THE GENERAL BOARD

United States Forces, European Theater

COMBAT EXHAUSTION

MISSION: To make a study of the condition known as "Combat Exhaustion" as it occurred in the European Theater of Operations and to report the procedures which were found to be most effective in its prevention and treatment and in the rehabilitation of combat exhaustion casualties after they had been discharged from medical installations.

The General Board was established by General Orders 128, Headquarters European Theater of Operations, US Army, dated 17 June 1945, as amended by General Orders 182, dated 7 August 1945 and General Orders 312 dated 20 November 1945, Headquarters United States Forces, European Theater, to prepare a factual analysis of the strategy, tactics, and administration employed by the United States Forces in the European Theater.

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SCOPE: The scope of this study is limited by the fact that combat exhaustion was not a reportable disease in the European Theater of Operations and therefore statistics necessary for a complete study are not available. The early departure from the European Theater of Operations of large numbers of experienced specialists in the field of neuropsychiatry also limited the scope of the study from the standpoint of making a thorough scientific investigation from the medical approach. The General Board is aware of the special study already made by the Special Commission of Civilian Psychiatrists and the splendid report prepared by this commission is available in the War Department. Therefore it is neither necessary or desirable for The General Board to duplicate the work previously accomplished and so ably reported upon by this special commission. The study by The General Board is made primarily for the purpose of reviewing the findings of the special commission of civilian psychiatrists and of integrating their conclusions and recommendations with those of experienced combat duty commanders, and of presenting these findings and recommendations to the War Department from the viewpoint of The General Board.

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APO 408

COMBAT EXHAUSTION

CHAPTER 1

DEFINITION AND FACTORS WHICH INFLUENCED THE INCIDENCE OF COMBAT EXHAUSTION IN THE EUROPEAN THEATER OF OPERATIONS

SECTION 1

DEFINITION OF THE TERM "COMBAT EXHAUSTION"

1. "Combat Exhaustion" is the term which has been used to describe a group of conditions which occurred chiefly among front-line troops during combat and to a lesser extent in the period immediately prior to combat. One or a combination of these conditions became evident in certain individuals when they were confronted with combat situations which were in contrast to their previous environments. It is impossible to give a clear, concise, scientific definition of the term "combat exhaustion" because the term was coined and applied primarily for psychological reasons in an attempt to fix in the soldier's mind the idea that he could be cured simply by rest.[1] Combat exhaustion has been defined as "The disorganization of the cohesive forces constituting the normal individual, produced by the stress of war, and resulting in an ineffective combat soldier. The incidence and severity of the condition are influenced by the social and psychological background of the individual, and his military training and experiences, combined with the effects of fatigue, hunger, fear and environment."[2]

2. Combat exhaustion was not considered as a reportable disease in the European Theater of Operations and therefore no exact statistics are available as to the incidence of this disease. There was a total of 102,989 neuropsychiatric casualties in the European Theater of Operations and a major portion of these were combat exhaustion cases. The majority of these casualties occurred in combat divisions. Many of these casualties were subsequently returned to duty but combat exhaustion was one of the most important causes of non-effectiveness among combat troops.[2] The condition occurred among all types of individuals and was encountered in two widely separated periods of combat.

a. That, for want of a better name, may be called the "first type" occurred among troops in combat for the first time. It usually occurred either just before actual entry into combat or during the first five days of combat. The incidence of this type was particularly high among infantry replacements who had not been thoroughly trained for their assigned tasks and who were not integrated into their unit or indoctrinated with the spirit of the unit prior to the time that they participated in actual combat.[3]

b. The "second type" occurred among the experienced battle-tested veterans who had undergone continuous, prolonged and

severe fighting. It usually began to manifest itself after a period of about four months of combat and the first indications were increased irritability, a loss of interest, decreased efficiency and carelessness on the part of the individual as to his personal safety. The second type was not as common as the first type but fewer cases of the second type were returned to duty.[4]

c. There are intermediate stages between these two types and combinations of the fatigue and fear elements have been encountered. It has been noted that individuals who have been wounded and returned to combat are particularly prone to develop combat exhaustion. Other cases have resulted from intense artillery or aerial bombardment, even though the bombardment may have lasted for only a few hours.[5]

SECTION 2

FACTORS WHICH INFLUENCED THE INCIDENCE OF COMBAT EXHAUSTION IN THE EUROPEAN THEATER OF OPERATIONS

3. In the initial phases of the invasion of the Continent of Europe, the incidence of combat exhaustion was within the expected limits. It is believed that certain individuals are not suited for the business of killing and are unable to adjust themselves to the dangers and hardships of battle. The experiences gained in the European Theater of Operations has not provided us with any method for identifying these individuals and removing them from the unit prior to the time they actually engage in combat. Certain individuals and units were subjected to unusually difficult and terrifying conditions during the initial phases of the invasion and as a result suffered many combat exhaustion casualties. These two factors accounted for the combat exhaustion that occurred in the severe hedgerow fighting just prior to and during the breakthrough at St. Lo.[3]

4. In preparation for the attacks at St. Lo, the units to be engaged in the assault were brought up to full strength with replacements. Replacements were requisitioned by the units on the basis of their MOS numbers to fill vacancies and had to be assigned to the various companies, platoons and squads as individuals on the basis of their MOS qualifications rather than as at least partially trained integrated units. Frequently there was not sufficient time to indoctrinate these replacements and to integrate them into the units. They were in dire need of the benefits to be derived from good leadership. Too many did not receive these benefits for two reasons. Some units did not have good leaders but another very important factor, unfortunately unavoidable in actual combat, is that replacements who joined a unit and were immediately sent into combat did not have the opportunity to become acquainted with and learn modern battle-lore from their non-commissioned officers and officers who were good leaders.[6]

5. Another factor in the increased incidence of combat exhaustion which occurred during the intensive action which resulted in the breakout from the Normandy beachhead was the fact that the combat units which had made the assault landings had been in continuous contact with the enemy over a prolonged period, had been engaged in severe fighting without opportunities for resting and had not achieved the expansion of the beachhead they had expected. In this period, many of the better type soldiers actually became exhausted both mentally and physically and for the first time in the

campaign considerable numbers of these individuals began to seek means of escape. Self-inflicted wounds also were encountered in appreciable numbers for the first time.[7]

6. After the breakout from the beachhead and during the pursuit of the enemy across Northern France, there was a noticeable drop in the incidence of combat exhaustion. This is attributed to the rise in morale incident to the victory, the excitement of the chase and the preoccupation of the troops with the move across France. The limited movement had been replaced with feverish activity, the fighting had decreased in intensity, the troops could see the result of their efforts and there was a feeling that the war would soon be over.[8]

7. When the advance of the Allied Forces was suspended in the vicinity of the German border, many changes took place. The troops gradually realized that the enemy had not been completely defeated and that the end of the war was not so near. The tactical situation again became static. The fighting increased in intensity. Units began to receive replacements in considerable numbers. The warm summer weather gave way to the rains, cold and snows of autumn and winter. The front occupied by the Allied Forces was very wide and in some places was thinly held. The Allied positions were not occupied in sufficient depth and there were insufficient troops to permit units to be withdrawn from contact for rest and rehabilitation. New and inexperienced divisions began to arrive direct from the Zone of the Interior without the benefits of a period of acclimatization and indoctrination in the British Isles and some of these units were short-trained. Due to the manpower shortage, most of the newly arrived units contained a high proportion of individuals who had been screened out of the units which left the Zone of the Interior earlier. The troops who had been fighting continuously all the way across France developed the feeling that they had done their part and should be afforded some relief. Combat exhaustion received considerable newspaper publicity as a source of manpower loss so that the psychological reason for using the term "combat exhaustion" was defeated since the troops became more aware of the psychiatric implications of the condition. Also the average soldier began to realize that his chances of relief from combat were limited except through medical channels. For these reasons, it can be seen that conditions were ripe for an increase in the incidence of combat exhaustion.[8]

8. The medical department realized that there was likely to be an increase in the incidence of combat exhaustion in the fighting along the German frontiers in the autumn and winter of 1944, and made preparations to care for these casualties. The medical department can not and should not be criticized for making these preparations. However, the news soon spread among the troops that they could avoid distasteful duty at least temporarily by getting into medical evacuation channels. It is very difficult under combat conditions to distinguish between malingering and mild combat exhaustion. No statistics are available but the commanders of combat units who have been interviewed are of the opinion that quite a number of troops took advantage of the opportunity afforded them by the medical department to be evacuated as combat exhaustion cases. This trend was soon recognized and appropriate measures were taken to prevent its further development.[9]

9. Trench foot began to make its appearance at about the time referred to in the preceding paragraph. It is of interest to note that as the curve showing the incidence of trench foot went up, the curve for combat exhaustion went down and at about the time of the German counter-offensive through the Ardennes the two curves crossed. Again

statistics are not available but it is the belief of combat unit commanders that the troops were taking advantage of the opportunity afforded them by the medical department to be evacuated with trench foot as a means of avoiding the hazards of combat. This trend did not develop sufficiently to be analyzed because at this time the Ardennes battle took place. This battle had several influences on the incidence of combat exhaustion. The comparatively quiet tactical situation suddenly became fluid and inactivity for a great many troops was replaced by excitement and movement. A great many atrocity stories appeared and there were stories of exceptional heroism on the part of the Allied troops. Many troops became angry with the enemy for the first time and there was a definite increase in the will to fight. Command installations for the rehabilitation of mild combat exhaustion cases and medical installations for the treatment of the more severe cases suddenly found themselves in the front lines and in some cases were overrun by the enemy. The normal chain of medical evacuation was somewhat disrupted and it became less convenient to use as a means of avoiding combat. While these factors tended to decrease the combat exhaustion rate, the very severe fighting, the inadequacy of food and clothing at times, the miserable living conditions and the physical exhaustion of many troops tended to increase the rate. As a result of these combinations of circumstances, there was no appreciable change in the overall incidence of combat exhaustion during this period.[2]

10. Early in 1945 after the Ardennes battle, there was a general regrouping and redistribution of Allied Forces, many replacements arrived from the Zone of the Interior and many new combat units also appeared in the theater of operations. The fighting for the most part was local, aimed at the seizure of limited objectives. The weather continued to be especially unfavorable both for the units in the line and for replacements and new units being processed through the ground force replacement command and the staging and assembly areas for new units. These factors tended to increase the incidence of combat exhaustion but fortunately much had been learned about its prevention by this time and corrective action was taken in all echelons to put these measures into effect. The prevention of combat exhaustion and the closely allied condition of trench foot was given considerable attention and it was emphasized that this prevention was a function of command. The importance of good leadership was stressed. It was realized that units must not only have good leaders but that newly arrived replacements must be afforded an opportunity to know and be imbued with the spirit of their leaders before they went into combat. To this end, division commanders established training centers where replacements were concentrated in division rear areas and indoctrinated with the spirit of the unit and adequately trained in the tasks they were to perform, before they were sent into combat. This system had been used with considerable success by at least one division in the early stages of the Normandy campaign. A plan was put into effect whereby ablebodied men in rear headquarters and service installations were to be trained and sent into combat units as infantrymen. The infantry soldier had long felt that he was bearing a disproportionate share of the hardships and dangers of war and this step which tended to equalize the hardships and dangers was a boost to the morale of the infantryman with long and continuous combat service. However, the wide frontage covered by our troops did not permit the desired amount of rotation of combat troops out of the line, neither was there ever devised a satisfactory scheme for relieving men with long and continuous combat duty from the front lines and assigning them to more or less permanent duties in rear areas.[2]

11. During the preparation for the spring offensive in 1945, there was a noticeable rise in morale, and a feeling of confidence

that the big push would end the war developed among the troops. The fighting during the winter months had developed good leaders who had learned more of the art of taking care of their men. Replacements had been assimilated into units and indoctrinated with the spirit of the older men. The newly arrived units had been well trained and had built up their esprit-de-corps. The medical department had increased the efficiency of its triage system for combat exhaustion casualties and medical channels of evacuation had become less accessible as a means of avoiding combat. The supply situation had improved and better clothing and food were available to the troops. With the breakthrough onto the Cologne Plain, the advance northeast along and across the Moselle River, and especially after the surprise crossing of the Rhine River at Remagen and the breakthrough into northwestern Germany by the Americans and British, the incidence of combat exhaustion began a downward trend which continued until the termination of hostilities on 9 May 1945.[2]

CHAPTER 2

PREVENTION OF COMBAT EXHAUSTION IN THE EUROPEAN THEATER OF OPERATIONS

SECTION 1

COMBAT EXHAUSTION IS TO A GREAT EXTENT PREVENTABLE

12. Combat exhaustion is to a great extent preventable as has been proven in the European Theater of Operations by such units as the 2 Cavalry Group. It is very important that the occurrence of this condition be prevented. It is much easier to prevent the development of the condition than it is to treat the casualties after they have developed combat exhaustion.[10, 2]

SECTION 2

METHODS USED FOR THE PREVENTION OF COMBAT EXHAUSTION IN THE EUROPEAN THEATER OF OPERATIONS

13. The application of the principles of good leadership was the most effective method for the prevention of combat exhaustion. It is not the purpose of this paper to define or discuss leadership but rather to show how leadership can and did result in a lowering of the incidence of combat exhaustion in the European Theater of Operations. Too often the failure of some one individual leader has been blamed for the high incidence of combat exhaustion in a unit. In order to prevent combat exhaustion, there must be a continuous chain of good leaders throughout the several echelons of command who are cognizant of their responsibilities.

14. Unit spirit (esprit-de-corps) is closely related to good leadership, the former being to a great extent dependent upon the latter, and is equally as important as good leadership in the prevention of combat exhaustion. Human beings are so constituted that they have a need of feeling that they as individuals are important parts of a group. The regimental organization is especially well suited for the development of this group spirit. In addition to the group

spirit, the regiment can take advantage of its history, prestige, traditions and symbols and by fostering faith in its leadership can achieve a cohesive unit, the members of which will seldom, if ever, develop combat exhaustion. Many little things contribute immeasurably towards the development of this unit spirit. Examples are: the wearing of shoulder patches and regimental insignia; a neat, but serviceable, combat uniform which the soldier is permitted and proud to wear when he visits rear areas; the staging of frequent dress parades with martial music and the display of national and regimental colors while training or resting in rear areas; and the practice of shaving daily even under the most adverse combat conditions.[10]

15. The relief of units from the line for short periods of rest and rehabilitation not only affords the individual an opportunity to rest and thereby prevents mental and physical exhaustion but it fosters within the soldier's mind the idea that his leaders are concerned about his welfare; and such relief is one of the most important factors in promoting morale. These periods of relief should not be of too long a duration and after the troops have had sufficient time to relax and rest mentally and physically they should be provided a well organized military training program together with recreation and entertainment, which will prevent them from becoming morose and from having time to develop a sense of self-pity. A continuous effort must be made to avoid boredom.[10]

16. The rotation of individuals with long and continuous combat service to more or less permanent assignments in rear areas or in the Zone of the Interior was not practiced to any appreciable extent by the Field Forces in the European Theater of Operations. This system was put into effect for flying personnel by the Army Air Forces. The infantry soldier knew that air crews were rotated to the United States after they completed a certain number of missions and he resented very strongly the fact that the only way he could get relief from combat was to be killed, wounded or taken prisoner. He felt that it was unjust for many able-bodied individuals to be permanently assigned to safe and comfortable positions in higher headquarters and rear area service installations while he had to continue on indefinitely in his combat assignment. After a period of 90 to 120 days of continuous combat, many front-line soldiers became obsessed with this idea and many cases of combat exhaustion could have been prevented if there had been a policy of permanent rotation for these individuals after a certain number of continuous or cumulative days of combat.[11]

17. A great deal of emphasis has been placed upon the importance of screening to eliminate from combat units those individuals who were not suited for combat duty. It is believed that too much emphasis has been placed upon this subject. It should be emphasized that the experiences in the European Theater of Operations have developed no method which enables one in a majority of instances to determine in advance who will be the most effective fighters, although it is undoubtedly true that the methods of personality scrutiny used at induction centers did eliminate a large number of individuals unfit for military service because of severe intellectual and emotional limitations and defects.[11]

18. Maintenance of a high order of discipline is essential in the development and maintenance of an effective fighting force. The discipline of a national army (such as the American Forces in the European Theater of Operations) in a general mobilization is very different from the discipline of the professional soldiers in the days of von Clausewitz. The discipline maintained by good leaders in units of the United States Forces in the European Theater of Operations was a

discipline from within, (the discipline of persuasion) rather than a discipline from without (the discipline of punishment). The good leader had faith in human nature. He knew his men, he was their friend, he insisted that they be treated as human beings, he looked after their wants, and he was firm but just in his dealings with them. Military discipline is defined in Field Manual 21-50 as "The prompt, intelligent, willing, and cheerful obedience to the will of the leader. Its basis is the voluntary subordination of the individual to the welfare of the group. It is the cementing force which binds the members of a unit; which endures after the leader has fallen and every semblance of authority has vanished -- it is the spirit of the military team." Units which maintained this type of discipline had a low incidence of combat exhaustion.[10]

CHAPTER 3

TREATMENT OF COMBAT EXHAUSTION IN THE EUROPEAN THEATER OF OPERATIONS

SECTION 1

TREATMENT AT THE DIVISION LEVEL

19. In the early days of combat in the European Theater of Operations, it was recognized that cases of combat exhaustion which were evacuated to medical installations in the Communications Zone were very difficult to treat and rehabilitate. In an effort to prevent the evacuation of combat casualties any further to the rear than was necessary a great deal of emphasis was placed upon treatment in the forward areas. Actually very little treatment ever was performed in battalion aid stations but a great deal of energy was expended in an attempt to have combat exhaustion casualties treated at this level. In retrospect, it is believed that a more conservative policy in reference to treatment in the forward (battalion aid station) areas would have been more effective. Before continuing this discussion of treatment, it is desired again to emphasize the importance of prevention rather than treatment. Treatment at the battalion aid station level is so closely related to prevention that it is hard to make a distinction. The battalion surgeon should and usually did know the men in his battalion. He frequently was the first officer to become aware of the early symptoms of combat exhaustion in the men of his battalion. Usually individuals with impending or sub-clinical cases of combat exhaustion would consult the battalion surgeon in the battalion aid station. A good drink of whiskey, hot drinks and warm food and perhaps a mild sedative, plus a few reassuring words from the battalion surgeon, followed by a few hours of sleep either in the battalion aid station or in the vicinity of the battalion command post frequently would suffice to restore the individual to full duty. It is a matter for academic debate as to whether this should be called definitive treatment or whether it is prevention. The battalion surgeon is at times confronted by malingerers. He may or may not be able to differentiate between malingerers and true cases of combat exhaustion. One of his most important duties is to direct every effort towards making this differentiation and to insure that malingerers do not get into medical channels of evacuation. When the battalion surgeon is confronted by a clear-cut case of combat exhaustion which can not be restored to duty by a drink of whiskey, a mild sedative and a few hours rest, he has no other alternative but to evacuate him to the

rear through medical channels. It is believed that the functions of the battalion surgeon as outlined above have not been set forth clearly in directives from higher headquarters in the European Theater of Operations. It is also believed that the battalion surgeon can not do more than carry out the procedure outlined above.[12]

20. The regimental surgeon and the regimental aid station are not normally considered as a link in the chain of evacuation from the battalion aid station to the division clearing station. It has been the experience of several regimental surgeons in the European Theater of Operations that the regimental aid station can be used effectively as a triage point for a more careful investigation of cases suspected of malingering and as a regimental rest area for the definitive or prophylactic treatment of mild cases of combat exhaustion. The battalion surgeon knows the men in his battalion and is in a better position to judge them and thereby effect careful triage, but the conditions under which he normally operates, at times tend to preclude his doing so. The medical officers in the division clearing station do not know the members of the division as individuals and are prone to treat them as "just another case of combat exhaustion". Midway between the battalion surgeon and the division clearing station is the regimental surgeon who, to a certain degree, is familiar with the men in his regiment and it is believed that the regimental aid station can properly be used as a triage point and as a regimental treatment center for mild cases of combat exhaustion.[5] Commanders of combat units have stated that division neuropsychiatrists in several instances have not appreciated the viewpoint of regimental and battalion commanders. There has been a tendency for division neuropsychiatrists to consider the occurrence of combat exhaustion in an individual as a definite indication that the individual is mentally abnormal. Even though this thesis may be sound from the standpoint of the neuropsychiatrist, such a procedure for the handling of combat exhaustion casualties makes it more difficult for regimental and battalion commanders to administer military justice in their respective organizations. It is believed that the mission of the division neuropsychiatrist could have been accomplished in a manner more satisfactory for all concerned had young, general duty, medical corps officers been given special training in neuropsychiatry and assigned as division neuropsychiatrists and had the neuropsychiatrists with considerable training and experience been used exclusively to the rear of division clearing stations.[1,2,9]

21. At the division clearing station medical officers are confronted with battle casualties with a variety of wounds and injuries. These casualties will die or suffer unnecessarily unless they are given prompt and adequate care. At the division clearing station medical officers are also confronted with the physically sick, who either have to be evacuated or who require rest, nursing care and minor treatment. It is only natural that these medical officers engaged in the treatment referred to above should be somewhat hesitant to undertake the diagnosis and treatment of combat exhaustion cases, the nature of which the average medical officer does not thoroughly understand and for the treatment of which he has received little or no special training. It is for these reasons that the divisions in the European Theater of Operations established a triage and treatment center, staffed by the division neuropsychiatrist and his enlisted assistants (tables of organization did not provide for these enlisted assistants) in conjunction with the division clearing station. In such triage and treatment centers capable division psychiatrists were able to perform careful triage of combat exhaustion cases and to prevent the evacuation from the division of some of the mild cases which could be returned to duty in a few days. These mild cases were given sedatives and afforded an opportunity to rest and after they had rested they

were treated by psychotherapy, but many of them (mostly newly joined replacements) were not ready for immediate return to duty. Such cases were transferred to a division rehabilitation center operated by line officers under command supervision, where they underwent a period of indoctrination and training and from where they were returned to their battalion for full military duty. This form of treatment did much to prevent the development of chronic neuropsychiatric disorders and was a deterrent to those individuals who otherwise might have used medical channels of evacuation as a method of avoidance of duty. Cases of combat exhaustion which could not be transferred to the division rehabilitation center within a period of three to five days were evacuated to army medical installations.[2]

SECTION 2

TREATMENT AT THE ARMY LEVEL

22. The army medical installation which serves as the link in the chain of evacuation between divisions and the general hospitals of the Communications Zone is the evacuation hospital. The conditions which have been described in paragraph 20 as prevailing in the division clearing station were also encountered in evacuation hospitals. It was soon learned that when combat exhaustion casualties were processed through the normal chain of evacuation that they either interfered with the missions of the evacuation hospitals in caring for surgical casualties or that proper triage and treatment of the combat exhaustion casualties were not obtained. For this reason, the several armies in the European Theater of Operations established medical installations for the primary purpose of sorting and treating cases of combat exhaustion. These centers were called by various names in the several armies. Since there was no table of organization for such a unit, companies of medical gas treatment battalions, evacuation hospitals, clearing companies and combinations of clearing companies, collecting companies and field hospitals were utilized for this purpose. These installations were staffed by pooling the neuropsychiatrists from the various army medical units. Combat exhaustion casualties were segregated in these centers where the hospital atmosphere was avoided as much as possible. This encouraged rapid recovery and obviated the impression on the part of the casualty that he was suffering from a serious or incurable illness. It avoided the possibility of "infecting" non-psychiatric casualties as would have occurred had they been treated in the evacuation hospitals. It relieved evacuation hospitals of the burden of this specialized type of treatment. It made it possible to maintain an efficient and standard form of treatment and simplified the control of patient disposition. Casualties which could not be returned to duty from army neuropsychiatric centers within a reasonable length of time (this length of time depended upon the tactical situation) were evacuated to the Communications Zone. The disposition of casualties which were recommended for limited duty presented a difficult problem which was never satisfactorily solved. If the neuropsychiatric cases were recommended for limited duty at the army level, it was necessary for them to be transferred to a hospital in the Communications Zone for further administrative procedures before they could be reassigned. If such cases could have been reclassified within the army and sent directly to reinforcement centers for reassignment, in most instances, excessive hospitalization, reduplication of work and a needless occupancy of bed space in Communications Zone installations would have been avoided and the fundamental therapeutic aims facilitated.[3]

SECTION 3

TREATMENT IN THE COMMUNICATIONS ZONE

23. The treatment of combat exhaustion casualties in the Communications Zone in the European Theater of Operations varied considerably from time to time and was dependent upon the tactical situation, the procedures employed by the armies and facilities available in the Communications Zone. Prior to the establishment of the army neuropsychiatric treatment centers, a relatively large number of minor cases of combat exhaustion were evacuated to the Communications Zone. The fact that the casualty had arrived in a general hospital tended to fix in his mind the idea that he was suffering from a serious condition and such cases were very difficult to treat. Later on during the campaign, when the armies effected more efficient systems of triage, the relatively large number of mild cases reaching the Communications Zone decreased considerably. With the establishment of hospital centers in the Communications Zone, it was possible to pool the neuropsychiatrists from the several general hospitals in the center in one general hospital which was designated to receive all combat exhaustion casualties arriving in the hospital center. This procedure was very effective in facilitating the treatment and control of such cases and in general was quite satisfactory. Following the advance across Northern France and at the time when general hospitals were being set up in the Advance Section of the Communications Zone, a general hospital which had been organized in the United Kingdom for the specialized treatment of neuropsychiatric conditions was established in the Advance Section of the Communications Zone at Ciney, Belgium. Unfortunately, the Ardennes battle occurred soon after this hospital was established and the German advance was halted on the grounds of this hospital plant, necessitating the evacuation of the hospital. This disruption of the functioning of this hospital prevented a full evaluation of the benefits that could be derived from its employment. However, the results obtained during the limited operation of the specialized neuropsychiatric general hospital showed that about 90 percent of the cases were returned to duty while only approximately 75 percent of the total cases evacuated to the Communications Zone were reported to have returned to duty. There are no reliable statistics to show what proportion of the total number of cases returned to duty were returned to front-line combat duty but of the 819 cases returned to duty from one general hospital which specialized in the treatment of neuropsychiatric conditions only eight and three tenths percent (8.3%) were returned to full combat duty.[2]

24. Following the treatment of combat exhaustion casualties in Communications Zone hospitals, the casualties required a period of rehabilitation before being returned to full duty. Experience in the European Theater of Operations has shown that centers established for the purpose of providing this rehabilitation should be separate and distinct from hospitals, should be in the hands of line officers who understand the patients' conditions and motivating factors and the "trainees" in these centers should be kept busy in some useful occupation in order to avoid boredom. Boredom in such a center is one of the principal factors in lowering morale and in causing a recurrence of the neuropsychiatric condition. Rehabilitation centers should be authorized a staff sufficiently large to enable them to efficiently perform their missions. In the experiences of the Army Air Forces it has been found that the proportion of one staff member for each trainee can be used to advantage. It is the opinion of The General Board that a smaller staff could probably function satisfactorily. The staff should be permanent and it is believed that the best source of personnel for this staff is combat casualties who have recovered from their wounds and who have been classified as limited service.

It is recommended that combat exhaustion casualties not be assigned as members of the staff. However, all members of the staff should have had actual combat experience in order to understand the problems of the "trainees". Although the rehabilitation center should be separate from medical installations, the service of a qualified neuropsychiatrist is required to coordinate and supervise the program. The rehabilitation center must also be kept separate from reinforcement depots because the "trainees" in the centers tend to overemphasize their experiences and invariably adversely effect the morale of the reinforcements.[2]

CHAPTER 4

CONCLUSIONS

25. The members of the Medical Section of the Theater General Board are familiar with and have studied at some length the "Report of the Special Commission of Civilian Psychiatrists Covering Psychiatric Policy and Practice in the US Army Medical Corps, European Theater, 20 April to 8 July 1945" and concur in the findings and recommendations of this special commission of civilian psychiatrists. The conclusions and recommendations in this report are made for the purpose of presenting the information from the viewpoint of The Theater General Board, United States Forces, European Theater.

26. Combat exhaustion was one of the major causes of non-effectiveness among combat troops in the European Theater of Operations. For a considerable period of time too much emphasis was placed upon it as a cause for evacuation.

27. The incidence of combat exhaustion varies with the tactical situation, the quality of leadership, the state of discipline, the morale of the troops, the method of processing replacements, the weather, the state of training and the length of time that the troops have been in combat.

28. Combat exhaustion is to a great extent preventable and emphasis should be placed on prevention rather than on treatment.

29. A number of effective methods were used for the prevention of combat exhaustion in the European Theater of Operations with varying degrees of success, depending principally upon the force of application and the military exigencies of local situations. They were:

a. The application of the principles of good leadership.

b. The maintenance of unit spirit and esprit-de-corps.

c. Periodic relief of front-line troops for rest and rehabilitation.

d. Rotation of individuals from combat units to assignments in rear areas or the Zone of the Interior.

e. Indoctrination and training of replacements and their assimilation into the unit prior to entry into combat.

f. The maintenance of a high state of discipline.

g. Screening for the purpose of eliminating those individuals with mental and physical defects.

CHAPTER 5

RECOMMENDATIONS

30. It is recommended that the use of the term "combat exhaustion" forward of the army rear boundaries be continued but that all casualties that are evacuated to general hospitals in the Communications Zone be given individual and scientific diagnoses.

31. All echelons of the medical service must be "combat exhaustion conscious" and careful triage must be performed in each echelon for the purpose of preventing the evacuation of combat exhaustion casualties any further to the rear than is necessary.

32. Separate facilities for the triage and treatment of combat exhaustion casualties should be available at the regimental level, the division level, in the army and in the Communications Zone.

33. Facilities for rehabilitating combat exhaustion casualties when they are discharged from medical installations should be available at the division level, at the army level and in the Communications Zone. It should be possible for army medical installations to discharge combat exhaustion casualties to the army rehabilitation center and the army rehabilitation center should be able to reclassify these individuals and get them back into the reinforcement "pipeline" without having to send them to a Communications Zone installation back of the army rear boundary.

34. Young, general duty, medical corps officers should be given special training in practical neuropsychiatry (with special emphasis on combat exhaustion and neuropsychiatric reactions in war) and should be assigned as division neuropsychiatrists. Older medical officers with considerable training and experience in the field of neuropsychiatry, unless they are especially suited for duty with combat units, should be employed exclusively in assignments in rear of division clearing stations.

BIBLIOGRAPHY

1. Personal experiences of Members of the Committee.

2. Interview with Lieutenant Colonel Joseph S. Skobba, 0313015, Consultant in Neuropsychiatry, Office of the Chief Surgeon, Theater Service Forces, European Theater.

3. Report of the Division Neuropsychiatrist, 1 Infantry Division.

4. Report of the Division Neuropsychiatrist, 8 Infantry Division.

5. Report of the Division Neuropsychiatrist, 29 Infantry Division.

6. Interview with the Surgeon, 4 Infantry Division.

7. Interview with the Surgeon, VII Corps.

8. Reports of the Surgeons, First US Army and Third US Army.

9. Interview with Chief of Staff, 29 Infantry Division.

10. Interview with the Commanding Officer, 2 Cavalry Group.

11. Report of Commission of Civilian Psychiatrists.

12. Manual of Therapy, Office of the Chief Surgeon, European Theater of Operations.