

## Treatment of Combat Fatigue Remains Big War Problem

By EDWARD P. MORGAN  
Times Foreign Correspondent

LONDON, Nov. 24.—Last time they called it "shell shock."

This time it has a nicer name: "Combat fatigue."

Quick to scissor through technical nonsense, soldiers at the front simply say you've "blown your wig" or "flipped your lid."

Under any name, combat fatalities—blown off less wounds of fright and exhaustion—have provided army medics since the United States began fighting wars more than a century ago, one of their most important and challenging problems.

In keeping with our tradition of superlatives American G. I.s get the best medical care, with the most expensive equipment, that any army in the world can give.

### Treatment Deficient

But more than one army psychiatrist says today that treatment for those complex emotional bruises to a soldier's brain and nervous system is still deficient despite some brilliant progress since World War I.

They admit that the "N. P."—the boy tagged with neuro-psychosis—is one of their biggest worries, which may blossom like a larkspur into a poisonous and costly social problem after the war.

Nobody has yet invented a way to wage war without fear.

According to some authorities, the percentage of shock cases has not changed much since the Civil War—they are likely to run a substantially high percentage of the total casualties.

So long as battles are fought by human minds and nerves, there will continue to be "wounded." Progress in this field has been heartening, sometimes exciting, but psychiatrists say that two main complicating factors keep it from being better:

1. The "unselectiveness" of selective service.

2. The brass-hat attitude—admittedly shrunken but still dominant in some officers—that unless a soldier has a bandage on, he isn't hurt.

We had to have a big army quickly. Inevitably, some draft boards reasoned about the village problem boy like this:

"Put him in the army. The army will make a man out of him."

### Doesn't Always Work

It doesn't of course. The army often makes matters worse by putting him in combat where he will crack instead of in some service unit where he might do a fair job.

Some doctors argue that the British are much more discriminating about these placements than we are; that they have fewer square miles in round holes.

Combat fatigue sounds a little sissified and men suffering from it sometimes are accused of gold-bricking. A skilled psychiatrist can quickly separate losers from legitimate cases.

One main trouble seems to be, in the army's United Kingdom base section, anyway, a lack of psychiatrists and facilities.

One hospital I saw recently was functioning as a rehabilitation center where the men were supposed to be given "finishing touches" to make them fit again for combat. But there wasn't one psychiatrist in the place.

Some of the army's largest hospitals in England are not staffed with psychiatrists.

### Patients Sent to Rear

This means that regular medical officers and nurses must handle "N. P." cases themselves. They are not trained for it and they usually do not like it.

They get rid of these patients when they can, by passing them back to hospitals in the rear echelons.

This puts a strain, not on the physical facilities, which are wonderful nearly everywhere, but on the psychiatric staffs.

For example, one 1000-bed hospital was organized to handle only 20 combat-fatigue casualties. It actually has 120 men in its N. P. wards, with only one regular pay-

chiatric officer and two assistants (untrained in psychiatry) to treat them.

It is physically impossible for one psychiatrist to give concentrated personal attention to 120 men.

Some of these patients will be sent home as unfit for further combat.

But what to do with borderline cases is a problem. If they are returned to battle, they are almost sure to land back in the hospital.

They still are capable of doing some kind of work in the army but there are no adequate facilities to screen them and fit them to the right place.

One reason that rear hospitals are short-staffed on psychiatrists is that many have been sent to the front to treat casualties on the spot. This war has proved the success of such psychiatric first aid.

### Colossal Operation

But the European offensive is a colossal operation and everybody can't have enough of everything all the time.

"As it is, your boy is getting fine care, better, probably, than he ever had at home."

But the medical corps is always looking for conditions to improve and for faults to remedy. Treatment of combat casualties is one of them.

This problem is not peculiar to our army alone. Even with the saturated indoctrination which they get for their respective causes, Russian soldiers and German soldiers suffer from shock like anybody else.

Our Russian allies have given us very little inkling of how they treat it, and the Nazis, of course, find it embarrassingly difficult to explain why the master race betrays any human weaknesses at all.

Copyright, 1944, by The Indianapolis Times and The Chicago Daily News, Inc.

## MANUAL GIRLS SING AT BROOKSIDE PARK

A musical program featuring the girls' glee club of Manual high school will be presented at 3 p.m. Sunday at Brookside park community center.

The glee club will be directed by Freda Hart. Tade Dolan will act as master of ceremonies and will sing his own composition, "Gee, Isn't It Great to Be an American."

Albert Stump and Albert M. B. Sharp, chaplain at Ft. Harrison, will speak. Members of the Red Cross committee sponsoring the program are Mrs. A. J. Huesing, Mrs. Mary Cahill, Mrs. Herman Scott, Mrs. Harry Argus and Mrs. Walter Baxter.

Carol Overstreet, Jean Snarr, Jodelle Doll and Dolores Smith, members of Senior Girl Scout Troop 38, will be ushers.

## 1945 DEFICIT LOOMS ON ESSENTIAL TIRES

WASHINGTON, Nov. 24 (U. P.)—Some labor and equipment now being used to make tires for passenger autos may have to be diverted to make up an anticipated deficit of 1,500,000 heavy truck and bus tires, according to Hiland G. Batcheller, chief of staff of the war production board.

He said the tire industry estimates that its maximum output of heavy tires during the first three months of 1945 will fall 25 per cent short of the basic military and essential civilian need for that period.

Some main trouble seems to be, in the army's United Kingdom base section, anyway, a lack of psychiatrists and facilities.

One hospital I saw recently was functioning as a rehabilitation center where the men were supposed to be given "finishing touches" to make them fit again for combat. But there wasn't one psychiatrist in the place.

Some of the army's largest hospitals in England are not staffed with psychiatrists.

### Patients Sent to Rear

This means that regular medical officers and nurses must handle "N. P." cases themselves. They are not trained for it and they usually do not like it.

They get rid of these patients when they can, by passing them back to hospitals in the rear echelons.

This puts a strain, not on the physical facilities, which are wonderful nearly everywhere, but on the psychiatric staffs.

For example, one 1000-bed hospital was organized to handle only 20 combat-fatigue casualties. It actually has 120 men in its N. P. wards, with only one regular pay-

chiatric officer and two assistants (untrained in psychiatry) to treat them.

It is physically impossible for one psychiatrist to give concentrated personal attention to 120 men.

Some of these patients will be sent home as unfit for further combat.

But what to do with borderline cases is a problem. If they are returned to battle, they are almost sure to land back in the hospital.

They still are capable of doing some kind of work in the army but there are no adequate facilities to screen them and fit them to the right place.

One reason that rear hospitals are short-staffed on psychiatrists is that many have been sent to the front to treat casualties on the spot. This war has proved the success of such psychiatric first aid.

### Colossal Operation

But the medical corps is always looking for conditions to improve and for faults to remedy. Treatment of combat casualties is one of them.

This problem is not peculiar to our army alone. Even with the saturated indoctrination which they get for their respective causes, Russian soldiers and German soldiers suffer from shock like anybody else.

Our Russian allies have given us very little inkling of how they treat it, and the Nazis, of course, find it embarrassingly difficult to explain why the master race betrays any human weaknesses at all.

Copyright, 1944, by The Indianapolis Times and The Chicago Daily News, Inc.

1. The "unselectiveness" of se-lective service.

2. The brass-hat attitude—ad-mittedly shrunken but still domi-nant in some officers—that unless a soldier has a bandage on, he isn't hurt.

We had to have a big army quickly. Inevitably, some draft boards reasoned about the village problem boy like this:

"Put him in the army. The army will make a man out of him."

Doesn't Always Work

It doesn't of course. The army often makes matters worse by putting him in combat where he will crack instead of in some service unit where he might do a fair job.

Some doctors argue that the British are much more discriminating about these placements than we are; that they have fewer square miles in round holes.

Combat fatigue sounds a little sissified and men suffering from it sometimes are accused of gold-bricking. A skilled psychiatrist can quickly separate losers from legitimate cases.

One main trouble seems to be, in the army's United Kingdom base section, anyway, a lack of psychiatrists and facilities.

One hospital I saw recently was functioning as a rehabilitation center where the men were supposed to be given "finishing touches" to make them fit again for combat. But there wasn't one psychiatrist in the place.

Some of the army's largest hospitals in England are not staffed with psychiatrists.

Patients Sent to Rear

This means that regular medical officers and nurses must handle "N. P." cases themselves. They are not trained for it and they usually do not like it.

They get rid of these patients when they can, by passing them back to hospitals in the rear echelons.

This puts a strain, not on the physical facilities, which are wonderful nearly everywhere, but on the psychiatric staffs.

For example, one 1000-bed hospital was organized to handle only 20 combat-fatigue casualties. It actually has 120 men in its N. P. wards, with only one regular pay-

chiatric officer and two assistants (untrained in psychiatry) to treat them.

It is physically impossible for one psychiatrist to give concentrated personal attention to 120 men.

Some of these patients will be sent home as unfit for further combat.

But what to do with borderline cases is a problem. If they are returned to battle, they are almost sure to land back in the hospital.

They still are capable of doing some kind of work in the army but there are no adequate facilities to screen them and fit them to the right place.

One reason that rear hospitals are short-staffed on psychiatrists is that many have been sent to the front to treat casualties on the spot. This war has proved the success of such psychiatric first aid.

Copyright, 1944, by The Indianapolis Times and The Chicago Daily News, Inc.

1. The "unselectiveness" of se-lective service.

2. The brass-hat attitude—ad-mittedly shrunken but still domi-nant in some officers—that unless a soldier has a bandage on, he isn't hurt.

We had to have a big army quickly. Inevitably, some draft boards reasoned about the village problem boy like this:

"Put him in the army. The army will make a man out of him."

Doesn't Always Work

It doesn't of course. The army often makes matters worse by putting him in combat where he will crack instead of in some service unit where he might do a fair job.

Some doctors argue that the British are much more discriminating about these placements than we are; that they have fewer square miles in round holes.

Combat fatigue sounds a little sissified and men suffering from it sometimes are accused of gold-bricking. A skilled psychiatrist can quickly separate losers from legitimate cases.

One main trouble seems to be, in the army's United Kingdom base section, anyway, a lack of psychiatrists and facilities.

One hospital I saw recently was functioning as a rehabilitation center where the men were supposed to be given "finishing touches" to make them fit again for combat. But there wasn't one psychiatrist in the place.

Some of the army's largest hospitals in England are not staffed with psychiatrists.

Patients Sent to Rear

This means that regular medical officers and nurses must handle "N. P." cases themselves. They are not trained for it and they usually do not like it.

They get rid of these patients when they can, by passing them back to hospitals in the rear echelons.

This puts a strain, not on the physical facilities, which are wonderful nearly everywhere, but on the psychiatric staffs.

For example, one 1000-bed hospital was organized to handle only 20 combat-fatigue casualties. It actually has 120 men in its N. P. wards, with only one regular pay-

chiatric officer and two assistants (untrained in psychiatry) to treat them.

It is physically impossible for one psychiatrist to give concentrated personal attention to 120 men.

Some of these patients will be sent home as unfit for further combat.

But what to do with borderline cases is a problem. If they are returned to battle, they are almost sure to land back in the hospital.

They still are capable of doing some kind of work in the army but there are no adequate facilities to screen them and fit them to the right place.

One reason that rear hospitals are short-staffed on psychiatrists is that many have been sent to the front to treat casualties on the spot. This war has proved the success of such psychiatric first aid.

Copyright, 1944, by The Indianapolis Times and The Chicago Daily News, Inc.

1. The "unselectiveness" of se-lective service.

2. The brass-hat attitude—ad-mittedly shrunken but still domi-nant in some officers—that unless a soldier has a bandage on, he isn't hurt.

We had to have a big army quickly. Inevitably, some draft boards reasoned about the village problem boy like this:

"Put him in the army. The army will make a man out of him."

Doesn't Always Work

It doesn't of course. The army often makes matters worse by putting him in combat where he will crack instead of in some service unit where he might do a fair job.

Some doctors argue that the British are much more discriminating about these placements than we are; that they have fewer square miles in round holes.

Combat fatigue sounds a little sissified and men suffering from it sometimes are accused of gold-bricking. A skilled psychiatrist can quickly separate losers from legitimate cases.

One main trouble seems to be, in the army's United Kingdom base section, anyway, a lack of psychiatrists and facilities.

One hospital I saw recently was functioning as a rehabilitation center where the men were supposed to be given "finishing touches" to make them fit again for combat. But there wasn't one psychiatrist in the place.

Some of the army's largest hospitals in England are not staffed with psychiatrists.

Patients Sent to Rear