



〈Special Issue Articles〉 Medicine in the Korean War

Psychiatric Casualties during the Korean War: Focusing on American and Common Wealth Soldiers[†]

YEO In-sok*

1. Introduction
2. Evacuation systems of the psychiatric casualties
3. Psychiatric problems and their treatment
4. Mental Health of US Prisoners of War (POW)
5. Conclusion

1. Introduction

The Korean War was an important event in the formation of modern Korea. Its effects can still be felt in many areas of Korean society today. Healthcare in Korea was also heavily influenced by the Korean War, and modern medicine and healthcare in Korea can be seen as shaped by the Korean War (Lee, 2014). Most studies on the Korean War have focused on the military and geopolitical aspects of the war. Relatively few studies

[†] This work was supported by the National Research Foundation of Korea(NRF) grant funded by the Korea government(MSIT) (No. 2022R1F1A1070808).

* Professor, Department of Medical History & Institute for History of Medicine, Yonsei University / E-mail: isyeo@yuhs.ac

have focused on the medical aspects of the Korean War. The topics that have been studied are the control of epidemics during the war (Lee, 2013), the Mobile Army Surgical Hospital (MASH) (Han, 2021), medical aid from Scandinavian countries (Park, 2010), and the introduction of new surgical fields and technologies. Little research has been done on the psychiatric aspects of the Korean War. War puts those who participate in it through physical and mental extremes, causing not only physical injuries but also psychological trauma and damage. However, studies on the medical aspects of the Korean War have been limited to topics related to physical injuries and their treatment, and there are no studies that systematically summarize the traumatic effects on the human mind thrown into the midst of war, the consequences of these effects, and the medical efforts made to address these problems. In particular, soldiers captured by enemy forces face many difficulties not only physically but also mentally. Therefore, this study aims to identify the mental health problems faced by soldiers who participated in the Korean War and how these problems were treated psychiatrically. In addition, we will explore how the peculiarities of the Korean War were reflected in the psychiatric problems of the veterans. In this paper we have mainly used articles written by military doctors who took part in the Korean War, published in military medical journals during and after the war. And most of the statistics quoted are from official US Army publications. Based on these historical materials, we attempted to provide a more comprehensive view of psychiatric aspects of the Korean War and to place it in the historical context of the development of psychiatry in the 20th century.

2. Evacuation systems of the psychiatric casualties

The Korean War began with a sudden and unexpected invasion by North Korea. South Korea was faced with an invasion for which it was not prepared for. The same was true for the allied forces, including the US military, which entered the war in support. Drafted at short notice to fight a war in a faraway land, the soldiers were psychologically unprepared and thrown directly into a hail of bullets and shells. This caused extreme stress for the soldiers, and as a result, in the case of the US military, about a quarter (250/1,000) of the early soldiers were sent to US military hospitals in Japan or the United States (Hawaii) for psychological problems such as severe anxiety (Flood, 1954: 40). Once evacuated, most of these soldiers never returned to the front. Faced with this situation, and recognizing that the management of the soldiers' psychological problems were essential to the successful conduct of the war, US military authorities began to assign psychiatrists to every division in August 1950 (Koontz, 1950: 444).

Programs to deal with psychological problems such as anxiety were also introduced, and after six to eight weeks, the number of soldiers sent to the rear for psychological problems dropped significantly. In particular, Colonel Al Glass, who arrived in Korea in October 1950, distributed a combat psychiatry manual based on his experience in World War I and II, and established a three-tiered system of care transfer. According to this, patients were to be treated in the first division, the second in Korea, and the third in Japan or the United States (Glass, 1954: 725). However, in the early days of the war, when the first and second levels were inadequate, the patients were often transferred directly to the third level of US military hospitals, and from March 1951 onward, psychologically unfit soldiers

were pre-screened and assigned to non-combat positions to reduce unnecessary rearward transfers.

The British did not initially send psychiatrists, but the Canadians did, and they rotated through the combat theaters to gain field experience. In late 1950, the British established a base hospital (the 29th British General Hospital) in Kure, near Hiroshima. It was a 600-bed hospital with a total staff of 300, including medical staff (*BMJ*, 1951: 556). Of these beds, 30 were allocated to psychiatric patients. With the overwhelming power of American airpower, the Allies could easily transport patients in trouble from the front to hospitals in Japan, but this ease of transport had a negative side effect. Initially, the majority of patients were sent to Kure, but later only about 30% were sent to the base hospital at Kure, and in 1952, the psychiatrists insisted that the base hospital in Kure should be moved to Korea. In order to minimize the number of patients sent back as much as possible, combat fatigue, which was the most common case, was treated at Field Dressing Stations (FDS) run by the Canadian Army, which had shown good results (Jones, 2000: 256). Later, the role of the FDS expanded and it became a kind of small general hospital, with 24 beds allocated for psychiatric patients. In the US military, combat fatigue was treated by operating a mobile psychiatric detachment, the equivalent of a mobile surgical hospital, which traveled from front to front.

The US military, which deployed the largest number of troops, also had the largest number of psychiatric patients, and for those who needed in-patient care, psychiatric wards were set up within existing hospitals or separate psychiatric hospitals were established. Planning for a psychiatric ward at the 64th Field Hospital in Pyongyang began on 27 November 1950. A facility for about 100 patients was established near the main hospital

building. There was also a psychiatric center at the 4th Field Hospital near Seoul and a small psychiatric unit at the 8054 Evacuation Hospital in Busan in the rear. In the north-east of the peninsula, the 121st Field Hospital had a psychiatric unit supported by the hospital ship *Consolation* (Glass, 1953: 1566). However, when the Chinese offensive began in late November, the wounded were all transferred to the 64th Field Hospital in Pyongyang. However, when the continued attacks forced them to abandon Pyongyang and retreat, the 64th Field Hospital was forced to close. The psychiatric team of the 64th Field Hospital was integrated into the 4th Field Hospital of the US Eighth Army, and the 4th Field Hospital became the main hospital in Korea (Glass, 1953: 1567).

Meanwhile, patients sent directly from Korea to Japan were initially transferred to the 118th Base Hospital in Fukuoka, close to the Korean peninsula. However, as the Chinese offensive began in earnest, the number of casualties increased rapidly, and by the end of November and December 1950, more than 1,000 patients a day were being transferred. As a result, casualties beyond the hospital's capacity were transferred to hospitals in Tokyo and Osaka. The 118th Base Hospital was also expanded to 1,600 beds. At the same time, the 141st General Hospital at Camp Hakata, 18 miles from Fukuoka, was expanded to relieve the burden on the 118th Base Hospital. The 141st Base Hospital expanded its psychiatric ward to accommodate most of the psychiatric patients sent from Korea. A separate facility was built away from the main hospital to house about 200 psychiatric patients (Glass, 1953: 1568).

Next, we look at the actual size of the psychiatric caseload during the war. In the US Army, at the divisional level, hospitalizations for psychiatric problems accounted for 9 per cent of all hospitalizations. At the non-

divisional level, it was 5 per cent (Reister, 1973: 8). Psychiatric outpatient visits were 23,043 for combat troops and 15,438 for other personnel, giving a total of 38,481. This is about 3.5 per cent of the total outpatient visits of 10,928,162. The rest of the population here refers mainly to prisoners of war, so it is likely that a significant proportion of prisoners also received psychiatric care (Reister, 1973: 11). It tends to peak in February and then falls slightly, ceasing in May. This is due to an increase in psychiatric admissions and malaria cases as the weather improves and fighting becomes more active (Reister, 1973: 56).

The total number of beds operated by the US Army during the Korean War was as follows. 380 beds in the forward first line and 900 beds in the second line. The first line hospitals were mostly mobile surgical hospitals and the second line hospitals were evacuation hospitals. Special hospitals included the Epidemic Hemorrhagic Fever and Frostbite Hospital (200 beds) and the Psychiatric Hospital (300 beds) (Reister, 1973: 58). The Psychiatric Hospital was established in April 1952 to treat and rehabilitate patients with psychiatric problems among US and UN forces in Korea. It was jointly operated by the 123d Medical Holding Company and the 212th Psychiatric Detachment (Reister, 1973: 64).

The rear (Communication Zone) hospital had 1,200 beds and the prisoner of war hospital had 1,700 beds. A total of 1,829 patients were admitted to the psychiatric hospital, with an average of 48 inpatients and an average length of stay of 7.4 days, which was not long compared to that in the rear convalescent hospitals, with the exception of the First Line Mobile Surgical Hospital, where patients were sent after first aid. Of the total number of in-patients, 214 were sent back to Japan (Reister, 1973: 58). The number sent back to the United States directly from the

battlefield was much higher. For psychiatric patients, a total of 5,999 were sent to the United States, mostly Army. Of these, 3,321 were admitted to closed wards and 2,678 were admitted to open wards.

Changes in inpatient admissions by year show that in the first six months of the war, from July to the end of the year, 3,470 patients were admitted. The following year, in 1951, 6,705 patients were admitted for the entire period, a similar number to the previous year. In 1952, the number of admissions was much lower, with 2,495 patients admitted, and in 1953, the year of the Armistice, 895 patients were admitted over a seven-month period (Reister, 1973: 116). This shows that psychiatric admissions were high in the early years of the war, 1950 and 1951, when there was a lot of fighting, and decreased as the fighting subsided.

3. Psychiatric problems and their treatment

Under the extreme conditions of war, soldiers suffer from a wide range of mental health problems. During the Korean War, 37 per 1,000 US soldiers suffered from psychiatric problems, compared with 12 per 1,000 during the Vietnam War. The nature of soldiers' psychiatric problems also varied according to the stage and course of the war. First, in the early stages of the war, from about June 1950 to November 1951, when the fighting was so intense that the casualty rate reached 460 per 1,000 soldiers, a relatively large number of soldiers complained of psychological symptoms such as anxiety, fatigue, and combat stress. The majority of these soldiers were infantrymen. As the war entered a period of stagnation with only minor skirmishes around the ceasefire lines, the casualty rate dropped to 170 per 1,000 in 1951 and 57 per 1,000 in 1952. The predominant symptoms

then shifted to nostalgia-related frustration and despair, or alcohol and drug addiction (Jones, 2000: 257). This pattern was similar in the Commonwealth forces. In the early stages of the war (December 1950 to November 1951), 554 out of a total of 16,000 British troops were sent to Kure Hospital in Japan for psychiatric problems. This was a high rate of 35 per 1,000 men. Of the 544, more than half, 287, were diagnosed with anxiety disorders, and 73 (13%) were diagnosed with dissociative states or conversion disorders. These symptoms often developed after heavy shelling.

In the second phase of the war, the FDS played a more active role, and as a result, the number of psychiatric patients admitted to the division's base hospitals dropped significantly, accounting for only 2.3% of all admissions. Combat fatigue patients were mostly treated at the FDS, with more than half of them returning to the front, and about 30% being transferred to the Kure Hospital. In any case, as the intensity of the war decreased, fewer soldiers complained of psychiatric symptoms. The divisional psychiatrists made regular visits to forward units, and each time they saw many cases of suspected somatization disorder. Common symptoms were chronic back pain, digestive problems, and vasomotor disorders. However, these symptoms were often physical manifestations of anxiety, anger, and demoralization, so the actual number of psychiatric patients with somatization may have been higher than the statistics suggest, as the treatment of these patients focused on their primary physical symptoms rather than their psychiatric problems (Jones, 2000: 258).

1) Combat Fatigue

A psychiatric condition that was particularly characteristic of the Korean War was what the US military termed 'Combat Fatigue'. Also known as 'Battle Exhaustion', it is a psychiatric condition characterized by a variety of symptoms, including extreme exhaustion and helplessness, in soldiers who have been exposed to stressful combat situations over an extended period of time. It was first reported in the British military in the early days of World War I under the name 'shell shock'. It could be treated early with aggressive treatment programs. To deal with it, the US military first established a mental health unit to train regimental and battalion medics, and a mobile psychiatric detachment to travel to the front lines. More than half of the American soldiers treated for combat fatigue in the field were able to return to duty within one to six hours. Neuroleptics such as barbiturates and short-term psychotherapy were used to treat patients with severe anxiety, with considerable success (Grinker, 2022: 228).

In the Commonwealth forces, by contrast, there were 21 cases of combat fatigue per 1,000 casualties at the end of 1952, compared with 200 per 1,000 at the time of D-Day, the most heavily fought day of the Second World War. This is thought to be due to the lull in the war after 1952, when there were fewer extreme stress situations with constant shelling or bombing. In treatment, patient motivation was seen as the most important part of returning to work. After treatment, most patients were retrained and returned to work, although not in their original positions. 66% of the soldiers sent to the base hospital in Kure returned to work. In this case, however, they had been deployed to the rear rather than the front lines. The Australian Army, on the other hand, had a higher rate of trips to base hospitals, but this was due to an inflexible policy on the part of

the Australian military authorities rather than a problem with the soldiers. In the British and Canadian militaries, soldiers treated for combat fatigue were reassigned to other, less dangerous positions, but Australian military authorities insisted on frontline deployment (Jones, 2000: 259).

2) Mental health problems of wounded soldiers

The aforementioned combat fatigue is caused by the intense mental stress of being in a combat situation, whether you are injured or not, which results in various psychiatric symptoms. On the other hand, various types of physical injury sustained in combat can also cause psychiatric symptoms. In World War I and World War II, wounded soldiers were reported to feel honored in the early stages of their injuries as if they were a badge of honor, but the resulting disabilities demoralized and disaffected them (Miller, 1940). In addition, hemiplegics and quadriplegics may have difficulty in accepting themselves because of the disruption to their body image. It was reported that 64 out of 100 amputees suffered from anxiety or other psychiatric symptoms (Randall, 1945: 645).

Meanwhile, a psychiatric interview survey of 75 wounded soldiers admitted to the orthopedic wards of the US Naval Hospital in Bethesda and Walter Reed Hospital in Washington, D.C., for injuries sustained during the Korean War reported some notable findings regarding the mental problems experienced by wounded patients. For example, 17 patients with limb amputations showed reckless behavior and traits characteristic of exhibitionism, but their emotional distress was no different from that of other orthopedic patients. This was judged to be a reflection of the patients' pre-existing pathological personality problems prior to the injury and not related to the nature of the injury (Noble, et al., 1952: 495-

9). However, these amputees exhibited a characteristic feature of the Rorschach test: a strong resistance to the drawing test, with a tendency to leave the drawing unfinished or to draw the limb in a distorted form. This was thought to reflect the disruption to their body image caused by the amputation.

And it was the overall pattern that was significant. When comparing patients with mild injuries to those with severe injuries, there was little difference in the rate of psychiatric symptoms. This suggests that the development of psychiatric problems is not related to the type or severity of the injury, but rather has more to do with the patient's pre-existing personality of the patient. On the other hand, the types of psychiatric symptoms reported by plastic surgery patients were not significantly different from those reported by orthopedic patients with limb injuries, but the severity of the symptoms was much greater. This may be because most of the injuries were to the face, making it more difficult for patients to accept their disfigured faces (Noble, et al., 1952: 499).

3) Psychological factors of Cold Injuries

One interesting fact is that frostbite, which affected many soldiers during the Korean War, was associated with psychiatric symptoms. The first winter of the Korean War was very cold, and there were far more cases of frostbite than would be expected from the climatic factor alone. Other factors have been proposed to explain this phenomenon, including inadequate warm clothing, fatigue, and fear (Hanson, 1964: 1307-1316). Indeed, the winter of 1950-51 saw many cases of frostbite, some of which were so severe that more than 4,000 were evacuated to rear area hospitals in Japan (*Lancet*, 1952: 233). This unexpectedly high incidence of frostbite

cases was thought to be caused by the extreme stress that the intense fighting of the first year of the war placed on the soldiers. Stress contributes to frostbite in both behavioral and physiological ways. First, extreme stress prevents soldiers from paying enough attention to the changes in their environment to take adequate measures to protect themselves, and as a result, they neglect to take care of their bodies, making them more susceptible to frostbite. Physiologically, anxiety triggers the sympathetic nervous system, which causes vasoconstriction and sweating, lowering the temperature of peripheral areas of the body and increasing the risk of frostbite. It has also been observed that there is an inverse relationship between the occurrence of frostbite and the development of psychiatric symptoms, suggesting that the physical damage caused by frostbite acts as a mechanism to inhibit the development of psychiatric symptoms in situations of extreme stress (Jones, 2000: 259).

Psychological factors such as stress can both promote and inhibit the development of frostbite. A Commonwealth Army unit arrived in Korea in the summer of 1950 with no special winter equipment, yet the unit had the lowest incidence of frostbite of any Allied force during its first winter. This was attributed to the commander's decision to allow small fires in the trenches and the frequent replacement of dry socks, as well as the high morale of the troops were cited (Malcolm, 1952: 10, 74).

On the other hand, this large number of frostbite cases included many patients with subjective symptoms without objective findings. The 'cold feet' syndrome, with its predominance of numbness, may have been a secondary gain from the disease or another manifestation of low morale, and it is reasonable to assume that the marked decrease in psychiatric patients during this period is in fact related to the increase in frostbite

cases. There was also an increase in self-inflicted injuries. They were considered a combination of cold numbness and inattention, which is also thought to be largely psychological (Glass, 1953: 1565).

4) Japanese encephalitis and its mental sequelae

Japanese encephalitis was one of the major infectious diseases that threatened American troops stationed in Japan and Korea after Japan's defeat in World War II. During World War II, the US military suffered more casualties from malaria than from fighting in the Philippines and other South China Islands. After this bitter experience, the US military undertook a systematic effort to control the mosquito, the vector insect that carries malaria. After being stationed in Japan, the US Army also recognized the seriousness of mosquito-borne Japanese encephalitis and systematically studied the mosquito fauna in Japan and Korea as a basis for vector control (La Classe, 1950).

Despite these efforts, there were a number of casualties from Japanese encephalitis during the Korean War. As its name suggests, Japanese encephalitis is a serious disease in which virus attacks the brain, damaging it and causing a variety of neuropsychiatric problems and even death. Therefore, in November 1950, a study of brain dysfunction caused by Japanese encephalitis was conducted at the 361st Station Hospital by a team of researchers, including psychiatrists. During the late summer and early autumn of 1950, a total of 300 cases of Japanese encephalitis occurred among combatants, and 10 per cent of whom died. Patients presented with headache, neck stiffness, altered consciousness after fever, confusion, delirium, and unconsciousness. The acute febrile phase lasts about 7-10 days and requires intensive care. Once the fever

has subsided, consciousness returns to normal, but in some cases, severe sequelae remain. In a study of 200 patients who recovered from febrile illness at the 361st Station Hospital, 30 had severe mental dysfunction, and all were flown to the United States. The remaining patients underwent neurological testing, EEG, psychological testing, and psychiatric evaluation to determine residual brain damage. They were all placed in positions with more restricted duties than before, mostly in the Tokyo area. After discharge, they were followed up twice at three-month intervals. Headaches, nervousness, and tension were common complaints, but mood disturbances were rare, and the persistence of these symptoms seemed to depend on the patient's adjustment to the new job (Glass, 1953: 1400-1401).

4. Mental Health of US Prisoners of War (POW)

Allied soldiers captured by enemy forces were not only denied the minimum conditions necessary to maintain their health by the North Koreans or the Chinese, but were often tortured and beaten to death. The official number of US Prisoners of war is 6,656, but this excludes those who died after capture, so the real figure is actually much higher. After the Chinese Communist Party (CCP) Army intervention, the POWs were held in North Korean POW camps run by the CCP Army. These camps were located in rugged mountains and remote areas where escape was impossible. Those captured early in the war could spend up to three years in a camp (Ritchie, 2002: 901). In the harsh conditions of cold and starvation, POWs faced the following psychological challenges, among others psychiatric symptoms due to nutritional deficiencies: Inadequate

nutrition for basic survival led to weakness and various illnesses, especially beriberi (lack of thiamine) and pellagra (lack of niacin), two vitamin deficiencies that disrupted the central nervous system and led to psychiatric problems such as memory loss, coma, and dementia. The experiences of the American soldiers captured by the North Koreans were strikingly similar to those of American soldiers captured by the Japanese during the World War II. They experienced forced marches over long distances, called 'death marches,' inadequate food to survive, insufficient clothing and shelter from the cold, violent punishment for minor infractions of rules, and witnessing of the spectacle of fellow prisoners shot in cold blood. To avoid the anxiety caused by these conditions and to protect themselves mentally, prisoners smoked cannabis or exhibited emotional withdrawal (Lifton, 1954: 733).

1) Brainwashing

In October 1951, the administration of all Allied POWs, including American soldiers, was transferred to the hands of the CCP Army, and the POWs faced a new situation. While the physical treatment of POWs was better than before, they were forced to undergo a political reformation. This process, known as "brainwashing," had not been experienced by prisoners of previous wars and was unique to the Korean War which out broke in the background of Cold War. Brainwashing is a program of thought modification using emotional insults and psychological techniques used by the Chinese to convince prisoners of the superiority of communism or to change their minds. It was an attempt to change an individual's ideological identity through forced confessions of past wrongdoing, re-education, and solitary confinement.

Brainwashing consisted of three phases that were carried out simultaneously: isolation, thought control, and political conditioning. First, isolation was a method of emotionally isolating prisoners by physically separating them from their peers and superiors who shared similar values, in order to facilitate the indoctrination of new values. Officers, especially those who could influence the rank and file, were separated and housed in separate camps. Intensive lecture and discussion programs aimed to devalue the values that individuals had previously attached to their family, religion, army, country, etc. so that they no longer identified themselves with those values.

Thought control was carried out by eliciting confessions of past misdeeds, self-criticism, or writing in praise of communism from prisoners. No actual physical harm was inflicted during this process, but subtle threats of physical harm, denial of repatriation, and return to the harsh conditions of the past were made (Lifton, 1954: 734). This control was constant and emotionally draining for the prisoners, not only physically. Political conditioning consisted of lectures and group discussions. Learning was initially compulsory, but later took the form of “special study groups” for “advanced” students. The content consisted of repetition of communist principles and slogans, criticism of ideologies opposed to communism, and highly arbitrary and authoritarian judgements about what was true and what was false. Prisoners were given no routine. This enforced idleness was to encourage the reading of available literature, consisting mainly of Communist Party newspapers, magazines, books, and novels criticizing negative aspects of American society.

POWs subjected to this systematic indoctrination experienced considerable emotional turmoil, similar to that experienced by children

faced with inconsistent and unpredictable parental demands (Hunter, 1956: 100). The Chinese elicited responses from the POW population by rewarding and punishing them appropriately for cooperation and resistance. On the other hand, the attitudes of the brainwashed prisoners varied. Many would make the appropriate level of compromise without offending the CCP, but not go beyond certain limits. Some, however, unable to withstand the tension and anxiety of this tightrope walk, would go beyond these limits and actively collaborate. They did so, however, not because of any change in their political beliefs, but because of material advantages. Conversely, there were a small number of prisoners who resisted strongly and did not cooperate at all. These were individuals who tended to maintain an exceptionally strong sense of self-identity, or who were naturally resistant to authority of any kind, and the Chinese classified them as either 'progressive' or 'reactionary' depending on the success of their brainwashing and the degree of their cooperation. These classifications were seen as opposites among the POWs, so that a POW classified as 'progressive' was considered a traitor or even a subordinate, while a POW classified as 'reactionary' was considered a badge of honor (Lifton, 1954: 734).

2) Psychological reactions and social adjustment problems after repatriation

As the war drew to a close, POWs were repatriated. American POWs handed over to the US Army by the Chinese were psychiatrically examined at Incheon. They exhibited clinically similar psychological reactions: they appeared confused and unenthusiastic about their release from captivity. In the interviews, they showed apathy, a lack of spontaneity, a dull, monotonous tone of voice, and a marked decrease in responsiveness. On

the other hand, they showed signs of nervousness and distrust of their new surroundings and were extremely defensive, especially when asked about their experiences in captivity. They showed guilt, which related to all stages of their captivity: the process of becoming prisoners, the deaths of their comrades and their own survival, their primitive behavior in captivity, and especially any kind of cooperation, however trivial.

The returnees went home by boat. On the boat, however, there was a conflict between the returnees. Those who had collaborated with the Red Army during their captivity were threatened by other returnees, and the conflict had escalated into a fistfight. When the two groups were physically separated to prevent further escalation, there were no further clashes. The returnees received group therapy during the voyage. Although only a small proportion of the total number of returnees were subjected to group therapy, they showed an interesting response: their behavior was a repeat of that seen in the camps. Those who had been labelled “reactionary” for their stubborn refusal to be indoctrinated were equally resistant to group therapy. On the other hand, those who had been cooperative with the Red Army in the POW camps were more likely to participate and cooperate in group therapy, suggesting that the response to the CCP’s brainwashing program was not influenced by its content or particular circumstances, but rather by each individual’s basic attitude to authority (Lifton, 1954: 738).

While it is true that the experience of being a POW was traumatic for many individuals, official statistics published by the US military indicate that the rate of development of psychiatric problems was not high. A study of 3,743 released US servicemen found that the majority (3,073, 82.1%) were mentally healthy. About 18% had psychiatric symptoms, and 37 had

the most severe psychosis, representing 1.0% of the population. Other conditions included 267 (7.1%) psychoneurosis, 219 (5.8%) personality and behavioral disorders, 33 (0.9%) mental retardation, and 112 (3.0%) transient personality disorder (Leister, 1973: 90). These figures are based on official statistics published by the US military, but they are the result of a survey conducted shortly after return. However, because of the nature of psychiatric disorders, it is impossible to tell from these statistics how the various psychological traumas of the POW experience negatively affected subsequent social adjustment. In fact, those who have returned home after having been POWs have tended not to feel the same sense of belonging to the community to which they had originally belonged, and showed stronger psychological attachments to groups of people who shared their experience of captivity (Lifton, 1954: 789). And some of the repatriated suffered from the suspicion of those around them that they had been brainwashed into becoming spies during their captivity.

5. Conclusion

The Korean War is characterized by the fact that it was a large-scale war that took place only five years after the end of World War II, and that it was the first clash between two blocks in the background of Cold War. In particular, brainwashing of prisoners of war and their subsequent psychological problems are characteristic of the Korean War in the context of the Cold War. These characteristics are reflected in the medical aspects of the Korean War, particularly in the psychiatric history of the Korean War, which is the subject of this article. As the Korean War broke out only five years after the end of the Second World War, the experiences and

achievements of the Second World War were used in the Korean War. In terms of personnel, many of the soldiers who fought in the Second World War also fought in the Korean War. This continuity with the Second World War had both positive and negative aspects. On the positive side, treatment and transport systems were quickly put in place to respond to the large numbers of soldiers with psychiatric problems on the front lines early in the war. This is an example of a positive use of the legacy of the Second World War. On the other hand, the negative side of the coin was the much higher frequency of psychiatric symptoms among veterans of the Second World War (Glass, 1954: 1392). This could be explained by the fact that the psychological trauma experienced on the battlefield during the Second World War remained latent and was reactivated in the Korean War as a kind of conditioned reflex.

Finally, let's look at the significance of the Korean War for the development of psychiatry in the 20th century. During the First World War, psychiatrists mainly treated conversion disorders, in which psychological problems manifested themselves in physical symptoms such as speech and gait disorders. During the Second World War, however, psychiatrists found an overwhelming number of soldiers suffering from anxiety and depression. Psychotherapy was effective in treating these patients, and this line of treatment continued into the Korean War, where it was actively used to treat combat fatigue patients. Psychotherapy is treatment through dialogue. This helped to improve the negative image of psychiatry, of which the main treatment had been identified with the confinement in asylum. It is noteworthy that the active use of short-term psychotherapy in the treatment of psychological trauma patients during the Korean War led to the development and boom of dynamic psychiatry in the United

States in the 1950s and 60s after the war. The Korean War can be seen as an important turning point for the golden age of psychiatry and psychoanalysis in the 20th century.

Key Words : Brainwashing, Combat Fatigue, Korean War, Prisoners of War, Psychiatry

투고일: 2023.08.31 심사일: 2023.11.04 게재확정일: 2023.12.10

참고문헌 REFERENCES

<Primary Sources>

- “British Medical Services in Korea,” *BMJ* (1951), p. 556.
- “Editorial: Cold in Korea,” *Lancet* (1952), p. 233.
- Anderson, Clarence L., et al., “Medical Experiences in Communist POW Camps in Korea,” *JAMA* 156-2 (1954), pp. 120-122.
- Flood, J. J., “Psychiatric Casualties in U.K. Elements of Korean Force,” *Journal of the Royal Army Medical Corps* 100-1 (1954), pp. 40-47.
- Glass, Albert J., “Psychotherapy in the combat zone,” *American Journal Psychiatry* 110 (1954), pp. 725-731.
- _____, “Psychiatry in the Korean Campaign, A Historical Review,” *U. S. Armed Forces Medical Journal* 4-10 (1953), pp. 1387-1401.
- _____, “Psychiatry in the Korean Campaign, A Historical Review,” *U. S. Armed Forces Medical Journal* 4-11 (1953), pp. 1563-1583.
- Hunter, Edward, *Brainwashing* (Pantianos Classics, 1956).
- Knoontz, Amos R., “Psychiatry in the Korean War,” *The Military Surgeon* 107-6 (1950), pp. 444-445.
- La Classe, Walter and Satyu Yamaguti, *Mosquito Fauna of Japan and Korea* (Tokyo: Office of the Surgeon, HQ, 8th Army Apo 343., 1950).
- Lifton, Robert J., “Home by Ship: Reaction Patterns of American Prisoners of War Repatriated from North Korea,” *American Journal of Psychiatry* 110 (1954), pp. 732-739.
- Miller, Emanuel, *The Neuroses in War* (New York: The Macmillan Co., 1940).
- Noble, Douglas, Marion Roudebush and Douglas Price, “Studies of Korean War Casualties,” *American Journal of Psychiatry* 108 (1952), pp. 495-499.
- Peterson, Donald B., “The Psychiatric operation, Army Forces, Far East, 1950-53 with statistical analysis,” *American Journal of Psychiatry* 112 (1955), pp. 23-28.
- Randall, Guy C., et al., “Psychiatric reaction to amputation,” *JAMA* 128 (1945), p. 645.
- Reister, Frank A., *Battle casualties and medical statistics U.S. Army experience in the Korean War* (Washington, D.C.: The Surgeon General Department of the Army, 1973).

<Secondary Sources>

- Grinker, R. Richard, trans. Haeyoung Jung, *Jeongsangeun eobda [Original title: Nobody's Normal]* (Seoul: Memento, 2022).
- Han, Bong-seok, "Medical Support Research During the Korean War: Centered on the Activities of the 8th Army Mobile Surgical Hospital," *Yonsei Journal of Medical History* 24-1 (2021), pp. 7-38.
- Hanson, H. E. and R. F. Goldman, "Cold injury in man: a review of its etiology and discussion of its prediction," *Military Medicine* 134 (1964), pp. 1307-1316.
- Jones, Edgar, "Army Psychiatry in the Korean War: The Experience of 1 Commonwealth Division," *Military Medicine* 165-4 (2000), p. 256.
- Lee, Im-ha, "The Public Health and sanitation of the United Nation Civil Assistance Command, Korea (UNCACK) -Focus on the communicable diseases-," *Society and History* 100 (2013), pp. 325-359.
- _____, "The Chronic Communicable Disease Control of the United Nation Civil Assistance Command, Korea (UNCACK)," *Salim* 49 (2014), pp. 281-311.
- Newman, Richard A., "Combat Fatigue: A Review to the Korean Conflict," *Military Medicine* 129 (1964), pp. 921-928.
- Park, Jiwook, "The Medical Assistance of Swedish Red Cross Field Hospital in Busan during and after the Korean War," *Korean Journal of Medical History* 19-1 (2010), pp. 189-208.
- Ritchie, Elspeth Cameron, "Psychiatry in the Korean War: Perils, PIES, and Prisoners of War," *Military Medicine* 167-11 (2002), p. 901.

Abstract

Psychiatric Casualties during the Korean War: Focusing on American and Common Wealth Soldiers[†]

YEO In-sok*

A crucial gap in the medical history of the Korean War is the history of psychiatry during the Korean War. War puts those who participate in it through physical and mental extremes, inflicting not only physical injuries but also psychological trauma and damage. However, studies of the medical aspects of the Korean War have been limited to topics related to physical injuries and their treatment, and there are no studies that systematically summarize the traumatic effects on the human mind thrown into the midst of the war, the consequences of these effects, and the medical efforts made to deal with these problems. As the Korean War was fought only five years after the end of the Second World War, the experiences and achievements of the Second World War were used in the Korean War. In terms of personnel, many of the soldiers who fought in the Second World War also fought in the Korean War. This continuity with

[†] This work was supported by the National Research Foundation of Korea(NRF) grant funded by the Korea government(MSIT) (No. 2022R1F1A1070808).

* Professor, Department of Medical History & Institute for History of Medicine, Yonsei University / E-mail: isyeo@yuhs.ac

Received: Aug. 31, 2023; Reviewed: Nov. 4, 2023; Accepted: Dec. 10, 2023

the Second World War had both positive and negative aspects. On the positive side, treatment and transport systems were quickly put in place to respond to the large numbers of soldiers with psychiatric problems on the front lines early in the war. This is an example of a positive use of the legacy of the Second World War. On the other hand, the negative side of the coin was the much higher frequency of psychiatric symptoms among veterans of the Second World War. This could be explained by the fact that the psychological trauma experienced on the battlefield during the Second World War remained latent and was reactivated in the Korean War as a kind of conditioned reflex. In addition, the brainwashing of prisoners of war and their subsequent psychological problems are also characteristic of the Korean War in the context of the Cold War. These psychiatric features of the Korean War will provide a useful historical example for understanding and helping those who are inevitably involved in war and suffer from mental distress.

Key Words : Brainwashing, Combat Fatigue, Korean War, Prisoners of War, Psychiatry