Army Psychiatry in the Korean War: The Experience of 1 Commonwealth Division

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This study seeks to investigate the incidence of psychiatric casualties in 1 Commonwealth Division during the Korean War. It had been hypothesized that these casualties were unusually low compared with earlier conflicts. Casualty returns and psychiatric reports were analyzed and showed that the war fell into two phases determined by the intensity of combat, which, in turn, influenced the nature of the psychiatric disorders encountered. Rates of acute combat stress were closely correlated with battle casualties, although not with total psychiatric admissions of nonbattle injuries. The limitations imposed on the psychiatric liaison service by the medical organization suggested that the incidence of psychosomatic cases, including cold injury, may have been unintentionally underreported.

Introduction

Despite the prediction made by General MacArthur in November 1950 that the troops would be “home by Christmas,” the Korean War proved to be a protracted and large-scale conflict. It began in June 1950, when North Korean forces crossed the 38th parallel and rapidly overran most of the South until they were halted by a desperate defense behind the Rakdong River. Although United Nations troops drove the Communists back into their own territory, the war continued for another 3 years until an armed truce was signed on July 27, 1953. Some 5.7 million U.S. troops were deployed, and 54,000 died in combat or in captivity.1 The United Kingdom contributed 81,084 servicemen to the 17-nation United Nations force, of whom 1,078 were killed and 2,674 were wounded.2 Although a growing number of studies have investigated military and political aspects of the war, comparatively little research has been directed toward its medical aspects, particularly the treatment of soldiers with psychiatric disorders. Having analyzed admissions of U.K. troops to the base hospital from January to November 1951, Flood observed that the number of psychiatric casualties, including cases of acute combat stress, was unusually low. He attributed this to the relative absence of “intense enemy shell fire and aerial bombing.”3 However, a reexamination of the medical returns for 1 Commonwealth Division suggests that the true incidence of psychosomatic disorders may have been underrecorded and that some cold injuries, particularly in the first half of the war, may have fallen into this category.

Military Context

The fighting fell into two distinct phases. At first, it was a war of movement, when the North Koreans pushed United Nations troops back to a thin strip of land around Pusan and when the Allies regained lost ground, driving north to the Yalu River. After the front line solidified just below the 38th parallel in mid-1951, it became a static conflict of attrition.

Already stretched by deployments to Europe, Hong Kong, and Malaya, the British government found itself facing a manpower crisis. National service was extended from 18 months to 2 years, and reservists were called up. Because the war appeared to have little relevance to Britain’s fortunes and failed to inspire a strong patriotic spirit, it was anticipated that there was considerable potential for psychiatric breakdown in a force largely composed of conscripts and reservists.3 The first U.K. troops sent to Korea, later part of 1 Commonwealth Division, were the Middlesex Regiment and the Argyll and Sutherland Highlanders. Forming 27 Brigade, these units landed at Pusan on August 29 and were quickly sent into action near Taegu.4 Lieutenant Colonel Malcolm commented of the Argyll and Sutherland Highlanders that although this was “a regular battalion,” relatively few had seen any active service and it had not fought as a unit since leaving Palestine in 1948.5 About half of the soldiers of 27 Brigade were national servicemen with no experience of combat,6 and a high proportion of 29 Brigade, which arrived in November 1950, were reservists, many of whom were discontented by their unexpected recall. Most of the reservists sent to Korea had joined the regular army in the late 1930s and had seen a considerable amount of active service before recently settling into a peacetime lifestyle.7

Medical Organization

Because it was possible to evacuate the sick and wounded rapidly by air, the base hospital (29 British General) was set up not in Korea but at Kure, Japan, 140 miles from Pusan.8 An RAMC psychiatrist, Captain J.J. Flood, ran a 30-bed unit established in November 1950. In Korea itself, the divisional psychiatrist, Major J.F. Robitaille, RCAMC, was attached to the 25 Canadian Field Dressing Station (FDS), which was then in a school building at Seoul.9 However, a growing number of air medical evacuations to the Kure psychiatric unit, including those for mild and moderate cases of battle exhaustion, prompted a change in management. Previous wars had demonstrated that cases of combat stress reaction became increasingly intractable the further soldiers traveled from their comrades and the front line. The role of the FDS was redefined in August 1951 as “that of holding minor sick and injuries from the division and thereby obviating a large proportion of such cases from being evacuated out of Korea,” and by December 1951, the

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FDS functioned as a "small general hospital." In addition, a clinical officer in psychiatry, Captain R.G. Godfrey, RAMC, was sent to Korea in August 1951 to enable a greater number of patients to be treated at the FDS, where a 24-bed psychiatric facility had been established. Although not a qualified specialist, Godfrey had 8 months of experience working in an adult psychiatric assessment unit in East London and had spent another 2 months working with Flood at the Japanese base hospital. In general, regular British officers with psychiatric qualifications were not deployed to Korea but kept in Germany, the United Kingdom, and other long-term postings. By contrast, the Canadian military regularly rotated divisional psychiatrists to give its officers combat experience, and Robitaille was succeeded by Major F.C.R. Chalke, who in August 1952 handed over to Major J.L. Johnson, RCAMC.

Psychiatric Presentations

Psychiatric casualties among U.S. troops were recorded as 37 per 1,000, higher than in the Vietnam War (12 per 1,000) and equivalent to those recorded in certain theaters during the Second World War. Reiter found that these fell into distinct groups according to the phases of the war. The mid- to high-intensity combat from June 1950 until November 1951, when battle casualties increased to 460 per 1,000 troops, led to a preponderance of anxiety and fatigue states, and the highest levels of combat stress were recorded. Most of those affected were infantry soldiers. The static warfare that followed led to a decrease in battle casualties, from 170 per 1,000 in 1951 to 57 per 1,000 in 1952. Norbury showed that the low-intensity fighting was associated with increasing numbers of nontactical symptoms (despair, frustration, and alienation), alcohol and drug abuse, and character and behavior problems.

This pattern was replicated in 1 Commonwealth Division. In the year from December 1950 to November 1951, 554 U.K. soldiers from a division of just over 16,000 were evacuated to Japan for psychiatric assessment, giving a total casualty rate of 35 per 1,000. Of these, 52% (287 patients) were diagnosed as suffering from anxiety disorders, and 13% (73 patients) were diagnosed with dissociative states or conversion disorders, which were more common after periods of intense shelling or mortar attacks. The initial peak in psychiatric casualties also owed something to the nature of the troops that had been deployed. The Canadian brigade, for example, was not a regular unit but had been hastily recruited from veterans, reservists, and volunteers, 25% of whom were found unsuitable within 6 months. Their first infantry battalion to arrive in Korea soon lost substantial numbers from chronic medical conditions, and another 150 men were sent back with disciplinary and psychiatric problems. Major Chalke, an expert in personnel selection, doubtless owed his posting to the attempt to stem the flow of evacuees.

In the second stage of the war, as the FDS took an increasingly active role, psychiatric admissions to the divisional base hospital decreased appreciably (Table I). In May 1952, for example, psychiatric inpatients represented only 2.3% of total admissions, and in the next year they fluctuated between a high of 5.4% in February 1953 and a low of 0.6% in November 1952, at a time when the division was 18,500 strong. No equivalent medical returns survive to provide statistics for the early part of the war.

The admission figures to the base hospital in Kure, however, understate the true incidence of psychiatric casualties because patients were initially referred to the FDS for treatment and were evacuated only if their conditions proved intractable. Although an incomplete series of monthly returns has survived, these figures show a much higher incidence of psychiatric casualties (Table II). The majority of FDS admissions were diagnosed as suffering from psychoneuroses, a group of disorders in the main composed of anxiety and dissociative states together with conversion disorders. Of lesser significance were personality disorders. Most cases of battle exhaustion were treated at the FDS, and these are analyzed below. More than half of these patients were psychiatric admissions.

### Table 1

<table>
<thead>
<tr>
<th>Month</th>
<th>Battle Casualties</th>
<th>Nonbattle Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physical Injuries</td>
<td>Battle Exhaustion</td>
</tr>
<tr>
<td>May 1952</td>
<td>80 (4.3)</td>
<td>3 (0.2)</td>
</tr>
<tr>
<td>June</td>
<td>92 (5.0)</td>
<td>0</td>
</tr>
<tr>
<td>July</td>
<td>121 (6.7)</td>
<td>3 (0.2)</td>
</tr>
<tr>
<td>August</td>
<td>87 (4.9)</td>
<td>1 (0.1)</td>
</tr>
<tr>
<td>September</td>
<td>237 (13.1)</td>
<td>7 (0.4)</td>
</tr>
<tr>
<td>October</td>
<td>287 (15.5)</td>
<td>7 (0.4)</td>
</tr>
<tr>
<td>November</td>
<td>146 (7.9)</td>
<td>3 (0.2)</td>
</tr>
<tr>
<td>December</td>
<td>110 (5.9)</td>
<td>0</td>
</tr>
<tr>
<td>January 1953</td>
<td>5 (0.3)</td>
<td>0</td>
</tr>
<tr>
<td>February</td>
<td>3 (0.2)</td>
<td>0</td>
</tr>
<tr>
<td>March</td>
<td>125 (6.5)</td>
<td>2 (0.1)</td>
</tr>
<tr>
<td>April</td>
<td>301 (15.5)</td>
<td>5 (0.3)</td>
</tr>
<tr>
<td>May</td>
<td>213 (10.9)</td>
<td>5 (0.3)</td>
</tr>
<tr>
<td>June</td>
<td>221 (11.2)</td>
<td>1 (0.1)</td>
</tr>
</tbody>
</table>

Figures in parentheses indicate numbers per 1,000 troops based on the monthly returns of the 1 Commonwealth Division's strength. Nonbattle psychiatric admissions refer to the base hospital at Kure in Japan. No data survive for the earlier period from August 1950 to April 1952.
were returned to duty, although usually in a less active role, and approximately 30% were evacuated to the base hospital.

Although the low intensity of the fighting in the second half of the war undoubtedly played a major role in reducing the rate of psychiatric breakdown, it also appears that the limitations imposed on the liaison service may have lead to underreporting of psychosomatic disorders. The divisional psychiatrists regularly visited front-line units, where they would be asked to see soldiers with cases of suspected somatization. These commonly presented with backache, and in August 1952, Colonel G.L. Morgan-Smith, the Assistant Director of Medical Services, found it necessary to remind medical officers that “chronic low back pain, gastrointestinal disturbances and vasomotor symptoms are often bodily responses to anxiety, resentment or low morale.” However, once a patient had been referred to a medical or surgical specialist at the FDS, there was little opportunity for psychiatric input. Given the ease of aeromedical evacuation, soldiers with unexplained or intractable physical symptoms were flown to Japan for further investigation. In the 14 months from May 1952 to June 1953, the chief causes for admission to the base hospital were respiratory (10%), gastrointestinal (2.7%), and skin reactions (10.3%). It is likely that some of these cases represented somatic expressions of psychological distress. An American study of orthopedic patients evacuated from Korea, for example, showed that psychiatric symptoms were present in 56% of the sample, the majority of them combat stress.18

Combat Fatigue and Battle Exhaustion

“Combat fatigue,” as it was termed by U.S. forces, or “battle exhaustion,” as it was known to Commonwealth troops, proved to be an important feature of Korean War psychiatry. Approximately half of U.S. servicemen treated for combat fatigue were returned to duty within 1 to 6 hours, and 70% were shown to have mild symptoms.19 The success of the American treatment program owed much to Colonel Albert J. Glass, a veteran of the Second World War.20 U.S. divisional psychiatry rapidly became operational within 8 weeks of the beginning of hostilities, and by October 1950, the three levels of treatment, based on the Army’s recent experience of war, were in place.21-22 Glass had organized mental health sections to train regimental and battalion medical officers and set up mobile psychiatric detachments, called “KO teams,” to reinforce divisions at times of heavy fighting so that combat fatigue could be treated rapidly and effectively as close to the front line as possible.23,24 In the initial phase of the war, U.S. medical services appeared to have responded more efficiently than their British counterparts. This may have been a reflection of the divided chains of command within the Commonwealth Division, the smaller scale of its deployment, and the manpower shortages it faced.

In December 1952, Major Johnson, the divisional psychiatrist, reported that the proportion of battle exhaustion to battle casualty cases for the Commonwealth Division was only 21 per 1,000, significantly lower than the 200 per 1,000 recorded for the British Second Army between July and September 1944 during the intense fighting in Normandy.25 From May 1952 until the end of the war, only 37 cases of battle exhaustion were reported among 2,026 casualties, giving an average rate of 18 per 1,000, although in September 1952 it increased to 24 per 1,000 and between January and March 1953 no cases were referred to the FDS.26 It is possible that these low levels also reflect the growing experience of battalion medical officers, who in this quieter phase of the war may have been managing mild cases at regimental aid posts to keep soldiers within their units. Blood and Gauker established an association between the intensity of fighting and the incidence of disease and nonbattle injuries for U.S. troops during the assault on Okinawa (April to June 1945) and in Korea between February and June 1951.27 For the 1 Commonwealth Division, battle exhaustion cases were found to be closely correlated with battle casualties (Spearman’s ρ = 0.001), although no such relationship could be detected for psychiatric admissions to the base hospital (Spearman’s ρ = 0.599) or nonbattle injuries (Spearman’s ρ = 0.68). In October 1952, Captain Godfrey had observed that increased enemy artillery fire usually led to higher referral rates. Commonwealth troops were rarely subjected to sustained or concentrated shelling or aerial bombardment, and between battles they often endured lengthy periods of inaction.

With regard to treatment, Captain Godfrey concluded that “motivation is of paramount importance in determining the chances of a patient’s return to full duty. This is particularly true among the less severe cases of battle exhaustion.”28 Although the majority of patients returned to some form of duty, few returned immediately to their battalions. Most were sent to the divisional reinforcement unit for further training and as-

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>May 1952</th>
<th>September 1952</th>
<th>November 1952</th>
<th>December 1952</th>
<th>January 1953</th>
<th>February 1953</th>
<th>May 1953</th>
<th>June 1953</th>
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<tbody>
<tr>
<td>No significant disorder</td>
<td>8</td>
<td>20</td>
<td>10</td>
<td>11</td>
<td>16</td>
<td>10</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>Psychoneurosis</td>
<td>20</td>
<td>28</td>
<td>33</td>
<td>31</td>
<td>46</td>
<td>34</td>
<td>39</td>
<td>40</td>
</tr>
<tr>
<td>Battle exhaustion</td>
<td>7</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organic disorders</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Personality disorders</td>
<td>6</td>
<td>9</td>
<td>7</td>
<td>12</td>
<td>7</td>
<td>7</td>
<td>7</td>
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</tr>
<tr>
<td>Psychosis</td>
<td>3</td>
<td>1</td>
<td>7</td>
<td>3</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Learning difficulties</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not yet diagnosed</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>43 (2.3)</td>
<td>56 (3.1)</td>
<td>58 (3.1)</td>
<td>52 (2.8)</td>
<td>78 (4.2)</td>
<td>59 (3.2)</td>
<td>70 (3.6)</td>
<td>67 (3.4)</td>
</tr>
</tbody>
</table>

These are the months for which data are available; the records for the intervening periods have been lost or destroyed. Figures in parentheses indicate numbers per 1,000 troops.

TABLE II
PSYCHIATRIC ADMISSIONS TO THE 25 FIELD DRESSING STATION (MAY 1952 TO JUNE 1953)
essment. Flood recorded that 66% of patients evacuated to Kure for treatment were returned to military duties, although it is unlikely that many of these returned to front-line units in Korea. In Italy during 1943 and 1944, for example, the exhaustion center serving the British 10 Corps succeeded in returning 90% of soldiers to duty, although only 30% returned to combat with their original battalions. The high proportion of Australian troops requiring evacuation to the base hospital related to the inflexible regulations imposed by Australian military authorities rather than the quality of Australian servicemen. In British and Canadian units, men suffering from battle exhaustion could be assigned to other duties, but Australian soldiers had to be fit for service in a front-line company at the end of treatment or they were removed from the division altogether.

Despite the work of the FDS, resistant cases of battle exhaustion were encountered, and these patients were evacuated to Kure, where Major R.D. Davies, RAMC, had succeeded Flood. Between January and May 1952, five servicemen with acute combat stress reaction were flown to Japan, representing 15% of all psychiatric admissions. In June 1952, the military authorities explored the idea of transferring the base hospital to Korea, a suggestion supported by the psychiatrists, who argued that it would not only improve opportunities for liaison work but also prevent the "backward-looking attitude of mind that develops and becomes fixated and immovable the further the patient is from the scene of active warfare."

Cold Injury

The Korean War, recalled Brigadier R.V. Franklin, the Deputy Director of Medical Services, was popularly invested "with a variety of hazards to the health of troops required to serve there. . . . The climate, particularly the winter was one of the aspects that gripped and held public imagination." Frostbite assumed significant proportions in the harsh winter of 1950-1951, when temperatures were reported as low as -27°C and when some U.K. troops had yet to be issued proper clothing and equipment. Between November 1950 and February 1951, 120 Commonwealth servicemen from a division of 10,000 were admitted with cold injuries, of whom 66 were diagnosed as suffering from frostbite, 37 with trench foot, and 22 with exposure conditions.

During both the Second World War and the Korean conflict, cold injuries occurred primarily among servicemen engaged in battle. Hanson and Goldman estimated that the number of cases reported during combat was greater than would have been predicted based solely on temperature and wind chill, and they proposed exposure, immobility, improper attention to clothing, fatigue, and fear as explanations. During the winter of 1950-1951, more than 4,000 (i.e., >50%) United Nations cold-injury casualties were flown to a special treatment unit in Japan. The U.S. Army became concerned about the incidence of cold injuries, a number of cases being considered to have been self-inflicted by men who had removed their boots or neglected to take proper precautions.

Stress plays a central role in combat cold injury because of both its behavioral and physiological manifestations. It can lead a soldier to fail to protect himself from the environment, and in extreme cases it can produce total immobility. Physiologically, fear or increased activity of the sympathetic nervous system leads to vasoconstriction and sweating, which contribute to significant temperature reduction in the extremities. Psychiatrists in Korea observed that as the incidence of frostbite increased, the number of psychiatric casualties decreased. A comparison between 110 frost-bitten servicemen and 20 hospitalized soldiers showed that the former had a lower drive for prestige, took fewer precautions against the cold, and exhibited a greater range of hypochondriacal beliefs. It was hypothesized that physical injury could have served as a defense against psychiatric disorders in situations of intolerable stress. An investigation conducted during the Second World War of 21 U.K. soldiers with vasoneuropathy after chill, or trench foot, showed that 12 were preoccupied with problems at home, 5 suffered from psychological disorders, and 8 exhibited emotional instability. Ten of the soldiers admitted that they experienced uncontrollable fear when in action.

The role of morale as a protection against cold injury was exemplified by the Argylls. They had arrived in Korea during the summer and were still wearing tropical kit when the winter arrived, forcing them to acquire clothing and equipment from U.S. troops. Despite their lack of preparedness, the battalion had the lowest incidence of frostbite of any front-line United Nations unit in the harsh winter of 1950-1951. This was because the commanding officer gave permission for small fires to be lit in the trenches but also because unit morale remained high and great emphasis was placed on preventative measures such as regular changes of dry socks.

The conditions in Korea, where troops were continuously in the open and exposed to intense cold at night but only moderate cold during the day, gave rise to a form of cold injury intermediate between frostbite and trench foot that almost exclusively affected the lower limb. Watts showed that cases were most common in the infantry, with a mean rate of 2.15% (range, 7.82-0.65%). Other troops had a mean rate of 0.37% (range, 1.54-0.12%). Although a higher incidence was predicted in older reservists, no marked difference was detected, and battalions composed of recalled Second World War veterans recorded below-average rates.

During the next winter, it was considered that "the division has reached the stage when one should treat every case of cold injury within our lines as a self-inflicted wound." The incidence of frostbite decreased greatly, and in 1952-1953 only 30 first-degree and 5 second- and third-degree cases were recorded, and no amputations were necessary. The admission rate of 12.0 per 1,000 recorded in the winter of 1950-1951 had decreased appreciably to 1.9 per 1,000 two years later. Unfortunately, the monthly casualty figures do not systematically record cold injuries, thereby preventing statistical comparison with battle injuries and psychiatric referrals.

Conclusion

From January to November 1951, when some of the bitterest fighting took place, often in adverse conditions, the incidence of psychiatric disorders in 1 Commonwealth Division increased to 35 per 1,000, almost equivalent to the 37 per 1,000 calculated for U.S. forces. The delay in setting up a forward treatment unit until August 1951 and the limitations imposed on the liaison

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service reinforce the impression that psychiatric casualties may have been unintentionally underrecorded. It is possible that some patients with psychosomatic and factitious disorders were evacuated to the base hospital in Japan without assessment by a military psychiatrist. The incidence of acute combat stress reaction was comparatively low in the second half of the war and was closely correlated with battle casualties. Although this was primarily a consequence of the changed character of the fighting, it also might have reflected the greater experience of regimental doctors and psychiatrists in the field, who may have detected cases earlier and been more discriminating in their referrals to specialist units. At the onset, when the organization was rudimentary and located far from the front line, proper diagnosis and treatment were compromised. Reduced numbers of referrals to the base hospital may have been a reflection of a more effective clinical system.

What, then, are the lessons to be learned from the Korean War? First, the work of the FDS confirmed the efficacy of Thomas Salmon’s system for treating battle-exhausted troops quickly and close to their combat units. It is significant that this method had to be rediscovered so soon after the Second World War in the same way that Captain Frederick Hanson had resurrected it in the North African campaign. Morale appears to have protected servicemen from breakdown, and the regular rotation of armored regiments and infantry battalions every 12 months helped to preserve this group spirit. Whole units arrived and departed together rather than in “trickle postings.” This policy did much to retain a sense of team loyalty so essential to the fighting spirit. Troops were generally spared the terrors of aerial bombing and constant shelling, and one of the main problems encountered by units when not on the front line was boredom. However, the low figures for psychiatric admissions during the second half of the campaign may have led the military authorities to underestimate the potential for breakdown and encouraged a rationalization of Army Medical Services, which saw the number of military psychiatrists cut from 82 in 1948 to 42 in 1958, at a time when the British Army grew from 418,000 to 450,000. Finally, the loss or destruction of substantial sections of the medical corps archive, including statistical returns, emphasizes the need for accurate record keeping during conflicts and careful preservation of historical evidence once the fighting has ended.

Acknowledgments

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