COMBAT PSYCHIATRY - THE DIVISION PSYCHIATRIST

UNCLASSIFIED

UNITED STATES NAVY
TRAINING FILM
MN 7499B
1954
CASCADE PICTURES OF CALIFORNIA, INC.

COMBAT PSYCHIATRY

THE DIVISION PSYCHIATRIST

NO ACTUAL CASUALTIES ARE SEEN IN THIS FILM: PROFESSIONAL ACTORS AND MARINE CORPS PERSONNEL PORTRAY PATIENTS.

The beach has been secured and the various companies of the medical battalion are ashore and functioning. This ambulance is on its way from the battalion aid station to the forward medical company, a few miles to the rear. It carries both wounded and psychiatric casualties. The battalion medical officer who saw these patients decided that more definitive evaluation and treatment was necessary. At the forward medical company, the psychiatric cases will be seen by the division psychiatrist for screening and therapy. A few miles further to the rear is a smaller N.P. unit, attached to one of the other medical companies, and under the care of an assistant to the division psychiatrist. The purpose of this rear unit is the care of those comparatively few patients who require more than a few days of rehabilitation prior to their return to duty. It also provides prepared accommodation should the forward medical company make a sudden tactical move, necessitating the immediate disposition of all patients. However the main and most vital effort in the operations of the division psychiatrist is at this point, and forward of it.

“In there.”

“Let’s go in the tent now, fella.”

This is the admission tent where all the casualties-psychiatric, wound or other-are received for initial evaluation and sorting.

“What’s that, uh? What are you doing?
- Jerry, help Pete! Pete, look out, Pete. They’re coming! Stand still I’m coming. OK, you dirty rats. Take cover. Watch out our right flank. We got to get outta here. We can’t, Lieutenant says we gotta stick it.
- Alright, son, alright… You’re all right now. Easy now… You’re in a hospital. I’m the doctor.”

Here is a severe dissociated reaction. Because of his disturbing influence on the other psychiatric patients, it's essential that he be immediately sedated, unless otherwise contraindicated. And if possible, kept apart from the others until he is quieted.

"Better get him over to that empty pyramidal right away. And have somebody stay with him. I will be over in a few minutes.
- Yes, Sir. Tomans, Williams!
- Pete, help Daley! Pete I'm with you still….. Hi Jerry, Pete help Daley.
- Easy, easy…
- I'm with you Pete, I'm with you, I'm with you Pete! I'm with you Pete
OK, six and up coming… Look out, Jerry. Hit the flank… Ok, Pete, cover.
- Know where you are? You any good on this thing?"

Some patients may appear to be in poor condition when admitted; yet recovery can be fairly rapid. This is particularly true when the condition has been precipitated by a sudden severe psychological trauma, as in this case. Here we also know from the man's tag that his prior combat adjustment has been adequate.

SHAKEN BAD BY EXPLOSION WHICH KILLED A BUDDY. WOULD NOT GIVE UP WEAPON. HARD CHARGER BEFORE. JAMES GAMM…

Therefore he should not be written off immediately as a poor bet for return to duty without further observation.

"Put this man down next to the corpsman station. I'll be in shortly.
- Theo!
- You need some rest. We'll see you get it.
- What's the story, son?
- I don't know… I don't know…
- Come on.
- I just crapped out, that's all. I've had enough of this bloody stuff. You can call it yellow if you want to.
- Alright, son, I'll talk to you later. Take it easy, boy! That's just chow call… Bed him down.
- Yes, Sir. Franci.
- Get some chow for this man.
- All right."

***

"I want some more spuds!
- Yesterday, you ate like a bird, today like a horse.
- I'm going to defend you guys tomorrow. It will be good.
- How long have you been here?
- Three days.
- Three days! Damn if they're going to get me be back to duty […]"

The psychiatrist never misses the late night visit to assure that the anxieties and […] is as far as possible during these difficult hours. Adequate rest […] especially with the early acute cases are of critical therapeutic importance.

"How's it been tonight, Al?
- It's been pretty quiet tonight, Sir. Except for Sprugs: he's still awake. I gave him 6 grains about 2 hours ago.
- Let's have a look at him.
- Alright! Easy… Take it easy… Perfectly safe. It's the doctor talking. You're in a hospital. You're having a bad dream, that's all. You're all right. You understand?
Better give him 3 grains.
- Yes, Sir.
- That will help you. Now you know where we are? You're all right.
- What happened, Doc?
- Fella had a bad dream, that's all. Come on. Back to sleep. Lie down. Hit the sack. Come on.
- Hey Doc, is he gonna be okay?
- Yeah, he's gonna be all right.
- If that happens again, we'll have to move him out of here.
- Yes, Sir.
- I'll have a look at Sprugs.
- Can't sleep, son?
- No Doc, I, I was thinking about Joe.
- Joe?
- He was killed 2 days ago.
- I'm sorry. You must have been very close.
- We were. We went through boot together, joined the outfit at the same time. We used to go out on liberty together. We had it all figured out, ~~for~~ what we were gonna do on our first liberty, after we got out of here.
- Tell me about him.
- We used to kid around a lot. He always knew how to get the guys laughing. I.. I'm gonna miss him.
- Yeah, I expect so. I'll tell you what. Why don't we talk about him some more in the morning, huh? You get some sleep now. You have any more trouble, you let the corpsman know.
- Okay, Sir.
- Goodnight."

***

"Come on, chow down, you guys. Let's go, chow down. Come on Smith, chow down. Chow is almost over, let's go. Come on, you too: let's go. Get out. Chow down: hit the deck.
- I don't want none.
- Doctors orders. It's real good.

- They're getting their chow in bed back there. Why can't I get mine?
- They came in yesterday. Room-service for the first morning only. So come on, Ron: hit the deck."

After the second day, most patients are required to be up and around at reveille, police the areas around their cots, to shave, fresh up and get their own breakfast. This discourages feelings of being an invalid; it helps prevent the self-indulgence of regression. As a general principle however, an effort is made to provide anxious, freshly arrived casualties with at least 24 hours of complete relief from anxiety-provoking stimuli, both external and internal. They're therefore sedated as necessary and permitted to sleep as long as they want the day after admission.

"Hi Jim!
- What?
- What are you doing here?
- I don't know… Must have gone off my rock.
- Yeah? I never thought ol' Blood and Guts would get shook.
- So, what place is this?
- Man, this is fat. You've never had it so good. Good chow, plenty of time to relax. Hey, Jim, I see you got your harmonica with you."

Practical considerations may determine the xxx necessity for having the majority of psychiatric patients quartered in the same tent. However, with the exception of the few severely disturbed types, strict segregation is contra-indicated. The presence of a few selected non-psychiatric ambulatory patients in the same tent is desirable. The comparative cheerful and relaxed behavior of the non-psychiatric cases tends to dissipate the atmosphere of gloom, anxiety and failure that pervades the tent of N.P. casualties.
The feeling of being unique and isolated is dispelled. This mesh curtain merely provides the newcomers with an opportunity to sleep and rest with less distraction.

Getting the patients out of the tents after sick call for some sort of game or activities keeps them from lying around and brooding over their symptoms. However, with physically or emotionally exhausted men, it is important not to push prematurely or tactlessly. This may cause resentment, aggravate symptoms and complicate treatments.

Twenty-four hours after admission, the psychiatrist should be seriously considering dispositional possibilities. After subsidence of the patients' acute anxiety, the psychiatrist must not delay the return of casualties to their units. Secondary symptomatic and attitudinal elaborations are thus prevented from interfering with adequate re-identification.

The marine's awareness and feeling that he's an integral and useful part of his own fighting group is in itself a powerful influence for the control of anxiety. There are several factors which the psychiatrist takes into consideration in determining disposition: how long a man has been in combat, how well he has borne up on the combat stress until he became a casualty, how severe the precipitating stress, how stable a man's pre-combat personality as

far as can be ascertained. What improvement he has shown since admission, the nature of the symptoms and the quality of his motivations for further combat.

There is PFC Sawyer. When he came in 2 days ago, he was a bit shook but alert, responsive and vocal. He'd been in combat some months and performed well until the sergeant was here. He then became temporarily confused and terrified. The battalion medical officer, because of a flood of casualties, was unable to hold him. Sawyer showed pretty quick recovery, although his tough talking conceals a lot of self-doubt. The quicker we get him back, the better.

And over there is corporal Wilson, admitted the day before yesterday. A good combat record and an aggressive hard charger. He's reacted to the stress of considerable combat by symptoms of tension and morbid irritability. Flew into a violent rage recently because of some trivial provocation. This was followed by a period of prolonged weeping. He was bitterly ashamed of his performance and has reacted with rather sullen withdrawal. However tension seems to have lessened and he's had good motivation.

If the psychiatrist can reach him, let him abreact some of his hostile feelings and assure him that he's still a good and worthy marine, he should be able to return to full duty within 3 or 4 days of relief from battle tensions.

Here is an old hand, Sergeant Browning. He's had his share of combat and perhaps a bit more. He is a career man and was a good NCO, in part because of some obsessional characteristics. In recent weeks, he's become increasingly anxious and ineffective, indecisive, fumbling and fearful. He lost the confidence of his platoon. There is depression and there is guilt. It is most probable that the sergeant's combat usefulness is at an end. It's always necessary to consider the influence on their men of anxious, uncertain NCOs burdened with the responsibilities of leadership.

However, it's likely that the sergeant can be restored to non-combat duties, even within the division. Perhaps releasing a fresh NCO from a rear echelon job as a line company replacement. Two or three weeks of rest, judicious activity, relief of his feeling of personal failure, and restoration of his sense of being useful and wanted, are indicated. Since there is now no question of returning him to ~~into~~ combat, this will be accomplished at the small NP unit in the rear, with a medical officer assisting the division psychiatrist as the time and facilities. But it must be re-emphasized that the majority of N.P. cases are handled at the forward medical company or by the battalion medical officer.

This boy came to us 2 nights ago: crying, shaken, in his confusion, asking for his mother. Obviously rather immature and yet, very sincere. Been in combat only a very short time. Broke down on patrol during a rather light small arms exchange with the enemy and had to be left behind. Acute symptoms cleared up rapidly when informed he might not be returned to his company. Has some clerical experience. Believe he is one of the few cases we can sent to the division adjutant with the justifiable request for non-combat duty assignment within the division. It's important to be conservative with this kind of recommendation because the

word may quickly spread that the psychiatrist is the man to see if you want to exchange your foxhole for a rear echelon job.

Experience will gradually refine the psychiatrist judgment of his patients' capacity to extend further stress. At first, he may return a few men to duty who will be useless or even a menace to the welfare and safety of the outfit. But he is more likely to evacuate a larger number who might still carry on effectively had they been properly returned to duty. Gradually, he learns however that many of the men he sees can take somewhat more in the way of further combat stress than at first seemed possible.

Experience will also teach him to carefully watch his own emotional condition: over-identification with his patients, or hostile projection of his own dissatisfactions and feelings of fatigue, may upset the careful balance of his judgment.

"Say, Doctor.
- Hello Kane! How's that neck?
- Oh, pretty good, Sir. Say, Dr. Mullen, what's with Jimmy? I can't get any music out him. He must be pretty bad.
- Well, look, Bill. Why don't you stick around with him? Don't push him. Just treat him the way you always do. I think he's gonna pull out of this in a few days.
- Back to the outfit?
- Uh-huh.
- Oh, good. Oh, thank you, Doctor.
- All right."

"Hey Johnny, what's the scoop on Morrison there?
He's from Smith's outfit with the patient back there with the fractured jaw. Smith told me he's been more than useless the two weeks they've been on the line. Never even fired his piece.
- Know anything more about him?
- Yes, Sir. One of our own shells went over, got more scared than usual. Started screaming and yelling, went into some kind of a trance.
- I will have a look at him. Get his chart, will you?
- Yes, Sir."

Here is one of the few about whom there is little doubt. An obviously immature personality. Minimal stress, progressive symptomatology. No improvement in 24 hours since admission. Unless the rear divisional area is perfectly secured, and their control is uncontested, he's not going to be of value even in a rear echelon job within the division.

"Better put him on the evacuation list.
- Yes, Sir.
- Who's that officer over there?
- That's Lieutenant Pierce. He's S1 of third bat 5th.
- Oh by the way, how is Blackie?
- He still over at the battalion CP.

- Making out OK?
- Very good.
- Morning.
- I am Lieutenant Pierce, Commander.
- Good to see you, Lieutenant. Come to visit your men?
- Yes, Sir. The colonel was wondering how they were getting along.
- How do they look to you?
- Fine, Sir. Much better than when they left.
- Yeah, I think they get along pretty well myself. Oh, by the way, I'm going up to your outfit today to see your medical officers. How about keeping me company on the way?
- Be glad to. I'll send my jeep back.
- Good. I've got some patients interview. I'll pick you up in about half an hour.
- Fine.
- Make yourself at home."

***

"Oh, hello, Walker. Come on in: I'll see you now.
Sit down, Walker."

This is the interview tent. You may not have one provided for you. Improvisations are in order. The N.P. unit must be self-sufficient and ready to move from one medical company to another within a few hours' notice. You may have to scrounge and hoard the equipment essential to your more or less independent operation.

"Pretty tense this morning, Walker. S'ppose you tell me about it?
- The damn McQuire back at the tent. He can't stop talking about it.
- About what? Combat?
- If he don't stop, I'll shoot him. So help me! Dammit you don't know what it's like out there. Nobody knows who ain't been there.
- You're right, Walker, I can't know. You live with it. Look, sometimes it helps if you talk about it. You can tell me as much or as little as you like. Come on, it may help."

Probably the chief therapeutic usefulness of the interview in combat psychiatry, lies in permitting the ventilation of feelings of terror, resentment and grief, which, if too intensely expressed in the presence of fellow patients, might create disruptive anxiety within the group. Although private interviewing is also used in some cases for the primary purpose of individual therapy, as for instance, to relieve the feelings of guilt and failure, the principal efforts of the division psychiatrist is directed toward the group as a whole.

"Is Dr. Mullen in?
- Yes, Sir, but he's busy right at the moment.
- Take a seat.
- What kind of doctor is this?

- Well, I'll tell you, fella. We've taken all kinds of x-rays, all kinds of tests. We haven't yet found out what the trouble is. Sometimes, backs like yours have to do with them nerves. And we might ask Dr. Mullen here to have a look at you and see what he thinks.
- Well, I'll see you again later, Walker.
- Yes, Sir.
- Hello, Lee.
- Hello, Sam.
- Come on in.
- Standby a moment, please.
- Now what's the orthopedic department have on its mind today?
- Oh, another back. Negative findings. Physical that it is. Probably another one for your collection.
- Sit down. I'll give you a cup of coffee. There is a cup under the desk there."

On occasion, there's lack of understanding as to the role and usefulness of the psychiatrist. He moves from one medical company to another as the tactical situation demands. And there is sometimes apprehension that the presence of his N.P. unit is going to strain existing facilities. Therefore, effort in the direction of winning friends and influencing people is sometimes necessary. Perhaps the most important area for cooperation is the so-called psychosomatic problem, as it appears in the medical, surgical and orthopedic wards. Failure to recognize N.P. cases disguised as organic disorders can result in an appreciable leakage of manpower.

"I'll have a talk with him, huh?
- Come on in, Ross. George, will you get my jeep ready? I'm shoving off for battalion in a few minutes.
- Yes, Sir."

***

"Stop again. This is a rough trip: you make it down here often?
- Well, I've got the whole division to cover. I like to get to each of the units about once a month if I can.
- That's quite a job.
- Keeps me going. You see, if I can get these battalion medical officers to spot mild N.P. cases and hold them up forward, we can bring them back to duty much faster.
- How about the men from our unit that you have, Doctor?
- Well, I think your visit was a great help to them. It's a big boost to a patient's morale when one of his officers comes to visit him. I just wish more of the line would do as you did. You see, it not only helps the patients, but it gives us a chance to find out more about them. The more we know of a patient's history, the more sure we are of what we send back to you.
- If that means getting men back to duty faster, you'll soon be overrun with companies and battalions COs. Is there much difference as to the number of N.P. casualties you receive from battalions?

- Some outfits have lower rates than others. See the number of N.P. casualties, all things being equal, is a pretty good gauge of morale and leadership.
- Here we go.
- Hold your hat."

***

- "Hi, Delaney! How are you?
- Good to see you again, Doctor.
- How things going on out there?
- Oh, pretty fair.
- Thanks for the ride, Doctor. See you later.
- Glad to have the company. Any particular problem?
- No, umm, but I have a few men to be sent down to you tonight.
- Mm, you do have a problem. Let's have a look at them.
- All right, Sir."

The newly arrived battalion medical officers are often unaware of their importance in the treatment of psychiatric casualties. They frequently evacuate men without considering the strong support the individual receives from his identification with his own fighting unit. One of the most important functions of the division psychiatrist is continuously to remind the battalion medical officers that, generally speaking, the chances of returning a man to effective duty, diminish with each successive rear-ward evacuation. Furthermore, the battalion medical officer is in a particularly influential position because he shares his men's dangers and stresses. He can talk to an emotionally disturbed man with sympathy, understanding and authority, better than any other medical officer in the division.

"How about some pinochle, Hash?
- No, I don't think so. I'm not… I'm not much at this cards playing stuff.
- Oh, you can try at least."

In the absence of the psychiatrist, his corpsmen continue to prescribe daily routine.

"How about you, Jim? Come on. Maybe later.
- That was five rounds. In the last five rounds, the guys were all around us on the switch line. And I thought we had it and all of a sudden, wham!
- Mike, come here: may I talk to you?
- Be right there, excuse me.
- Yeah, Doc?
- How about knocking it off? David's shook enough as he is now without you reminding him about it.
- Sure, Doc. Sorry I mean, I just didn't think.
- OK.

The mixing of NP casualties with other patients is desirable, but sometimes supervision is necessary.

“Sure, how about you, Ken? Play some pinochle?
- OK.
- OK, sit down. Put his name down too. Ready yet, Jim? Come on, let’s play.
- Well… OK.
- Atta boy, here, cut.”

It is impossible to overemphasize the importance of securing and keeping at least one or two intelligent, understanding and responsible corpsmen. A good one can aid you immeasurably. A bad one, by his own anxiety or hostility, can sabotage your best efforts.

“How’s that shoulder, Chris?
- Fine, Sir.
- Good. Dr. Willow will check it later on.
- Duty party, Grusack?
- Yes, Sir.
- Good.
- Hutch?
- Yes, Sir.”

Generally, it’s better practice to inform men of their impending return to duty in the presence of other patients. In private interview, men will tend to offer various reasons for delaying return to duty, leading to unprofitable discussion and possible resentments. On the other hand, few men who are actually fit for duty will firmly state their reluctance to return if buddies are listening, and especially if it’s been publicly indicated that others are going back to duty with them.

“Alright. All men for duty party muster at the adjutant’s tent at 10 hundred and get transportation to division casual for reassignment. Good luck.”

NAVY DEPARTMENT
UNITED STATES OF AMERICA
MN 7499 B
1954
THE END

“SEA POWER FOR SECURITY”

Transcript : Séléna Turquetil