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Psychiatry in the Korean War: Perils, PIES, and Prisoners of War

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In the initial months of the Korean War, very high numbers of psychological casualties occurred among American troops, 250 per 1000 per annum. Initially, these men were evacuated to Japan or the United States, and very few of them were returned to duty. Then the principles of early and far-forward treatment, learned in the previous world wars, were reinstated. Up to 80% of neuropsychiatric casualties were returned to duty. During and after the war, the prisoners of war were believed to have been "brainwashed," have "give-it-upitis," and exhibit apathy and depression. Mistakenly believed to be signs of moral decay, the psychiatric symptoms during and after release were probably a result of extended inhumane treatment and vitamin deficiencies.

Introduction

The Korean conflict has frequently been referred to as the Forgotten War, although the beginning of that war is familiar to students of military history. The slogan, "Remember Task Force Smith" motivates young medical officers in their training. The 50th anniversary of the Korean War renewed interest in the politics and battles from 1950 to 1953. This essay hopes to illuminate the successes and failures of Army psychiatry in that bitter period. The events of September 11, 2001 and the ongoing war in Afghanistan highlight the importance of remembering those lessons.

When North Korea poured into South Korea on June 25, 1950, the United States was ill-prepared to respond. The undermanned Battalion Task Force Smith was flown over from Japan only a week later and sent to beat back the North Koreans. The U.S. soldiers did not have adequate rockets to stop the T-34 tanks. Despite individual and unit heroism, Task Force Smith was overrun.

The survivors retreated toward the port city of Pusan. But shortly thereafter, thousands more troops arrived to reinforce the Pusan perimeter. Later, General McArthur's forces landed at Inchon. After Allied Forces pushed back up into North Korea, China joined the war. Hundreds of thousands of Communist Chinese soldiers poured into what the United States called a "police action," pushing the U.N. allies to retreat in frozen and hostile terrain. Two and a half more years of war ensued, to end in a stalemate on the 38th Parallel, later to become the demilitarized zone. The American dead numbered 36,516 and the wounded 103,264. Seven thousand two hundred forty-five became prisoners of war, and 8,176 were not accounted for and presumed dead.¹

The management of psychiatric casualties in Korea was based

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upon the programs developed in World War II, which were a "rediscovery" of the forgotten work of British and American psychiatrists in World War I. The basic principles, later codified as "proximity, immediacy, expectancy, and simplicity," or "PIES," directed simple immediate treatment, on the front lines, with the expectation of return to duty.²⁻⁷

The history of the Korean War and military psychiatry is a large topic, and many areas will be only briefly outlined. The sweeps back and forth across the peninsula of the Armed Forces and particular battles will be discussed only in reference to their psychological toll. The reader is referred to other sources for further information on the politics, fighting, and military medicine.⁸⁻¹¹

Much of the information about psychiatric intervention in the first year of the Korean War is drawn from the published works of COL Al Glass, principally because few other authors published on that topic. Reference is made to a number of unpublished accounts.

The Korean War: The First Year

Throughout the Korean conflict there were perils of weather and terrain: unbearable heat and monsoon rain, or bitter frigid cold and wind, fierce jagged mountains and sucking rice paddies. Especially in the first year, there was fear of the overwhelming hordes of enemy soldiers, danger from infiltrators both in front of and behind the lines, the presence of desperately poor and starving refugees, and the chances of being tortured and executed if captured. This first year has been generally split into phases according to the campaigns, which will be described further in succeeding sections.

The Beginning of the War—July through September

In the first months of the Korean conflict, from June to September 1950, both the physical and psychological travails were overwhelming. Many of the soldiers were initially pulled from easy occupation duty in Japan, with inadequate uniforms (including winter clothes), arms, or training. Few knew anything about the trials they were to face: "He is the average American boy, just under 20 who was pulled from his malted milks and basketball scores. . . ." ¹² They faced tough, experienced, and sometimes brutal North Korean and Chinese soldiers. "Inferiority in numbers and weapons in July and August caused a disproportionate degree of external stress and terror."¹³

The rate of psychological casualties was extraordinarily high, 250 per thousand per year (Fig. 1).¹⁴⁻¹⁶ A "severe anxiety reaction" is described as follows: "He would usually come in looking markedly fatigued with face drawn and expressionless or full of terror. Tremulousness, voice difficulty, dilated pupils, rapid pulse, profuse sweating, tremors, and sometimes tearfulness . . . insomnia, anorexia . . . battle dreams."¹⁷

As there were initially no psychiatrists in the Korean Theater, impaired soldiers were evacuated to Japan or the United States. "The average number of neuropsychiatric casualties on the airlift (to the US) had been approximately 20 per week from June through October 1950."¹⁸ Approximately 1,800 casualties were evacuated from Pusan to Japan during July, August, and early September of 1950. Only 50% of psychiatric patients were salvaged even for noncombat duty.^{19,20}

Psychiatrists were placed in the divisions in August, following lessons learned during World War II. Divisional psychiatry became operational within 6 to 8 weeks after the onset of hostilities. The evacuation rate diminished markedly.

The United Nations Offensive

The United Nations Offensive lasted from September 15 to November 26, 1950. Following the Inchon landing, Seoul was retaken in tough street-to-street fighting. The troops then rapidly pushed up to the Yalu River in North Korea.

The 1st Marine Division, which bore the brunt of very heavy fighting in Seoul, incurred a large number of psychiatric casualties and illustrated the "deleterious" effect of evacuation. Casualties were first evacuated to a comfortable hospital ship near Inchon. Very few Marines could be returned, perhaps because few wanted to leave the hot food, showers, and safety of a ship for the mud, cold, and danger of the front. Somewhat later, when they were treated in a primitive field hospital with rest, sedation, and superficial psychotherapy, 50% were returned to duty.¹⁹

COL Al Glass arrived as the Theater Consultant to the Far East in October 1950. He promptly handed out copies of a guide to Combat Psychiatry, which was a special edition of the Army Medical Department Journal, published in 1949.⁷ This comprehensive book summarized the lessons of those past two wars. He also emphasized the practice of far-forward early intervention, instituted a biweekly psychiatric report, and implemented the term "combat exhaustion."

A three-echelon system of treatment was also developed—the Division, the Theater (Korea), and the Zone of the Interior (Japan and the United States). In the first echelon, psychiatrists were assigned at the Division level to the 2nd, 24th, and 25th Infantry Divisions and the 1st Cavalry Divisions. They were able to slow the flow of evacuees from the divisions, returning 50 to 70% of them to combat.²⁰ (The term "echelon" is used by COL Glass and differs in its meaning from the current uses of echelons of care.)

In the second echelon, supposed to be hospitals serving the Korean Theater, the psychiatric services were initially very limited. Hospitals moved rapidly as the front lines shifted. Thus, patients often were evacuated to the third echelon, Japan or the United States (often Tripler Army Medical Center). Hospitals were located in Japan at Tokyo, Osaka, Fukuoka, and the 7th Infantry Division. Those evacuated out of Korea were vulnerable to group suggestion, the comforts of the hospital, and the night-life in Japan and Hawaii. Few could be returned to active duty.¹⁹

The Chinese Communist Offensive

After China responded to the Allied penetration north of the Yalu, hundreds of thousands of Chinese soldiers swarmed across allied lines. During this next phase, the Chinese Communist offensive from November 26, 1950 to January 15, 1951,

Allied Forces retreated back down the peninsula. The weather was consistently well below zero, and many ill-equipped men died from the frigid cold and exhaustion. Division medical support was limited to emergency care and evacuation. Only a low incidence of psychiatric casualties was reported: "Plane evacuation was uncertain and used mainly for the physically disabled; all others had to fight their way out in a do-or-die manner."²⁰

Medical and surgical casualties from the heavy fighting overwhelmed the hospitals in Korea and Japan. Two convalescent hospitals for psychiatric patients were established in Japan during this period, which freed up beds for the wounded. At these hospitals, the patients, in fatigue uniforms, participated in calisthenics and other training activities. Emphasis was placed on outpatient evaluation and treatment, whenever possible, with an expectation of return to duty.^{19,20}

The Winter Offensive

The U.N. forces rallied. Seoul had to be re-taken. The Winter Offensive from January 15 to April 22, 1951, described as "Operation Killer," was a period of digging in. There was a more secure battle line with no rear infiltration. "Defeatism turned to grim determination."^{15,20} Fewer men were killed taking ground of little strategic significance. Cease-fire negotiations took place. There was hope that the war would shortly end.

Patients who developed "combat stress" tended to be either novices or, on the contrary, those who had been in combat more than 6 months. "Old Sergeant syndrome" referred to soldiers from World War II who, after 6 to 9 months of conflict, developed psychiatric symptoms and often had to be evacuated from theater.²⁰ "Approximately 60% of those admitted during this month had been in combat for more than 6 months, which indicated a need for a rotation policy."²¹ This latter report, from the 25th Infantry Division, helps to institute the individual 1-year rotation. (To rotate soldiers after only 6 months was probably impractical.)

A high incidence of frostbite and other accidental injuries continued.²² Undoubtedly, some of these individuals wished to return home in an honorable fashion. "The increase of other types of accidental injuries tended to confirm the viewpoint that the dispirited and unhappy soldier may become apathetic to an injury that may possibly rebound to his personal benefit and remove him from a traumatic environment."²⁰

A new policy was developed in March 1951, whereby a soldier not psychologically fit for combat could be reassigned in support functions. This avoided unnecessary evacuation to the Zone of the Interior and maintained manpower.²⁰

The Spring Campaign and Truce Negotiations

The next phase, the Spring Campaign, was another Communist offensive that lasted from April 22 until July 10, 1951. The U.N. forces withdrew, and a low rate of psychiatric casualties was reported. After a May 28 counter attack, "uphill fighting against determined opposition," there was an increase in psychiatric casualties, but more than 90% were returned to duty.

From July to October 1951, truce negotiations by the United Nations took place. There were limited offensives. The rate of psychiatric casualties dropped to 32 to 36 per thousand per year (Figs. 1 and 2). During this period, the influence of the 1-year

rotation became evident, which included the disruption of the sustaining power of group identification and the "short-timer syndrome." "The rapid shift of key personnel, officer and enlisted, usually just at the time when they become most effective, has considerably disturbed the unity of the group."²³ On the other hand, this improved morale and probably reduced the number of self-inflicted injuries. A sign posted on the road in May 1952 read "Never fear; rotation is here; accidents unnecessary; drive carefully."^{15,20}

The Later Years—1952 and 1953

COL Glass was transferred back to the United States in October 1951. Various division psychiatrists and consultants continued to post reports. In general, psychiatric cases continued at the above low but steady pace until the armistice in 1953. The emphasis on the battalion aid station and division clearing station as the first levels of psychiatric treatment continued. One report emphasized the higher number of psychiatric casualties among those units employed to hold their positions against the enemy's counterattacks.²⁴

Most reports describe a return to duty rate of 65 to 90% (Figs. 1 and 2). Significantly there were few "repeaters" among those diagnosed with combat stress, treated, and returned to duty. Reports from 1951 and 1952 state that 5 to 10% were "Neuropsychiatric Repeaters."²⁴⁻²⁶

Some of these consultant reports praised the newly created Army residency training programs.²⁷ "The credit for this is in part due to the wisdom of the Surgeon General, who during the past five years has successfully prosecuted the development of an Army residency training program."²⁸ On the other hand, nearly all of the psychiatrists sent to Korea were quite junior. Some consultants stressed the young psychiatrist's lack of training: "The suggestion was made by several medical officers that it would have been more useful to them to have had more indoctrination into the principles of combat psychiatry and to have learned more about the treatment and disposition of such patients. . . ."²²

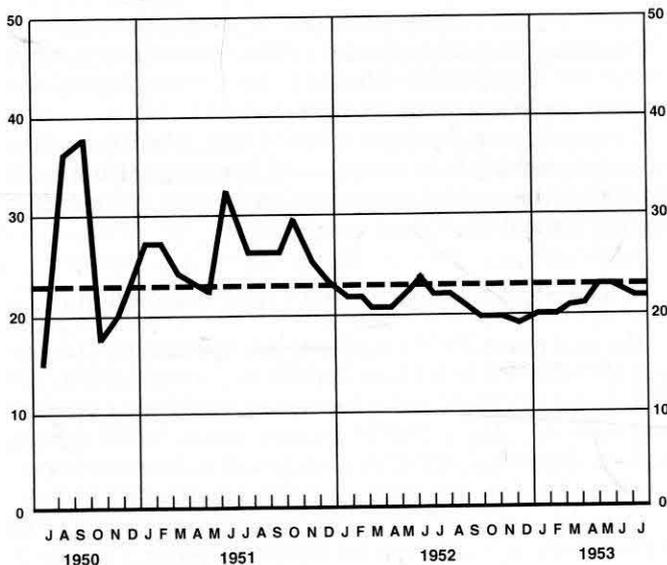


Fig. 1. Rates of psychiatric casualties throughout the Korean conflict from July 1950 to July 1953. Source: COL Glass (Fig. 3), p 186.

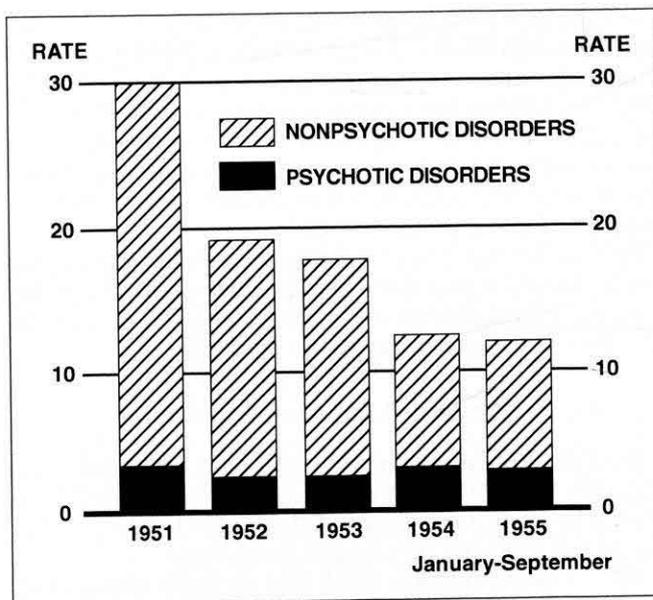


Fig. 2. Rates of psychotic and nonpsychotic disorders throughout the Korean conflict. Source: COL Glass (53), p 191.

The importance of the psychiatrist being part of the military was emphasized: "The relationship of the psychiatrist to the group is no longer that of an effete practitioner in an ivory tower, nor that of a rebel, nor that of a sooth-sayer promising comfort to anyone who 'feels badly'. Rather, the psychiatrist is a soldier, a member of the group, with a common mission to be accomplished. . . ."²⁹

Symptoms and Treatment

Early descriptions of psychological reactions turned into psychiatric disability were written about from patients evacuated to Tripler Army Medical Center in Hawaii and to the United States. "SGT Crymes, 33 years old, 6 years in the service . . . saw considerable combat . . . in World War II . . . I had a concussion. The tank fired point blank at us. . . I cracked up. I got nervous and began to cry. The lieutenant sent me back to the station.' The patient states that of the ten men with him, seven were caught and he saw them have their hands tied behind them and were shot with machine guns. He has been given phenobarbital."³⁰

Initially the stories of atrocities were doubted. "These two patients discussed Korean atrocities and insisted that they had seen prisoners trussed up, their ears cut off, and their tongues cut out. I felt somewhat doubtful about the stories they told of atrocities. . . ."³⁰

The mainstay of initial treatment was the basic doctrine of PIES as described above, including reassurance, explanation, ventilation, rest, and food (Fig. 3). The book *Back Down the Ridge* described the results of one successful treatment this way: "After three days of such treatment. . . one lanky mountain boy, who had arrived trembling and sobbing that he could never go back, sat silent for a minute. Then he stood up. 'Hell', he said, 'I guess somebody's got to fight this god-damned war,' picked up his rifle and started trudging up the trail toward the sound of the guns."¹²



Fig. 3. CPL Jean watches over an acutely ill neuropsychiatric patient in restraints, Neuropsychiatric Ward, Treatment of Patients with Combat Fatigue and Severe Mental Illness. Source: Armed Forces Institute of Pathology.

Barbiturate (amobarbital and thiopental sodium) therapy was used both for sleep and interviews. "Included in the treatment was a routine insistence on cleaning up, shaving, and eating within the first 6 to 12 hours. With severe anxiety reactions and psychotics, amyltal sedation was used the first night starting with six grains and with repeat amounts until enough had been given to ensure restful sleep."³¹

Nonconvulsive shock therapy was also attempted. A consultant brought over a "Reiter type of apparatus". . . . His preliminary results were encouraging. Twenty patients . . . were selected and given daily nonconvulsive therapy for from 7 to 10 days. About 50% of these patients showed varying degrees of improvement.¹⁵ " However, similar results could be obtained by the standard simple methods of treatment.

Drug abuse was a major problem with Army soldiers addicted to opiates in port towns such as Pusan. Heroin use went from smoking to intravenous injections. The Chinese were believed responsible for the import of the drugs, in an effort to sap the fighting strength of the Americans. In some units, as many as half the soldiers were believed to be addicted.

There was uncertainty as how best to handle cases of drug abuse and ineffective soldiers—through medical or administrative channels? To evacuate them from the theater was to reward them for bad behavior. To incarcerate them was to drastically reduce the strength of the units. They functioned well on the job, but were believed to contaminate others.¹⁵

As opposed to the European theater in World War II, there was

a very low absent without leave rate. Essentially, there was no safe place to run to; life outside of the unit was even more dangerous than life within.^{15,31}

The Walter Reed Army Institute of Research sent over teams of researchers several times during the conflict. Drs. Gentry Harris and David Rioch visited in both 1950 and 1953. They described the difference in the stress in forward and rear areas and further distinguished the stresses of the combat zone into the actual fighting vs. the stress of living in those primitive conditions. Reactions to combat in forward areas were more likely to be dissociative and more consistent with "combat exhaustion," whereas those in the rear zones were likely to exhibit a manifestation of a previous behavioral or personality disorder. The critical importance of the buddy system to the men in the combat zone was apparent: if a soldier was unable to get a buddy, or lost one, he was far less effective.³²

American Prisoners of War

Service members were given no preparation for the possibility of capture or guidance as to what to divulge if they were taken captive. In the beginning of the war, the North Koreans generally did not keep prisoners. Americans were usually executed, sometimes after torture or mutilation. Photographs portray American corpses with their hands tied behind their backs and shot in the head. "American soldiers were found who had been burned and castrated before they were shot; others had their tongues torn out. Some were bound with barbed wire, even around the head and mouth."⁸

After the Chinese joined the war, captured Americans were sent to Chinese-run prisoner of war (POW) camps in North Korea, usually after forced marches, during which unknown thousands died. A total of 6,656 Army troops were recorded as taken prisoner.³³ The official death toll in captivity was 38%.⁹ That number however probably does not include the men who perished before reaching the camps: "The suffering was intense as the weather was extremely cold, and many prisoners froze their feet. The average food ration consisted of one rice ball a day and little or no water. Many died from malnutrition, dysentery, beri-beri and pneumonia. . . . Prisoners who were unable to continue the marches because of exhaustion were killed by the Communist guards."³⁴

Those who survived the marches were "greeted with a cigarette," and with seeming kindness by their Chinese captors. They were barely fed, however, and received little or no medical attention. They were separated and isolated, with the military structure deliberately broken down. They were subjected to continuous propaganda and lessons on the virtues of Communism. Many lived in these extremely primitive camps for more than 3 years. Since the camps were in remote areas of North Korea, there was little possibility of escape.³⁵

Some of the POWs made statements favorable to their captors or propaganda speeches supporting communism. Minorities were especially targeted for propaganda about the "fat cats" of Wall Street. The "brainwashing" issue became central to a controversy, which raged in the United States during and after the war.³⁶⁻⁴⁰

Brainwashing was described as being composed of several elements: thought reform (confession and re-education), milieu control (isolation); guilt, shame, and confession; emotional re-

wards for participating; and a change in inner identity.^{41,42} Others disagreed as to how profound or unique the brainwashing really was.⁴³

Five Army physicians were taken captive and survived to publish their experiences in a 1954 article in the *Journal of the American Medical Association*. Prisoners suffered horrendous living conditions, almost no food and no medicine. "The Thanksgiving, 1950, meal of one group of 500 men furnishes a typical example. Each man received a millet ball weighing less than 200 g, and the whole group was given soup prepared by boiling nine heads of cabbage in water. . . . The prisoners slept and lived on the floors of these filthy, crowded compounds. It was common for them to awaken in the morning and find that the man sleeping on either side had died during the night."⁴⁴

The physicians described the apathy caused by the lack of vitamins in the food and used the term "give-it-upitis." "It made them realize that the individual's fighting spirit had to be maintained at a high level for him to survive any illness."

Unfortunately, this term was picked and taken out of context. "The erroneous impression has been created that prisoners of war who were in good physical health gave up and died; this is not true. Every prisoner of war in Korea who died had suffered from malnutrition, exposure to cold, and continued harassment by the Communists. Contributing causes to the majority of cases were prolonged cases of respiratory infection and diarrhea. Under such conditions, it is amazing, not that there was a high death rate, but that there was a reasonably good rate of survival."⁴⁴

The POWs were actually suffering from a variety of nutritional diseases such as beri-beri (thiamine deficiency) and pellagra (niacin deficiency). Both can cause central nervous symptoms, including memory impairment, confusion, and dementia^{45,46} (W. Shadish, personal communication).

"Little Switch" and "Big Switch" were the terms given to the operations to return the American POWs. "Little Switch" was supposed to be for the medically ill, although some physically healthy communist "collaborators" were put in that group, and there were many medically ill in the subsequent "Big Switch." "Little Switch" patients were regarded as hospital patients and were returned through medical channels by air. In "Big Switch," the rest of the POWs returned to the United States, usually by boat. Twenty-one POWs stayed in North Korea.

During the return home, "Little Switch" and "Big Switch" returnees were interviewed about their symptoms and experience. Symptoms of apathy, retardation, blandness, and depression were described. "The average repatriate was dazed, lacked spontaneity, spoke in a dull, monotonous tone with markedly diminished reactivity. At the same time he was tense, restless, clearly suspicious of his new surroundings."⁴¹ These symptoms were sometimes attributed to brainwashing and moral weakness, not to chronic disease and lack of vitamins.^{36-38,41,47-49}

The returning POWs (3,323 Army personnel) were treated with suspicion and often hostility. Congress and the American public was concerned about both the possibility of past collaboration, accounts of atrocities committed by Americans against their fellow prisoners, and the fear that the soldiers could have been brainwashed by the Chinese and still be spying for them.⁴⁸ Clearly some atrocities were committed, but the inclusion of collaborators in the initial "Little Switch" operation led to false

inflated reports.³⁹ A few soldiers were court-martialed for alleged atrocities against their fellow soldiers.

Problems with readjustment included: reintegration difficulties, finances, disinterest in the environment, the idiomatic communication among POWs, curiosity seekers, and public concern about indoctrination.^{41,42} Controversies about Korean POWs continued to rage during the 1950s. Was "give-it-upitis" due to a soft society? Were they traitors or victims? How powerful was the "brainwashing"? How many actually committed atrocities against their fellow prisoners?³⁶⁻⁴⁰

The POWs were followed in research studies for years.^{50,51} Generally, they readjusted into American society, but continued to have both psychological and physical symptoms, including elevated rates of death from trauma.^{50,52} The term "post-traumatic stress disorder" had not yet been coined.

Conclusions

The story of psychiatry in the Korean War has largely been forgotten. I believe that the lessons learned need to be remembered, and especially in light of the current war in Afghanistan and potential future conflicts, and incorporated into warfighting plans today.

This essay has described briefly the serious psychological stresses of the Korean War, especially for combat soldiers during the first year of conflict and for the POWs. The quick and effective efforts of the Army Medical Department in reducing psychiatric disability are noteworthy. "The evacuations for Japan and Korea for neuropsychiatric disability have been less than one-third of the number so evacuated from combat areas during World War II."⁵³

Dr. Marshall also had an opinion on the reason for the reduction of stress casualties: ". . . I would contribute progress to three factors: 1. Revival of the spirit of the good company; 2. Improvement in evacuation of the battle casualty; 3. The absence of a hospitable rear: Korea does not look good anywhere."³²

This account demonstrates extremely well the importance of the basic psychiatry principles of PIES. These concepts, and other refinements, have been incorporated into a 1999 Department of Defense Directive, "Combat Stress Control."⁵⁴ The concepts continue to be refined and updated. A conference held in 2001, "Mass Violence and Early Intervention," builds upon the earlier body of literature about combat psychiatry.⁵⁵

In my opinion, the United States did less well in understanding and treating those who had been captured, endured "Death Marches," endured years of captivity in horrendous circumstances, and then returned home to a suspicious and forgetful nation.

Vital lessons to be remember for future conflicts include: (1) the importance of early and quick treatment of psychiatric symptoms; (2) proper training, adequate arms, warm clothes, and unit cohesion; (3) the need to train service members how to survive if captured; and (4) the recognition that organic mental disease can masquerade as apathy and mental retardation.

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References*

1. Korean War statistics, as of June 1, 2000, prepared by Washington Headquarters Services.
2. Glass AJ: Psychotherapy in the Combat Zone. *Am J Psychiatry* 1954; 110: 725-31.
3. Hausman W, Rioch DM: Military Psychiatry. *Arch Gen Psychiatry* 1967; 16: 727-739.
4. Salmon TW, Fenton N: Neuropsychiatry in the American Expeditionary Forces, Volume X. The Medical Department of the United States Army in the World War. Washington, DC, United States Government Printing Office, 1929.
5. Artiss KL: Human behavior under stress—from combat to social psychiatry. *Milit Med* 1963; 128: 1011-15.
6. Drayer CS, Glass AJ: Neuropsychiatry in World War II. Vol II. Overseas Theaters. Washington, DC, Office of the Surgeon General, 1973.
7. Combat Psychiatry, The Bulletin of the Army Medical Department, November 1949.
8. Fehrenbach TR: This Kind of War: A Study in Unpreparedness. New York, Macmillan, 1963.
9. Cowdry AE: The Medics' War. U.S. Government, Center for Military History, 1986.
10. Applebaum R: South to the Naktong, North to the Yalu. Washington, DC, Center for Military History, 1960.
11. Mossman BC: Ebb and Flow: November 1950–July 1951. Washington, DC, Center for Military History, 1990.
12. White WL: Back Down the Ridge. New York, Harcourt, Brace and Company, 1953.
13. 8th U.S. Army Annual Report, 1950.
14. Korea: A Summary of Medical Experience—July 1950 to December 1952.
15. Glass AJ: Preventive psychiatry in the combat zone. *United States Armed Forces Med J* 1953; 4: 683-92.
16. Peterson DB: The psychiatric operation. *Army Forces, Far East, 1950-53. Am J Psychiatry* 1955; 112: 23-38.
17. Annual Medical Report, 1950.
18. Fabing HD: Report to Surgeon General, December 30, 1950.
19. Glass AJ: History and organization of a theater psychiatric services before and after June 30, 1951. *Recent Advances in Medicine and Surgery, Army Medical Service Graduate School, Washington, DC, April 19-30, 1954, pp 358-72.*
20. Glass AJ: Psychiatry in the Korean Campaign. *United States Armed Forces Med J* 1953; 4: 1387-1583.
21. Annual Report, 25th Infantry Division, 1951.
22. Peltz WL: Report to Surgeon General U.S Army on Tour of Medical Installations of Far East Command, November-December 1951.
23. Headquarters 2D Infantry Division.
24. Annual Report, 7th Infantry Division, 1952.
25. Analysis of Division Psychiatric Cases January through May 1952, September 3, 1952.
26. Flumerfelt J: Report to Surgeon General. U.S. Army on Tour of Medical Installations of Far East Command, August 1951.
27. Caldwell JM: The Present Status of Military Psychiatry, presented to the Medical Service Company Officer Course, April 30, 1952.
28. Gaskill HS: Report to Col. John Caldwell, April 12, 1951.
29. Report, 1952.
30. Boxman KN: Report to the Surgeon General, August 24, 1950.
31. Marshall SLA: Combat stress. *Recent Advances in Medicine and Surgery* (April 19-30, 1954), Vol 2, Medical Science Publication No. 4. Washington, DC, Walter Reed Army Medical Center, pp 347-57, 1954.
32. Harris FG: Experiences in the Study of Combat in the Korean Theater. II. Comments on a Concept of Psychiatry for a Combat Zone. Washington, DC, Walter Reed Army Institute of Research, October 1956.
33. Segal J: Factors Related to the Collaboration and Resistance Behavior of U.S. Army PW's in Korea. Washington, DC, George Washington University, December 1956.
34. Korean War Atrocities: Report of the Committee on Government Operations. Washington, DC, United States Government Printing Office, 1954.
35. Communist Interrogation, Indoctrination and Exploitation of Prisoners of War, Department of the Army, May 1956.
36. Mayer WE: Brainwashing—the Ultimate Weapon. Copy of Lecture, 1956.
37. Mayer WE: Why Did Many GI Captives Cave In? *US News & World Report*, February 24, 1956.
38. Kinhead E: In Every War But One. New York, WW Norton, 1959.
39. Biderman AD: March to Calumny. New York, Macmillan, 1963.
40. Biderman AD: Dangers of Negative Patriotism. *Harvard Business Review*, November-December 1962; 40(6): 93-99.
41. Lifton RJ: Home by ship: reaction patterns of American prisoners of war repatriated from North Korea. *Am J Psychiatry* 1954; 110: 732-39.
42. Lifton RJ: Brainwashing in Perspective—A Psychiatric Approach of Chinese Communist Thought Reform. Washington, DC, Walter Reed Army Institute of Research, October 1956.
43. Farber IE, Harlow HF, West LW: Brainwashing, conditioning and DDD (Debility, Dependency and Dread). *Sociometry* 1957; 20: 271-85.
44. Anderson CL, Boysen AM, Esenstein S, Lam GN, Shadish WR: Medical experiences in communist POW camps in Korea. *J Am Med Assoc* 1954; 156: 120-2.
45. Peck CC: Medical Care for Repatriated Prisoners of War. San Diego, Ca, Center for Prisoner of War Studies, January 1973.
46. Denny-Brown D: Neurological conditions resulting from prolonged and severe dietary restriction. *Medicine* 1947; 26: 41-113.
47. Communist Psychological Warfare (Brainwashing), Consultation with Edward Hunter, Committee on Un-American Activities, Washington, DC, United States Printing Office, 1958.
48. Segal HA: Initial psychiatric findings of recently repatriated prisoners of war. *Am J Psychiatry* 1954; 11: 358-63.
49. Strassman HD, Thaler MB, Schein EH: A prisoner of war syndrome: apathy as a reaction to severe stress. *Am J Psychiatry* 1956; 112: 998-1003.
50. Schein EH, Cooley WE, Singer MT: A Psychological Follow-up of Former Prisoners of War of the Chinese Communists. Part I: Results of Interview Study. Cambridge, MA, Massachusetts Institute of Technology, March 1960.
51. Biderman AH: Further Analysis of POW Follow-Up Study Data. Washington, DC, Bureau of Social Science Research, February 1, 1965.
52. Nefzger MD: Follow-up studies of World War II and Korean War prisoners. *Am J Epidemiol* 1970; 9: 123-38.
53. Policies and Directions, Surgeon General's Report.
54. Charts from Glass AJ: The Symposium on Preventive and Social Psychiatry. Washington, DC, Walter Reed Army Institute of Research, Walter Reed Army Medical Center, April 15-17, 1957.
55. Combat Stress Control, Department of Defense Directive 6490.5, February 23, 1999.
56. Ritchie EC, et al.: Mental health and mass violence: evidence-based early psychological intervention for victims/survivors of mass violence: a workshop to reach consensus on best practices. National Institutes of Health Publication No. 02-5138, Washington, DC, U.S. Government Printing Office.

*Note: Some of these references are from medical department reports or unpublished letters. Some lack identifying information, such as the author or date. Copies of the unpublished reports are available upon request.