PREVENTIVE PSYCHIATRY WITH COMBAT TROOPS
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It is now well known that the army units which participated in the North African invasion and the Tunisian campaign learned, by experience, many valuable lessons about modern warfare. The performance of the Medical Corps was such that it elicits pride in any member who contributed to its work and accomplishments. However, certain phenomena occurred that attracted the interest of many officers, especially psychiatrically oriented medical officers. It is this aspect of the campaign about which I am making this second report. It is based upon my own observations and impressions while serving as an Infantry Battalion Medical Officer during this campaign, as well as an informal follow-up acquaintance with many of these men through each echelon of medical evacuation to the United States after the campaign. Since these are personal impressions, they obviously are subject to the cautious acceptance and criticism that such individual reports warrant. Acknowledging these limitations, this is offered to invite the attention of psychiatrists to some of the more urgent problems of the foot soldier as I saw them during combat, and to show how practical, preventive psychiatric measures can be utilized to help minimize psychiatric casualties in a combat zone, and to indicate further how such measures can simultaneously increase the fighting efficiency of the soldiers.

In previous reports, material was presented to indicate how morale, leadership, discipline, classification and assignment, and psychiatric casualty incidence were different aspects of the same problem. Each seemed to have direct influence upon the others. Men properly assigned, with capable leaders and good unit loyalty were well disciplined, had good morale and consequently few psychiatric casualties. Too great a deviation of any one of these factors from an ideal balance made the soldiers in that unit more vulnerable to psychiatric breakdowns.

On the battlefield, the basic motivating force for the soldiers seemed to be ego preservation. The battle situation became acutely personal, and the war became considerably less abstract. Men were attacking because they were ordered to attack, and their chief concern seemed to be their reputation with themselves, their fellow soldiers and their officers. It was interesting to observe that most of those cited for gallantry or heroism admitted that they performed as they did because it was expected of them; they had an audience. It is unlikely that many of these men would have risked their lives to perform such hazardous duties if they had not been observed by others, provided, of course, that the performance of that duty was not required for their own personal safety. They expressed little hate for the enemy and they had little desire to kill. Rather, their aggressive action was motivated by a positive force—love more than hate—manifested by (1) a regard for their comrades who shared the same dangers, (2) a respect for their platoon leader or company commander who led them wisely, and beclouded them with everything at his command, (3) a concern for their reputation with their leaders, and (4) an urge to contribute to the task and success of their group and unit. They were fighting for themselves and for their unit, and in that way for their country and their cause.

Now let us consider this in relation to the psychiatric casualties. Most of the psychiatric casualties in the area in which I served were acute anxiety states. Psychotic reactions were rare and conversion hysterias were few. Fear and tension were present in practically every man in the front lines, and this led to considerable difficulty in evaluating psychiatric casualties. Where the physiological signs of fear blended into signs and symp-

1 Read at the Centenary Meeting of The American Psychiatric Association, Philadelphia, Pa., May 15-18, 1944.
tions of a clinical syndrome was often difficult to decide. Fatigue as the result of physical exertion, lack of restful sleep, and an almost constant state of tension was often an important component of the acute anxiety states.

Another component, more interesting, yet not quite so clear, was something which for discussion purposes might be referred to as the X-factor. It was something which corresponds to whatever courage is; it was something, which when present, indicated good morale. Whether this factor was conscious or unconscious is debatable, but this is not so important. The important thing is that it was influenced greatly by devotion to their group, or unit, by regard for their leader and by conviction for their cause. It seemed to explain why a tired, uninspired, disgusted soldier was a labile, emotional tone that inflicted vicious insults that inflicted their most damaging wounds; but it was here, too, that inspiring leadership played its great role. Such news brought new demands of our leaders. It emphasized their strategic position within the group. On the battle field, leaders, especially the junior officers and the non-commissioned officers who had direct personal contact with their men and lived with them, had a great influence upon them, primarily because of intensified comradeship within the unit. Good leadership meant good morale and this, in turn, meant a low psychiatric casualty rate and good performance. It indicated that this X-factor was strong, that it enabled men to control their fear and combat their fatigue to a degree that they themselves did not believe possible.

Good morale seemed to be a subtle emotional tone, which at its maximum, enabled the soldier to perform to the very best of his ability, despite the inevitable hardships and threats to his life. That it was labile, the officers soon learned. The maintenance of good morale required constant attention to, and concern over, the factors responsible for it. In combat, the company commander or platoon leader could not, of course, do much about the abstract levels of morale but he was in a very good position to manipulate morale at the more concrete levels. For instance, he saw to it that his men got the best possible food under the circumstances; he sent blankets up to them at night-time if it were at all possible; he made every effort to keep them well supplied with water and ammunition; he saw to it that promotions were fair; he made certain that good work and gallantry were properly recognized; he got mail, news and information to them when possible; he made sure that violations of rules were treated quickly and fairly; but above everything, by such actions, he made his men feel that they were not alone, that he was backing them up with everything humanly possible. That, plus technical ability constituted a good leader.

Observations such as these seem to point to the core of our psychiatric problem, that is, anxiety; and at the same time they suggest a method of meeting this problem. The theme of military preventive psychiatry may well be: combating anxiety. This may be done in a three-fold manner, (1) by detecting the important factors, ranging from abstract to concrete levels, which give rise to anxiety, (2) by detecting the available forces which can effectively thwart or minimize these anxiety-producing factors, and (3) by helping the command to devise practical measures to accomplish this in the shortest possible time. Here is where psychiatric common sense can be of utmost value.

Let us consider an illustration of a practical application of this common sense. It was observed that many of the men did not seem to express much hate for the enemy and this, of course, was associated with the incidence of anxiety and psychiatric casualties. It was natural, then, for some of our officers to state that we must inculcate hatred for the enemy in our men in order to beat the enemy. While on the battle field it was difficult to gather men together for pep talks because dispersion was so essential, and during the lull between battles, tired soldiers did not seem to care for speeches about how wicked the enemy was, or why Fascism is an evil force. Combat soldiering became too personal, realistic and concrete to attract an audience with remarks resembling ethical or political platitudes. These men were more interested in such things as: When will we be relieved? When are the other units coming up to help out? How did we do compared with the other battalions? Did the other outfits fight as hard as we did? And were their casualties as heavy as ours? In essence it was "me and my gang, how are we doing?—And how about the others?" Sensing this, the battalion commander gathered his men to-
gether while preparing for a new offensive, and, in their own language, said, in effect—
"I know as well as you do that the going has been tough. Perhaps I sweat it out more than you do because I have more to worry about. But you have done a fine job and I am proud of every single man in my outfit. I assure you that everything possible will be done to give you the best available support and I will not order you to attack unless I am confident that you have a real chance to succeed. The harder we fight now, the sooner we can finish this mess and get back to living the way we wish." This, I believe, demonstrates the wisdom of detecting and utilizing the available forces which can effectively thwart anxiety-producing factors. Had this battalion commander, on that occasion, talked about the advantages of democracy over Fascism, or about the evil things that Hitler has been doing during the past ten years, it would have undoubtedly struck a sour or unresponsive note with the men. Instead, he wisely seized upon one of the strong motivating forces in his men, namely, a respect for him as a leader, a desire to maintain a reputation with the other men, and an urge to participate in the accomplishments of the group. And his method was a frank, direct talk. It is interesting to note that this very capable, confident commander, who knew no formal psychiatry, had the intuitive common sense to do the appropriate thing at the right time. There is much that field psychiatrists are able to learn by observing these real leaders in action; and by transferring this knowledge to others less fortunate in their endowment as leaders, they are performing a valuable service. The method used by this battalion commander in this instance, suggests that in our concern over the lack of great hatred among our soldiers for the enemy, we might more wisely take measures to foster greater unit-loyalty (a tendency already present) instead of attempting to foster greater hatred for the enemy (a tendency not so marked). In other words, if our soldiers are motivated more by love than by hate, then why not make every effort to maximize what already exists?

Now let us consider an example of how the psychiatrists can offer the command useful advice. It was observed that a soldier's identification with a group—be it platoon, company, battalion or division—was an important stabilizing influence during combat. Also, it was observed that an important anxiety-producing factor was a lack of this identification. Individual soldiers and officers coming up as replacements were often so lonely and felt so much like utter strangers that at times they were actually frightened by the strange newness of their associations. For many, this was their first experience under fire. And it was in this setting that they went into battle. Going into battle as part of a group with many friends is difficult enough, but going into the same battle as a stranger with no friends, must be utterly miserable. Similarly the plight of the new platoon leader given command of a group of battle-wise veterans at times became serious. It was not surprising then that some of them did unwise or foolhardy acts to convince themselves and the men that they were not afraid. And it was not surprising either that physical casualties among them were very high. These observations combined suggest the advisability of replacing casualties by groups instead of individuals, if at all possible; replace companies, battalions, regiments or divisions. But the doing is not as simple as the mere saying of it. So many other considerations must be accounted for to effect such replacements. That is why it is, of necessity, a decision for the command to make, but the psychiatrist can suggest this as a factor to be considered.

Now a third illustration. Recently there has been much comment to the effect that many of our soldiers do not appreciate fully why we are fighting. It is no doubt true that many of them had little knowledge of socio-political complexities of the various countries and their boundaries, and they were perhaps not able to verbalize adequately the meaning of the Four Freedoms. But in spite of this, the men I served had a fundamental confidence that our way of living was the right way and were convinced that no enemy could change it. They were confident of victory, but they were concerned about the sacrifice necessary to win. Here again was a fertile source of anxiety. Who is supposed to sacrifice? Few of us or all of us? If few of us, why should it be me? Should not all of us contribute? That is why the soldiers living for months in mud and sweat and misery
are viciously insulted when they hear that some of us try to make unwarranted profits, or to loaf or to indicate by absurd notions of patriotism that we do not appreciate the sacrifice and work of our fighters. These thoughts haunt the minds of many men during the hours of waiting and monotony of combat duty. Such things stir up anxiety. If these same things did not occur, then there would be less anxiety. Thus, although these men may not be able to verbalize eloquently why we are fighting, they know very well how we can fight better, and from them we can learn much about war, and much about how we can all contribute and sacrifice. If we, as doctors, can accurately and convincingly report these needs of the combat troops, then perhaps our rear echelon and our civilian support can become more wisely oriented and more productively engaged in an all-out war effort. Such reports might even influence many legislators and editors by showing them the practical necessity of unselfish interest and unity of action during war. Such reports might impress many with the urgency of the time factor; how dissension and bickering at home now reflects itself in the drive and efficiency of our fighting teams.

But on the battle field, there were available forces complementing good leadership which effectively minimized anxiety. They were: (1) proper classification and assignment, (2) adequate discipline, and (3) good doctors.

1. It is difficult to overestimate the value of proper classification and assignment of soldiers. When a soldier felt properly placed in his unit he tolerated more stresses and strains in order to maintain that assignment. For instance, two jeep drivers in our detachment refused a promotion and a less hazardous assignment simply because it meant giving up driving their vehicles, a job that they preferred to anything else. It was obvious that many men were disgruntled and performed their duties poorly because they were unwisely assigned. In the Infantry it is very difficult to expect a high degree of job satisfaction when the bulk of the men are obtained from civilian occupations. However, in many instances it was possible to increase the degree of job satisfaction by shifting around within the unit and establishing a close liaison between the personnel officers, company commanders and the doctors. The problem of classification and assignment may be more aptly described as re-classification and re-assignment.

2. In some of our units it was observed that although every effort was made to lead men wisely and inspire them to use their own initiative as much as possible during combat, there were still some men who regarded this effort of tolerant leadership as a form of coaxing or seduction, and as a result tended to violate established and known regulations. For that reason, it appears essential that along with this maximum effort to inspire men, there must at the same time be a thorough understanding with the men that a firm military discipline must be maintained at all times. The majority of soldiers conform to regulations and do so even though it irritates or inconveniences them to various degrees. However, they resent even more the fellow soldier who defies regulations without receiving appropriate and judicious punishment. To see regulations violated without punishment tempts men to do this themselves and thus contributes to the turmoil of potential anxiety.

3. The rôle of the doctor in this attempt to combat anxiety is important and unique in that he treats casualties, and at the same time functions in an advisory capacity to the unit commander. In this way, our field medical officers can contribute to a program of psychiatric prophylaxis, and it is extremely important for field medical officers, especially the battalion surgeons, to have a psychiatric orientation. In addition, the medical officer should identify himself as an integral part of his combat unit. The more familiar he is with the technical and practical details of his unit, the more effective will be his knowledge of the men. The doctor should feel convinced that military medicine during combat is quite different from civilian medicine during peacetime. The traditional sympathy expected from the doctor must be present, of course, but in a much broader manner, in that the total situation must be kept in mind when treating one particular individual. It is necessary to channelize sympathy for the men who are struggling with themselves to remain at their posts to
continue the fight as ordered. With this regard and respect for our fighting men medical care at times has the superficial appearance of being blunt and unsympathetic.

The therapeutic value of authority and command has its place during combat. Forms of therapy based upon the development of insight have little value there. It was observed many times that psychiatric casualties did not occur simply because they were not permitted to occur. During one of the more difficult engagements in Tunisia, when our battalion was subjected to a series of enemy bombings and strafings for several hours while launching an attack, our casualties were very heavy. One of the medical aid men, after several harrowing experiences, became confused, disoriented and cried tearfully at the top of his voice, begging to be evacuated. Because of the heavy casualties and the battle situation, the need for every single medical soldier was very urgent. Therefore, his medical officer was forced to use every means possible to minimize the number evacuated. Because of these circumstances, he grabbed this confused, tearful soldier and in a somewhat forcible manner, pointed out to him how he was letting down and failing the soldiers who were continuing the fight, and was sternly ordered to drag himself a fox-hole and to stay there until ordered otherwise. That he did, and at dawn the next day he came to this same medical officer and in a slow, apologetic, guilty manner, even though mildly tremulous, sought forgiveness for his behavior the evening before, and asked if the whole incident could be forgotten, if he continued to do his assigned duties. He was, of course, assured that such behavior was understandable, but could be controlled, and was promptly assigned to work. He carried on efficiently as a litter-bearer and jeep driver for the following two months, during two battles, until he was finally wounded in the hand during an enemy bombing raid. Using almost any clinical standards, this soldier was certainly a psychiatric casualty at the time, but because of forceful, immediate psychotherapy he was able to conquer his acute anxiety and continue at his assigned duties throughout several subsequent combat engagements. The dependency of the individual upon group identification, ego preservation and the critical role of leadership with these men formed a fertile situation for strong authoritative suggestive therapy.

To detect the many impinging forces which tend to stir anxiety in soldiers, it is necessary for the psychiatrist to get into the field himself, to become intimately associated with the stresses and strains of the soldiers' minds; and to thwart these forces the psychiatrist must have a close liaison with the officers in command. Unless the psychiatrist can convince his commanding officer that he understands the problems in a practical way, and unless he can make himself understood in the language and feelings of the line officers, then he is of little value; but if he can, by his knowledge, his attitude, and his conduct, "sell himself" to the line officers, then his value is great.

There are those who argue that a doctor is stepping out of his sphere when he concerns himself with whether or not mail gets to the men, whether or not men are confident in their leaders, whether or not discipline is appropriate, whether or not the folks at home appreciate what the fighters are doing, or whether or not the workers at home are working, or the merchants are profiteering. But psychiatric casualties are real—and these are the factors that contribute to anxiety which increase the soldiers' vulnerability to mental distortions. Concern about this is no different from the concern of the army doctor who thoroughly delouses hordes of filthy civilians to avoid a typhus epidemic among the on-coming troops. It is detecting and eliminating causes of disease, instead of waiting for disease to occur, that attempting to treat it.

Also, there are those who argue that this is a command function and of no concern to the doctor. Of course, it is a command function—almost everything in the combat zone is a command function, but here the doctor is an adviser to his commander, who is burdened with the innumerable details of the logistics of war. The commander is supported by specialists for this very reason. By applying psychiatric common sense in this practical dynamic way, even though in an indirect manner, the psychiatrist becomes
a valuable aide to the combat commander, in his attempt to maintain aggressive control of his combat unit.

Every individual in the rear echelon—both military and civilian—can contribute in a real way toward minimizing the forces producing anxiety in the fighting soldiers, by evaluating all his attitudes and actions in terms of their effect upon the soldier who is actually doing the fighting. If by our actions we express sincere appreciation and full support, we considerably reduce the number of anxiety-producing forces that impinge upon his mind and thus aid him in mustering and converging all his ability to attack and fight until the battle is won.