniques developed by the Royal Army Medical Corps. His subsequent, influential report described shell shock as the result of a mental conflict between duty and self-preservation, and recommended that treatment commence as soon as possible after the onset of symptoms and as close as possible to the front lines.[15,16] Salmon also advocated, without much success, the establishment of outpatient facilities for treating veterans after the war.[17] Unfortunately, the lessons of wartime psychiatry were mostly forgotten in peacetime. Most American psychiatrists continued to believe that mental illness was caused by a relatively stable predisposition related to inheritance, constitution, or early childhood experiences. Along these same lines, shell shock was perceived as a chronic, untreatable condition for which a great number of ex-servicemen were institutionalized or received pensions for many years after the end of the war.[18]

When World War II broke out in Europe in 1939, American psychiatrists contemplated how they could contribute to the war effort if the United States became involved in hostilities. At the annual meetings of the American Psychiatric Association in May 1940, 1941, and 1942, the importance of screening volunteers and inductees was discussed extensively. If screening was sufficiently thorough, it was asserted, most men predisposed to mental breakdown could be detected and excluded, which would significantly reduce the incidence of mental disorder near the front lines.[19] In December 1940, the influential psychoanalyst Harry Stack Sullivan was appointed by the Selective Service System to organize psychiatric screening of inductees.[20,21] According to Sullivan, psychiatric selection needed to weed out both individuals with severe and persistent forms of mental illness as well as those with a history of maladjustment or a predisposition for mental breakdown. Under Sullivan's screening program, up to 2.5 million men were excluded for emotional or mental defects. Later named the "lost divisions," they were equivalent to approximately 11% of inductees; by comparison, during World War I, only around 2% had been excluded.[22] Initially, the American military was in favor of Sullivan's approach because it ensured that the best, healthiest, and most capable young men were inducted into the military. Unfortunately, the proposed screening program proved to be difficult to implement. Selection boards were staffed by physicians who had no psychiatric training and who were responsible for reviewing great numbers of recruits, with only a few minutes available for each psychiatric examination. In practice, exclusions from the military were based not on psychiatric diagnoses, but on social prejudice; for example, African Americans were rejected much more frequently than others.[23] In early 1942, confronted with growing opposition to psychiatric screening, Sullivan resigned.[24] Moreover, events soon showed the screening approach to be ill conceived. During the North African Campaign, the first major military engagement of the American military forces in the European Theater of Operations, breakdown incidence was much higher than expected, and rose as high as 35% of all wounded in the Tunisia Campaign of November 1942–May 1943. By contrast, the incidence had been 2% in World War I, and it would be 12% for World War II as a whole. Given the demonstrable failure of psychiatric screening, coupled with the increasing and later acute shortages in military manpower, the exclusion policies were rescinded in early 1943.

Allied military action in North Africa had commenced in June 1940 with the Western Desert Campaign, when British armed forces stationed in Egypt invaded Italian-occupied Libya (the Italians were later reinforced by the German Afrika Korps). Field Marshal Erwin Rommel (nicknamed the Desert Fox) assumed the leadership of the German forces in early 1941. The next year, Field Marshall Bernard Montgomery took over the leadership of the British 8th Army with the aim of protecting the Suez Canal and forcing the Axis powers westward. After Montgomery's victory at the second battle of El Alamein (October–November 1942), the German forces retreated to Libya and Tunisia. The strategy central to the Tunisian Campaign (November 17, 1942–May 13, 1943), which began immediately thereafter, was to attack the German forces from two sides, with the aim of forcing a German surrender: the British continued to attack the German forces from the east of Tunisia while the Allied forces attacked them from the west.

During the preceding invasion of northwest Africa—Operation Torch, November 8–16, 1942—the Allies invaded Morocco and Algeria, which were occupied by troops loyal to the French Vichy regime. The Allies had hoped that the French would capitulate quickly and then cooperate with the Allies, which turned out not to be the case. Resistance in Oran and all of Morocco was fierce; only Algiers was occupied relatively easily (after a coup d'état by the French resistance just before the invasion). Lengthy and difficult negotiations with French officials followed, which slowed down the movement of the troops and gave Rommel time to reinforce his positions in Tunisia. The Tunisian Campaign was therefore off to a slow start. The inexperience of II Corps and the American troops (this was their first major military engagement), coupled with the lack of coordination between the American, British, and French troops and between the infantry and the air force, resulted in complications and setbacks. In February 1943, the Allied

forces suffered a devastating defeat at Kasserine Pass at the hands of Rommel and his Afrika Korps—which indisputably constituted the nadir of the Tunisian Campaign.

The high incidence of mental breakdown during the initially disastrous Tunisian Campaign was related to the lack of experience and training of the American armed forces and to the initial superiority of the German army. In 1941, a leading British military officer opined that the American forces were "more unready for war than it is possible to imagine."[25] Two years earlier, the U.S. Army ranked seventeenth in the world in size, just behind Romania's.[25] In a relatively short time, a great number of men had to be drafted and trained, the armed forces organized, and military equipment manufactured, which was a daunting challenge for a nation still mired in the Great Depression. The short training periods and lack of experience of virtually all officers and enlisted men were evident in Operation Torch. Military historian Rick Atkinson commented as follows: "As for combat, TORCH revealed profound shortcomings in leadership, tactics, equipment, martial élan, and common sense."[25] According to Atkinson, the campaign had been plagued by a lack of planning and severe deficiencies in organization. Existing units were scattered; transportation and supply problems became major headaches; and discipline deteriorated. During the Tunisian Campaign, Dwight Eisenhower, supreme commander of the Allied Forces in North Africa, confided to a friend: "The best way to describe our operations to date is that they have violated every recognized principle of war, are in conflict with all operational and logistical methods laid down in textbooks, and will be condemned, in their entirety, by all Leavenworth and war college classes for the next 25 years."[25] Given this state of affairs, it is unsurprising that the American armed forces suffered numerous painful setbacks and high numbers of casualties, along with a complete loss of morale—conditions conducive to a high rates of mental breakdown. (Similar conditions also prevailed during the Guadalcanal Campaign (August 1942–February 1943) in the Pacific Theater of Operations, which experienced the same high rates of mental breakdown.) After the devastating defeat at Kasserine Pass, Eisenhower restructured the Allied command. In early March 1943, Major General George S. Patton was placed in command of II Corps and ordered to turn things around. Under his command—through better organization and better coordination of troops, who were now themselves much more experienced—the Tunisian Campaign came to a successful end in May 1943. Patton's efforts were, of course, greatly aided by Montgomery's forces, which had invaded Tunisia from the East.

When the North African Campaign commenced, no arrangements had been made for treating the psychiatric casualties of war.[26] Army policy dictated that mentally ill soldiers be removed from the battlefield and repatriated to receive treatment in American mental hospitals. These individuals were thought to have preexisting conditions and could therefore not be restored to service (and if their condition revealed itself within six months of enlistment, they were not entitled to a war pension). While the number of soldiers suffering from psychiatric symptoms was still relatively small, this policy appeared reasonable. In August 1942, Roy Halloran, superintendent of the Metropolitan State Hospital in Waltham, Massachusetts, and professor of psychiatry at Tufts College Medical School, was appointed as the first chief of psychiatry of the U.S. Army Medical Corps. He endorsed screening as essential to reduce the psychiatric casualties of war. According to him, war was the "proving ground of men": it revealed those individuals whose mental health had already been compromised but who had been able to maintain a more or less normal life during peacetime. It was only during battle that their true condition was mercilessly revealed. He did not believe that there were unique, war-related psychiatric syndromes; for the psychiatrist, war was business as usual.[27] When, in late 1942, the first reports on war neurosis at the front lines became available, its incidence was unexpectedly high. At one point, more soldiers were leaving the North African Theater of Operations than were arriving there to replace them. With so many soldiers breaking down, military officials demanded that solutions be found to stem the tide. Potentially facing severe manpower shortages, they were receptive to a different approach to military psychiatry, one that emphasized treatment near the front lines rather than screening.

In January 1943, Roy Grinker and his resident, John Spiegel, organized treatment for soldiers suffering from war neuroses at the (British) 95th General Hospital in Algiers. Grinker was a leading American neurologist and psychiatrist whose interests had expanded to include psychiatry, psychoanalysis, and psychosomatic medicine after his initial training in neurology. Although both Grinker and Spiegel had been appointed by the air force (probably motivated by the high cost of training pilots), they initially also treated army patients. As soon as they arrived in Algiers, they were confronted with large numbers of soldiers who had broken down at the front line and who suffered from severe and debilitating anxiety attacks, repetitive nightmares, tremors, stuttering, mutism, startle responses, and amnesia. Soldiers displayed unusually florid symptoms—more florid than during any point later in the war. Before the battle of Kasserine Pass, neuropsychiatric casualties had been between a fifth and a third of all medical battlefield evacuations.[25] After this devastating defeat, large groups of severely traumatized American troops fled more than 60 miles away from the frontlines to Algeria. More than 1700 men in need of psychiatric treatment were transported to the 95th Hospital, while many soldiers who remained at the front line were showing symptoms of mental instability. Repatriating all of them would have depleted the Allied forces to an

unacceptable degree. From a military perspective, treatment near the front line—with the expectation that soldiers could be returned to a combat role—now became a necessity.

Following the ideas of Abram Kardiner,[28] who had treated shell-shocked patients of World War I, Grinker and Spiegel interpreted mental breakdown using the psychoanalytic notions of repression, regression, and ego defense mechanisms, the last of which, in response to the extraordinary stresses of battle, produced the symptoms of war neuroses: "Depending upon its strength at the moment, the ego then reacts with the anxiety and helplessness of a child and abandons the scene altogether (stupor), or refuses to listen to it (deafness), or to talk about it (mutism), or to know anything about it (amnesia)."[29] After being confronted with great numbers of patients displaying unusually florid symptoms related to free-floating anxiety and conversion disorders, Grinker and Spiegel developed psychotherapeutic methods for treating acute war neuroses with the aid of sodium pentothal, which they named narcosynthesis. During treatment, they offered soldiers an opportunity to abreact their trauma by reexperiencing it in a hospital environment in the presence of supportive, protective, and understanding therapists.[29,30] The therapists induced a dream state or twilight sleep by injecting sodium pentothal, after which most soldiers spontaneously started to express their anxiety. While the psychiatrist fulfilled the soldier's need for protection, the soldier's ego was nurtured, and he was encouraged to abreact his trauma.

The reported results of this treatment were impressive. Grinker and Spiegel portrayed the power of psychotherapy in almost messianistic terms: "The stuporous become alert, the mute can talk, the deaf can hear, the paralyzed can move, and the terror-stricken psychotics become well-organized individuals."[29] After issuing caveats about the difficulties of compiling reliable statistics under wartime conditions, they claimed that they had been able to return just over 70% of their patients to some form of duty. However, fewer than 2% of their patients were able to return to combat.[31] Most patients displayed their symptoms again in full force when they thought they would be returned to the front lines, and many patients recovered only after they had been assured repeatedly that they would never have to see combat again. Based on their experiences, Grinker and Spiegel wrote a manual for medical officers on treating war neuroses, of which 45,000 copies were distributed.[31] In rewritten form, it became a classic in psychosomatic medicine after the war.[29]

The hospital where Grinker and Spiegel worked was located three to five hundred miles behind the front-lines. It could take two to five days after the onset of symptoms before soldiers arrived there; when the front moved eastward, it could take up to ten days. According to Salmon, whose ideas were rediscovered at this time, stress-related disorders had to be treated as soon as possible after the onset of symptoms; delays in treatment could cause symptoms to become ingrained and resistant to treatment. It was therefore desirable to organize psychiatric treatment much closer to the front lines. In late March 1943, Frederick Hanson and Louis Tureen were attached to II Corps and started working at a clearing station within hearing distance of the Maknassy front in Tunisia. Hanson, an American psychiatrist who had previously been associated with the Canadian armed forces in the United Kingdom (where he participated in the Dieppe Raid), had already gained considerable experience in treating war neuroses. His initiatives proved to be highly successful; he claimed that he was able to return up to three-quarters of affected soldiers to combat.

Hanson's approach was simple and straightforward. It consisted of rest, reassurance, persuasion, suggestion, social pressure, and elements of manipulation. Believing that exhaustion had been the main cause of mental breakdown, he instructed that soldiers displaying psychiatric symptoms at clearing stations receive a sedative, warm food, and blankets, and that they be allowed to sleep. They were reassured that nothing was wrong with them and that they would be able to return to their units soon. In many cases this approach was sufficient for symptoms to abate; Hanson claimed that up to 30% of acute psychiatric casualties could be restored to combat duty within 30 hours, and up to 70% after 48 hours.[32] In such cases, chronic sleep deprivation had been largely responsible for the onset of symptoms by lowering the soldiers' resistance to anxiety. Once soldiers had caught up on their sleep, symptoms often disappeared. As Hanson stated: "The effect is a transient one and produces no lasting alteration of the personality, and when the effects of fatigue have been counteracted, the ability to withstand the emotional stresses of combat returns to its former level."[33] Upon Hanson's urging, soldiers displaying psychiatric symptoms were initially diagnosed as suffering from combat fatigue; only when symptoms did not abate after a few days of rest were they referred to a hospital removed from the front lines for further treatment. After the war, it became clear that many officers had provided this type of commonsense treatment to their soldiers when they suspected a breakdown was imminent. In most cases, this informal type of treatment was sufficient.[34] Not surprisingly, Hanson labeled the approach of Grinker and Spiegel academic and ineffective, whereas Grinker and Spiegel found Hanson's methods superficial. They argued that Hanson's approach, although sound, effective, and based on common sense, hardly qualified as psychiatric treatment.

Many officers and military officials remained suspicious toward psychiatrists and the patients they treated, as illustrated by an incident on August 3, 1943, during the Sicilian Campaign, when General Patton, encountering a patient at a field hospital who was suffering from combat fatigue, slapped him for being a coward. This incident eventually

led to Patton's being relieved of his command; paradoxically, the full integration of frontline, or "forward," psychiatry in the medical services in the European Theater of Operations followed in the months after the incident. Likewise, in October 1943, the prominent psychoanalytic psychiatrist Moses Kaufman arrived in the Pacific Theater of Operations with a brief to organize psychiatric treatment facilities there. Though he was greatly inspired by the work of Grinker and Spiegel, he quickly discarded the use of sodium pentothal and relied, instead, on hypnosis and suggestion.

In December of that same year, after the untimely death of Roy Halloran, William Menninger took over as director of the Neuropsychiatry Division in the Surgeon General's Office. Menninger had a keen interest in psychoanalysis and in furthering the social applications of psychiatry, but a strong distaste for the abstract theoretical discussions and divisive debates that had been common among psychoanalysts. Feeling a close affinity to the interventions developed by frontline psychiatrists, Menninger tirelessly promoted Hanson's and Kaufman's practical, commonsense approaches.[35] Treatment manuals were provided to military physicians; information booklets on the psychology of the fighting men were distributed among soldiers; and discussions about the nature of fear and how to manage it were organized among them as well. The success rates of psychiatric treatment were reported to be high, which fueled the self-confidence of psychiatrists. For military officials, one of the main selling points of forward psychiatry was that the display of psychiatric symptoms was not rewarded by repatriation, which, in their eyes, would inevitably undermine morale. Due to the presence of psychiatric treatment near the front line, war neurosis no longer constituted a one-way ticket home. Military psychiatrists became gatekeepers for the military—or as Sigmund Freud had called them during World War I, machine guns behind the front lines.

After its prolonged involvement in the Mediterranean Theater of Operations, psychiatric care was no longer limited to treating the acute cases of war neuroses that were now seen as inevitably accompanying major engagements. It became clear that even the best and most seasoned troops would eventually break down. Psychiatrists started to observe the so-called old sergeant syndrome during the Italian campaign. This syndrome was apparent in soldiers who had been "the nucleus of the fighting elements of their units and were considered by their officers to be the backbone of the Infantry—the key men and the 'old reliables'. A large number of them had received citations, awards, and medals for outstanding conduct and devotion to duty."[36] After prolonged exposure to battle—for some of them, more than 80 days—these soldiers became jittery, depressed, weary, and anxious. They became unusually tremulous, no longer displayed their usual courage, and lost their self-confidence. These men often attempted to overcome their condition and were reluctant to seek medical attention. It became apparent that even the best soldiers could serve only for a limited period of time. Eventually, they would either break down or be killed or wounded. This realization led psychiatrists to propose a limited tour of duty, which was implemented only during the Vietnam War.[37]

Grinker and Spiegel had argued that individuals suffering from war neuroses were neither cowards nor weaklings. Quite the contrary, they wrote: "It would seem to be a more rational question to ask why the soldier does *not* succumb to anxiety, rather than why he does."[29] Army psychiatrists came to believe that they were not treating pathological conditions in abnormal individuals, but normal reactions of perfectly healthy and previously well-adjusted individuals who had been exposed to extraordinary stressful situations. As two leading military psychiatrists stated, "it was necessary to shift attention from problems of the abnormal mind in normal times to problems of the normal mind in abnormal times."[38] After the Tunisian Campaign, American psychiatrists acknowledged that every man had his breaking point; estimates of when this point was reached varied between 100 days to a full year of battle exposure. Because all men would break down at some point, breakdowns did not reflect negatively on their masculinity, courage, or vigor. In war, the mettle of even the hardiest and bravest of men proved to be limited. Instead of interpreting mental breakdown as the more or less inevitable result of predisposition, military psychiatrists now viewed it as resulting from the extraordinary stress of warfare on normal, well-adjusted soldiers. Against this background, psychiatric treatment near the front lines, rather than repatriation to American mental hospitals, became the preferred approach. This new approach to, and understanding of, psychiatric problems viewed them as occurring in otherwise normal individuals—problems that were, by definition, different in nature than those appearing in individuals with severe and persistent forms of mental illness—thus continuing a trend of interwar psychiatry.[39]

Apart from leading to the institutionalization of forward psychiatry, the participation of American psychiatrists in the Tunisian Campaign led to a number of initiatives aimed at boosting morale. One of the first psychiatrists to observe war neurosis was Herbert Spiegel, who had been commissioned as a general physician in Tunisia and was present at the invasion of Oran.[40] Spiegel treated nervous soldiers and observed that morale was inversely related to breakdown incidence. When fighting was going well and battles were won, when soldiers trusted their officers and generals (as well as the way that the war was being conducted), when they felt that their training had adequately prepared them, and when they felt supported by the home front, breakdown incidence was low (which explains, too, why breakdown incidence was so high during the Tunisian Campaign, as none of these conditions obtained).[41] Spiegel also observed that

the motives that inspired soldiers to fight were not related to hating the enemy or Nazism, or to honoring the ideals of democracy and liberty. Instead, group loyalty and the deep emotional bonds between soldiers were of prime importance (one of the main lessons of World War II was the importance of group cohesion). After the war, Spiegel wrote, with Kardiner, an updated version of the latter's seminal text on war neurosis.[42] Observations like Spiegel's inspired sociological theories that related nervous breakdown to individual motivation and group characteristics rather than to the intensity and duration of individual exposure to battle. Because breakdown incidence was inversely related to morale, military officials concluded that improving morale would greatly aid the war effort (it would constitute preventive psychiatry on an army-wide scale). These conclusions were subsequently confirmed by a group of sociologists, led by Samuel Stouffer, who used interviews and questionnaires to study American soldiers and what motivated them.[43] One measure to boost morale was the well-produced "Why We Fight" series of war propaganda movies, which drew a stark contrast between the forces of liberty and the forces of darkness, and elaborated on the war atrocities committed by the Axis powers.[37] These movies were followed by group discussions led by officers. Such initiatives were not especially successful, however, since the motives of most fighting men were not related to the ideals of democracy and liberty, but to the emotional bonds within their unit.

As a consequence of its ongoing participation in World War II, military psychiatry underwent a decisive change in its theoretical orientation, which resulted in different types of intervention strategies. During the first years of the war, most psychiatrists believed that mental illness and mental disorder were the outcome of predispositions that were revealed when the stresses of life were sufficiently great. During the war, these views came to be replaced by a psychodynamic perspective that ascribed the causes of mental breakdown to the extraordinary stresses that warfare imposed on essentially normal and healthy individuals. In several studies that followed soldiers whom psychiatrists had predicted would break down, the soldiers actually performed as well as others, thereby demonstrating the limited usefulness of screening.[44] This theoretical reorientation increased the scope of American psychiatry to include the pathological reactions of essentially normal individuals to extraordinary stress. It also led to a much more optimistic attitude toward the efficacy of psychotherapeutic treatment, at least if it was received soon after the onset of symptoms. These changes had far-reaching effects on American psychiatry after World War II, when treatment within the community was advocated over institutionalization in mental hospitals. This new understanding justified psychiatric attention to less serious forms of mental disorder because treatment would prevent conditions from becoming more serious. Citing the high rejection rate for psychiatric reasons and the high rate of breakdown in the armed forces, psychiatrists presented mental health as a necessary national resource that needed to be protected and fostered.

After the war ended, many former military psychiatrists extolled the virtues of psychiatry. In 1946, the National Mental Health Act was passed, which led to the founding of the National Institute of Mental Health in 1949 and to an unprecedented level of funding for psychiatric research. Grinker and Spiegel wrote a book generalizing the results of their work to peace and incorporating Hans Selye's concept of stress.[45–47] In 1946, the former director general of medical services for Canadian armed forces, G. Brock Chisholm, urged psychiatrists to use their insights into human nature to remodel modern society.[48] He became the first director-general of the World Health Organization in 1948 and tirelessly advocated the importance of mental health. That same year, during the first International Congress on Mental Health, participants asserted that psychiatry had a central role to play in preventing World War III and in stimulating world citizenship.[49] William Menninger, president of the American Psychiatric Association in 1948–49, appeared on the cover of *Time Magazine* on October 25, 1948, and continued to advocate an Americanized, medicalized, and popularized version of psychoanalysis.[50] Harry Stack Sullivan became actively involved in international activities promoting peace and gave a seminal paper at UNESCO's 1948 International Tensions Conference.[51]

During the war, it had been reported that forward psychiatry was highly successful. When a statistical analysis of treatment results was conducted after the war, however, it appeared that the success of interventions had been greatly overestimated.[52] At the conclusion of the war, many veterans still received treatment for psychiatric syndromes, as illustrated in John Huston's film *Let There Be Light*, produced in 1946 but released only in 1981. Unfortunately, the corrosive effects of war were, for many veterans, too serious to be alleviated by the treatments that could be provided. In addition, the long-term effects of battle trauma, which became much better known after the Vietnam War, were not fully appreciated at the time. Dynamic psychiatrists were accustomed to treating acute stress reactions, which, by definition, occurred a relatively short period after a traumatic or stressful experience. When veterans sought medical attention for anxiety, depression, and other psychiatric symptoms, few psychiatrists related those conditions to the veterans' war experiences, and because the symptoms had become chronic, psychiatrists assumed that underlying psychopathology must be involved; at the time, stress reactions occurring immediately after a traumatic event were considered fundamentally different in nature to psychiatric reactions occurring at a temporal distance. Psychiatrists who had not participated in the war effort also did not

generally appreciate the psychiatric consequences of participating in warfare. A final deficiency in the postwar psychiatric care of veterans was that psychiatrists increasingly focused their attention on the community and on prevention, and paid less attention to the group of deeply troubled veterans and the institutions where they would receive treatment.

Although American psychiatrists became interested in predisposition again after the war, that concept was now defined mostly in psychodynamic terms. This renewed emphasis is most noticeable in the accounts of Edward Strecker (who had been a psychiatrist at the front lines during World War I). In his *Their Mothers' Sons*, the high incidence of mental breakdown in the American army was related to the permissive child-rearing methods of modern America and the lack of character of young American men.[53] Strecker mostly focused on mental breakdown in soldiers who had never seen battle (including those in service units and those who broke down during training) and distinguished them from the few heroic soldiers who broke down after lengthy engagements with the enemy. An element of racial prejudice, however, may also have been at work here; the soldiers in service units were disproportionately African American.[23] In any case, Strecker contrasted the few real heroes who had broken down after prolonged battle exposure with the great many soldiers who had broken down for no obvious reason.

In the years before the American participation in World War II, war neuroses or shell shock was viewed as a chronic condition for which many ex-servicemen were institutionalized. Psychiatrists of different theoretical orientations agreed that a preventive approach, which would screen out individuals predisposed to mental breakdown, would alleviate this problem and obviate psychiatric care near the front lines. A screening system more rigid than any previous one was implemented, but the unprecedented incidence of breakdowns during the Tunisian Campaign demonstrated that the system was ineffetive. The exigencies of war, coupled with the military demand to maintain manpower, allowed psychodynamically oriented psychiatrists to introduce psychiatric treatment near the front lines. The perceived success of this intervention increased both the self-confidence of psychiatrists and the social esteem of the profession after the war. American psychiatry came to be dominated by psychoanalysis—even though the psychiatric approaches that had been successful during the war emphasized environmental stress rather than the internal dynamics of desire. During the 1950s, it became clear that the success rates of psychiatric intervention near the front lines were greatly overstated. In addition, psychiatrists typically did not relate veterans' complaints that first showed up after the war to their combat experiences; the delayed onset of traumatic responses was recognized only after the Vietnam War. Paradoxically, the growth of postwar psychiatry was based on overestimations of the success of psychiatric interventions pioneered during the war and on theoretical assumptions that were at odds with those on which those interventions were based.

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