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Christine M. Silverstein

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FROM THE FRONT LINES TO THE HOME FRONT: A HISTORY OF THE DEVELOPMENT OF PSYCHIATRIC NURSING IN THE U.S. DURING THE WORLD WAR II ERA

Christine M. Silverstein, EdD, RN, MPA
Summit Center for Ideal Performance, Ramsey, New Jersey, USA

During World War II, psychiatric nurses learned valuable lessons on how to deal with the traumas of war. Using psychohistorical inquiry, this historian examined primary and secondary sources, beyond the facts and dates associated with historical events, to understand why and how psychiatric nurse pioneers developed therapeutic techniques to address the psychosocial and physical needs of combatants. Not only is the story told about the hardships endured as nurses ministered to soldiers, but their attitudes, beliefs, and emotions, that is, how they felt and what they thought about their circumstances, are explored. In this study the lived experiences of two psychiatric nurses, Votta and Peplau, are contrasted to explicate how knowledge development improved care and how this knowledge had an impact on the home front in nursing practice and education, as well as in mental institutions and society, long after the war was won.

In October 2003, mortar fire lit up the night sky over the base camp near Baquba, Iraq, where 21-year-old Specialist Abbie Pickett served as a combat lifesaver (Carey, 2005). She focused on the care of the wounded by flashlight, and did not notice until nearly too late that a medic who worked with her was bleeding to death nearby. Frantically, she treated his wounds and evacuated him to a medical station. Although her colleague survived the assault, Pickett, like many American combatants in Iraq, was maimed. After her return home to Wisconsin, she felt cut off from her comrades in arms and wished she had died during the attack. She
struggled with life, attempting to secure counseling and gain relief from drugs, while she searched her conscience for reasons to justify her pain. With an increasing number of casualties mounting, Pickett is not alone (Bulkeley, 2004). Veterans suffer from the physical, mental, and emotional traumas of war in Iraq, as many combatants have in other wars. Some have experienced brain injuries, severed arms and legs, and organ and spine damage, as well as posttraumatic stress disorder (PTSD). Sergeant Bryan Anderson, at 25, held the distinction of being a celebrity as one of the war’s triple amputees. “Modern medicine saved him and now he’s the pride of the prosthetics team at Walter Reed” (Hull & Priest, 2007).

Journalists from the Washington Post painted a grim portrait of the treatment of returning combat veterans, who easily explode into frustration and rage when imprisoned in deplorable conditions reminiscent of dilapidated and overcrowded postwar mental institutions of the past. Amid mice droppings and cockroaches in Building 18 at Walter Reed Army Medical Center, they became addicted to drugs and alcohol, using them as sleep aids and pain killers (Hull & Priest, 2007; Priest & Hull, 2007). Incidences of depression, suicide, and domestic violence among vets are the telltale scars of Iraqi warfare (Caplan, 2004; Corbett, 2004). Many veterans refuse counseling to avoid the stigma of mental illness and to ameliorate the fears of being called weak cowards. Critics assert that a diagnosis of PTSD is the kiss of death for a military career (Bulkeley, 2004), which further deters veterans from seeking psychological assistance.

In the midst of political confusion, Congress passed a vote of “no confidence” for President Bush’s war tactics in Iraq, which some critics believed further demoralized the troops. There are calls to treat the anguished vets with “listening and walking” cures and for society to accept them with open arms (Caplan, 2004; Davis, 2005; Leichman, 2004). Fortunately for these combatants, there is a precedent for such interventions, as discussed in this article, which explores the history of the development of psychiatric nursing in the U.S. during the World War II era and the contributions psychiatric nurses made to nursing and American society at home and abroad (Silverstein, 2007).

A CHANGE OF HEART

The concept of war neurosis, as classified in 1980 as PTSD in the DSM-III (American Psychiatric Association), was not new. Psychological trauma associated with war dates back centuries. During the Civil War it was called “soldier’s heart.” In the trenches of World War I, medics
referred to it as “shell shock” (Lasiuk & Hegadoren, 2006). The social attitude about shell shock did not firmly support the combat soldier (Moore, 2003; Peplau, 1989). From the onset, “soldiering” developed the reputation as a device used by malingerers to escape from danger or duty (Pittman, 1974, pp. 13–14). However, when American psychiatrists successfully set up field hospitals to treat soldiers who had neurotic and psychotic conditions from the trenches, surgeons and general medicine became more interested in aspects of psychological care. Along with a more open-minded perspective on mental health came the establishment of a new medical division in the army for neuropsychiatry; America grew “far more receptive to the idea of mental hygiene than it had been in previous years” (Pittman, 1974, p. 7).

In 1943, after slapping a battle-fatigued soldier in Sicily, General George S. Patton was reprimanded by General Eisenhower and was ordered to apologize to the 7th Army troops (Snyder, 2003). During the battles of war, society began to understand that every person had a breaking point (Lasiuk & Hegadoren, 2006). Consequently, this benevolence generated sympathy and eventual financial support for the treatment of the mentally ill, especially for the soldiers who returned home from the war. Aside from providing a reason to improve psychological care for veterans, the Second World War also served as a powerful impetus for making citizens aware of the impoverished conditions in mental hospitals and the enormous size of the challenge of mental illness in America (Pittman, 1974). During the military draft and the pre-induction exam for recruits, the magnitude of the increasing problem of psychiatric disorders was exposed. At the beginning of the war, directly following the destitution of the Great Depression, a large number of potential recruits did not qualify for military service because of psychological disorders. As the war continued, the rejected inductees increased.

Psychiatric casualties were exceedingly high and obvious during the early war and continued up to the last battles fought (Ambrose, 1997). On Okinawa over 26,000 psychiatric cases were recorded (Hemingway, 1998). A field manual on the subject issued in 1945 estimated that approximately 30% of soldiers would experience battle fatigue during their tours of duty (Callaway, 2002). Out of the inductees in the army, who were subsequently given medical discharges, 40% were psychiatric cases (as cited in Church, 1982). As casualties of war, they required psychological interventions.

During the battles, there were severe shortages of psychiatric nurses, so desperate attempts were made to recruit them. A nurse lieutenant instantly became a qualified psychiatric nurse as she came off the gang-plank in a Philippine port. A major approached her and asked if she had
any experience with psychiatry. Upon answering, “Yes ma’am, I have” in Butler Hospital in Providence, Rhode Island, the major escorted her in a jeep to the 118th General Hospital and told her that she was now the new head nurse of a psychiatric ward. Her account follows (O’Grady, 1995):

“Well, how many patients do you have?” She said, “Two hundred,” and I said, “How many nurses?” She said, “You.” I was a little bit overwhelmed. I said to her, “Why did you choose me?” and she said, “Because you have red hair and I promised the boys a red head.” I looked at her and she had red hair and she was going home.

UNPREPARED FOR THE ONSLAUGHT

There were 3,000 psychiatrists for military and civilian use in the United States at the start of WW II (as cited in Church, 1982). A lack of knowledge of etiology of mental illness, a lack of adequate methods to treat patients in large numbers, and a lack of the role of treatment and prevention added to the challenges during the war. Military nurses had little preparation to care for the mental reactions of soldiers. In addition, they had to endure hardships of their own during the battles. A nurse, who served in the South Pacific, related the travails of wartime (Brown, 1944):

Top of all this with the major emotional shocks—grief for the laughing comrade suddenly and grotesquely dead beside him, compassion for the suffering of the wounded, fear itself, and the physiological reaction to the unfamiliar smells of fear and pain and to the stench of the unburied dead. (p. 1135)

In Norman’s (1999) account of the challenges of American nurses trapped on Bataan by the Japanese during the Second World War, she spoke about their struggles:

Before the buckets of bloody limbs and the white crosses on the jungle floor, the women of the Army Nurse Corps did not really think themselves part of the profession of arms. Yes, they were in the army . . . but they were healers, not soldiers. . . . Theirs was a culture of care, not nodding plumes and bugles and battle cries. The army was an arena for men, and women were on the periphery of that domain, that place of male passage. (p. 39)

Military nurses were learning new ways to care for mental disorders and for the soldiers traumatized by war, simply because they had to, for the problems confronting them on the battlefields were different
from those experienced in mental and general hospitals back home. The psychologically-oriented nurse had to “acquire a true sympathy and real understanding . . . considering how she herself would feel, how she would like to be treated, what her reaction would be, had she been fighting” (Brown, 1944, p. 1136).

When she dressed up as Santa Claus, the red-headed nurse stationed in the Philippines, Lucille Spooner Votta (O’Grady, 1995), learned new skills first-hand. She explained how she participated in the war effort during the holidays:

I got all the corpsmen to work with me and we made little baskets and put them at everybody’s place for Christmas morning. One man, who was in seclusion, he was very ill, he was stark naked in his little cell and I went and I gave the basket to him. He said, “Ma’am, this is the nicest Christmas I’ve ever had.” There were many touching things that I loved.

FRONTLINE IMPACT ON NURSES

“About 90 per cent of the combat exhaustion cases in the European Theatre returned to duty as a result of prompt and skilled handling. . . . They were treated successfully with sedatives or narcotics and also by use of hypnosis and group therapy” (90% battle fatigue cases cured, 1945). This rapid turnover kept the corpsmen busy. Votta, hand-picked by the major, stood alone on a neuropsychiatric ward and had limited experience with psychiatric nursing. However, she had ten enlisted corpsmen that could “run the hospital” without her. She related her experience with insulin shock (O’Grady, 1995):

It was from them [the corpsmen] that I learned most of the things. . . . They were doing actual shock therapy with insulin. I kind of felt it was worthwhile because if we really could help these people then they might not be sick for the rest of their lives. Some of them, the large number we gave shock . . . When people had been out they got a sort of battle fatigue and they went a little off.

In contrast, Hildegard Peplau’s wartime experience was quite different from Votta’s. In June of 1943, Peplau graduated with a bachelor’s degree from Bennington College, Vermont, with a strong concentration in psychology, and enlisted in the Army Nurse Corps (Callaway, 2002). Her intention was to work on the front lines in psychiatry, and she systematically maneuvered her way to the 312th Station Hospital and School for Military Neuropsychiatry for the European Theatre, where most of the psychiatrists from Britain and other European countries
came to study (D’Antonio, 1985). The school and hospital were located at Shugborough Park, near Stafford, Staffordshire, England, on the estate of the Earl of Litchfield (Callaway, 2002). At the 312th, Peplau lived in a Nissen hut with six to seven other people. They had a pot-bellied coal stove that polluted the air, and they slept on cots. In the two years she was in England during the war, there were only two days of sunshine (Peplau, 1992).

Since there were so few “trained” psychiatrists, and servicing the emotional needs of the soldiers was great, many physicians took one- to six-week crash courses on how to become a psychiatrist (D’Antonio, 1985; Peplau, 1992). All of these male physicians, Peplau knew personally. She became acquainted with noted psychiatrists, such as Menninger, Chief U.S. Psychiatric Consultant to the Office of the Surgeon General (Callaway, 2002). Peplau was the sole nurse permitted to audit the courses and was the only nurse in charge of a unit without a physician (D’Antonio, 1985). During evenings at the Officers’ Club, Peplau (1992) learned much about psychiatry. She described her experience at the club:

It had a big fireplace with plenty of wood brought in by the privates. A couple of nurses, faculty and doctors would sit around and discuss psych therapy and cases, etc. . . . An enduring seminar for me. I learned a great deal. Visiting VIP psychs—William Menninger, Strecker, Bowlby of England. They would join us. By the time I came home, I knew a lot about the core of psychiatry. (p. 34)

Peplau (1992) reported to the clinical director. Neurotic and psychotic cases, flown directly in from the front lines, made it exciting for her:

Patients were brought as quickly as possible from the battlefield. There were always fresh cases, and we developed new methods of rapid treatment. The division psychiatrist tried to give rapid treatment right there at the front. If it didn’t take he sent them back to the units further back. Then they were flown back to the 312. (p. 33)

The soldiers who were pinned down by mortar fire for extended periods of time were most likely to be affected by combat exhaustion (Callaway, 2002). At the earliest possible time, the medical officers at the 312th were instructed to induce narcosis. After having hot soup, the soldiers were given 6 grains of sodium amytal and were put to bed. If this did not induce deep sleep, up to 12–18 grains were used. Dr. William Sargant of St. Thomas’ Hospital in London advocated the use of deep sleep therapy (DST), and he was a frequent visitor to the 312th. DST hoped to calm patients down and increase accessibility to dialogue.
Jacob Klaesi, a physician from Zurich, is commonly associated with the use of prolonged sleep therapy, which was the first of the “physical therapies” of the twentieth century that purported to offer some transitory relief for functional psychosis (Shorter, 1997).

“Avant-garde” treatments in psychiatry were in use. Peplau (1992) worked on the experimental unit and did not always approve of the treatments provided, as is evident by her comment:

Doctors could do anything they wanted. I looked upon some of what some did with horror. EXPERIMENTS! They gave a lot of pentathol interviews. They tried new mixes of amytal treatment. (p. 33)

In conjunction with drugs, ether was used (Callaway, 2002). Peplau (1992) described the procedure:

Sampliner used to give a drop of ether to patients . . . with hysterical paralysis. . . . He got a can of ether, punched holes in it, and then would drip it on a mask held over the patient’s nose. . . . the patient would enter a twilight zone—at that point he would frequently talk. Then he’d become a little more unconscious. The patient, when he came to, was schizoid. (p. 33)

During the deep sleep treatments, the soldiers received large doses. They took the drug and awakened only to use the bathroom and to eat twice a day. The rest of the time, they slept around the clock. Peplau (1992) detailed the treatment:

I think it was 8 days. . . . After that they had flaccid muscles. They had to work their way back up to physical shape. We had to watch that they didn’t vomit or choke, and that they were still breathing. Only one died that I knew of. . . . I always thought it was a dangerous treatment. (p. 34)

Peplau looked upon Dr. Sampliner’s practices and experimentation with “utter contempt” (Callaway, 2002, p. 111). Since she believed that they were “obscene,” she voiced her views early on, urging modifications in the prescribed treatments (p. 111). Peplau (1992) hated experiments with young soldiers “who could not say no” and were so trusting. After the war, Dr. Sargant abandoned DST and referred to it as “the most problematic” of the physical therapies in psychiatry (Callaway, 2002, p. 111).

Since it was recognized that soldiers fatigued by battle suffered from exhaustion, lack of sleep, insufficient food, and a decrease in morale, sub-coma insulin shock therapy was used, lasting from five to seven days (Callaway, 2002). High caloric forced feedings were added to the insulin treatment to improve weight gain, and patients gained an average
of one pound a day. On her unit at the 312th, Peplau (1992) worked with sub-coma insulin shock therapy. She explained how she encouraged soldiers to talk:

My observations were not of insulin per se. As the individuals got drowsy, they entered a sub-conscious twilight stage. They would think food carts rolling down the plank-board walkways outside the units were cannons. They became hysterical. On the ward I was training corpsmen to sit between two beds to watch—to try to get them to talk rather than act out their sub-conscious memories. This became very useful. They’d perspire terribly. . . . I’d wipe their brow, give them orange juice. They’d come out of it, calm down, and take a shower. That was the treatment. (p. 34)

Peplau went beyond the stupor of sleep and insulin therapies, and on her unit she introduced the idea of walking and talking with patients as they discussed their traumatic experiences and battle fatigue, one-on-one (Callaway, 2002). Eventually Peplau (1992) incorporated these methods into standard practice on her unit in the following ways:

I was permitted to have groups of patients in the kitchen. Sitting around the table and talking. I was not a sophisticated interviewer or psychotherapist. But I was interested—I’d make eggnog and buttered toast. They were amazingly useful. . . . Also I was allowed to talk with individual patients. There was no private place—so it was hard to do. I took them on walks, I would listen. (p. 33)

ESTABLISHMENT OF PSYCHIATRIC NURSE CONSULTATION

The programs implemented in military hospitals at war became the treatment of choice for the mentally ill at home. Along with support from the military, a campaign to increase federal government involvement in a nationwide plan to combat mental illness commenced. Endeavoring to mobilize the resources within nursing, a psychiatric nurse consultant position became available.

In 1942, the American Psychiatric Association began the Nursing Consultation Project through a grant from the Rockefeller Foundation. Laura Fitzsimmons, formerly at Saint Elizabeth’s Hospital in Washington, D.C., served as the first consultant to evaluate educational facilities for the training of nursing personnel, with special emphasis on attendant, student nurse, and postgraduate programs for nurses. The purpose of the project was to study the adequacy of personnel, give guidance in the development of programs in the preparation of nurses in mental
hospitals, and formulate standards for courses (Church, 1982). By 1943, in her assessment, Fitzsimmons clearly listed the underlying causes of the generally poor quality of care. She decried the fact that outmoded customs persisted, and she created a highly successful manual for U.S. Army attendants. The Committee for Psychiatric Nursing subsequently included all Fitzsimmons’ recommendations.

Fitzsimmons suggested that the public be educated to the needs of mental patients, for this would help to increase funding (Church, 1982). Also included were recommendations for the establishment of uniform standards of training for attendants and the strengthening of basic nursing schools in mental hospitals. In addition, Fitzsimmons recommended an increase in affiliations for student nurses and postgraduate courses, a provision of uniform standards for all patients in mental hospitals, and the recognition of the status of RNs, all centralized under competent nursing directors. In the Annual Report to the American Psychiatric Association of the Survey Project that Fitzsimmons partook in from July 1943 to June 1944, she stated that she looked forward to a time when psychiatric nursing would be included in the basic curriculum of every student. Within a year, federal funding strengthened schools, and subsidies promoted affiliations of nursing students in mental institutions.

In the Survey Project Report, Fitzsimmons concluded that the timing of the project was fortuitous, for “the general acceptance and even eagerness for psychiatric nursing, which has been evidenced by the general nursing groups, is almost revolutionary” (as cited in Church, 1982, p. 197). With an increased awareness of the need for psychiatric services after the war, government funding made monies available through legislation for mental health workers.

**LEGISLATION SUBSIDIZES NURSING EDUCATION**

Nursing shortages were escalating in early wartime, and the National Nursing Council for War Service grew from this emergency (Lynaugh, 2006). By June 1943, the shortages reached a crisis that inspired a solution known as the “Bolton Bill” (Church, 1982). Frances Payne Bolton, Congresswoman from Ohio, introduced the legislation to Congress. In 1943 the Bolton Act, Public Law-74 of the 78th Congress, officially known as the Nurse Training Act-U.S. Cadet Nurse Corps, was passed for the purposes of assuring a supply of mental health professionals in hospitals, health agencies, and war industries, as well as nurses for the armed forces (Pittman, 1974). It provided for the training of nurses through grants to institutions. The federal funds appropriated amounted to $1,200,000. For psychiatric nurses they covered tuition, fees, and
maintenance for students in postgraduate programs. Funds also provided for advanced programs in universities and colleges, which prepared graduate nurses for teaching and nursing service positions, as well as for positions in clinical fields, like psychiatric nursing.

Eugenia Spalding, a nurse education consultant, recommended at a National League meeting that psychiatric nurses take advantage of new federal funding for education through the Bolton Act (Pittman, 1974). With knowledge that the funds were available, nurses began to envision graduate study in the university, and as psychiatric nursing called for a commitment from other nurses, graduate nursing programs began to spring up. Peplau (1982) reported that by 1943, three universities began a program in advanced psychiatric nursing. These programs focused primarily on baccalaureate-level education for nurses, even though they were “graduate” courses in the university. By 1945, 126 nurses had graduated from the programs.

The Bolton Act was considered a temporary stop-gap measure during the war, but its impact was felt by nursing for many years beyond the initial effect (Church, 1982). The Division of Nursing Education of the U.S. Public Health Service originated after the passage of the Bolton Act. An appointed director, Lucille Petry Leone, was the most widely known nurse in the United States during World War II. She later became the first female and first nurse Assistant Surgeon General. Leone did much to improve the recruitment of large numbers of able students, which did much to stem the tide of shortages. During this timeframe, psychiatric nursing had support through an increase in the number of affiliations for psychiatric experiences. By the end of the war, more than three-quarters of nursing schools offered psychiatric nursing as part of their curricula. Church commented that it was ironic that a negative force, such as a war, could provide benefit for the nursing profession. The Second World War directed nursing to unify its resources, providing timbre to the voice through which it could express itself.

Peplau, psychiatric nurse of the twentieth century, described her experiences as “just plain good luck.” She always considered the nurse’s role in psychiatry (D’Antonio, 1985). However, when it came time to implement her plan of introducing psychotherapeutic interventions, she had nothing to go on. To Peplau, the situation was “something of a nightmare,” for nursing practice, she believed, was at a low level (D’Antonio, 1985). Peplau had good exposure. While serving in the army, she had the opportunity to build on her previous work at Bellevue and Chestnut Lodge with Frieda Fromm-Reichmann. In addition, she had on-the-job training during the war, for she learned the practice of psychotherapy from everyday experiences, from readings and group discussions, from
lectures, and from observations and interactions with physicians (Callaway, 2002). The extensive knowledge Peplau gained, along with the prolific notes she took on her patients, later became the foundation for her book, *Interpersonal Relations in Nursing* (1952/1991), upon her return home.

**CIVILIAN NURSES’ ROLE**

The programs implemented in military hospitals became the treatment of choice for the mentally ill in the States. Wartime psychiatrists and nurses educated the civilians at home to the fact that a “personality wound” was just as valid as a physical wound (Brown, 1944, p. 1137). It was not a sign of weakness. Although Brown acknowledged the importance of the psychiatrist, she stressed the essential role of the psychiatric nurse in working with those affected by war trauma. Brown stated:

> The psychiatric nurse can and must play an important role in this recovery if the wounds in the personalities of these boys are to heal cleanly without leaving the incapacitating scars in their nervous systems and minds, too often found in the backwash of war. (p. 1136)

Since one out of every three casualties returned from the war with a neuropsychiatric illness (Fitzsimmons, 1944), nurses on the home front were advised to prepare themselves for the returning service men, for they would be expected to answer more questions than ever before about mental illness (Hatfield, 1944).

**NURSE VETS HOMEBOUND**

In 1944, Gregg, a physician, suggested that nurses returning from military service needed acceptance by others while they made adjustments or re-conversions to postwar civilian life. He expressed:

> If they [nurses] do not find their former positions satisfactory on return it will not be fair to resent their changed viewpoint or to charge them with ingratitude or feelings of superiority. They have changed, irrevocably; they have been changed by experiences too deep and lasting to be erased, forgotten, or ignored. (p. 923)

Despite Gregg’s (1944) admonitions, nurses discharged from military service felt their suggestions had little value to hospital administrators, as one nurse commented (David, 1947):
Being an ex-Army nurse and familiar with the “suggestion box,” I believe such a plan would be welcome at a large hospital such as the one I am employed by. A nurse can see many times . . . just what changes might save work. . . . At our hospital, no suggestions whatever are taken from a nurse. (p. 458)

Nurses who participated in the war effort had challenges adjusting to everyday life after the war was over. Norman (1999) wrote about one such nurse named Eleanor, who believed the war experience of entrapment on Bataan by the Japanese would expedite captancy. However, when her superiors at Birmingham General refused to promote her, she began to question whether others resented the publicity she had been getting. Her friends urged her to prepare to leave the service. By 1946, she had reached a breaking point, requiring visits to a psychiatrist for depression. Norman explained that the promotion issue was not the principal source of problems for Eleanor by saying

Her disquiet really came from the war. She simply could not reconcile the sacrifice she’d made—the suffering that had earned her the sobriquet of hero—with the indifference and anonymity she was experiencing in everyday life. (p. 256)

NURSES BENEFITED FROM WAR EFFORT

On May 19, 1947, Eli Ginzberg (1947), a professor of economics at Columbia University, gave a speech at Teachers College for the Homecoming of the Alumnae of the Division of Nursing. He noted that, although nurses held strong and differing opinions about the definition of nursing, he chose to focus on the three “Rs” of recruitment, the role of the nurse, and the rewards of nursing. Ginzberg believed nursing gained from the war experience of the army and listed some benefits, such as doctors and nurses learning to work together as a team, team efficiency improving, nurses becoming valued members of the team, and adjunct personnel enabling the army to reassign nursing service. Some doctors had difficulty changing their attitudes and actions towards nurses, Ginzberg indicated, but they could not devalue the nurse’s role in evacuating hospitals during attacks. When the army nurse became a sanctioned officer, it raised the prestige of the nurse, as well as “her” pay and other benefits.
THE NATIONAL MENTAL HEALTH ACT

The introduction of nurses into the role of mental health consultant, such as the one Fitzsimmons held, raised questions as to what place nurses would take within the traditional team of mental health workers. Clayton (1976) reported that the appointment of Dr. Robert Felix as the first director of the National Mental Health Institute was an event of profound significance for psychiatric nursing education. The original plans for the National Mental Health Act (NMHA) of 1946 did not mention nursing as a part of the psychiatric-mental health team. Nurses’ work, with few exceptions, explained Clayton, was technical, restricted, and custodial. However, since Felix had worked with nurses during his early residency training at Johns Hopkins and during the war, he had direct contact with psychiatric nurses, so he included them along with the traditional triad of psychiatrists, psychologists, and social workers. Felix believed that nurses would benefit from advanced clinical training programs and that this training would help to correct the old mentality of mental hospital nursing.

Although Felix included nursing as a member of the interdisciplinary team, there was much opposition to this move from psychiatrists, psychologists, social workers, and nurses (Draper, 1988). It was felt that “the nurse should not infringe on the territories of the established team members” (p. 424). Draper speculated that the concern for territorial turf of the disciplines was a factor that facilitated the movement of the public health nurse into mental hygiene and restricted the psychiatric nurse from that role.

Mereness (1956), a psychiatric nurse who later became a dean of the school of nursing at the University of Pennsylvania, viewed factors that contributed to the success and failure of team functioning for psychiatric nurses. She believed that recruitment of professional nurses in the psychiatric setting would be encouraged if there were more opportunities for nurses to become active members of the interdisciplinary team. Such collaborative planning and coordination of effort would result, Mereness posited, in the elevation of nursing to professional status.

By the end of 1945, legislators were becoming more aware of a growing number of persons in society whose mental illness required hospitalization. According to Pittman, there were 462,714 resident patients in mental hospitals. Of the 125,000 patients admitted, 75% were first-time admissions. The U.S. Census Bureau, Division of Mental Hygiene, revealed that there were only 4,252 psychiatric nurses employed in state hospitals in 1940 (as cited in Fitzsimmons, 1944).

There were reports in 1945 that the Second World War exacted a heavy toll on the mental health care system, for the nurse-patient ratio
was 1:135 in mental hospitals, which was dangerously below the ratio of 1:20 recommended by the APA (as cited in Clayton, 1976). By 1946, 60% of all patients hospitalized in VA institutions had psychiatric illness, at a cost of $40,000 or more per person (as cited in Church, 1982). With a large and ever-growing population of Americans requiring treatments for mental illness, federal funding stepped in to stem the tide.

On July 3, 1946, the 79th Congress passed the National Mental Health Act, H.R. 4512 (Pittman, 1974). The bill awarded grants designed to attack mental illness through training of mental health personnel, supporting research that searched for cause, treatment, and diagnosis of mental illness, and setting up treatment centers that addressed prevention, treatment, and diagnosis (Smoyak, 2000). A National Mental Health Advisory Council and the establishment of the National Institute for Mental Health (NIMH) resulted from the enactment of the NMHA. The passing of the act provided the greatest impetus for the evolution of psychiatric nursing as a major specialization within the profession (Church, 1982).

The funds stimulated the growth of graduate programs for psychiatric nurses, “which ultimately led to the development of not only psychiatric nursing, but of the whole field of nursing as well” (Peplau, 1989, p. 20).

PEPLAU TAKES ADVANTAGE OF FUNDING

Peplau (1989) believed that government funding after the war was a great bonus for nursing, and she and other military nurses took advantage of this opportunity for education. By 1945–1946, Teachers College, Columbia University, offered a two-credit mental hygiene course taught by nurses, not physicians. This course surveyed the principles of mental hygiene with application to the personal and professional needs of nurses engaged in hospitals, public health, and nursing schools (Announcement of Teachers College, 1945–1946). In the same announcement, there is the first listing mentioned of a course in advanced psychiatric nursing. It was a 7–8 credit course for nurses who had a satisfactory introduction to psychiatric nursing and for those who wished to specialize as teachers and supervisors of psychiatric nursing in hospitals, nursing schools, and the community. Students had a four-month internship in a psychiatric hospital. Other courses listed in the Announcement related to the medical and scientific aspects of psychiatric care and to the social and community components.

Brimming with confidence after her discharge from the army in 1945, Peplau made the decision to apply for admission into a postgraduate course at Teachers College (Callaway, 2002). The initial rejection of her application at the college, because of her dubious avant-garde
background at Bennington and the war—rare credentials for nurses at the time—did not deter her. Peplau gained admission after she reminded her interviewer that the Veteran’s Administration would take exception to the claim of inadequate credentials under the GI Bill. She took the one-year postgraduate course, leading to a master’s degree in 1947. Her tuition for courses at the William Alanson White Institute (WAW) in New York and 400 hours of psychoanalytical training received funding from the GI Bill (D’Antonio, 1985). The instructor at the institute, who was not a nurse, spent all of the time berating the students who participated in the war effort.

**IMPLICATIONS FOR PSYCHIATRIC-MENTAL HEALTH NURSING**

“Earned, Not Given.” These words can be applied to the work of psychiatric nurses and the troops who served during World War II. Fortunately for psychiatric nursing and the military, nurses, like Peplau, had the “plain good luck” to be present, to observe, to experiment, and to conduct research. The data Peplau collected became the first nursing theory and the first systematic methods for therapeutic nurse-patient interaction. Her work laid the foundation used in contemporary theory development and psychotherapy, which are rapidly becoming lost arts (Silverstein, 2003, 2006).

Through the courageous efforts of Peplau, Fitzsimmons, Leone, Spalding, and many other nurses not mentioned in this article, today’s psychiatric-mental health nurses have learned from the past and have clearly benefited in the 21st century. There is evidence in nursing literature that the work of early psychiatric nurse pioneers has played an instrumental part in the establishment of the healing environment (La Torre, 2006; Smoyak, 2002), the creation of nursing consultation models (Morgan, 2006), and the identification of the therapeutic core of psychiatric mental health nursing in interpersonal communication courses (Horsfall & Stuhlmiller, 2001; Perraud et al., 2006), as well as in the establishment of protocols for the treatment of PTSD (Lasiuk & Hegadoren, 2006; Weeks, 2007). This is great news for psychiatric nurses, as they struggle to remain on the front lines in New Orleans during a mental health crisis, two years after the destruction from Hurricane Katrina (Harrison, 2007; McNulty, 2007). It is also good tidings for contemporary combatants, when depression is taking its toll on them and on Iraqi and Afghanistan vets, who are experiencing the highest suicide rates in the U.S. Army since 1980 (Mundell, 2007).
SUMMARY

During WW II, the military learned valuable lessons on how to deal with the psychological traumas of war, and so did psychiatric nursing. This exploration into the history of the development of psychiatric nursing in the U.S. during the war tells the story of the hardships nurses endured as they ministered to the combatants on the front lines. It contrasts the experiences of two psychiatric nurses, Votta and Peplau, to explicate how knowledge development improved the care of those with combat fatigue and how this knowledge had a ripple effect in nursing and society long after the war was won.

In addition, within the context of this article, the war efforts of nurses, such as Fitzsimmons and Leone, are highlighted to show how they effectively acted as consultants, administrators, educators, and politicians to improve conditions in mental institutions as well as on the battlefield. The work of these nurses served to set standards in nursing education, graduate programs in psychiatric nursing, and mental institutions.

CONCLUSION

After taking the brunt of criticism for charges of neglect of combat veterans in Walter Reed’s Building 18, there were signs of hasty repairs and cleanup (Milbank, 2007). In reply to the charges, Lt. Gen. Kevin Kiley, the Army’s Surgeon General, “painted over the problems” and denied the severity of conditions by stating, “I do not consider Building 18 to be substandard.” Milbank (2007) pointed out that the general missed the larger point. That is, Walter Reed’s problem is not “of mice and mold,” but it is a result of bureaucratic ineptitude that has impeded the recovery of wounded soldiers. Facing a plethora of challenges in redefining the education of advanced practice psychiatric nurses (Paquette, 2006), how does Milbank’s comment pertain to psychiatric-mental health nursing today? What roles do psychiatric-mental health nurses play in assisting combat vets in the tradition of Nightingale and Peplau? At a time when war and turmoil are commonplace, what can they learn from their history and apply to the present and the future?

Peplau followed the dictum: “He who hesitates is lost.” She knew how to cut through “red tape” and encouraged nurses to do so to improve mental health. Since the 1940s, it has been the responsibility of psychiatric-mental health nurses to take the baton from their predecessors and run with it in the race against war, trauma, disaster, terrorism, and chaos. With conviction and vision in the 21st century, they can continue the tradition of creating and implementing innovative ways to
conduct nursing research, psychotherapy, consultation, therapeutic interactions, politics, curriculum development, and combat and disaster nursing—from the front lines to the home front.

REFERENCES

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