

CHAPTER 5

BATTLE FATIGUE**5-1. Introduction**

Battle fatigue is the approved US Army term (AR 40-216) for combat stress symptoms and reactions which—

- Feel unpleasant.
- Interfere with mission performance.
- Are best treated with reassurance, rest, replenishment of physical needs, and activities which restore confidence.

a. Battle fatigue can also be present in soldiers who have been physically wounded or who have nonbattle injuries or diseases caused by stressors in the combat area. It may be necessary to treat both the battle fatigue and the other problems.

b. Battle fatigue may coexist with misconduct stress behaviors. However, battle fatigue itself, by definition, does not warrant legal or disciplinary action.

c. Several of our allies use other terms for battle fatigue such as combat reaction, combat stress reaction, or battle shock.

5-2. Contributing Factors Which Cause Battle Fatigue

There are four major contributing factors which cause battle fatigue. They are—

- Sudden exposure.
- Cumulative exposure.
- Physical stressors and stress symptoms.

- Home front and other existing problems.

Any one factor may suffice if intense enough. Usually two, three, or all four factors can collectively produce battle fatigue.

a. The first factor is the sudden exposure or transition to the intense fear, shocking stimuli, and life-and-death consequences of battle. This occurs most commonly when soldiers are committed to battle the first time but can happen even to veteran soldiers when they come under sudden, intense attack. Soldiers in “safe” rear areas may be overwhelmed by the horrible stimuli and consequences of war without themselves being under fire. This is an occupational hazard for rearward command and support personnel, including medical.

b. The second factor is the cumulative exposure to dangers, responsibilities, and horrible consequences. Exposure can cause repeated grief and guilt over loss of fellow soldiers. It can also give the sense that one’s own luck, skill, and courage have been used up. The rate of accumulation depends on the rate of losses (KIA, WIA, died of wounds [DOW], and other causes) and of “close calls” with disaster and death (including being wounded oneself). Periods of rest, recreation, and retraining in which new supportive, cohesive bonds are formed may temporarily reverse the accumulation but not stop it completely.

c. The third factor is the physical stressors and stress symptoms which reduce coping ability. Sleep loss and dehydration are especially strong contributors. Also important are physical overwork, cold, heat, wetness, noise, vibration, blast, fumes, lack of oxygen, chronic discomfort, poor hygiene, disrupted nutrition, low-grade fevers, infections, and other environmental illnesses. These stressors are also in the

area of responsibility of preventive medicine. In moderate amounts, such physical stressors contribute to battle fatigue but are reversed by rest and time for restoration. In higher doses, they cause serious illness or injury requiring specific medical or surgical treatment. When the major contributing factors to battle fatigue are physical stresses that can be reversed, treatment is usually simple and recovery is rapid. However, physical factors are not necessarily the cause of battle fatigue. When the soldier is diagnosed, the absence of obvious physical stressors should not detract from the positive expectation of rapid and full recovery.

d. The fourth factor is the home front and preexisting problems.

(1) Israeli studies found that the strongest factor which distinguished between soldiers who were decorated for heroic acts and those who became battle shock casualties was having had many recent changes on the home front. The negative home front problem may be a "Dear John" letter, a sick parent or child, or bad debts. Or it may be something positive—being recently married or becoming a parent. Worrying about what is happening back home distracts soldiers from focusing their psychological defenses on the combat stressors. It creates internal conflict between performing their combat duty and perhaps resolving the home front problems or concerns.

(2) The second strongest factor found in the Israeli studies was unit cohesion: the soldiers who became stress casualties were often committed to battle alongside strangers, while those who became heroes were alongside unit members they knew well, trusted, and depended on. These findings confirm observations from previous wars. Other baseline stressors which are often cited include lack of information; lack of confidence in leaders, supporting units, or equipment in comparison

with the enemy's; and lack of belief in the justness of the war (which may reflect lack of support for the effort in the US).

(3) It is worth noting that individual personality makeup does not predict susceptibility to battle fatigue. Careful studies by the US Army after WWII and by the Israelis since the Yom Kippur War all show that there is no clear relationship between neurotic traits or personality disorders and battle fatigue. People with these traits were no more likely to become battle fatigue casualties and no less likely to be decorated for valor than were those soldiers who tested as normal.

(4) There are personality factors which may predict who will be poor soldiers (or who may be prone to commit acts of misconduct if given opportunities or excuses to) but not who will get battle fatigue. There are good predictors of battle fatigue but individual personality type is not one of them. Anyone may become a battle fatigue casualty if too many high-risk factors occur. However, personality factors may help predict who is less likely to recover quickly after being disabled by battle fatigue.

e. There are two common themes which interact in varying combinations in most battle fatigue casualties—loss of confidence and internal conflict of motives.

(1) Battle-fatigued soldiers have often lost confidence in—

- Themselves—their own strength, alertness, and abilities, or the adequacy of their training.
- Equipment—their weapons and the supporting arms.
- Buddies—other members of the small unit, or in the reliability of supporting units.

- Leaders, to include—
 - The skill and competence of the small unit leader or the senior leadership.
 - Whether the leaders care about the soldiers' well-being and survival.
 - The leader's candor (honesty) or courage.

These doubts, plus the soldiers' estimate of the threat situation, raise questions about their chances of surviving and/or of succeeding with the mission. Loss of faith in whether the "cause" is worth suffering and dying for also plays a role. It has been said that soldiers join the military services for patriotism, but they fight and die for their buddies and trusted leaders. Soldiers do not want their comrades or themselves to die for an unjust cause or for other's mistakes. Loss of faith may even spread to a painful loss of belief in the goodness of life and other spiritual and religious values.

(2) Combat, by its nature, creates conflicts between motives within an individual. The desire for survival and comfort is in conflict with the fears of failure or disgrace and the soldier's loyalty to buddies. Leaders' actions must—

- Raise the soldiers' confidence.
- Help resolve the soldiers' internal conflict in favor of his sense of duty.

5-3. Signs/Symptoms of Battle Fatigue

a. *Simple Fatigue.* The simple fatigue or exhaustion form of battle fatigue is normally the most common. It involves tiredness, loss of

initiative, indecisiveness, inattention, and, when extreme, general apathy. These cases may show some features of the other forms, especially anxiety and pessimism, but not to the degree that they cannot rest and recover in their own unit (duty) or in a nonmedical support unit (rest). However, the tactical situation may call for them to rest in medical cots if no other suitable place is practical.

b. *Anxious.* The anxious form is naturally one of the most common, given the danger of combat. Symptoms include verbal expressions of fear; marked startle responses which cease to be specific to true threat stimuli and become generalized; tremor; sweating; rapid heartbeat; insomnia with terror dreams, and other symptoms of hyperarousal. This form is often seen while the soldier is close to the danger and shifts to the exhausted or depressed forms as he is evacuated towards the rear.

c. *Depressed.* The depressed form is also common. It may have the slowed speech and movement of the simple fatigue form or the restlessness and startle responses of the anxious form. The depressed form also has significant elements of self-doubt, self-blame, hopelessness, and may include grief and bereavement. The soldier may be pessimistic about the chance for victory or survival. The self-blame and guilt may be about perceived or actual failures in the combat role or mistakes made. It may be related to home front issues. Or it may be relatively pure survivor guilt—the irrational feeling of a survivor that he should have died with members of his unit or in place of a buddy.

d. *Memory Loss.* The memory loss form is usually less common, especially in its extreme versions. Mild forms include inability to remember recent orders and instructions. More serious examples are loss of memory for well-learned skills or discrete loss of memory for an especially traumatic event or period of time.

Extreme forms include disorientation and regression to a precombat (for example, childhood) state. Total amnesia, or a fugue state in which the soldier leaves the threatening situation altogether, forgets his own past, and is found wandering somewhere else (having taken on another superficial identity), can also occur. Physical causes of amnesia such as concussion or substance misuse (for example, alcohol) must be ruled out in such cases.

e. Physical Function Disturbance.

Disturbance of physical function includes disruptions of motor, sensory, and speech functions. Physical injuries or causes are absent or insufficient to explain the symptoms.

- Motor disturbance includes—
 - Weakness or paralysis of hands, limbs, or body.
 - Sustained contractions of muscles (for example, being unable to straighten up or to straighten out the elbow).
 - Gross tremors; pseudo-convulsive seizures (sometimes with loss of consciousness).
- Visual symptoms may include—
 - Blurred or double vision.
 - Tunnel vision.
 - Total blindness.
- Auditory symptoms may involve—
 - Ringing (or other noises) in the ears.
 - Deafness.
 - Dizziness.

- Tactile (skin) sensory changes include—
 - Loss of sensations (anesthesia).
 - Abnormal sensations, such as “pins and needles” (paresthesia).
- Speech disturbance may involve—
 - Stuttering.
 - Hoarseness.
 - Muteness.

(1) The physical symptoms often begin as normal but transitory incoordination, speech difficulties, or sensory disruption. These symptoms are triggered by physical events, such as explosions, mild concussion, or simple fatigue. They are magnified when emotions cannot be expressed because of social pressure or heroic self-image. They are, therefore, most often seen in the “elite” units or groups who show few other cases of battle fatigue, such as officers or the airborne and rangers in WWII. They are also more common in individuals from social classes and cultures that receive less education and/or do not learn how to express feelings in words.

(2) In some cases, the physical “disability” may have a clear symbolic relationship to the specific emotional trauma or conflict of motivation which the soldier has experienced. The disability may make the soldier unable to do his job and so relieve him from danger, such as classic “trigger-finger palsy.” The symptoms may be reinforced by reducing his anxiety and eliminating internal conflict of combat duties. Symptoms also may be reinforced by receiving the relative luxury of rear area food, hygiene, and sleep. However, not all cases fit that pattern.

Some soldiers with significant loss of function from battle fatigue have continued to perform their missions under great danger. Medical personnel must be alert to new physical forms of battle fatigue which mimic physical injury, such as might be attributed to lasers, radiation, or chemical agents.

f. Psychosomatic Forms. These psychosomatic forms of battle fatigue commonly present with physical (rather than emotional) symptoms due to stress. These include—

- Cardiorespiratory—
 - Rapid or irregular heart-beat.
 - Shortness of breath.
 - Light-headed.
 - Tingling and cramping of toes, fingers, and lips.
- Gastrointestinal—
 - Stomach pain.
 - Indigestion.
 - Nausea/vomiting.
 - **D i a r r h e a .**
- Musculoskeletal—
 - Back or joint pain.
 - Excessive pain and disability from minor or healed wounds.
 - Headache.

According to some WWII battalion surgeons, the psychosomatic form of battle fatigue was the most

common form seen at battalion level. This type of case may have accounted for a large percentage of all patients seen at battalion aid stations (BASs) during times of heavy fighting.

g. Disruptive Forms. Disruptive forms of battle fatigue include disorganized, bizarre, impulsive or violent behavior, total withdrawal, or persistent hallucinations. These are uncommon forms of battle fatigue, but they do occur. Battle fatigue symptoms are a nonverbal way for soldiers to communicate to comrades and leaders that they have had all they can stand at the moment. Battle fatigue takes on whatever form the soldiers expect. It is important, therefore, to create positive expectancies and to eliminate the belief that battle fatigue soldiers usually do crazy, senseless, or violent things. Leaders, medics, and combat stress control personnel must ensure that battle fatigue casualties are never referred to as psychiatric casualties.

5-4. Labeling of Battle Fatigue Cases

a. As stated earlier, battle fatigue is the US Army approved label for this condition. Fatigue implies that it is a normal condition which can occur in anyone who is subjected to the extreme mental and emotional work of combat missions. Fatigue also implies that it gets better quickly with rest. The term should be applied to the normal but uncomfortable reactions to combat stress. It should also be used with the more seriously impairing responses in order that it not take on the connotations of breakdown or a release from duty. However, some cases do require treatment in medical facilities, skilled counseling, and even brief tranquilizing or sedative medication.

b. Historical experience proves that it is important not to try to make early distinctions among battle fatigue cases based on presumed causes and likely response to treatment. Cases

due to acute emotional stress versus subacute physical stress versus chronic cumulative stress may need somewhat different treatment. These cases have, on the average, different likelihood for successful return to duty. However, these battle fatigue cases may be quite impossible to distinguish at first by their appearance and symptoms. Accurate individual history may be unattainable during battle and especially during the first interviews. All cases should, therefore, be called battle fatigue and be treated immediately with positive expectation of rapid, full recovery, as close to their units as the tactical situation permits. It is essential to avoid dramatic or medical/psychiatric labels for this condition.

CAUTION

Do not prejudge whether a battle fatigue soldier will recover quickly or slowly based on initial appearance. The symptoms are very changeable. Do not rely on initial information about the relative contributions of acute emotional stress, physical fatigue, chronic exposure, or baseline factors. The incomplete history may be misleading.

- (1) Consider each contributing factor in designing treatment.
 - (a) How to reassure.
 - (b) How much rest.
 - (c) What to replenish first and most.
 - (d) What activities to assign to restore confidence.

- (2) Keep positive expectation for recovery.

- (3) Get more validated information from the rested soldier and the unit.

- (4) Revise the plan based on response to treatment.

c. Battle fatigue may occur in anticipation of the action, during the action, or after the action (during lulls when sick call is again possible or when the unit returns to a safe rear area). Usually, the rise in battle fatigue casualties is preceded by 1 to 3 days of increases in the number of soldiers wounded and killed. All of these cases are still called "battle fatigue" as long as the soldiers are in the theater of operations and are expected to recover and return to duty. The terms *conflict fatigue*, *crisis fatigue*, *stress fatigue*, or *field fatigue* may be used for peacetime cases which are reactions to intense mission stressors but do not involve actual battle or life-and-death consequences. These cases should be treated the same way as battle fatigue with no negative connotations.

d. Sublabeling of battle fatigue cases is based solely on where they can be treated. Hence, sublabels depend as much on the situation of the unit as on the symptoms shown by the soldier. The labels *light and heavy*, *duty and rest*, *hold and refer*, when added to the label *battle fatigue*, are nothing more than a short-hand or brevity code for saying where the soldier is being treated or sent. They have no other meaning and only transient significance. The sublabel should be updated as the soldier improves or arrives at a new echelon of care.

e. Figure 5-1 diagrams the choices that lead to the several sublabels for battle fatigue cases.

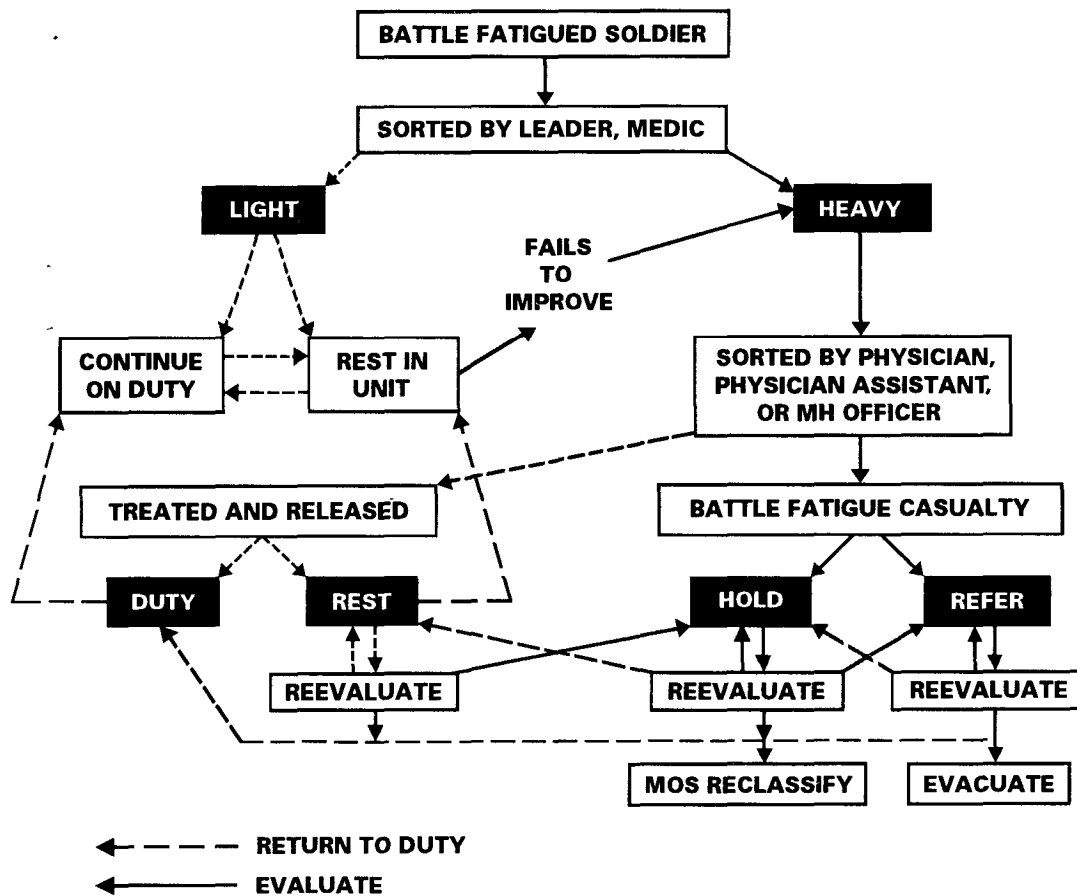


Figure 5-1. Diagram of sorting choices and labels for battle fatigue cases.

(1) Light battle fatigue can be managed by self and buddy aid, unit medics, and leader actions. Most soldiers in combat will have light battle fatigue at some time. This includes the normal/common signs of battle fatigue listed in the Graphic Training Aid (GTA) 21-3-4 (available from US Army Training Audiovisual Support Centers). Light battle fatigue also includes the warning (or more serious) signs listed in GTA 21-3-5, provided the signs respond quickly to helping actions. Soldiers with these symptoms do not need to be sent immediately for medical evaluation and can continue on duty. If the symptoms persist after rest, they should be sent to their unit surgeon or physician assistant at routine sick call as heavy.

(2) Heavy battle fatigue (previously called severe) deserves immediate medical evaluation at a medical treatment facility. The symptoms may be—

- Temporarily too disruptive to the unit's missions.
- A medical/surgical condition which requires observation and diagnosis to rule out the necessity for emergency treatment. The medical triager sorts the heavy battle fatigue soldiers based on where they can be treated.

(3) Duty cases (previously called mild) are those who are seen by a physician or

physician assistant but who can be treated immediately and returned to duty in their small unit.

(4) Rest cases (previously called moderate) must be sent to their unit's nonmedical CSS elements for brief rest and light duties; rest cases do not require continual medical observation.

NOTE

Duty and rest cases are not medical casualties because they are still available for some duty in their units. However, those heavy cases who cannot return to duty or rest in their unit the same day are battle fatigue casualties.

(5) Hold cases are those who can be held for treatment at the triager's own medical treatment facility because both the tactical situation and the battle fatigue casualties' symptoms permit. This should be done whenever feasible.

(6) Refer cases are those who must be referred (and transported) to a more secure or better-equipped medical treatment facility, either because of the tactical situation or the battle fatigue casualties' symptoms. Refer becomes hold when the soldiers reach a medical treatment facility where they can be held and treated.

NOTE

The hold and refer sublabels of heavy battle fatigue do not necessarily mean that a soldier is less likely to recover or will take longer to recover than cases treated as rest. However, the simple fact of holding or evacuation itself often prolongs the treatment and decreases likelihood of full recovery and return to duty.

f. There is no easy rule for deciding whether any specific symptom of battle fatigue makes the soldier a case of duty, rest, hold, or refer battle fatigue. That will require judgment based on—

- What is known about the individual soldier.
- The stressors involved.
- How the soldier responds to helping actions.
- What is likely to happen to the unit next.
- What resources are available.

Battle fatigue symptoms can change rapidly based on a soldier's expectations. A successful combat stress control program prevents unnecessary evacuation and shifts battle fatigue cases from refer to the hold combat neuropsychiatric triage category. More importantly, it shifts many soldiers from hold category to rest and duty category. This allows them to recover in their units and keeps them from overloading the health service support system.

5-5. Severity of Symptoms and Response to Treatment

a. The severity of symptoms and the speed and extent to which they respond to treatment are directly related to the intensity, lethality, and duration of the battle incidents which caused them. The following are general planning estimates which may be modified greatly by specific factors, such as unit cohesion, training, and leadership.

b. Leader and medical personnel in forward areas should expect as many or more soldiers

to present with duty or rest battle fatigue as there will be hold and refer cases. It is essential that the former not become casualties by unnecessarily evacuating or holding them for treatment.

c. In general, the more intense the combat, especially with indirect fire and mass destruction, the more cases become heavy and need holding or referral, and the harder it is for them to recover quickly and return to duty.

d. Fifty to eighty-five percent of battle fatigue casualties (hold and refer) returned to duty following 1 to 3 days of restoration treatment, provided they are kept in the vicinity of their units (for example, within the division).

NOTE

When returned to their original units after successful treatment for battle fatigue, soldiers have no increased risk of relapse compared to their buddies who have not yet had battle fatigue. New soldiers who suffer battle fatigue during their first combat exposure deserve a second chance under supportive circumstances. They are no more likely to breakdown again than is another new replacement. However, it must be noted that treatment for battle fatigue will not turn a previously poor soldier into a good soldier. Soldiers who have accumulated too many terrible experiences may also reach a stage where reassignment to less dangerous duties is advised.

The variation of success rates between 50 and 85 percent can be due to several factors besides the intensity of the combat. Combat stress control planners must evaluate them critically. An 85 percent restoration rate could be the result of

effective far forward treatment of true hold cases. Alternatively, it could occur because many easily treated cases are being held and rested in medical cots (and classified as hold) instead of being released to their units as duty or rest battle fatigue. That situation, in turn, could be due either to inadequate training and consultation to forward units or to a tactical situation which prevents maneuver units from resting any marginally effective soldiers.

e. Fifteen to fifty percent of battle fatigue casualties do not recover within 72 hours. The wide variation is due both to the intensity and nature of the battle and to the availability of far forward treatment. A large number of these battle fatigue casualties (10 to 40 percent of the original total) do return to some duty within 1 to 2 weeks. This is accomplished only if they continue structured, equally positive treatment. This treatment may be provided in a nonhospital-like atmosphere of a medical treatment (tactical) facility in the combat zone. Premature evacuation of battle fatigue soldiers out of the combat zone must be prevented as it often results in permanent psychiatric disability. If the tactical situation permits, the evacuation policy in the corps should be extended from 7 to 14 days for the reconditioning program, as this will substantially improve the returned to duty rate and decrease subsequent chronic disability.

f. Five to fifteen percent of battle fatigue casualties fail to improve sufficiently to return to duty in the combat zone. Further reconditioning treatment can return many of these to useful duty in the COMMZ. Final evacuation to CONUS should not exceed 5 percent of total battle fatigue casualties. In retrospect, many of these soldiers have preexisting personality types or other neuropsychiatric conditions which did not make them become battle fatigue casualties in the first place but did interfere with full recovery. A lesson plan on how to identify, treat, and prevent battle fatigue is provided in Appendix E.