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# Treat 'Em Up Front and Treat 'Em Early

**"Crazy docs," soldiers call them—the medics who use front-line psychiatry in Korea to save battle-numbed minds. Result: recovery for 98 per cent of our shock victims**

By MICHAEL DRURY

**Neuropsychiatric casualty is tagged for evacuation, treated as close to front line as his condition permits. Symptoms of shock state may range from constant crying to hysterical paralysis, but quick treatment can make difference between recovery and lifetime neurosis**

FEAR is the foot soldier's constant companion in combat. It reaches long gray fingers into the food he eats and the water he drinks. It forms a hard knot in his stomach and, when darkness comes, it riffles the hair on the back of his neck and jerks him into a listening crouch out of his fitful rest. There is no escape; you learn to live with it or else—after two days or two hundred days, you reach a breaking point. Then, suddenly, you're not a good soldier; you're a human being scared senseless.

You may go inexplicably blind or deaf. You may bolt in panic. You may freeze in your foxhole, unable to speak or move. You may weep, stutter, shake, vomit, or scream in your sleep. You're what military lingo calls NP—a neuropsychiatric casualty—and you'd be washed up right there except for one thing: a new-old treatment called front-line psychiatry—old because the basic principles were known in World War I, new because they've been applied in Korea more extensively than ever before.

In the bitter early days of Korean fighting, NP casualties siphoned off as much as a third of some forward units. Most casualties were evacuated, often to the United States where they crowded hospital wards and got no better fast. Very few of them saw combat again. Then, armed with World War II know-how, the Army dispatched to Korea a regular Army psychiatrist, Colonel Albert J. Glass, a dark, stocky, energetic native of Baltimore, then serving as neuropsychiatric consultant to the Far East Command.

The Navy sent Commander Charles (Sam) Mullin, Jr., of Cambridge, Massachusetts, an intent, soft-spoken, forty-two-year-old psychiatrist with long civilian and military experience in wartime England and at the naval hospital in Philadelphia. In Korea, Commander Mullin worked exclusively with the Marines, whose medical services are supplied by the Navy. And since there is only one Marine division there, he served both as combat psychiatrist and consultant.

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**Rest, hot food and clean clothing away from immediate combat area quickly overcome most cases of combat exhaustion. Battle-weary soldiers get encouragement from the front-line psychiatrists, but no pampering. They are told they will return to combat after resting**

Each in his own bailiwick, Glass and Mullin barnstormed Korea like circuit riders preaching a gospel: Treat 'em up front and treat 'em early—get 'em soon enough and you won't have as many NPs. They preached it to battalion surgeons and platoon sergeants at the front, to regimental medical officers and division commanders a few miles to the rear, to field and evacuation hospitals still farther back—in short, to anyone along the evacuation trail who might encounter an NP casualty on his way out. They all but talked themselves out of a job, making "everybody a psychiatrist at the front." That's what they wanted.

They knew that a man fights—when he's at the front—not for big principles, his country's welfare, freedom or democracy, but for the handful of guys in his unit. Pride and identification with his outfit are what keep him going. The closer to that outfit you can treat an NP case, geographically and chronologically, the greater its pull and support, and the better his chances for recovery. To evacuate him means losing his man power. It demoralizes the remaining men—"Only a sucker'd stay here and fight when you can give in to the creeps and get pulled off honorably." And, not least, evacuation tends to freeze the patient in his neurotic state. If he leaves his buddies, guilt haunts him and, sometimes to justify himself, he has to keep having symptoms. He may well remain a neurotic for the rest of his life.

To demonstrate the effectiveness of front-line psychiatry, Mullin and Glass squatted in the mud with battle-weary soldiers, or sat with them on boards in pup tents or bedded them down on litters propped between ammunition boxes—and they sent them back to duty, recovered, by the score. The Army snatched psychiatrists-in-the-making from its resident-training program in U.S. hospitals, recalled M.D. reservists with psychiatric leanings and some who bore the government an obligation because they had obtained all or part of their medical education at government expense during World War II. Glass gave them a quick indoctrination in Tokyo and within weeks there was a combat psychiatrist attached to every fighting division in Korea. Not all of them were highly trained, to be sure, but they were qualified.

Quickly dubbed "the 'crazy' docs" by the fighting men, in a few months these young psychiatrists-by-order-of-Glass reduced the losses from mental and emotional crack-ups to an all-time low. Today, the Korean record of NP discharges stands at two men per thousand per year, compared with 24 per thousand per year in 1943 and 16 in 1945.

Much of the credit belongs to battalion surgeons, the front-line medics who are the first to see NP casualties and who, if they have been properly in-

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**If evacuated in time, 70 out of every 100 NPs return to duty after a few days' treatment. Less than ten per cent of these battle-fatigue cases ever need further psychiatric help**

structed by the combat psychiatrist, can do most to keep mild cases mild. Now, of every 100 NPs reporting to forward aid stations, 45 go back to their units in a few hours. Rest, hot food, mild sedation and encouragement are what do it. Another 25 return after the same kind of treatment for a slightly longer period, perhaps overnight, at the regimental or division level, where the psychiatrist has his headquarters.

Only 30 move farther away, to rear-area hospitals, and half of this number are salvaged for noncombat work. Of the 15 who are sent to Japan, ten remain at jobs there. Only five have to be shipped back to the States.

A rest–hot-food–mild-sedation–encouragement formula sounds simple—but it works. Near Hoengsong in May, 1951, a Marine battalion was pinned down hour after hour by heavy mortar fire. There were 19 NP casualties among some 500 men —two companies of one battalion—where a more normal combat rate might have been two or three NPs. Within an hour, the 19 arrived by ambulance at the forward medical station, about four miles from the front. Huddled in the admissions tent where Mullin first saw them, they were a desolate, crying, shaking lot. One man was still fighting the battle, deploying men behind cots and tent poles. Another shouted, "Take cover!" every few seconds. A third sobbed dismally, "They got Jim! Jim's got it! Poor Jim!" over and over. In the Marine's term for it, they were "shook."

Mullin and his staff—Ensign Allen McMichaels, of Denver, a clinical psychologist with the Navy Medical Service Corps, and an Auburndale, Florida, corpsman named James Lee Hughes—made a quick visit to each man, no easy job since the tent was so small and crowded they couldn't all sit down. The interview consisted of asking what happened, listening, saying a kind word, perhaps patting a man's head or gripping his shoulder for a moment—something that would normally never happen in civilian practice—then indicating how much sedation (sodium amytal or nembutal) each man would need. Hughes gave them the capsule and a cup of hot soup.

They were allowed to sleep as long as they liked the next day. Special chow was arranged and magazines, writing materials, cards and games were provided. Shaving was required and clean uniforms supplied. At no time were the men put into pajamas or addressed as patients; they were Marines and expected to act like Marines. The second morning they were roused with reveille, ate at

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U. S. ARMY PHOTO

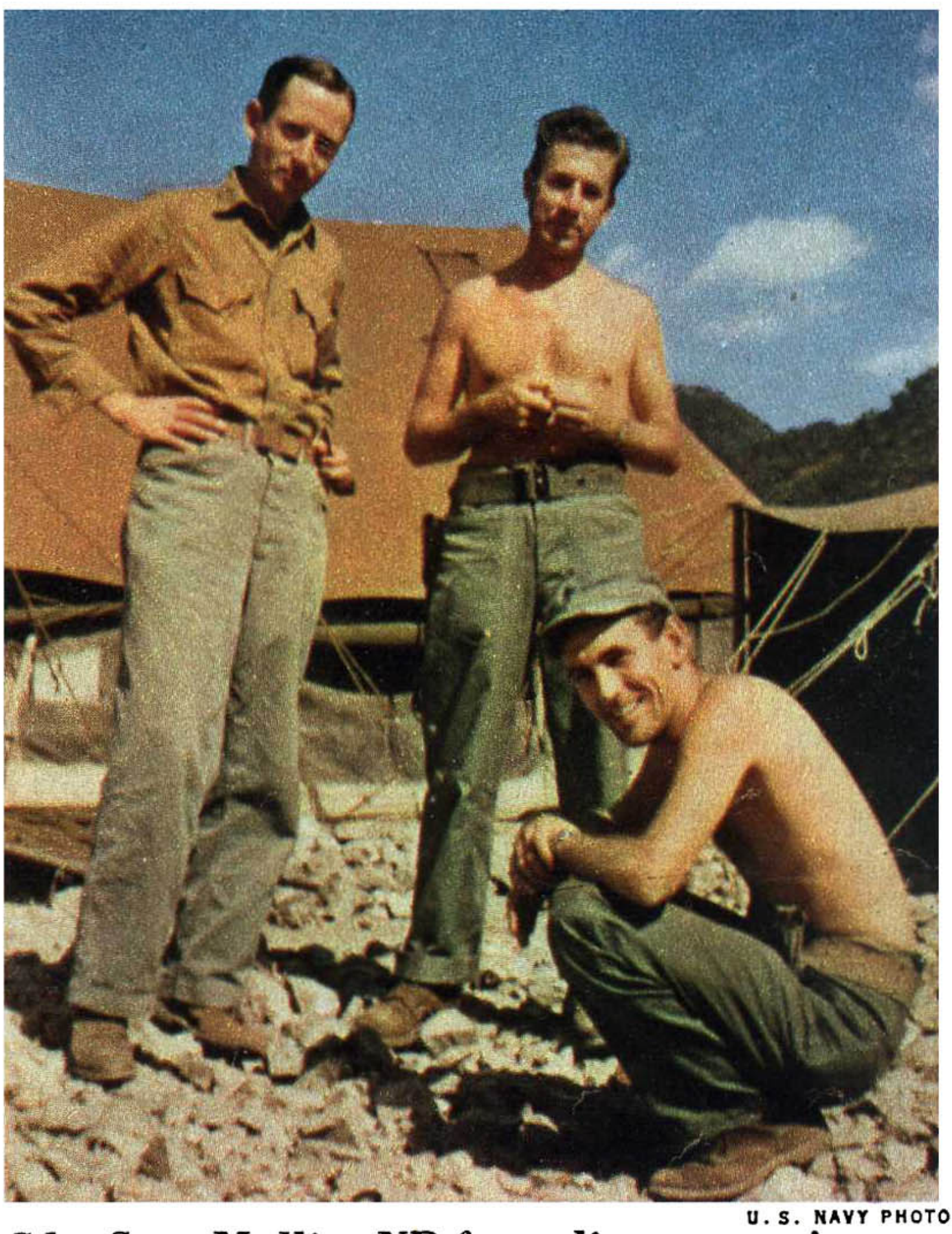
**Maj. Richard Conde, (l.), with Maj. Wilmer Betts, Raleigh, N.C., treated 3d Division NPs. Men called his tent "the Squirrel Cage"**

regular mess, marched a little, pitched horseshoes outdoors, all within earshot of the front. On the third morning, Mullin and McMichaels again talked to each man, reporting that a duty patrol was forming and asking how about going along. Only two said they couldn't face it again. Fifteen actually went back to combat that day; two were evacuated out of division; work was found for the other two behind the lines. Mullin never saw any of them again. Less than 10 per cent of NP casualties who go back to duty turn up a second time as psychiatric problems.

A civilian psychiatrist probably wouldn't have given a plugged nickel for the chance that any one of them would be a useful soldier again. By previous standards, each man needed months of treatment to find out why he broke when he did. But the combat psychiatrist doesn't give a hoot for why. He makes no attempt to deal with anything but the immediate acute crisis. There isn't time to analyze the soldier's deeper personal problems and, even if there were, it might only confuse him regarding the job at hand—fighting. It doesn't sound pretty at first and many a neophyte psychiatrist lost sleep over saving men from mental illness only to send them back to physical danger. But it isn't as cold-blooded as it seems. On the contrary; if the soldier can conquer his immediate fear, he has the best weapon on earth for coping with future problems: a personal victory instead of defeat.

## Resourcefulness Was Put to the Test

Most of the combat psychiatrists were pretty much on their own at first, depending on the day-



U. S. NAVY PHOTO

**Cdr. Sam Mullin, NP front-line–cure pioneer, with Lt. Cdr. George Stouffer, Chambersburg, Pa., and Lt. James Bittner, Royal Oak, Mich.**

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**Air evacuation at Hwangchon, Korea, is typical of emergency NP operations. Men who don't fully recover are reassigned to Japan or States. Only two out of 1,000 require a discharge**

to-day situation of their division, the amount of co-operation they got from the command, the equipment and personnel they could scrape up by their own talents.

If one was very lucky, he got another officer with psychological training to help him. It didn't happen often.

On paper the psychiatrist is attached to the division clearing company, its medical branch; and like any doctor in uniform, he's entitled to assistance from medical corpsmen. In practice, though, it didn't always work; so he recruited a staff wherever he could, not infrequently from among his patients. Combatmen on the staff proved to be useful. Most psychiatrists have never been riflemen themselves and the minute their patients realized it, they put on a record: "Cheez, Doc, you don't know what it's like. You can sit here and talk, but you ain't had it." Whereupon one of the doc's enlisted assistants would turn to another and ask not too innocently, "Let's see, Joe, how was it you got that Silver Star?" The patient usually subsided.

Commander Mullin's clinical psychologist, Ensign McMichaels, was a Marine sniper in World War II—a fact which was especially effective in shutting up the complainers.

One highly efficient corpsman attached to Korea's "crazy docs" was a former bartender from Boston whose adeptness in handling drunks apparently had been a sort of dress rehearsal for taking care of groggy infantrymen. Another first-class psychiatric assistant was a barber in civil life. ("I already heard every story in the book," he explains. "I recognize a dodge. Take a guy in my chair who don't wanna go home to mama because he shucked his pay envelope at the races. He gives me a pitch, the stuff he ought to say to her. Combat neuroses ain't so very different from mama neuroses.")

At one time the entire staff of Major Richard L. Conde let it ride, for a reason: a fundamental point in combat psychiatry is the light touch. The soldier is tired, not sick; and if he's scared, everybody else is too, so he's normal.

These off-the-cuff staff men sometimes had bizarre ways of helping. A young ex-hot-rod driver from California attached to a psychiatrist was cleaning a .45 in a tent where there were five NPs the doctor couldn't decide what to do with. Accidentally, the corpsman insisted later, he discharged the gun, putting a bullet harmlessly through the tent roof. One patient jumped over three cots, one began to be sick at his stomach, the other three shook like Lombardy poplars in a north wind. The psychiatrist evacuated all five of them at once.

"This is the kind of treatment I don't recommend," he says, "but I never made a faster or surer disposition of five patients." He also replaced the hot-rod driver.

Combat neuroses are not always expressed by crying or trembling. Headache, nausea, paralysis, amnesia, blindness or deafness, deep depression and apathy, dizziness and almost any noncontagious illness may result from neurotic causes. If an NP endangers the lives of others, this takes precedence over all other symptoms and he is almost invariably evacuated.

A neuropsychiatric disorder seen fairly often is *camptocormia*—Greek for bent back. The victim walks around with his back rigidly set at a 45-degree angle. He usually pleads, "Fix my back,

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**Brig. Gen. Rawley Chambers, Army chief of neurology and psychiatry, directs "up front and early" program jointly with Navy leaders**

Doc. Fix me up quick so I can get back to my outfit," without the least idea his trouble is neurotic. Somewhere in the far corners of his soul, he is resisting going back with superhuman strength.

At Inchon, Army Major Thomas T. Glasscock, a Kansas City, Missouri, psychiatrist, easily cured one case of bent back with a shot of sodium pentathol. When the drug wore off and the soldier found himself walking upright, he was furious. He tried to slug the psychiatrist but buckled over, once again in the grip of *camptocormia*. Glasscock ultimately eased him out of it, but it took several interviews with and without pentathol.

Around Taejon last year a rifleman was brought to Glasscock with one leg so paralyzed he couldn't feel a pin stuck half an inch into his thigh. His condition should have stemmed from a spinal hemorrhage, but there wasn't one and the medics concluded it was some form of hysterical paralysis.

## A Case of Sympathetic Paralysis

Under pentathol, the man revealed that he and a buddy had been knocked out by the same explosion. The other man's spine had been injured and his left leg paralyzed. Glasscock's man walked into the aid station under his own steam and developed his paralysis only at that point. So great was the companionship between them that the uninjured man had "taken on" his friend's wound out of sympathy and reluctance to go on without him.

The human mind is a tricky customer; it can sell itself a bill of goods and look the other way at the same time. No man, the combat psychiatrists say, really wants to quit in battle; but having once failed, however momentarily, he automatically digs in, holding on to a good thing—a legitimate reason for not fighting any more. It doesn't mean he's yellow. It means he's a normal human being with a distaste for being shot at. The Medical Corps calls it "secondary gain," the profit in being a casualty, and the GIs have the same idea when they call a minor physical injury a "million-dollar wound."

The night before Thanksgiving last year, the 7th Army Division was ordered to move up fast from a position about 40 miles in the rear. The psychiatrist, twenty-eight-year-old Major Dermott A. P. Smith, of Washington, D.C., had a 30-cot ward tent, occupied at the time the orders came through by six men who were entrenched in the conviction that they were too ill for further combat —the secondary gain. Smith himself felt the possibility that they might be right; but just then he needed their man power. He put it to them frankly.

They got out of bed, loaded the tent on a truck, moved up to the new area and set the tent up again by the light of artillery fire. Casualties were pouring in, so they hung around to help, stayed long enough to devour a Thanksgiving dinner the next day—turkey, stuffing, candy, nuts, the works—and then all six rejoined their own outfits. Not one of them knew he had been filibustering; yet being needed and doing a job had cured them. As a sergeant put it, "You're always fighting two wars, one with the enemy and one with yourself."

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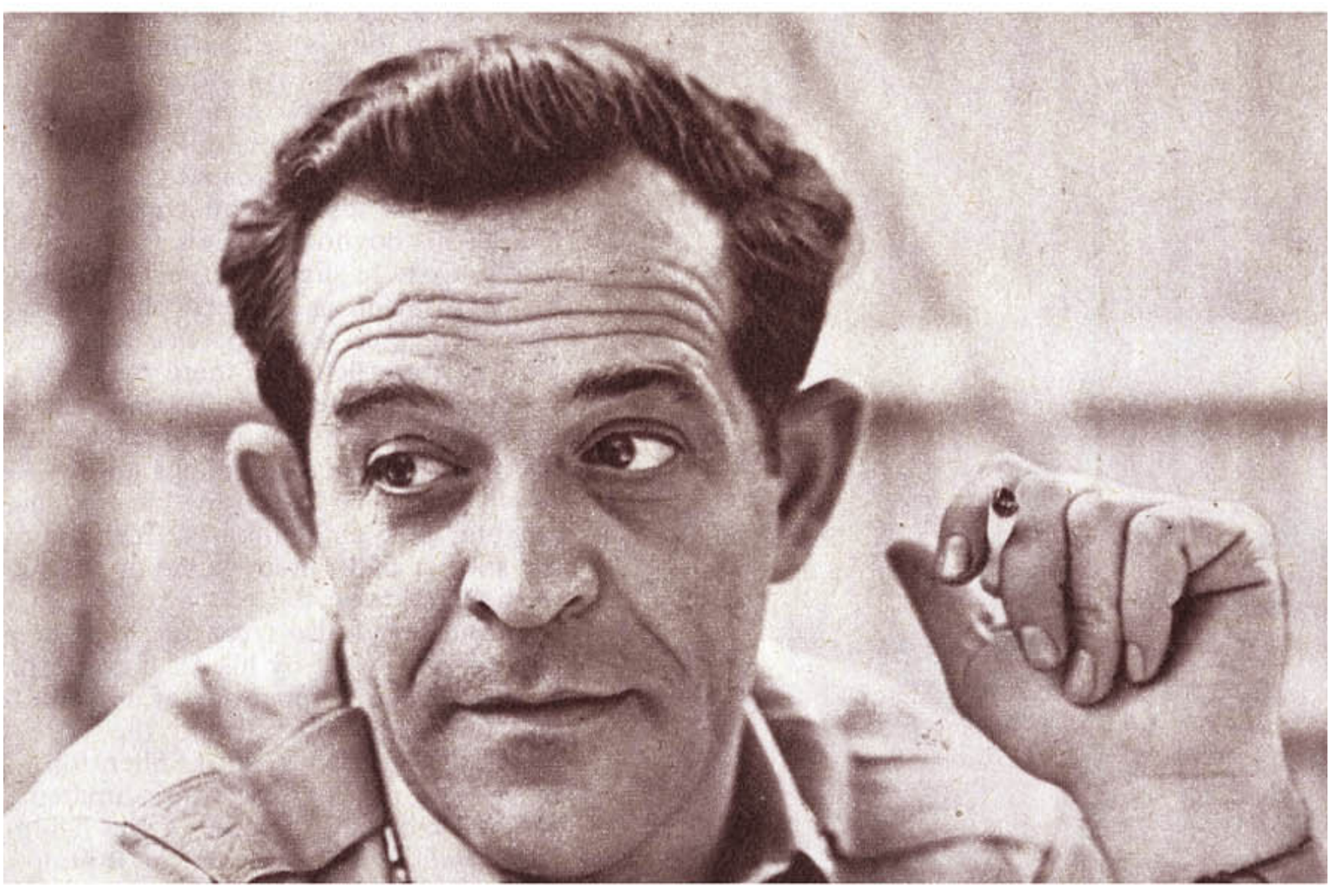
# *Up Front and Early*



**Colonel Albert Glass, military psychiatrist, set up fast-treatment techniques for Army shock victims in Korea. His assistants were obtained from hospital resident-training programs and from M.D. reserve forces. They're shorthanded, use cured NPs as orderlies**

NP patients brought back to division headquarters by corpsmen from their own outfits sometimes ask their escorts, "What's he like, this crazy doc? What'll he do with me?" And the stock reply is, "Oh, we'll be seeing you. Everybody goes back to duty from here." Firmly, insistently, the theme is reiterated from all sides: You will get rest and food and you will go back to work. It's a large part of the psychiatrist's job to indoctrinate his division with that idea and if he has done it well, it works perfectly.

Smith tells of an occasion when, while treating 30 patients, an understanding Army division commander decided to pay them a visit. The general made the rounds of the entire tent talking softly, personally, with each man for a few minutes. Even Smith was not invited into the conversation. At last, he stood up at the end of the tent and told them they were fine soldiers and he was proud of them—and 15 men got to their feet and asked to go back to duty.

## Language Troubles with Ethiopians

At times U.S. combat psychiatrists are called on to deal with other UN troops. Major Conde's division included a regiment of Ethiopians with whom he could converse only through a four-way language hookup. Glasscock once tried to aid some Red Chinese prisoners in various states of shock, but all he could get out of them was, "My spirits are bad." And Mullin cured a South Korean of hysterical blindness without ever learning what had caused it. There was no physical reason for him not to see, so Mullin described himself through an interpreter as a great and powerful doctor with strong medicine that would restore his sight.

"Judging from the translator's gestures," Mullin adds, "he must have jazzed up my story a bit." At any rate, Mullin gave the blind man pentathol and when it wore off he could see perfectly. It was that direct and simple.

In Washington, Brigadier General Rawley E. Chambers, the Army's chief of neurology and psychiatry, lists four techniques in front-line treatment: (1) treat as far forward as possible; (2) avoid a hospital atmosphere; (3) screen out recoverable patients quickly; (4) re-profile if necessary —that is, find the man a new job but don't lose him altogether. Most of this was learned in the shell-shock days of World War I and duly recorded in Volume 10 of its medical annals, and then forgotten by nearly everybody.

It was learned again, the hard way, in World War II, thanks in large measure to the pool of civilian psychiatrists who put on uniforms for the duration. Many of these men are still helping to sift, evaluate, classify. There were psychiatrists in Korea almost from the beginning, and their front-line treatment held up well, even at Pusan, according to Major General George E. Armstrong, Surgeon General of the Army. The observation is strongly seconded by Rear Admiral Lamont Pugh, Navy Surgeon General.

Glass in the Army and Mullin in the Navy and the handful of devoted, resolute men who worked with them proved that a few people in key positions could halt an avalanche of neuropsychi-

atric casualties. And it's quite possible too that civilian psychiatry will be learning from the not-so-crazy doctors of Korea new ways to give back to patients what they've lost—their faith in themselves.

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