27 March 1944
Bureau of Medicine & Surgery
Navy Department
Washington, D. C.

Lt. Col. W. C. Menninger, MC, A.U.S.
Neuropsychiatric Division
Surgeon General's Office
1818 H Street, N. W.
Washington, D. C.

Dear Bill:

I can't let this opportunity go by without writing to tell you how fine I think Capt. Herbert Spiegel's article on "Psychiatric Observations of an Infantry Medical Officer in the Tunisian Campaign" really is.

I read it in one of those little things which Col. Porter puts out from the School of Military Neuropsychiatry. It is dated March 2, 1944, and begins on Page 1.

I think Capt. Spiegel is to be highly complemented, for without doubt, it is the most forthright, intelligent, and understanding article that I have yet read. I am going to write and ask Col. Porter whether the Navy can get permission to use a condensed version of it in its BuMed News Letter. Maybe you are the people who give us the permission in the Surgeon General's office?

I might say that I was particularly impressed by Capt. Spiegel anyhow when he came back from Africa and made an appearance at the National Research Council, and his comments on that day were like a breath of Spring in an atmosphere which was otherwise greatly befogged.

I congratulate you on having him as a member of your organization.

Sincerely

Francis J. Braceland
Commander, (MC) USNR

FJB/ITM

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PSYCHIATRIC OBSERVATIONS IN THE TUNISIAN CAMPAIGN*

CAPTAIN HERBERT X. SPIEGEL, M.C., A.U.S.[1]

IT IS difficult to convey accurately the complexities of a combat outfit and the variety of reactions which occur among men during battle. For that reason it is emphasized that these are purely personal observations and impressions of an Infantry Battalion Medical Officer who lived with and served nine hundred soldiers during four major engagements of the North African Campaign, including one amphibious operation. No statistical evaluation has been attempted. It must be further emphasized that regardless of the accuracy of the observations, they were drawn from only a minute portion of the troops in that theater of operations. Actually, these are the observations of one particular officer, of one particular infantry battalion, during one particular campaign, at one particular time. Therefore, the danger of prematurely generalizing must be kept in mind. To give this presentation an even more personal note, I admit frankly that I found the entire experience as unpleasant and disagreeable as did most of my colleagues. I did my share of griping and complaining. Having come back intact, I appreciate the experience primarily because I learned to admire and profoundly respect the ordinary infantryman—the plain "G. I."—for what he is and for what he is doing.

To understand better the psychiatric casualties among combat infantrymen, it is necessary to appreciate to some extent the almost unbelievable rigors and hardships they must endure. There is a rather weird admixture of waiting, tension, boredom, confusion, furious activity, and monotony. In a warm, masterful manner, Ernie Pyle, in *Here Is Your War*, has written about these men, the many little insignificant things which reveal them not as mere stereotyped soldiers but as human beings who happen to be soldiers because of circumstances. In an expert account Major Ralph Ingersoll, in *The Battle Is the Payoff*, has conveyed rather accurately the peculiar combination of inactivity and furious action which modern battles demand. These two reports provide a good background for those seeking to understand the problems of the combat soldier.

On the battlefield, what motivated these men to push forward? There was one place where war lost a considerable amount of its abstractness and became acutely personal. Prior to his first exposure to enemy gunfire, the average soldier's chief concern seemed to be: "How am I going to meet it?"; "Will I be able to control myself?"; "Will I do what they expect of me?" Then after the first few hours this uncertainty began to change to mounting confidence in his reputation with the others. Eventually, his concern centered more about the probability of being killed or wounded. The battlefield became a fantastically real place where men strongly began to feel the utter finality of being killed; they began to compare in their minds the relative advantage of a wounded arm versus a wounded

* Presented at the 1944 meeting.

[1] Resident in Psychiatry, St. Elizabeths Hospital, Washington, D. C., on military leave of absence.

leg, or a blown-off leg versus a blinded eye. These men did not feel like glamourous and glorified knights of valor dashing forth disregarding danger to rid the world of evil. Nor were they, as many like to believe, a gang of rough, tough fellows who just loved to fight and went out of their way to find a scrap. They did not even express much real hate for the enemy. Instead, they were very sober, intensely realistic, peace-loving citizens who preferred a baseball field to a battlefield. At the time, however, they were serving in our army, in a large measure as a result of selection. They were acutely aware of the dangers ahead, but nevertheless they attacked and pushed forward because they were commanded to do so. They realized there was a tough job to be done and it was now their turn to contribute, at the same time keeping an eye to one side to see what the other fellow was doing. As one said, "I see my job and I'll do it; I hope that the other fellows do their share too." By "other fellows" he did not mean so much the men actually at his side because he was sure of them. He meant the men in back of his outfit, and the men in back of them along the thousands of miles of land and water to the rear. Perhaps such concern made it harder, but the important thing is that they pushed forward as ordered.

If abstract ideas—hate or desire to kill—did not serve as strong motivating forces, then what did serve them in that critical time? What enabled them to attack, and attack, and attack week after week in mud, rain, dust, and heat until the enemy was smashed? It seemed to me that the drive was more a positive than a negative one. It was love more than hate. Love manifested by 1) regard for their comrades who shared the same dangers, 2) respect for their platoon leader or company commander who led them wisely and backed them with everything at his command, 3) concern for their reputation with their commander and leaders, and 4) an urge to contribute to the task and success of their group and unit.

In other words, the interpersonal relationships among the men and between the men and their officers became more intense and more important. These cohesive forces enabled them to identify themselves as part of their unit. It enabled them to muster and maintain their courage in the most trying situations. It even led them at times to surprise themselves with gallant and heroic actions. They seemed to be fighting *for* somebody rather than *against* somebody. For example, when our Pioneer Platoon Leader was wounded in the shoulder and had to be evacuated, he protested with tears and begged to stay, not because he wanted to go out and kill anybody, but because, as he put it, "I just can't leave the fellows now, they need me." Or again, our young Supply Officer who, after two days and nights of constant work getting food and supplies up to his men under most difficult conditions, asked his medical officer for Benzedrine to keep him awake instead of trying to get a few hours of sleep. They were fighting for themselves and their unit, and in that way, for their country and their cause.

If that be so, then what practical significance does it have to psychiatrists? To answer this, let us first consider the psychiatric casualties.

The vast majority of psychiatric casualties which I saw were *acute anxiety*

states. Psychotic breakdowns were rare; conversion hysterias were few. These two obviously did not belong at the front and were evacuated immediately. Just how many anxiety states occurred was difficult to estimate, because we could count only those who were evacuated to the rear. But many, perhaps most, of them never were evacuated. They stayed at their posts and fought until the battle was over. Then their anxiety subsided. The decision as to whether an anxiety state was evacuated or not depended not only upon clinical symptoms, but also upon the battle situation, the need for men, the time of day or night, the weather, the terrain, and accessibility to the rear. It soon became apparent that a tense, tremulous soldier was not necessarily a psychiatric casualty. He was if we made him one and sent him back, but often he was *not* a casualty simply because he was *not permitted* to be one. A state of tension and anxiety is so prevalent in the front lines that it must be regarded as a normal reaction in this grossly abnormal situation. Where ordinary physiological signs of fear end, and where signs and symptoms of a clinical syndrome begin, is often difficult to decide. This is an important consideration because not only was some of the gallant and heroic work done by men and officers in acute anxiety states, but a considerable amount of the ordinary combat accomplishment was performed by ordinary men experiencing rather severe anxiety.

The overt symptoms varied from a feeling of tension, dry mouth, palpitation, perhaps mild tremors, through a more marked tension with increasing sensitivity to noises of any kind, to the extreme of gross trembling, screaming, crying, running about in confusion, and almost complete disorientation. These extreme states were not common. No doubt with careful and detailed study these states can be classified and subdivided into any number of types, but at the time and place of combat only two groupings were necessary—those who stayed and those who were evacuated. About those who were evacuated I know little because I saw them for only a short time. Hence this report is concerned more about those who stayed. If there were anything that appeared to be common to all these states besides fear, it was the factor of fatigue or exhaustion. Fatigue not only as a result of physical exertion and lack of restful sleep, but also as a result of a constant state of tension and anxiety.

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 that corresponds to whatever courage is; 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 seems to explain why a tired, uninspired, disgusted soldier had the clinical appearance of an anxiety state. It seemed to explain why some units could outdo others; it seemed to aid in controlling the ever present fear; and it seemed to aid in resisting fatigue. In the most stable fighting men this factor was not so prominent because of their innate ability to carry on, no matter what happened. But in the average soldier, which most of

them were, this factor attracted serious attention. Here was a critical, vulnerable and, to be precise, an influenceable component that often decided whether or not a man would be overwhelmed by his fear, anxiety, or fatigue. Here was a factor that often decided whether or not the man became a psychiatric casualty. It was here that news of strikes, profiteering, absurd patriotism and lack of real appreciation for what they were doing were taken as vicious insults and inflicted their most damaging wounds. But it was here too that inspiring leadership played its great role. This disgusting news brought new demands on our leaders. It emphasized their strategic position within the group. On the battlefield, leaders, especially the junior officers and noncommissioned officers who had direct personal contact and lived with their men, had a great influence upon them, primarily because of the 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 the X-factor was so strong it enabled men to control their fear and combat their fatigue to a degree they themselves had not believed possible.

Good morale seemed to be a labile emotional tone which at its maximum enabled a 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. The company commander or platoon leader could not, in combat, do much about the abstract levels of morale reflected by such questions as: Why are we fighting; why the profiteering, strikes, and so forth? 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; sent blankets up to them at night if it were at all possible; made every effort to keep them well supplied with water and ammunition; saw to it that promotions were fair; made certain that good work and gallantry were properly recognized; he got mail, news and information to them when possible; and he made sure that violations of rules were treated quickly and fairly. But above all, by these actions, he made his men *feel* they were not alone, that he was backing them up with everything humanly possible. That, plus technical ability, constitutes a good leader.

It was impressive to see men labeled by some as psychoneurotics or psycopaths perform well in battle under good leaders. One psycopath with about 250 days "absent without leave" on his record served so well that he was cited at least three times for gallantry in action. Of course, all psycopaths did not win citations, but at the same time some apparently stable men did not do well. What happened raised serious doubt as to the validity of the criteria that we ordinarily use to predict army adjustment. Predicting or detecting neurotic traits did not necessarily imply poor army adjustment. So often a soldier's success depended more upon where he was placed and who was his boss. A good leader enabled him to utilize what assets he had despite his unconscious conflicts; on the other hand, mental breakdowns occurred in some who appeared stable. In other words, often it was difficult to predict with an appreciable degree of accuracy.

It is just these few observations which point to the important possibilities of preventive psychiatry in this war. Psychiatrists can do more than merely diagnose, classify, and eliminate, or confine their interest and work to the psychiatric breakdowns which have already occurred. Here they have a great opportunity, in an advisory capacity, to prevent effectively many of these casualties from occurring. By divorcing themselves from the hospital bedside and becoming intimately associated with the rigors, tribulations and stresses of the soldier, they can more easily understand and appreciate the many factors ranging from abstract to concrete levels which influence the final reaction patterns of the soldier. Then by pointing out those factors to unit commanders, they will enable those commanders to evaluate and utilize this knowledge in terms of the many other and often more important factors necessary to organize and carry out a successful battle. It is in this way that psychiatrists can be of real value in maintaining good morale, can cooperate with and aid the commanders, especially the junior commanders who have most contact with the soldiers. They can, for example, point out how the man in the front lines harbors some degree of resentment toward the man in the rear echelons, and how this resentment can be successfully counteracted by giving the fighting soldier the feeling that everybody in back of him is supporting him 100 per cent. And if this soldier has a conviction that he is getting 100 per cent support, then he will know and we shall know that his leadership is good. It is the maintenance of morale in this sense that meets directly the component of an impending neurotic breakdown which often is the critical feature deciding whether the soldier will keep on going despite his fatigue and anxiety, or whether he will allow his tension to force him into defeat and to quit.

In Tunisia it was shown that in spite of many operational difficulties, good inspiring leadership induced the average everyday soldier to win battles and smash the enemy. The bulk of the psychiatric casualties can be regarded as artificial in the sense that they occur in a comparatively stable group of individuals, in an unusual manner, in a very distorted situation, and that with inspiring group leadership and loyalty they can be prevented. In this sense the name "war neurosis," or even "army neurosis," is appropriate. The number of psychiatric casualties that did *not* occur was a tribute to the leadership and unit loyalty.

With psychiatrists functioning in this manner, not only can potential psychiatric casualties be prevented to a large degree and thus the additional problem of secondary gain after hospitalization be avoided, but also, at the same time, the inevitably miserable life of the fighting soldier who sticks to his guns can be made more tolerable. Such attention indicates more support from the rear. It aids in making the fighter feel that he is not alone; that he is somebody and not just an expendable item. It thus yields a more efficient combat soldier and this result alone makes field psychiatry worth while.