

IN NEED OF MILITARY PSYCHOLOGY

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Abstract: *Military psychologists have a lot of responsibility. Their daily decisions affect individuals, families and the effectiveness of entire military units. Solid leadership skills are absolutely essential to the psychologists' ability to perform their military duties. The unique skills required of the military psychologist combine a mastery of traditional clinical psychology and an understanding of the functions and needs of the modern military. Although there are many challenges, a career in the armed forces is a very exciting and rewarding option for clinical psychologists. The hereby paper briefly describes the development of the profession of military psychology and various roles of the military psychologist through the years, starting from the Revolutionary War until the Vietnam War.*

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The History of military psychology is particularly rich and interesting. Although military history reaches back thousands of years, the history of formal military psychology is only a recent development, not even a century old. The development of psychology in the United States has had a similar growth trajectory as that of American military psychology, and it is easy to conclude that their history and growth are undeniably linked. However, the growth of military psychology has occurred in spurts, each related to the demands, psychological as well as military, of different conflicts.

Whereas formal psychology has been only recently introduced to the U.S. military, organizational, clinical, and operational psychological concepts are inextricably intertwined with the historical development of war. For example, the screening of individuals for military services and specialties has been a focus since the 1800s and has resulted in the development of the multiple aptitude and intelligent tests. Clinically, the gamut of mental disorders has been documented since the Civil War, and our understanding and ability to treat these disorders has been a major focus of military mental health professionals.

Despite the fact that the history of formalized military psychology is relatively short, its impact pervades the practice of psychology in the United States. Military psychology has evolved from very limited participation to an indispensable asset in combat readiness and policy development.

During the Revolutionary War (1775 – 1783) almost no attention was paid to the emotional toll of battle. In fact, adverse reactions to combat were often deemed a defect of character of cowardice. However, the war did see one of the first successful PSYOP (psychological operations) campaigns: the colonials distributed leaflets where they would be seen by British troops, encouraging their desertion. The leaflets advertised “seven

dollars a month, fresh provisions and in plenty, health, freedom, ease, affluence and a good farm” at Prospect Hill, but at Bunker Hill one would receive “three pence a day, rotten salt pork, the scurvy, and slavery, beggary, and want” (Walters, 1968, p. 23). The British retaliated with a propaganda campaign of cartoons, which depicted the Colonials as “a mob of cowardly, undisciplined, whiskey drinking, and mostly unkempt renegades” (Johnson, 1997, p. 9). Since then, psychological operations in the U.S. military have evolved to highly organized endeavours that have been credited for significantly influencing the outcome of war and conflict since World War II (Joint Chiefs of Staff, 2003).

During the Civil War, military medicine was in its infancy, although military physicians were responsible for the medical screening of recruits. If a physician missed an illness or failed to detect a malingered malady, he was fined (Lande, 1997), apparently because soldiers received a bonus for enlisting and occasionally would then reveal a physical illness or mental health condition to avoid service. It was during the Civil War that the first steps were taken to address the effects that combat and war had on soldiers. The concept of nostalgia was first described, and military doctors reported treating other such psychological concepts as phantom pain in amputees (Shorter, 1997), acute and chronic mania, alcoholism, suicidal behaviour, and sunstroke (Lande, 1997). Following the war, soldiers who presented themselves for mental health care were often diagnosed with chronic mania. Unfortunately, formal programs to address the veterans' problems were scant. These patients were mostly cared for at home – although at times housed in the local jail because of the lack of other appropriate means to keep them and other safe – and many were treated in insane asylum (Dean, 1997).

World War I (WWI) marked the official birth of military psychology. Specifically, in April 1917, Robert Yerkes, then the head of the American Psychological Association (APA), convened a group of psychologists, including James McKeen Cattell, G. Stanley Hall, Edward L. Thorndike, and John B. Watson. Their main purpose was to determine how psychology could help the war effort. The committee recommended that "psychologists volunteer for and be assigned to the work in which their service will be of the greatest use to the nation" (Yerkes, 1917). Committees were developed, ranging from the Committee on the Selection of Men for Tasks Requiring Special Skills to the Committee on Problems of Motivation in Connection with Military Service. On August 17, 1917, Yerkes was commissioned a major in the Army (Uhlener, 1967; Zeidner & Drucker, 1988), and by January 1918, Office of the Surgeon General (Zeidner & Drucker, 1988). Their work signified the first concerted efforts to screen military recruits and included such notable statisticians as E.L. Thorndike, Louis Thurstone, and Arthur Otis (Driskell & Olmstead, 1989).

The Army alpha (for those who were literate in English) and beta (for those who were not literate, who were literate in another language, and/or who failed alpha) intelligence tests were developed and administered to 1,750,000 men during the war (Kevles, 1968). The Army alpha evolved into the Wechsler-Bellevue Scale, the precursor to the Wechsler Adult Intelligence Scale, which is the most frequently used intelligence test today (Boake, 2002). Intelligence testing during WWI marked the first means of testing hundreds of individuals simultaneously and led Lewis Terman (1918) to emphasize the need for standardized administration of psychological tests. Intellectual testing was not the only focus during WWI. The Woodworth Personality Data Sheet, which became the model for subsequent personality assessments, was introduced at that time (Page, 1996), and Yerkes developed procedures to assess and select individuals to become officers and undertake special assignments (Zeidner & Drucker, 1988).

The success of psychological testing in WWI was the impetus for the earliest recognition of psychology as a respected field. The success of group testing had significant implications for organizations like grade schools, universities, and licensing boards. These tests also kindled the interest of private industry in search of help from psychologists with such problems as employee absenteeism, employee turnover, and ways to increase industrial efficiency (Zeidner & Drucker, 1988).

WWI also marked the creation of the specialty of neurosurgery and the means to solve the lives of American soldiers with head injuries. With these advances arose the field of cognitive rehabilitation, advocated heavily by Shepherd I. Franz, a psychologist at USGHI, whose efforts to create a rehabilitation research institute were unfortunately unsuccessful. However, Franz published manuals and books on cognitive assessment and "re-education" (Boake, 1989). Most military hospitals did provide rudimentary rehabilitation during WWI but were closed after the war because of lack of need.

Aviation psychology was born during WWI, and its major focus was on the psychological screening of pilots in order to select those most likely to successfully complete training and avoid aviation accidents (Driskell & Olmstead, 1989). Early work showed that the best candidates possessed high levels of intelligence, emotional stability (i.e. low levels of excitability), perception of tilt, and mental alertness (Koonce, 1984).

In addition to widespread intellectual testing and psychological screening, war neuroses were identified (Young, 1999). The first appropriate intervention for combat stress (i.e. shell-shock) was recognized, and the earliest cognitive restructuring techniques were documented well ahead of the development of formal cognitive theory (Howorth, 2000). Forward psychiatry was implemented, using the concept of PIE (proximity, immediacy, and expectation of recovery), and resulted in 40-80% of shell-shock cases returning to combat duty (Jones & Wessely, 2003). These early intervention principles remain the foundation of combat stress intervention today and the practice of combat stress units and platoons in all branches of service.

WWI also marked one of the first organized uses of chemical warfare, mustard gas (Harris, 2005). This gave rise to observations of "gas hysteria" and the recognition of a psychological response to threats of this nature. Lessons learned in WWI continue to guide mental health professionals in addressing the response to fears of and current terrorist threats to employ chemical and biological warfare.

This was a time of major growth for the field of psychology, the successes of which continue to have a profound impact on psychology practice today. G. Stanley Hall (1919) foretold the future when commented on the work of psychologists in WWI, noting that "only when the history of American psychology is recorded in large terms will we realize the full significance of the work."

Between 1944 and 1946, in addition to stronger organizational foundations, World War II (WWII) saw an influx of esteemed German and Jewish

psychologists to America, which served to significantly strengthen the field of psychology in the United States.

Psychologists were in high demand during WWII and worked in all branches of the military, as well as in such departments as the National Research Council, Psychological Warfare Services, Veterans Administration, and Department of Commerce (Gilgen, 1982). Work continued in psychometric testing, but a great diversification of developments and expansion in psychology occurred both during and immediately after the war. Boring (1945) published a comprehensive text on the application of psychology to the military, addressing such topics as adjustment to combat, personnel selection, morale, sexuality, and psychological warfare. He outlined seven fields of the "psychological business of the Army and Navy" (observation, performance, selection, training, personal adjustment, social relations, and opinion and propaganda; p. 3). A book was also published for military members about the application of psychological principles to enhance performance during the war (National Research Council, 1943). The Office of Strategic Services (OSS, now the Central Intelligence Agency) was developed, along with the first psychological selection program for individuals seeking positions as OSS operatives in espionage, counterespionage, and propaganda (Banks, 1995; OSS Assessment Staff, 1948). Individuals who helped to shape the field of psychology were once again employed by the military, including B.F. Skinner, who trained pigeons to guide missiles to targets prior to the existence of electronic guidance systems (Gilgen, 1982). However, Skinner did not deploy his trained pigeons because, as the bombings were essentially suicide missions for the birds, there was a moral objection (Roscoe, 1997).

Screening for military service was improved, and in 1940 the Army General Classification Test (AGCT) was developed by psychologists and introduced to measure the aptitude of recruits; it was also a means to select men for specialist courses (Zeidner & Drucker, 1988) and to become officers (Harrell, 1992). The AGCT was taken by over 12 million men for classification purposes and was valued over the intellectual testing format because of its minimization of verbal ability and the influence of formal education, its emphasis on spatial and quantitative reasoning, and its efficiency in administration (Harrell, 1992). After WWI, uniform aptitude testing in the military was mandated by the Selective Service Act of 1948, and the Armed Forces Qualification Test (AFQT) was born in 1950. Although every service branch utilized the AFQT, they also continued to use their

own screening procedures and instruments until 1968 (Defense Manpower Data Center, 1999).

Much of the improvement of classification and screening procedures was attributed to the military psychologist's opportunity to test large groups of individuals from various geographical and cultural backgrounds. This observation and subsequent recognition that tests must be interpreted differently, depending on an individual's background, were clearly documented during WWI, marking some of the first succinct reasoning for culturally fair psychological tests. An additional impact was the construction of abbreviated testing techniques, which could easily be applied in the civilian sector (Hunt & Stevenson, 1946). WWII also saw increased testing of personality, and in 1943 the Army began using experimentally a newly published test, the Minnesota Multiphasic Personality Inventory (MMPI), as a screening and selection instrument (Page, 1996; Uhlaner, 1967).

The increased emphasis on screening turned out to be a problem for those experiencing what was then identified as combat fatigue or combat stress). Because the thinking of the time was that screening would exclude those prone to the development of these problems, WWII did not utilize the lessons learned in WWI about combat stress reactions. Subsequently, little forward mental health (i.e. mental health providers in the field) was practiced, in favour of reliance on psychological screening to avoid negative psychological reactions to the war. The unfortunate result was that 40% of early discharges were attributed to combat fatigue (Neil, 1993), but it solidified the recognition by the military of the need for battlefield interventions and preparation for the psychological toll of combat (U.S. Department of the Army, 1948).

WWII saw the publication of multiple articles on malingering in order to avoid military service or discipline, then also referred to as gold-bricking, faking or the action of malingering. The attitude toward malingerers at this time is summed up by Hulett (1941), who noted that "it is indeed devastating to recognize as we must, that all men are not possessed of manhood, and that the yellow streak down the backs of some of our fellows is invisible to the unaided human eye" (p. 138). Common methods of malingering were purported to be the induction of symptoms with such substances as alcohol, epinephrine, sugar, and cathartics; claims of pain or other sensory problems (e.g. blindness); claims of motor dysfunction; feigning of insanity; self-mutilation; exaggeration of real symptoms; or refusing to get treatment for a curable condition (Campbell,

1943). Campbell noted that malingerers had psychopathic personalities and had no place in the military, with the exception of "work battalions and [being] forced to serve under strict and uncompromising discipline" (p. 354); they were the "leading pension and compensation seekers" (p. 352). Bowers (1943) noted four types of individuals with suspicious symptoms: hysteria, inadequate personality, malingering and mixed types.

During WWII, the top five mental health diagnostic categories were neurosis, personality disorder, alcoholism, epilepsy, and insanity (Stearns & Schwab, 1943). Notably, the inadequacy for military use of the existing mental health diagnostic system (Standard Nomenclature of Diseases and Operations) during WWII was a significant impetus for the development of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1952).

WWII marked the re-emergence of head injury rehabilitation on a large scale, with many of the leading psychologists later gaining prominence in the field of neuropsychology (Boake, 1989). Unfortunately, once again many of the rehabilitation centres were closed after the war, and the field did not emerge again until the late 1960s and early 1970s due to the increased number of survivors of motor vehicle accidents (Boake, 1989).

Aviation psychology continued to evolve during WWII with the development of the Army Air Force Aviations Psychology Program in 1941, the focus of which was to assist with the selection of aviation personnel (Driskell & Olmstead, 1989). In addition to the selection for such positions as pilots, navigators and bombardiers, research was also conducted on the service member-equipment relationship, particularly with the new equipment that was developed at that time (Koonce, 1984). In 1947 the Air Force became a separate branch of the military and industrial psychological research flourished in the new service (Hendrix, 2003). Following WWII, the field of aviation psychology grew dramatically, affecting practices of civilian airlines and creating new roles for aviation psychologists. These psychologists are now involved in a wide range of activities, from research and identification of individuals involved in terrorist activities to aircraft accident investigations (Koonce, 1984).

WWII was the first and only time to see the use of nuclear weapons. Survivors developed both acute and chronic psychological reactions, including withdrawal, severe fear reactions, guilt, psychosomatic symptoms, and posttraumatic stress disorder (PTSD; Salter, 2001). But going

beyond the effect that the bombings had on the people of Japan, the images from Hiroshima and Nagasaki in 1945 continue to instil fear into societies threatened with such use today. Concerns mount about the capacity of terrorists to obtain and use these weapons (Knudson, 2001). In a similar vein, WWII was known for Japanese suicide bombers, or kamikaze pilots. Kamikaze attacks accounted for a large proportion of the sailors who were wounded in action, second only to attacks that involved multiple weapons (Blood, 1992). Suicide bombers have arisen as heightened concern today, and some of the lessons learned in WWII are applicable to current terrorist bombers.

Military clinical psychology began in WWII, with the first military psychologists assigned to hospitals (McGuire, 1990; Uhlaner, 1967). Following the war, the growth of clinical psychology in the military continued. As there were too few physicians and psychiatrists to meet the emotional needs of veterans, psychologists provided both group and individual therapy in Veterans Administration (VA) facilities (Cranston, 1986). In 1946 the first psychology internship programs were established, enrolling 200 psychology interns within the VA system. These efforts resulted in increased acceptance of psychologists, not just as researchers and experts in assessment, but also as mental health providers (Phares & Trull, 1997). As after WWI, psychologists were demobilized following WWII; however, in 1947 they obtained permanent active-duty status (McGuire, 1990; Uhlaner, 1967). Two years later, the first military clinical psychology internship programs were established in the Army, one of which was at the Walter Reed General Hospital in Washington, DC.

The Korean War (1950 – 1953) saw psychologists in new positions – in service overseas, in combat zones, and on hospital ships (McGuire, 1990). The war also saw significant torture, as well as the execution of U.S. prisoners of war and gave rise to the concept of brainwashing (Ursano & Rundell, 1995). The U.S. troops were exposed to forced marches, severe malnutrition, inhuman treatment, and continuous propaganda and "re-education" or communism (Ritchie, 2002). The Korean experience prompted the military to make significant changes in survival schools.

Unfortunately, at first the principle of treating combat stress near the front line to enable military members to return to duty was not possible because of the abrupt start of the war and the lack of prepared support units (McGuire, 1990). This resulted in a rate of 250 per 1,000 troops to be declared psychological casualties. Later in the war, combat stress principles learned in previous

wars were established, and 80% (Ritchie, 2003) to 90% (Jones, 1995) of such cases returned to duty. Psychology's role in testing did not diminish during the Korean War, and the Army and Air Force published a technical manual outlining the roles of the military psychologist and proper interpretation of psychological tests (U.S. Departments of the Army and the Air Force, 1951) with such distinguished contributors as David Wechsler and Paul Meehl (Uhlener, 1967). Instruments created to select individuals for specific jobs and officer programs continued to be developed.

The Korean War was the first war in which a Bronze Star was awarded to an operational psychologist. Richard H. Blum, the first Army combat psychologist, who served in the 212th Psychiatric Battalion, earned the award for his role in the development of combat stress procedures (Stambor, 2005). Unfortunately, because of administrative issues, he was not awarded this medal until 2005.

Following the Korean War, the Army began to devote significant resources to the study of motivation, leadership, morale, and psychological warfare (Uhlener, 1967), and the concept of human systems related to military functioning increased in popularity (Zeidner & Drucker, 1988). The Air Force and Navy also created research centres concerned with what was then called human engineering. The goal toward increasing the performance of military personnel, given different equipment, various physical states (e.g., fatigue), and various environments, gave rise to increased research in human factors engineering (Roscoe, 1997; Uhlener, 1967).

After the Korean War, the Air Force implemented the Airman Qualifying Examination (AQK) in 1958 for administration to high school students. The Army and Navy shortly developed their own group ability tests, and ultimately in 1968 the Armed Services Vocational Aptitude Battery (ASVAB) was implemented to make a truly uniform aptitude tool (Defense Manpower Data Center, 1999). The ASVAB has proven to be an invaluable screening and aptitude tool for military recruits, and it has been regularly used by military

neuropsychologists over the years for assessment of head-injured service members, as its composite score is a reliable indicator of premorbid intellectual functioning (Kennedy, Kupke, & Smith, 2 (100; Welsh, Kucinkas, & Curran, 1990).

As in Korea, psychologists served in combat zones during Vietnam (1955 – 1975). Although forward mental health was practiced in Vietnam, low levels of traditional combat stress were seen. As in no other conflict before or since, however, there was an extraordinary amount of substance abuse. Also, a higher proportion of character disorders was diagnosed during the war, possibly related to the characteristics of individuals who could not avoid the draft. In other words, those with more resources remained in school or obtained exemptions to avoid military service (McGuire, 1990). In addition, the spirit of the times in the United States was highly tolerant of drug use, and this probably affected those serving in Vietnam as well. Because of the large numbers of troops who were abusing substances and who had to be medically evacuated from the theater, mandatory drug testing was implemented, as were increased opportunities for alcohol and drug rehabilitation.

Vietnam was a significantly complex war, which involved the use of weapons technologies not seen before and which could manifest significant destruction, even on the level of the individual soldier (Zeidner & Drucker, 1988). American military members faced a well-trained force and were confronted with jungle warfare, as well as horrific experiences when taken prisoner. Military rotation policies at the time dictated specific tour lengths for individuals as opposed to rotations of entire units, resulting in poor unit cohesion because of the constant arrivals and departures of personnel (Zeidner & Drucker, 1988). The attitude on the home front about the utility of the war in Vietnam was largely unsupportive of the troops. The psychological impact of all of the above is hypothesized to have resulted in high rates of posttraumatic stress disorder (PTSD), with many surviving veterans still suffering from those symptoms today.

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