Wisconsin Veterans Museum
Research Center

Transcript of an

Oral History Interview with

CHARLES B. LARKIN

Corpsman, Navy, World War II.
Pharmacist's Mate, Wisconsin Air National Guard, Cold War.

2000

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Larkin, Charles B., (1924-). Oral History Interview, 2000.
User Copy: 1 sound cassette (ca. 50 min.), analog, 1 7/8 ips, mono.
Master Copy: 1 sound cassette (ca. 50 min.), analog, 1 7/8 ips, mono.
Video Recording: 1 videorecording (ca. 50 min.); ½ inch, color.
Transcript: 0.1 linear ft. (1 folder).
Military Papers: 0.1 linear ft. (1 folder).

Abstract:

Charles B. Larkin, a Madison, Wisconsin native, discusses his World War II service as a pharmacist's mate with the Navy, and his later service with the 128th Fighter Interceptor Wing of the Wisconsin Air National Guard. Larkin talks about boot camp at Farragut (Idaho), hospital corps school at Great Lakes (Illinois) Naval hospital, and assignment to the U.S. Naval Hospital at Long Beach (California). After attending the Navy V12 program for officer candidates in Salem (Oregon), he comments on his service at the Naval hospital at the Bremerton Navy Yard (Washington). After the war, Larkin was assigned to the V12 unit at the University of Wisconsin-Madison, was released to inactive duty with the Navy Reserves, and finished medical school. Larkin describes enlisting in the Wisconsin Air National Guard, serving as a first lieutenant for the 128th Fighter Interceptor Wing stationed at Truax Field in Madison (Wisconsin), summer training at Volk Field Air National Guard Base (Wisconsin), and active duty during the Cold War. Prior to active duty, he talks about his duties as an acting flight surgeon, the common maladies of airmen, and their treatment. Larkin touches on the transition from propeller planes to jets as the 128th switched to F-89 fighter jets. After 1952, he comments on starting his career in Madison: an internship at Madison General Hospital, a residency at St. Mary's Hospital (Madison), a fellowship at the Veterans Administration Hospital (Madison), opening a private practice, and moving to California in 1961 where he got involved in psychiatry. Larkin discusses psychiatric work at VA hospitals with returning servicemen, analyzes his observations of post-traumatic stress disorder in people who had been prisoners of war, and comments on symptoms and treatment options for post-traumatic stress. He comments on how Allied troops fought combat fatigue and stress during World War II and explores problems caused by alcohol abuse. Larkin discusses training for military psychologists and what, psychologically, makes a good soldier.

Biographical Sketch:

Larkin (b.1924) entered the Navy in 1943 and was trained as a corpsman. He served in Naval hospitals in California and Washington, completed the V-12 Program, and entered inactive duty in 1946. After graduating from medical school at the University of Wisconsin-Madison, he reenlisted in 1950 in the Wisconsin National Guard and was commissioned as a 1st lieutenant. Larkin served with the 128th Fighter Interceptor Wing until it was deactivated in November of 1952. He pursued a career in psychiatry, worked in several VA hospitals, and, after retiring in 1987, he returned to Madison (Wisconsin) in 1991.

Interviewed by James McIntosh, 2000
Transcribed by Maren Maland, 2010
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Interview Transcript:

Jim: Alright, we're off and running.

Charles: We're off and runnin'! Okay, fire at will.

Jim: It's the 28th of June, the year 2000. Talking to Charles Larkin. Tell me where you're born, please.

Charles: Born in Madison, Wisconsin, June 6th, 1924.

Jim: 6th. '24. Madison. And, when did you enter military service?

Charles: I entered the United States Navy —ah— let's see, the 22nd of July in 1943.

Jim: Where did they send you?

Charles: I was sent to the U.S. Naval Training Station in Farragut, Idaho for a period of six weeks in boot camp and then subsequently transferred back to Great Lakes, Illinois to the Naval Hospital for eight weeks in Hospital Corps School. And –

Jim: Farragut was in Idaho, right?

Charles: Right.

Jim: And then Great Lakes for Corps School.

Charles: For Corps School.

Jim: How long was that Corps School?

Charles: It was an eight week course.

Jim: For medical corpsmen.

Charles: For medical corpsmen, right. I was upon completion of the course because I'd had one year of college I was given the rate of pharmacists mate third class.

Jim: Oh, so right off the bat.

Charles: Right off the bat.

Jim: Hey, that is pretty good.

Charles: Yeah, yeah.

Jim: And with all this high rank, where did they send you?

Charles: [Laughs] They sent a draft of us to the U.S. Naval Hospital at Long Beach, California which had been open about six months.

Jim: How long were you there?

Charles: Well, I was there from November of ’43 until March of 1944. Just a brief period of time.

Jim: So 3/44.

Charles: Right.

Jim: Then where?

Charles: Well, then I was very fortunate in being selected for the Naval training program, the V12 program, and I was sent to the Willamette University in Salem, Oregon.

Jim: Okay, sent to V12 program in Salem. Salem, Oregon. Alright. How long were you there?

Charles: I was there from March of ’44 until June of ’45. We had roughly completed the equivalent of two years of college in that period of time.

Jim: Then what?

Charles: From there I was sent to the Naval Hospital at Bremerton, Washington until September of 1945.

Jim: Bremerton?

Charles: Right. You probably were there.

Jim: No, never been to Bremerton.

Charles: Weren’t ya?

Jim: ‘Til when?

Charles: September.

Jim: 'Til September of '45?

Charles: Right, '45.

Jim: 'Til 9/45.

Charles: Right. And then I was assigned to the V12 unit at the University of Wisconsin in Madison from September through almost the end of January of '46.

Jim: Still in the V12?

Charles: Still in the V12, and I was released to inactive duty at that time. As you probably recall.

Jim: Yes. UW Medical School. V12. 'Til when?

Charles: 'Til—it was January 23rd of '46.

Jim: Of January '46. And then you were discharged?

Charles: No, released to inactive duty. Yeah, and then subsequently, eighteen months later in August of '47 I was given a discharge from the Naval service.

Jim: Inactive duty, right?

Charles: Inactive duty, yeah.

Jim: But you later returned into, went back into service. This was after you became a physician though, right?

Charles: Right, right. Yes, I entered the Air National Guard of the State of Wisconsin in November of –

Jim: You re-upped?

Charles: Re- upped, yeah [laughs]. In November of '50, 1950 and we went on active duty –

Jim: You re-enlisted after medical school.

Charles: Right.

Jim: After med school. When was that would you say?

Charles: November of 1950. And I was commissioned to first lieutenant in the Medical Corps.

Jim: You were out of med school and you were in your internship?

Charles: I had just completed the internship and was in –

Jim: After medical school. In 1950. Where did they send you?

Charles: Well, we were very fortunate. We reactivated the Air Force Base at –

Jim: You re-enlisted after—I didn't say what you—you were in the Air Force?

Charles: In the Air Force – USAF, right.

Jim: The USAF. Reserve?

Charles: Well, it was actually the Air National Guard.

Jim: Oh, ok.

Charles: Yeah, right.

Jim: Wisconsin National Guard.

Charles: Uh- huh, Wisconsin Air National Guard.

Jim: Okay. Now, as active reserve, you had to spend a bunch of meetings on a monthly basis or more often?

Charles: Well, a monthly basis and it would be one weekend a month, and then there was a two week summer camp that the –

Jim: What did that involve?

Charles: Well, that involved training basically.

Jim: Yeah, but for you, I mean.

Charles: Oh.

Jim: Giving physicals?

Charles: Giving physicals and then basically going ahead and care of the flyer and care of any of the enlisted personnel that might have minor illnesses, what have you.

Jim: Was there anything in the Air Force, dealing with this, with these pilots for instance, that was different than dealing with the Navy boys?

Charles: Well, these were all—the particular unit that I was assigned to basically were all people that were veterans of World War II, and practically all of them had had rather extensive combat experience flying either P-57—P-47s or P-51s.

Jim: Right. And the Air National Guard was stationed in Madison.

Charles: In Madison. There was also a unit in Milwaukee, and the two of us merged to form the 128th Fighter Interceptor Wing which was stationed at Truax Field.

Jim: And what was that called?

Charles: 128th Fighter Interceptor Wing, stationed at Truax Field in Madison. And we were part of the Air Defense Command which had just been established.

Jim: Did you have to, were you required to do any flying?

Charles: No, no. I was not. At that time I was considered a general medical officer, and in order to go ahead and do anything flying you had to go ahead and become a rated officer which meant you went through a flight surgeon school, and I had had a problem with an eye which made me basically disqualified. I did function, however, prior to our active duty as a flight surgeon.

Jim: Out of necessity?

Charles: Out of necessity. Right [laughs]. They just weren't hiring a lot of folks at that time.

Jim: So you really did act as a—

Charles: I really did. Yeah, I was a flight surgeon for the squadron in Madison.

Jim: What special problems, medically, did pilots have that you saw? Like ear problems or anything like that?

Charles: Yeah, mainly the problems that they would have would be those, an aerotitis secondary to flying—

Jim: How did that come about?

Charles: Well, sometimes they would develop it if they hadn't been able to clear their ears after a flight with the pressurization that they had, and also some of them on occasion would probably go ahead and try and fly with an upper respiratory which of course aggravates it.

Jim: Now, how did you treat those? Antibiotics?

Charles: Well, most of the time, conservatively was just sometimes taking them off flying status for maybe a week and treating them with nasal decongestants. At that time we had Neo-Synephrine, sometimes we would put them on something like chlorpheniramine with clear instructions that there would be no flying for a period of at least 48 hours after the last dose or after they were off medication.

Jim: Why? Was that medication interfering with flying?

Charles: Well, even chlorpheniramine had a mild sedating property. You didn't want to have anything that might interfere with their ability to fly the aircraft. Generally, pilots were in good health.

Jim: They responded well and they didn't mind being grounded?

Charles: No, they took it as a matter of fact. Unfortunately, most of these guys had had previous experience, and they just didn't—you know. And they were older at that time. These were men that were probably in their late 20s and some of them early 30s having fought in World War II. So they weren't rookies, as we would say.

Jim: Right. They could probably take better care of themselves than the younger men.

Charles: Younger men, right.

Jim: Any accidents you had to deal with?

Charles: Well, we had a couple of people that pronged in in 51s. This was a pretty hot airplane as you know, and it had a lot of torque, and sometimes if they came in hot on a landing they could go ahead and run into difficulty, and we had one gentlemen who sustained a compression fracture of his back and another one who had a more serious injury with a head injury, and he was, never went back to flying. The one with the previous compression fracture did return to flying status. He was never chronically grounded.

Jim: So what, in dealing with these, where would you send these guys?

Charles: Well, you know fortunately we had the facilities. We had a fifteen-bed dispensary –

Jim: At Truax?

Charles: At Truax. And it was, we had our inpatient facility where we could treat, let's say, minor to somewhat more major upper respiratories, and basically that was it. Insect bites that had developed allergic reactions, but for anything serious like an acute abdomen or an acute traumatic injury we could refer to Madison General or St. Mary's.

Jim: Oh, you could send them to private hospitals?

Charles: We could send to private hospitals, and the Air Force would reimburse the private physician we had called.

Jim: Sure. And venereal disease?

Charles: You know, we had a lot of clean cut guys, and the other thing is about the Guard, many of the people that were in the Guard were already married so we didn't have the problems. Only when we had younger troops, and I to be very honest with you, at this base never saw a case of acute gonococcal urethritis.

Jim: And did make a clinic area—I mean a sick hall every day?

Charles: Yes, sick hall every day.

Jim: Every day. Generally you would see about what, half a dozen or a dozen guys?

Charles: Oh, it depended. If we had upper respiratories that were seasonal, we could see anywhere from fifteen to thirty people. Usually the regular sick hall, probably around ten to twelve right in the morning, and that was basically it. Then we would also be available for anything in the way of emergencies.

Jim: How? You mean by phone?

Charles: By phone, right.

Jim: But you didn't live on the base.

Charles: No, no. We, the only time you lived on the base or stayed on the base was when you drew the officer of the day assignment, and then you stayed right there. There was one medical officer.

Jim: That was his turn. How often?

Charles: Well, let's see. We had one, two, three, four, we had five medical officers. So every fifth day.

Jim: And did you have any, did you go anywhere like they had a little summer deal that the Air, the group went to that you had to attend?

Charles: Well, yeah, this, after we went on active duty of course that all ceased, but the one time that we did go to summer camp, or the couple times I went, we went to Camp Douglas, Wisconsin, Volk Field and did the summer tour there and we had a small dispensary, and right.

Jim: Did they rotate any of these guys to Korea?

Charles: Yes, there were a few people that were sent to Korea, and they, actually the squadron, after we went on active duty the Air Force decided to go ahead and switch to F-89 which was a jet aircraft, and because of that the men that went through the jet transition that took almost one year for them to go through so half the squadron would go down for training, and then the other half would still stay there, and we were only activated for 21 months at the time so in October of 1952 the squadron was released back to civilian, being civilian, right.

Jim: Now, when these guys moved to jets from propeller planes, did that offer any new problems for you as a medical officer?

Charles: Well, not for me as a medical officer. It really sort of changed for some of these good gentlemen because this was their first exposure to jet aircraft, and it, the P-51, had been a very fine propeller driven plane, but the F-89 was a very, very hot fighter interceptor. It was an all-weather jet. So they had to really be able to adjust to the different flying conditions. The exact technical aspects I'm not fully aware of, but they had to go ahead and adjust to it.

Jim: You didn't notice any particular change in these guys? They seemed to handle it pretty well?

Charles: No, they really did. They were all eager to get into a new aircraft and to do their thing.

Jim: But there were no special problems being in a jet airplane versus a propeller driven from a medical standpoint.

Charles: Not from a medical standpoint, no. In fact, probably the F-89 really didn't pose any more problems than the P-51 did.

Jim: I was thinking about the pressure suits they wore with this that they didn't wear with the others.

Charles: Well, yeah, they basically that this is true that they did have to go ahead and learn because you could pull because of the speed and the more G-forces. Right. And they never—they adjusted to it well.

Jim: Alright. So when this is done, you went back to practicing medicine?

Charles: Went back to practicing medicine, and—

Jim: When did you first set up an office? I know you trained, you interned at Madison General. You don't need to review that particularly, but—so you went into general practice—

Charles: General practice. And I practiced from—well, from 1952, October until July of 1955, and then I went into a two year residency in internal medicine at St. Mary's hospital in Madison followed by a year of fellowship in chest disease at the Veterans Administration Hospital in Madison.

Jim: Don't get too far ahead now.

Charles: Right.

Jim: You reactivated in 11/52.

Charles: Yeah.

Jim: Was your, when you were with the National Guard unit, was that a full-time job?

Charles: Ah—when on—

Jim: You didn't do anything else.

Charles: No, that's right. When I was on active duty for the period from January '51 through October '52, that was full-time active duty. I was sent to several bases on temporary assignment during that time.

Jim: So, deactivated in '52 and then you went into practice at that time.

Charles: And I went into practice, right. And I maintained my membership in the Air Guard.

Jim: What do you mean by that?

Charles: Well, I just kept my commission in the Air National Guard and –

Jim: As a reserve.

Charles: As a reserve medical officer. Right.

Jim: To your reserve status. Inactive?

Charles: Inact—no active. Well, it was called active reserve because you trained one weekend a month –

Jim: Ah, so it was active.

Charles: Uh-huh. One weekend a month and two weeks during the summer.

Jim: And you resumed your practice, and then you went into—tell me again where you started, when to do the chest thing.

Charles: Oh, that was in July of ’57. The VA for a period of one year.

Jim: And then—

Charles: July of ’58 I went ahead and opened an office in Doctors Park in Madison and became associated with Larry Giles, another internalist.

Jim: And, how long did that last?

Charles: That lasted until April of 1961 when my family and I moved to California.

Jim: You had enough of the cold weather, or was this—

Charles: [Laughs] No, this was a—I was advised by a friend who was an ophthalmologist because I had a recurrent bout of uveitis that I should get into some kind of institutional practice, mainly with a little bit more of a regularity in hours. So I took his advice. My wife had always desired to get out of the cold weather so I said we’ll shoot west. So I took Horace Greeley’s advice and did.

Jim: So when did you get into psychiatry?

Charles: Well, that came a little later. I was age—let's see, 42 in 1966, and at the time State of California and the National Institute of Mental Health gave grants for any physician who was willing to go ahead and take a residency in psychiatry, but they would pay them a full-time staff salary, but the physician would have to agree to pay back a year of service for a year of training. So I went ahead and took a three year residency in psychiatry and a two year residency in neurology so I was, let's say, indentured—

Jim: Where did you train those?

Charles: I trained at Patton Hospital in San Bernardino which was a large state hospital affiliated with Loma Linda University, and that was for a period of three years. We also had affiliations with UCLA Medical Center, the Neuropsychiatric Institute. And my neurology residency was at University of Southern California Los Angeles County Medical Center for two years.

Jim: And you practiced primarily then after that training.

Charles: After that, yes I practiced then as a—I became chief of the inpatient service at San Bernardino General Hospital and in the Division of Behavioral Science, and I was there from—

Jim: As the staff chief of psychiatry.

Charles: Yeah, chief of the – right, Behavioral Science Division, right.

Jim: From when?

Charles: From, well, let's see. That was from '60, '69, '71—from '71 through—

Jim: 'Til you retired.

Charles: Yes, '78.

Jim: '78?

Charles: Right.

Jim: Six years.

Charles: Yes. Then I went full-time with the Veterans Administration and Loma Linda University.

Jim: Geez. You moved around a lot.

Charles: Yeah, yeah.

Jim: Full-time—VA and hospital work.

Charles: Yeah, at Loma Linda University.

Jim: Where's that?

Charles: That's in Loma Linda. It's a Seventh-day—

Jim: L-i-n-d-a?

Charles: Yeah, right. And I was there from '78 to '82, and I—

Jim: Yeah, and retired there.

Charles: No, I still hadn't retired. Then I went to the University of Nevada in Reno.

Jim: Oh. Same status?

Charles: Yeah. And then I was there –

Jim: And your status was still as a –

Charles: My status there at Loma Linda was I was the Chief of the Emergency Services of Psychiatry, and at the University of Reno and the VA I was Chief of the Outpatient Service.

Jim: For psychiatry.

Charles: Psychiatry, yeah.

Jim: And that wasn't a government hospital?

Charles: VA. Yup.

Jim: And University of Nevada –

Charles: Reno.

Jim: In Reno? The University of Nevada tie up, but the VA I don't understand.

Charles: Well, it was a dean's committee hospital, just like Middleton Hospital here. And the same way with Loma Linda, it was a Jerry L. Pettis Memorial Hospital.

Jim: For a year?

Charles: No, I was there from –

Jim: ’82 to when?

Charles: To ’86.

Jim: ’86.

Charles: Yup. And at that time—

Jim: You could have retired and still been(??) running that [unintelligible].

Charles: Yeah, that’s right. At that time, my wife became ill, my first wife became ill, and I retired actually in ’87.

Jim: Alright. Well, that’s a long, extensive career path.

Charles: Yeah.

Jim: Came back to Madison then?

Charles: Came back to Madison in 19—let’s see, I actually came back and married in 1991. I was in the Reserve you know all that time from—yeah—

Jim: So, now. General practice to chest to psychiatry. What do you think about all that?

Charles: Well, it was a varied career and one that I thoroughly enjoyed. You know, the one thing that I saw during this period of time was psychiatry was returning to its rightful role as a medical specialty mainly because of the breakthroughs in the psychopharmacologic agents that allowed us to be able to treat the major mental illnesses, particularly the schizophrenic reactions, the major depressions, the manic depressants, the—

Jim: So it made you real doctors.

Charles: It made us real doctors.

Jim: Which most of us in surgical specialties never really believed you were, you see.

Charles: [Laughs]

Jim: It was all, you know—

Charles: [Laughs] You are right.

Jim: Nebulous stuff. You know, why waste it on medical school.

Charles: Yup, they always said the psychiatrists were always afraid of blood [both laugh].

Jim: And you just didn't have any—your connection now with the military, the Air Force, is just ended.

Charles: I'm just a retired colonel in the Air Force Reserve.

Jim: And did your hospitals win any awards, in all of these VA hospitals you were in?

Charles: Ah, let me think. I think when we were at Loma Linda we were given an award for I think it was general patient care, but nothing that was –a – right.

Jim: Alright, well, let's talk about people that you have come in contact with in these hospitals. You've met many soldiers during(??) combat?

Charles: Met a lot of them, right.

Jim: How would they come to the Veterans Hospital, generally, in your unit? What was the problem?

Charles: Mainly these were all people that from the psychiatric standpoint were people that had been found to have some kind of degree of service connection, and the rating disability would vary from 10% all the way up to 100%. There were others that were admitted on an emergency basis because of circumstances that prevented them getting the hospitalization at another hospital, but by and large these were service connected.

Jim: From a psychiatric standpoint, did you see a lot of post-traumatic problems?

Charles: Yes, I did. In fact, we had one clinic strictly devoted to post-traumatic stress, and this was established in—let's see—about 1977, and I had a collection of people, primarily people that had been prisoners of war in both theaters, mainly in the European theater, but I had a few that had survived capture and imprisonment by the Japanese.

Jim: Did they seem to have lingering mental problems that the others didn't?

Charles: Well, the ones that did have were individuals that particularly the people that had been imprisoned by the Japanese, they had a more severe form of post-traumatic stress where many of them had had problems with being able to return to a gainful type of employment, mainly a lot of people that had had intrusive thoughts of their imprisonment. Many later because they used to treat their own illness also would become addicted to alcohol, some to drugs. But this, by and large, was the group that we were treating. The people that were from, that had been captured by the Germans, their degree of post-traumatic stress seemed to be of a lesser degree. Less intrusive thoughts, less incapacity, less startle reaction, more ability to adjust.

Jim: They were probably less hopeless about their situation than those in Japan who probably didn't know whether they were going to survive. I think most of the people I've talked to were German POWs. They knew they were going to make it if they just behaved themselves.

Charles: Exactly. Most of the ones that we had were people that had been in infantry outfits that had been captured or some that had been shot down with the Air Force, but they knew, just for the general tenor of the war, that the war was coming to a close. But, the ones in contrast to the Japanese, I had one man who had enlisted and lied about his age, and in 1940, and in those days the Army would send people even out of the States for basic training, and he was sent to the Philippines. Well, as you know, history, he was captured and at Bataan, was on the Bataan Death March. Survived that. Later was put on a ship that to be was to be sent to Japan. The ship was sunk; he was rescued. He made his way to Japan, and he spent the last three years in a coal mine prior to the end of the war and he, it was an amazing thing, that this young man lives in the formative years of his life in that kind of environment.

Jim: He was still reasonably adjusted?

Charles: Reasonably adjusted.

Jim: That's certainly a test.

Charles: Yeah. But he did have particularly quite intrusive thoughts he said at times.

Jim: What are intrusive thoughts?

Charles: Well, unwelcome things, particularly and especially—

Jim: You mean self-destructive?

Charles: Well, some of them were self-destructive, but others were also the association of a lot of dream states, a lot of dreaming. After that they would also, their thought process would sort of be connected to some of these dreams, and it was very hard for them to separate. They were never psychotic, but—

Jim: Did you notice that the younger men had more trouble adjusting to being prisoners of war than the older fellas?

Charles: Well, I think that probably, by and large **[End of Tape 1, Side A]** the more mature, the older, seemed to have a little bit of better adjustment than the younger. Also, some of the married people seemed to have had a better, you know—they wished to get back. Yeah.

Jim: The post-traumatic thing that we hear about all time, is it really any different than what affected the boys after World War II? As far as you can tell.

Charles: Well, I think it's probably more of a change in terminology. Historically if you go back to the time of the Civil War where they used to call it "soldier's heart" and then World War I where it was called "shell shock" or "nervous exhaustion," World War II "combat fatigue," and then of course, "post-traumatic stress syndrome" later. Probably one and the same animal, different terminology, but there was a definite degree of better recognition, and in effect, probably—certainly, hopefully better treatment from the standpoint.

Jim: Sure. Well, it is recognized now, where it was probably wasn't—

Charles: Right.

Jim: Give me the characteristics of what this would be to the soldier. Hopelessness or what? Was it more than that?

Charles: Well, it was a constellation of symptoms usually manifested by an inability to really relate effectively to people, startle reactions –

Jim: Even though they were friends that they –

Charles: Even though they were friends. Yeah. They tended to be on occasion short-fused, sort of ill-tempered, irritable. They would oftentimes find home situations difficult to deal with. Raising of kids seemed to be especially troublesome at times. A lot of history of divorce in these people. Also, like I mentioned previously, association of overuse of alcohol and later into drugs.

Jim: Consolation for the—

Charles: Yeah. They treated their own illnesses. Then the other thing is, on top of that, there were some that would develop major depressions which just was another layer.

Jim: They just totally, eliminated their outside world.

Charles: Yeah, yeah. Then the degree of helplessness and hopelessness became really manifested.

Jim: So generally, how would you approach these in a mild state, how would you approach these?

Charles: Well, in a mild state, the best thing that seemed to be—make them amenable to treatment was the ability to just relate in a way where they decathect, where they could just go ahead and talk, and to just—

Jim: Was it in a focus group? Or a one-on-one?

Charles: Well, we used to have both, and many times the group identification as a whole was a supportive one for them because they could see other individuals that had the same kind of symptoms or went through similar episodes. For those that had more major symptoms usually a one-on-one would go ahead and bring them out where they could confide in the psychiatrist.

Jim: Would you start medication along with—

Charles: Oftentimes we would put them on medication, and of course right away if there seemed to be a severe depressive component we would put them on an anti-depressant because this would really—

Jim: Did we go back to electric shock?

Charles: No, we didn't. This electric shock was only reserved for people who were totally resistant to what we say conventional therapy. Electric shock was still, can be lifesaving, particularly for individuals who have major depressions that are unresponsive to tricyclic anti-depressants or to lithium, but as we used to say in the jargon of psychiatry, if Edison medicine would, a series of treatments of six to twelve would turn things around.

Jim: But they would have to be hospitalized?

Charles: They'd have to be, yeah.

Jim: Did it seem to make a difference with all these patients what their experience was, or was it being away from home the factor, or what seemed to be the factors that set this syndrome off?

Charles: Well, the thing that probably was the single biggest thing was something within their own characterological makeup. In other words, there were some individuals who were just not as, quote, shall I say, strong, as others. They seemed to be in need much more of a supportive—

Jim: Couldn't adapt?

Charles: Yeah, it was tough for them to go ahead and really, fully adapt. You know the average GI didn't really go ahead and see himself as responding to a lot of this lofty things about saving the country and America first and what have you. They were just damn glad to get the war over with, to get out without having their fanny shot off, and this was basically what they were. They were – the average age was a little older for the Army and Navy going back to World War II, but these were people that were relatively young.

Jim: If they're older and married, there was less of this, right?

Charles: There seemed to be more stability, yeah. Because they more or less established themselves—

Jim: Well, they had something to attach to when they got home, and that's probably the difference.

Charles: Yup, this is right. They had something they had literally been attached to and wanted to return to.

Jim: That's what holds a man together when he's in combat, is the identification with his group, isn't that the only thing?

Charles: Group identification is the single biggest thing, right. It's the people who would never go ahead from the ones I've talked to, would never go ahead and be down on a man if he asked for help for what they saw as a need, but if he asked for help just to get out of avoiding combat, that was, they were dead set against that.

Jim: I understand, but it's difficult—how the service didn't treat those boys very well then if they shirked their duty and they're on the line. They'd usually send them back right away, didn't they?

Charles: [Coughs] This was where the, initially during World War II, they hadn't learned a lesson from World War I. There was a gentleman by the name of Thomas Salmon who was the Surgeon General who had went over to France during World War I and saw that the English and the French were treating their combat causalities in a way that brought about return to service. It was called – they would treat them as close to the front as they could. They would treat them immediately as much as they could which meant just short evacuation, and they would treat it in the most expeditious way. Lot of times for people that were on the line and who had just shown signs of plain fatigue, they would pull them off the line, put them into a rear area for just sleep and a couple of warm meals, and return them to duty, and they found that they would have people snapping out of things well. They found that those that were sent back and sort of got glued into a rear echelon area, they didn't do as well because they –

Jim: And of course they wouldn't come back to their outfit, and that was probably a factor, don't you think?

Charles: That could well be, yes. Exactly.

Jim: Because that was their identity, you see.

Charles: That was their identity. Yup.

Jim: So, but, in World War II we seemed to – we didn't adhere to the British.

Charles: Well, initially, because in North Africa they went back to the old standard of evacuating back to a distance, and this showed them to be ingraining this symptom. So, they went ahead and reviewed the literature and talked with, particularly the British who had been at war for a period of a few years, and they said you got to go ahead and use the old proximity, immediacy, and expedient—

Jim: You only need a few days, right?

Charles: Exactly, yeah. And this for combat fatigue or post-traumatic—acute post-traumatic stress, proved to be very effective treatment.

Jim: So most, majority of the boys would get back on the line if they didn't get back too far.

Charles: That's right. They would have a return of up to about 70 percent of the people that had that.

Jim: After a few days.

Charles: After a few days, that's right.

Jim: Three-fourths of the men.

Charles: Yup, right.

Jim: But of course, what we read is that no man can stand being on the line for a protracted period of time. There's a limit. Everybody has a limit.

Charles: That's right.

Jim: Is that your experience?

Charles: This is from the literature; it's been shown that, roughly, a man who is in combat for a period of ninety days or more is starting to run out of gas, and at that—

Jim: Too much tension?

Charles: Too much tension, too much stress, and these—that's why they should try and go ahead and rotate even parts of a division or a division. Pull them off the line for a period of time.

Jim: Prophylactically.

Charles: Prophylactically, exactly. And just prior to the Bulge this had been happening because many of the units that had been on the line from June up until December were pulled back for this purpose. And that's exactly at the time, sequentially, as when the Germans broke through.

Jim: What did the courage come from within, entirely, these boys, or is it the group feeling that makes these boys do heroic things as far as you can tell?

Charles: Well, you know, probably Jim it's a combination of both. You know there are some guys that are just innately tough, and they just don't seem to, quote, give a damn, I mean, whether in civilian life or military, and there are others who sort of follow the example of a few significant others that lead, and I think one of the biggest single things that I have heard and possibly you have too: "Geez, what if I really shirk my duty, and what would my parents think or my buddies think of me." And that was a thing that motivated them.

Jim: That's what drove most of them.

Charles: Drove most of them.

Jim: Now, what would the usual manifestations of loss of control that these guys would have on the line, do you know? Have you read about that?

Charles: Well, I think mainly for some, if they really became acutely agitated, where they just were not responsive to commands or they were threatening to other people in the unit. Others would manifest just the opposite where they would become more withdrawn, apathetic, and listless and just, you know, wouldn't communicate.

Jim: That was a sign that they were in trouble.

Charles: That was a sign they needed to go ahead and to get out of that particular environment. Right.

Jim: Now days would they treat these temporary – pulling of the line with anything other than rest, or was any medication involved?

Charles: Well, I think now days they have become more sophisticated. The Army has a full time division psychiatrist that is assigned to each outfit, and I don't know about the other branches of the service, but I know that there are psychiatrists that are assigned to particular areas such as in the Navy and then in the Marine Corps, so they have much more ready access. The other thing is, they are now treating general medical officers, flight surgeons, to recognize signs and symptoms of –

Jim: In themselves?

Charles: Or in people that come to them. In other words, they're giving them—sort of getting them more of a psychiatric orientation.

Jim: The leaders.

Charles: That's right. Yeah.

Jim: So they can recognize the trouble before there is trouble.

Charles: Trouble before there's trouble, yeah, right.

Jim: Well, I think that's really going to make a difference in the future. They're so much more knowledgeable about these things than they ever were before.

Charles: There are also other agents that we can use: a short term anti-anxiety agent, but of course some of those sedate a little bit so –

Jim: I know that the sedative factor enters in there, and then pretty soon he's not much of a soldier, or they certainly can't fly in those situations.

Charles: Not much of a soldier, that's right. Yeah, you can't use it in flying, especially with these sophisticated weaponry that we have now. Not at all.

Jim: You just blink and you are in trouble.

Charles: You're done.

Jim: Alcohol. Tell me about alcohol and the service. There's not much difference in civilian life but perhaps.

Charles: Yeah. I think the one thing that you found in any military instillation was the ready availability of alcohol, particularly in garrison states as they say or where you were in stateside duty, you know, non-commissioned officers clubs, officers clubs, ready access to it. And I think this is one of the big problems that there is still present in the military, the overuse of alcohol.

Jim: Regular Navy I know has an enormous problem.

Charles: Absolutely, yeah.

Jim: I don't know, is it boredom? Ennui, nothing else to do, and I guess they're away from home.

Charles: I think the combination of all these factors, and then of course the thing is that if you take alcohol and alcoholism and take the "ic" and the "ism" out of it, and look at it in the light of drug dependence, that's exactly what it is. Right.

Jim: Some of these places overseas I noticed the enlisted men could get beer, but unless had to be rated as a non-commissioned officer, up to that level, you know the lower ranks couldn't get whiskey. I don't know what difference that made, but I noticed that was a rule in some of the clubs I was in in Australia. Which is, I'd never heard that before.

Charles: Yeah.

Jim: Do you think that there is anything in training now that you could prepare these guys better for combat than they used to? So that they can steel themselves, or is there only one way to learn and that's to stick your nose into it.

Charles: I think there's—as witness in the Persian Gulf War, you had the assembling of a huge number of men, both active duty and reserve, but these were people, certainly the active duty people were grounded in what they were supposed to do and the reserve forces, many of them had had fairly intensive training in what they should do so you brought these people together. It isn't just like they were out of the civilian life, gone through a period of boot camp, and then put into it. So I think you have a more professional cadre of troops.

Jim: Better motivated.

Charles: Better motivated and better trained.

Jim: Yeah, and this is probably the best preventative then, to keep your sanity and when it gets rough?

Charles: Yeah, I think if you were going to go ahead and have to fight a war, you want to fight a war with somebody that damn well knows what they are going to do, you know.

Jim: So you don't feel so hopeless that you're so sure that you're going to get killed that the chances are, you do get out of it.

Charles: Your odds are better with somebody that's had more training, more experience.

Jim: So that's a decisive factor, isn't that, in combat? I'm gonna get killed in the next minute. Isn't that the thing that bugs them constantly?

Charles: That's right, that's one of the things that they recognize as the distinct possibility, but if they've got – if they're in a unit where there is this element of—[approx. 15-second pause in tape]

Jim: What else did I want to ask you? I don't know if—you don't know of any special programs the Air Force has that's different from any of the other services because of the type of equipment they handle?

Charles: No. I know that the Air Force screens very carefully in every aspect the people that are certainly flying, and also it trains very carefully from the psychological standpoint the people that are in the nuclear silos because they have the responsibility of that weapon in other words. And the other thing is, of course, they're usually teamed so they – it takes more than one person to go ahead and push the button.

Jim: Do you know of any special psychiatric evaluations for submariners?

Charles: No, I don't—

Jim: They're certainly a special situation.

Charles: Yeah, I think that—I don't know what the Navy does now, but I –

Jim: How do you do tests for claustrophobia or an [unintelligible]? I mean, "Do elevators bother you?" It must be more extensive than that, Charlie.

Charles: Well, it's gotta be. I, you know, I only—

Jim: 'Cause that would be a key question.

Charles: I only know in the Navy, when I went through boot camp, if you passed a physical, you know in other words, that they would put down submarine duty, it would put down qualified. Well, obviously it meant physically qualified.

Jim: Right. They never looked into the rest of it.

Charles: Yeah. Right.

Jim: Yeah, I would like to talk to some submariners to find out that. I find that these guys are not very communicative. I think they're—a part of their training is keep their mouth shut.

Charles: I'm sure there is an element—

Jim: Particularly with the nuclear submarine 'cause I've had a couple that have turned me down flat.

Charles: No kidding. Did they say that they were – their lips were sealed?

Jim: No, they said that "I just, I just don't feel comfortable and some of the stuff we were asked not talk about."

Charles: Not to—that's what I was wondering, yeah.

Jim: But I mean I think these are the guys on the line for all of us, more than anybody else.

Charles: Absolutely, yeah. They in the nuclear silos and of course the people that are still flying in the B-52s, you know they keep around the clock aircraft.

Jim: Have you ever talked to any of those people that did that? That was on the big, long missions like that—was ever a problem as far as you know?

Charles: I never personally have had that kind of a contact. I have had, having been stationed in the Reserve at March Air Force Base, I would run across some people that were on active duty with the Air Force that were flying B-52s, but they never divulged too much either regarding the circumstance of the –

Jim: The stress of being up in the air for as long as they are. Well, that's interesting. Is there anything we didn't talk about?

Charles: No—ah—I think the main thing this was the type of military psychiatry you see. The major mental illnesses are treated just like anything else.

Jim: Let me ask you this. Does the military have any special books or things for the officers, the medical officers to read, psychiatrically oriented?

Charles: Yeah, they, you know, they will go ahead—interestingly enough, the psychiatrists that came out of the Army service during World War II were really general medical officers or internists that had been given a short course, like six weeks in psychiatry, and they became psychiatrists in the military just because of sheer numbers. Later on these people came back and became formally trained after the war, and now days the Army has the system of setting up division psychiatrists for each active duty division, and then they also have ancillary people such as psychologists, social workers and the equivalent of nurse practitioners that also work with them. So they have a really a lot of coverage. Also, when they are not in a combat situation they also do a lot of community psychiatry types of service because of the large number of people that are in the service that are married who have dependents, especially wives, and there's a lot of sometimes –

Jim: Help them keep the family together.

Charles: Help them keep the family, yeah. This is one of the single biggest disruptive things in the loss of cohesiveness and troop morale, you know, people that have family disturbance.

Jim: Sure. So, the best soldier then is still an 18 year old who is single.

Charles: I think the best soldier from—

Jim: Like [unintelligible]?

Charles: Yup. From the standpoint of probably from a combat situation—

Jim: Because he has no attachments to consequence.

Charles: Exactly. Any he doesn't know too much, quote, period.

Jim: Yeah, both those are factors that they make a good soldier.

Charles: A good soldier, yeah.

Jim: Tell him to do something and he jumps.

Charles: And he does. Although there are many people who have the attachments and who are a little older who are able to sublimate to command structure, and they do their job.

Jim: Right. 'Course these are generally officers that think that they're—

Charles: A little more training.

Jim: Well, they've had more—they feel responsible.

Charles: Yeah, and they have men under 'em.

Jim: Yeah, the feeling of responsibility I think probably is a, I don't know, maybe that's protective factor for a guy's sanity is he gets higher in the ranks or not.

Charles: Well, I think it – the responsibility is one of the things that he takes on and regards as they say, seriously. You know, he says, "Geez, this is—"

Jim: Right, well, I've got a lot of people depending on me.

Charles: I've got a lot of people depending on me, and I damn well better do my job.

Jim: Okay. I can't think of any more there, pal.

Charles: Very good. Thank you. Well, this is—

Jim: Thank you. You did well.

Charles: Well, good.

Jim: You gave me all the stuff we needed.

[End of Interview]