PSYCHIATRIC CASUALTIES IN U.K. ELEMENTS OF KOREAN FORCE
DECEMBER, 1950—NOVEMBER, 1951

BY
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INTRODUCTION

This short paper has been written mainly to give an account of the psychiatric breakdown in U.K. troops engaged in Korea during the twelve months from December, 1950, to November, 1951. It includes also a short analysis of psychiatric casualties among the Australian, New Zealand and Canadian members of the Commonwealth forces who also came under our care. It does not include the R.N. and R.A.F. personnel referred for psychiatric opinion and disposal as there were so few that they have no statistical importance in this survey. It will be remembered that the Korean War started in June, 1950, and within a short while British troops were actively engaged in fighting the North Koreans. In November, 1950, the 29th British General Hospital arrived in Kure, Japan, to serve as a base hospital for the Commonwealth members of the Korean Force. By this time the 28th Brigade, which had been dispatched from Hong Kong and supplemented by an Australian battalion, was already an active fighting unit. The two U.K. battalions were two well-integrated units who had trained together in the New Territories adjacent to Hong Kong. It is worthy of note that on arrival in Japan there were but a few psychiatric casualties awaiting disposal even though the Brigade had been in a considerable amount of combat. About the same time as the arrival of the hospital the 29th Brigade was ready for action, but had not as yet actively engaged the enemy on a large scale. This Brigade was in the main one of reservist soldiers, all somewhat discontented with their recall, and it was clear that there was a high potential psychiatric breakdown within this member of the force. The majority of the reservists were men who had joined the Regular Army in the immediate pre-war years and had seen a considerable amount of active service, and when reverting to civilian life, though still on Class A Reserve, were physically and mentally fit. It was to be expected therefore that the vast majority were relatively mature, stable personalities capable of making a good social adjustment to their environment, and with combat experience behind them they were in possession of a fair measure of security. Indeed, these traits were present but were offset to some extent by the understandable resentment and hostility of being recalled. Reservists were a considerable problem over the first few months and, though presenting with anxiety symptoms often unrelated to battle, they had sufficient insight and judgment to know what was expected of them. Many such cases
precipitated by domestic upheavals and home worries were most adequately dealt with by Welfare Authorities.

The base hospital was structurally comfortable and adequate for our needs, comparing only too favourably with the harsh environment of Korea. In general it may be said that the Psychiatric Centre was "too far back" and if suitable accommodation could have been found in Korea itself it would have been easier to deal with those cases of mild to moderate severity in which a R.T.U. was considered worth while. It may be truthfully said that the psychological resistance to a R.T.U., whether conscious or unconscious, is inversely proportional to the distance of evacuation from the battle front. In August, 1951, a clinical officer in psychiatry was attached to a Canadian F.D.S. with good effect. This prevented the unnecessary long-distance evacuation of personnel purely for psychiatric opinion or assessment. The F.D.S. also acted as a Battle Exhaustion Centre but, due to the nature of the fighting, this type of case was uncommon as compared with campaigns of the 1939-1945 war. (See later.)

Situated near the hospital was a holding unit which carried reinforcements for the Korean force together with recovered battle casualties and sick soldiers again fit for duty. A considerable screening was effected and by close liaison with the M.O. and Adjutant of this unit many would-be psychiatric casualties were prevented, more often by recommending a hasty return to duty than advice to the contrary. Many of the cases referred were battle casualties who had recovered from superficial wounds and, although pronounced physically fit, persisted in complaining of impaired functions or persistent pain. A good number of these patients entertained their symptoms at a "near conscious" level. Providing, however, that this overlay did not amount to blatant malingering, it was considered advisable and advantageous to see such patients on one or two occasions for a period of psychotherapy. This was at times a rather tedious task, but such management usually paid a better dividend than a summary dismissal of the patient's symptoms (anxiety) as being imaginative or deceitful. It is quite certain that a soldier who can externalize his anxieties and fears to an ear which he recognizes as being both sympathetic and firm derives considerable benefit. His anxiety is predominantly the fear of personality disintegration in the face of danger rather than any specific fear of death, maiming or captivity by his enemy, and it was invariably on this theme that psychotherapy was gainfully rendered.

**ENEMY ENVIRONMENT AND MORALE**

The enemy, Chinese and North Koreans, inadequately supplied with artillery and air-striking power, compensated the deficit by attempting to overwhelm the opposition by gross numerical superiority. Their losses in large-scale offensives were reported to be enormous. They were most feared at night and, although initially silent in attack, during the battle they resorted to primitive methods of psychological warfare, sounding weird and oriental bugle calls.
This effect was at first eerie and nerve-racking, but, if calculated to lessen opposition morale, the result was short-lived and unimportant; certainly the matter was not stressed by patients suffering from acute psychiatric disturbances following combat either consciously or during abreactive treatment.

The climate in Korea is extreme. The cold winter appeared to be considerably less well tolerated than the warm, humid summer months. Living conditions were extremely harsh and weeks were spent in the open. Frostbite, a preventable condition, was not common during the winter 1950-1, but it is clear that the "cold injury," as the Americans have now labelled it, may constitute a serious problem. The U.S. authorities expressed grave concern about the high incidence in their troops, a significant number of which were considered to be self-inflicted by blatantly removing boots for a few hours or neglecting to take elementary precautions. It is probable that in future campaigns being undertaken in conditions of extreme cold the frostbite incidence will be the measure of individual, and therefore group, morale throughout the force. It is estimated that the extremely cold temperature was the soldier's greatest environmental hardship whilst in Korea.

Considering the many adverse factors, morale appeared to have maintained a surprisingly high standard which is reflected by the psychiatric breakdown, details of which appear analysed below. The dissatisfaction of the reservist, the impersonal, idealistic and remotely purposeful war, extremes of cold, heat and boredom, together with spurious peace offers, were factors not conducive to enthusiasm.

**DISPOSAL OF ALL CASES INTERVIEWED**

In the period of survey, 554 U.K. soldiers were referred for examination. Of these, 365 were recommended for a return to their unit; 112 were down-graded to medical category M2S3 and therefore became employable in base areas and were not a total loss; 8 men were given a category of M2S7 and 69 were evacuated to the United Kingdom. Of these 34 were psychotic, leaving only 35 soldiers who were sufficiently serious to require further hospital treatment for neurosis. It is noteworthy that during the year only ten officers were sent for interview. Three were diagnosed as Anxiety Reaction in obsessively perfectionistic personalities unrelated to battle circumstances, two had symptoms of headache with mild personality change following head injury. The other five developed excessive anxiety resulting from combat experience, and in all of these severe precipitating stress had occurred. Three officers were evacuated to England for further treatment and three down-graded to medical category M2S3 for three or six months.

<table>
<thead>
<tr>
<th>R.T.U.</th>
<th>M2S3</th>
<th>M2S7</th>
<th>M2S0</th>
</tr>
</thead>
<tbody>
<tr>
<td>365 (65.8%)</td>
<td>112 (20.2%)</td>
<td>8 (1.5%)</td>
<td>69 (12.5%)</td>
</tr>
</tbody>
</table>

A diagnostic breakdown is given in Table II below.
Anxiety state
Hysteria
Maladjusted and psychopathic personality and dullards
Schizophrenia
Organic reactive psychosis
Manic depressive psychoses
N.A.D.

<table>
<thead>
<tr>
<th>TABLE II</th>
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<tbody>
<tr>
<td>Anxiety state ... ... ... ... ... ... 287</td>
</tr>
<tr>
<td>Hysteria ... ... ... ... ... ... 73</td>
</tr>
<tr>
<td>Maladjusted and psychopathic personality and dullards ... ... 42</td>
</tr>
<tr>
<td>Schizophrenia ... ... ... ... ... ... 22+(? 4)</td>
</tr>
<tr>
<td>Organic reactive psychosis ... ... ... ... ... 1</td>
</tr>
<tr>
<td>Manic depressive psychoses ... ... ... ... ... 7</td>
</tr>
<tr>
<td>N.A.D. ... ... ... ... ... ... 118</td>
</tr>
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</table>

A note of explanation will be given on the cases seen.

Anxiety Reactions.—This was as usual the most common clinical entity encountered. The diagnostic rate is comparatively high, but many of these cases were mild and include a certain number of “dyspepsias.” This type of case was often amenable to reassurance and a special effort was made to follow them up when returned to their units, either by visiting them or by inquiries through their unit M.O. Often rather immature and dependent soldiers, this personal touch gave them a helpful measure of psychological support and security.

Acute “terror” or “panic” reactions are also included in this diagnostic group. These cases were at first surprisingly few and usually they had been adequately sedated on arrival at the base hospital. During the last few months of 1951 there was a considerable increase in cases of this nature, and almost certainly this was directly attributable to an increase in mortar and shell fire by the enemy. The diagnosis presents no difficulty—the patient is in a state of acute awareness, tremulous and uncommunicative, showing an excessive “startle reaction” to the slightest foreign auditory stimulus. The pupils are large and the alæ nasi often prominently dilated, as if the relatively dormant olfactory sense is being mobilized to augment the awareness of a subject in mortal danger. Sleep is easily induced with drugs though it may be interspersed with nightmares. Sodium amytal was used more than any other barbiturate, and in this connection it should be stressed that the initial dose should be large, say gr. 7½-9, as smaller doses of this particular drug were noted to have an excitatory effect, especially in the subject who was excessively mute and tense. The further sedation varied in amount and no particular rule can be laid down, though in severe cases a minimum of two days’ deep narcosis is advisable. During the waking period the patient was reassured and orientated, and if it was apparent that he wanted to talk about his battle experiences this was allowed, though no attempt was made to encourage an abreaction.

It is well known that any physical or mental condition which affects a medical evacuation from a threatening or dangerous environment will be recognized by the patient, consciously or unconsciously, as a decided asset which, however, is conflicting with his sense of duty. It is precisely this conflict that must be solved if the soldier is to be returned to duty. Indecision and inability to face this reality was noted in some cases to cause a picture of clinical depression. With the decreased intensity of anxiety the patient very often became withdrawn, solitary and tearful. He declined food and, despite sedatives, remained
Psychiatric Casualties in Korea

awake most of the night. Though the immediate psychopathology is obvious, the intensity of the repressed emotional experience is too great to expect a therapeutic acceptance. This depressive picture was more often observed in N.C.Os., where the sense of guilt was roughly proportionate to the sense of expected responsibility. On the whole the prognosis for an immediate return to duty in such cases was poor.

Fig. 1

i. Graph showing psychiatric casualties per 1,000 soldiers each month. The upper level of each block indicates the total psychiatric loss. The shaded area represents those soldiers evacuated from the theatre (M2S0).

ii. Above this appears a graph representing the total number of U.K. personnel in the theatre month by month.

Hysteria.—This group contained some who might well be classified as mild anxiety states, and also some post-concussional syndromes. Many were cases referred by medical or surgical specialists for assessment. Gross hysterical dissociation with conversion symptoms were not common, but again, with the increase in mortar and shell fire, they became more numerous. Hysterical stupor, blindness, and paraplegia or monoplegia were encountered in 20 patients.
All were amenable to treatment and showed a better total recovery rate than the acute panic and anxiety group.

*Psychopathic Personality and Mental Defect.*—In the Army one is always conscious of a tendency to label soldiers as Psychopathic Personalities, sometimes for administrative convenience, who do not truly present behaviour sufficient to justify the diagnosis. In this series 30 patients were assessed as being true Psychopathic Personalities (Type I and II), using as criteria a severe social maladjustment in both civilian and Army life with a history dating to childhood, together with an absence of a “normal” or average amount of insight. The majority of these cases presented because of pending disciplinary action and were unrelated to combat. Six patients with sexual aberrations (Psychopathic Personality, Type III) were interviewed, four of them again pending disciplinary action. Only six patients were considered to have an intellectual handicap justifying the diagnosis of Mental Defect.

*Schizophrenia.*—This diagnosis was made with certainty in 22 soldiers, who together with four suspected cases were all evacuated to England for further assessment. Only six of these could be related to battle experience, two of which became clinically evident in the front line. Simple and paranoid forms were the commonest types of schizophrenia encountered.

*Manic-Depressive Psychoses.*—Six soldiers were considered to have depressive symptoms with large endogenous components. They were mostly N.C.Os. in the older age group.

**Relative Incidence of Psychiatric Casualties**

In Fig. 1 are graphed the total number of troops in the theatre month by month as received from Field Records, B.C.F.K. On the lower part are graphed the psychiatric casualties in terms of total loss to the force through evacuation to England (medical category M2S0) and partial loss through down-grading to medical category M2S3 which necessitated restriction of the soldier to base areas only. These figures will be seen to be very small.

The high relative incidence for December to April can be attributed to the presence of reservist soldiers in the force, many of whom showed a lowered tolerance for hardship, to considerable enemy activity, including two large-scale battles, and to the stresses of the winter months. Peace talks began in July and the falling off of the casualty rate is presumably due to this, though there was still considerable patrol activity and from September there was a definite increase in mortar and shell fire.

During the year December, 1950, to November, 1951, there was considerable movement of troops in and out of the theatre and therefore the total monthly figures of troops reckoned as being in the theatre must be taken as being below the total number who could have been potential casualties. For example, the 28th Brigade was replaced in April by battalions from Hong Kong and the 29th Brigade was being replaced during the October-November period.
It is obvious from these figures that the loss of manpower due to psychiatric breakdown was negligible and presented no major problems to the administrative authorities. The writer has not at hand for comparison the exact monthly casualty and sick rate resultant from surgical and medical breakdown, but through observations and experience in the routine duties of Orderly Medical Officer admitting convoys of patients directly from the battle front, the proportion was roughly one psychiatric casualty for every twenty wounded or sick.

Some 275 cases from the Australian, Canadian, New Zealand, Indian and South African members of the Commonwealth Forces were interviewed. The personnel from these countries were almost entirely volunteers and together with some first-class material a considerable number of inadequate psychopaths and hysterics were included, whose tolerance for combat, hardship, and boredom was low. It was clear that their retention in the force would be detrimental to the morale of their particular group. Many had a previous (but undisclosed on enlistment) psychiatric history; a few members were even in receipt of pension for their "disability." The following is an analysis of all non-U.K. members of the Commonwealth Force who were interviewed:

<table>
<thead>
<tr>
<th>R.T.U.</th>
<th>M2S3</th>
<th>M2S0</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>138 (50%)</td>
<td>33 (12%)</td>
<td>104 (38%)</td>
<td>275</td>
</tr>
</tbody>
</table>

The combined number of non-U.K. troops in the Commonwealth units is not accurately available, but it would be fair to estimate it at about one-quarter to one-third of the total force. The percentage psychiatric breakdown was therefore considerably less in U.K. elements. This point is brought out not as a claim for superiority of any one member but to illustrate the very real importance and economy of psychiatric screening and personnel selection.

**TREATMENT**

Apart from continuous narcosis and abreactive therapy no other physical methods of treatment were used. The technique and management of these are well known and will not be given here. Abreactions were largely confined to patients presenting hysterical symptoms, and showed some quite dramatic "cures" which invariably enhanced the reputation of the operative psychiatrist. Reassurance, suggestion and an appeal to the soldier's sense of duty both to himself and, often more effective, to his unit are simple methods of psychotherapy which, despite an understandable scepticism because they are "simple" methods, give better results than might be expected. Psychotherapy at a "deeper level" was reserved for severe neurotics who, if recommended for evacuation to England, were confronted with a few weeks' delay. An alleviation of symptoms to some extent was usual, and any relevant psychopathology was forwarded with the patient's documents for the attention of the Military Psychiatrist at Netley.

**SUMMARY**

A brief report has been given on the incidence and type of psychiatric casualty encountered amongst British Commonwealth troops fighting in Korea.
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The breakdown per 1,000 men is almost negligible, and it is felt that this was almost certainly due to the absence of intense enemy shell fire and aerial bombarding. The R.T.U. rate for U.K. personnel was 65 per cent. and the number of relapses was insignificant. Anxiety reactions as usual were the most common clinical entity encountered and some success with a superficial form of psychotherapy can be claimed in a number of these cases.

The importance of psychiatric screening and personnel selection has been stressed and is exemplified by a comparison of U.K. troops with troops from other Commonwealth countries.

Frostbite has been mentioned and its incidence may in future campaigns be of importance in assessing the morale of a military force.

AN ANÆSTHETIST’S VISIT TO A U.S. ARMY HOSPITAL IN JAPAN

BY

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I visited the hospital, which was formerly a mission hospital and is now divided into a main block and an orthopaedic annexe, on 9th and 10th December, 1951, and had a most cordial reception from the anaesthetic staff. We discussed anaesthetic arrangements in both armies and I had an opportunity of inspecting their equipment and watching them at work.

In the main hospital there is one central theatre block with five single-table operating theatres. There is one small room for anaesthetic equipment and stores. Inductions are carried out on the operating table in the theatre. Each theatre has one full-time anaesthetic nurse in charge and she has all the necessary equipment on the spot. Supervising the five sisters is a recognized anaesthetiologist of the American Board.

Equipment

Each theatre has one Heidbrink or McKesson machine, standard Army models, using nitrous oxide, oxygen and ether only, and with double carbon dioxide absorption canisters. The former machine is good; the latter they considered poor because of the high resistance in the circuit.

The equipment and drugs are based on the simplest techniques and procedures, possibly because almost all the anaesthetics are administered by nurses. Each theatre has an anaesthetic trolley with adequate storage capacity for every likely requirement of the nurse during operation. Incorporated in the trolley is a suction pump for the use of the anaesthetist only. The nurse never leaves
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