
Battle Fatigue

LIEUTENANT COLONEL BRIAN H. CHERMOL

Despite the many improvements in his weapons, equipment, and tactics since World War I, the individual infantryman has changed little, either in his physical or his psychological makeup. And two truths formulated about men exposed to combat in World War I are still true today — that every soldier, at some time or other, will experience a physical or psychological reaction (or both) to combat and that every soldier has a “breaking point.”

The effects of combat stress on infantry units in battle have been documented throughout this century. In World War I, for example, the mere suggestion that the German Army was employing gas munitions in an area was enough to cause “mass gas hysteria,” rendering hundreds of soldiers temporarily ineffective, even though they were not actually exposed to gas. Medical records show that for every actual gas casualty in World War I, there were two “psychological” casualties. In World War II, which is probably a conservative model for future warfare, tremendous numbers of infantrymen became psychiatric casualties.

In World War II, as in all wars, infantry units had the highest rates of psychiatric casualties — one psychiatric casualty was medically treated for every three battle casualties (killed in action or missing in action — KIA/MIA). During the conflicts in Korea and Vietnam, the number of psychiatric casualties was relatively low, primarily because of the short combat tours, the improved logistical and medical support, the friendly air

superiority, and the low lethality of the engagements.

The term “psychiatric casualty” can refer to any number of psychological reactions to the stress of combat. These reactions can take many forms: Some soldiers suffer a recurrence of pre-existing psychotic disorders (severe emotional “breakdown” characterized by abnormal behavior, moods, and perceptions), or they have psychosomatic disorders such as diarrhea or nausea. Others unnecessarily prolong any hospitalization periods or display severe emotional reactions to bodily injuries such as facial disfiguration, for example. Still others abuse drugs or alcohol, or deliberately do not take preventive medications such as antimalaria pills. In some cases, they even inflict wounds or injuries upon themselves.

LARGEST CATEGORY

But the largest category of psychiatric casualties is “battle fatigue.” Battle fatigue (BF) is a soldier’s psychological and physical reaction to the fear and fatigue that are a part of all combat. Nearly every infantryman in a combat division, in fact, will eventually experience at least mild BF.

The symptoms of BF vary. A soldier may become increasingly emotional — crying easily, becoming irritable, using excessive profanity. Or he may experience sleep disturbances (have difficulty going to sleep or have nightmares), and exaggerated responses to

sudden nearby noises and movements. Because these symptoms are common in combat situations, they usually require no medical intervention, but the more severe forms of BF can render the infantryman ineffective, and medical intervention may then become necessary.

Battle fatigue is predictable. The number of cases varies with the intensity of the battle — the greater the number of wounded and killed, the greater the number of BF cases. BF also varies with combat exposure — the longer a unit is in continuous combat, the greater the number of BF cases. Other factors also can increase BF rates: near misses, the inability to take personal action (a unit under artillery or mortar bombardment, for example), the death or injury of friends or leaders, the anticipation of combat action, a lack of confidence in a unit or its leaders, primitive living conditions, lack of sleep and adequate nourishment, and pessimism regarding the outcome of a war or personal survival.

The effect of soldiers’ perceptions of the outcome of a war on their determination and perseverance has been demonstrated. There was a decrease in BF rates, for example, during the closing months of the successful European campaign in World War II; and there was a significant increase in BF rates after 1970 in Vietnam as support for the conflict faded.

Other factors, too, affect BF rates. The lack of effective leadership is one of them, as in World War II when similar units within the same tactical

organization had markedly different BF rates. Units with high BF rates either had poor leadership or their leaders had become battle or psychiatric casualties. Within the infantry in World War II, armored infantry units sustained the highest rate of BF casualties followed by regular infantry units, and then by such volunteer units as the airborne infantry and the Rangers. (Interestingly enough, although these volunteer infantry units had the fewest BF casualties, they sustained significantly higher battle casualty rates.)

The high BF rates among armored infantrymen can be attributed to several factors. These infantrymen resented their relative lack of mobile protection (trucks and half-tracks as compared to armored tanks); they were belittled by other infantrymen and the tankers; they had to put up with more primitive living conditions than the tankers they accompanied; and the tactical situation often required them to conduct dismounted (and unprotected) operations during the most hazardous times. (The use of armored IFVs and new tactics, along with improved enemy antitank capabilities, may equalize infantry and tanker battle losses in future conflicts, thus reducing the differences in their BF rates.)

Another factor in predicting BF rates is the type of operation. Fast moving, pursuit operations, for instance, typically produce fewer BF cases because morale tends to be high. Slow moving, high casualty-producing offensive operations against a determined enemy — such as the Army and the Marine Corps encountered in the Pacific during World War II — yield numerous BF casualties.

Retrograde operations, such as those at the beginning of the Korean war, elicited few BF cases, because the men knew that succumbing to BF would result in their death or capture. Static defenses under heavy enemy bombardment and assault, however, often produces high BF rates. Defenses that come under heavy mortar or artillery attacks with short lulls are particularly vulnerable, because

the lulls permit a soldier's imagination and anticipation to magnify his fear.

For many reasons, the battlefield of the latter part of the 20th century will be more fear- and fatigue-producing than any in World War II. That battlefield can be expected to include chemical and biological weapons that can incapacitate or kill quickly; tactical nuclear munitions that can destroy, burn, or irradiate; and laser beams that can blind or stun. In addition, the soldiers will have to wear protective clothing for long periods, and enemy anti-aircraft systems may deny air superiority to their own forces. They may have to fight throughout the day and night over long distances, relying on communication systems that can be jammed, monitored, or disrupted.

All of these factors will serve to increase the amount of psychological and physiological stress in infantry units. The ratio of BF to WIA/KIA may be as much as 1:3 or 1:2 during the initial 30 days of combat; but as sustained, high intensity combat continues, BF losses may begin to exceed battle losses until entire units are rendered ineffective.

TWO GROUPS

Battle fatigue tends to occur most commonly in two groups — men who are entering combat for the first time and those who have been engaged in sustained combat over many months. Soldiers in their initial exposure to combat will usually show the most dramatic symptoms — severe tremors and shaking, hallucinations, uncontrollable panic, crying, or stupor, and hysterical muteness, blindness or paralysis (without actual physical injury). These soldiers will need medical treatment at the battalion aid station, the brigade clearing station, or the medical support company (in the division rear). Eighty percent or more of them should be able to return to duty within a few days without further problems.

Other soldiers may experience mild

BF during the first few months they are in combat to the point that the unit commander may choose to have them temporarily perform administrative or supply duties to prevent more serious battle fatigue. Similarly, battalion medical personnel may be able to resolve many of the milder cases by simply having the soldiers sleep or perform light duty for a few days in the battalion rear or aid station area.

If combat continues for months, however, the "Old Sergeants' Syndrome" will appear. The soldiers may show apathy; slowness in thinking, responding, or moving; a lack of concern about their survival; dependence on others; confusion; mild tremors; vomiting or diarrhea; failure to eat; hypersensitivity to sounds or movements; sleep disturbances; open fearfulness; excessive smoking or noticeable reclusiveness; and depression or social withdrawal. In addition, those in leadership positions may demonstrate indecisiveness or poor judgment, or they may ask to be completely relieved of their responsibilities.

These soldiers usually respond well if they are removed from combat, but they may suffer a relapse upon returning to combat. Not surprisingly, such soldiers often occupy leadership positions in which they have demonstrated bravery under fire and have performed their combat duties conscientiously. Their problem is "burn out," and they may need more than just a few days of rest.

The initial treatment for BF of any severity typically will be accomplished in the battalion, brigade, or division rear area near a medical station and under the supervision of a behavioral science specialist NCO (MOS 91G) or a mental health officer (psychiatrist, clinical psychologist, or social worker).

Soldiers who do not recover in the division rear area within a few days will be evacuated to corps facilities. The farther to the rear a patient is evacuated, though, the less the chance for his recovery and the greater the chance of his suffering a long term psychiatric disability.

When a soldier does recover, the next problem is to re-integrate him into his parent unit. Most commanders prefer to get the recovered soldier back instead of replacing him with an inexperienced soldier. But this return is often especially difficult for certain categories of infantrymen — commanders and others in leadership positions, members of elite units, and "burnt out" soldiers. In the past the greatest success has been achieved in such cases by sending members from a soldier's parent unit to the rear to accompany him back to the unit. This demonstrates to the soldier that he is needed in the unit and is accepted by his fellow soldiers.

While not all BF can be prevented, a unit can take certain steps during mobilization and training periods and during combat to reduce its BF rates. It can train as it expects to fight, with

psychiatric casualties a part of its training scenarios. It can establish a "buddy plan" for detecting BF symptoms in its personnel and do all it can to improve unit cohesion, morale, and physical fitness. It should also provide good leadership; insure that both its soldiers and its leaders get enough rest; conduct pre-battle surveys to ascertain the unit's morale, will to fight, and confidence; and conduct post-battle group debriefings to permit its surviving soldiers to vent their feelings and develop better ways to conduct operations more effectively.

The infantry leader of tomorrow will have the technological means that will enable his unit to fight continuously both day and night over extended distances, but success on that battlefield will require him to recognize human limitations. The

challenge of closing with and destroying the enemy on the battlefield of the future is a formidable one, but one that must be met if this nation is to endure.

In the final analysis, success, as always, will depend on two factors: the ability of the infantry leader to motivate and employ his combat forces effectively, and the will of the individual infantryman to persevere in the face of hardship and danger.



LIEUTENANT COLONEL BRIAN H. CHERMOL is assigned to the Academy of Health Sciences at Fort Sam Houston. He holds a Ph.D. degree from the University of South Carolina and has served in command and staff positions with the 82d Airborne Division and in Vietnam.

Recruiting: A Dual Specialty

CAPTAIN DAVID P. MINER

One of the biggest challenges facing today's Army is the job of finding and recruiting young men and women to join it. To provide the leadership needed to meet this challenge, the Army has established a policy of assigning to the U.S. Army Recruiting Command (USAREC) only branch-qualified officers — those who have graduated from their advanced courses and normally, who have also successfully commanded units. Unfortunately, although these officers are highly qualified in their branch specialties, many are totally un-

prepared to assume their recruiting duties.

Recruiting duty is unlike any other assignment an officer will be given during his military career. In other nominative assignments, such as ROTC, Reserve liaison, or organizational effectiveness, an officer will still be surrounded by the Army's familiar support system. And he will continue to do such familiar things as teach, advise, or recommend better ways for his organization to accomplish its assigned missions.

By contrast, when he is assigned to

USAREC, the first thing an officer notices is how different the organization is from that of a division. Instead of platoons, companies, battalions, and brigades, he finds stations, areas, districts, and regions.*

At the district level, for example, a newly-assigned lieutenant colonel (the district's commander) will find a staff that is quite different from what he is

*Since this article was written, USAREC has designated its regions, districts, and areas as brigades, battalions, and companies to more closely parallel the structure of the rest of the Army.