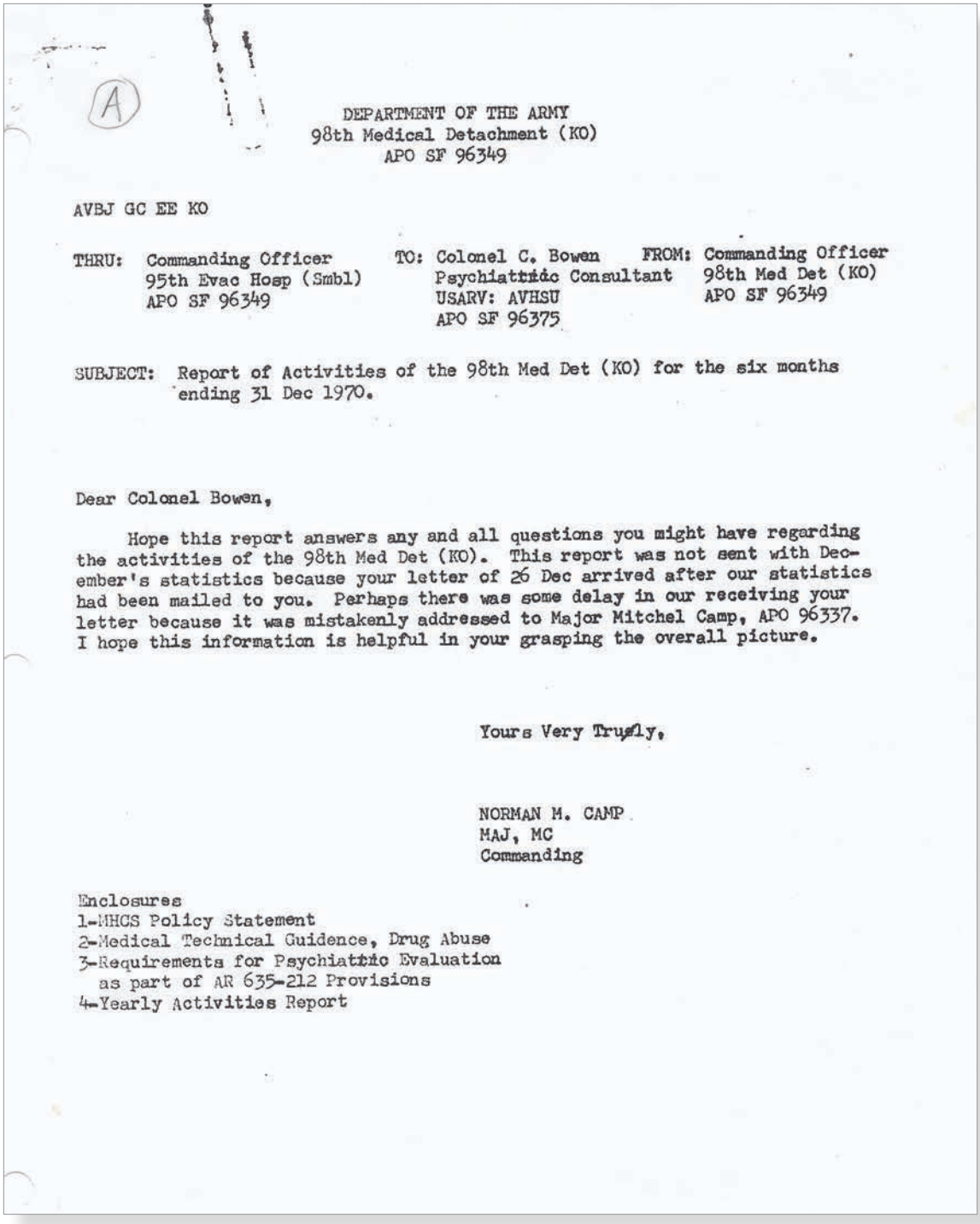
Appendix 1 98TH MEDICAL DETACHMENT REPORT



A

DEPARTMENT OF THE ARMY
98th Medical Detachment (KO)
APO SF 96349

AVBJ GC EE KO

THRU: Commanding Officer
95th Evac Hosp (Smbl)
APO SF 96349

TO: Colonel C. Bowen
Psychiatric Consultant
USARV: AVHSU
APO SF 96375

FROM: Commanding Officer
98th Med Det (KO)
APO SF 96349

SUBJECT: Report of Activities of the 98th Med Det (KO) for the six months ending 31 Dec 1970.

Dear Colonel Bowen,

Hope this report answers any and all questions you might have regarding the activities of the 98th Med Det (KO). This report was not sent with December's statistics because your letter of 26 Dec arrived after our statistics had been mailed to you. Perhaps there was some delay in our receiving your letter because it was mistakenly addressed to Major Mitchel Camp, APO 96337. I hope this information is helpful in your grasping the overall picture.

Yours Very Truely,

NORMAN M. CAMP
MAJ, MC
Commanding

Enclosures
1-MHCS Policy Statement
2-Medical Technical Guidence, Drug Abuse
3-Requirements for Psychiatric Evaluation
as part of AR 635-212 Provisions
4-Yearly Activities Report

AVBJ GC EE KO
SUBJECT: (Activities Report)

1. New Programs initiated in the 98th Med Det (KO) in the past 6 months.

A. Staff Changes:

1. Major Smith, C.O., was replaced by myself in Oct 70, with Major Cohen serving as temporary C.O. for 3 weeks prior to my arrival.
2. Dr. Finklestein DEROS in Sept 70.
3. Drs. Nathan and Barbara Cohen and Dr. Robinson, all fully trained psychiatrists, joined the 98th (KO) team in Aug 1970.
4. In Oct 70, Cpt Meshad MSW and Cpt Van Remortel MSW, were rotated to other units in country and Cpt Nygaard, MSW, joined the (KO) team in Nov 70.
5. In Oct 70, Cpt Olsen, psychologist, was rotated to the 935th (KO) team.
6. In Dec 1970, SFC Abrahams, NCOIC of the Mental Hygiene Clinic DEROS and was replaced by SFC Ortopan. In Sept SSG Grant, NCOIC of the Psych Ward was Med-evacuated to Japan and was replaced in Dec 70 by SFC Merkley. In Dec 70, SFC McKinney DEROS and in conjunction with this , MSG Kersey, attached to the 98th from the 95th Evac Hosp has become the 1st Sgt of the 98th Med Det (KO). MSG Kersey also serves the team doing Psychologicals on a limited scale and does much liason work between the 95th Evac Hosp and the 98th (KO) team.
7. Officer responsibilities are as follows: Maj N. Cohen is deputy C.O. and director of education and training. Cpt Nygaard is Detachment Executive officer and MHC administrator. Maj B. Cohen is MHC Director. Maj E. Robinson is Psychiatric Ward Officer.
8. In Nov 1970, all four psychiatrists attended a 2 day conference in Cam Rhan Bay of the psychiatrists in RVN. Also in Nov, Cpt Nygaard, SFC Abrahams and three social work specialists attended a 3 day social work conference in Cam Rahn Bay.
9. Because of a shortage of technicians with 91G and 91F MOS, technicians with other 91 MOS and college degrees in social sciences have been attached to the 98th Med Det and given OJT in these areas. Also begun is a program of cross training in which 91G personnel are being rotated to the psychiatric ward for one month of intensive OJT and vice versa for 91F personnel. This has proven to be valuable in increasing the ability of these specialists in their respective primary areas of functioning, as well as adding a new dimension of flexibility to the K.O. team.
10. In Oct a program of inservice education in basic psychology plus interview and counselling techniques was begun by Maj. N. Cohen on a once weekly basis.

AV GC EE KO
SU ECT: (Continued)

B. Mental Hygiene Clinic Changes:
1. A program of specialization has been developed in order to streamline clinic function and increase expertise. I am handling all legal and VIP cases, as well as community psychiatric and liason work. Drs. Cohen do all 212 evaluations. Dr. N. Cohen and myself do all inpatient consultations. Cpt Nygaard acts as clinic administrator, clinic triage and supervises closely the work of the technicians. All physicians share in general evaluation and therapy work.
2. Emphasis has been placed on education and information to referrer and referrees with the publication of documents by this MHC pertaining to MHC policy, drug information, drug amnesty program and requirements for 212 evaluation.
3. Emphasis has been placed on more extensive supervision of work of social work specialists, but without destroying their position as the primary mental health worker for the patient and his unit.
4. Emphasis has been placed on acceleration of time between when the patient is referred and when first disposition is made or certification is rendered.
5. Emphasis has been placed on more accurate clinic statistics with major revisions in data collection methods, especially related to drug abuse cases.
6. Much time and energy has been expended in creating a viable physical structure within the two shell buildings assigned to us by the 95th Evac Hosp, most of the time and energy has been during time off from primary jobs by the enlisted men.

C. Psychiatric Ward Changes:
1. Since Major Robinson has become the Ward Officer, a multi-focused effort has been generated to create a dynamic milieu therapy ward from what was previously more or less a holding ward for patients waiting to be air-evacuated to other treatment facilities. Steps in this transformation include: The designation of one physician as ward director, the commencement of ward staff meetings to discuss patients including patient treatment plans, commencement of group therapy on a daily basis, emphasis of ward staff expectation that patients will be returning to duty, commencement of a viable supervised work therapy program, the commencement of a recreation therapy program, and a concerted effort to screen out character and behavior disorders before admission. These efforts have served to reduce ward census, increase hospitalization time while greatly increasing percentage being returned to duty and decreasing psychiatric morbidity.
2. Emphasis has also been placed on more complete and informative narrative summaries, more accurate statistics, especially those drug related cases and more active liaison with the patient's unit.
3. Also created is a program of out patient Nallins Provocative test for heroin addiction. This is performed on the ward under close scrutiny of physician and nurse. It has proven useful in screening out those patients not truly requiring hospitalization and therapy and there by reducing ward census and psychiatric morbidity. In ten cases over the past 6 weeks, we have seen only one positive result.

Nalorphine = used for challenge test to determine opioid dependence

AVBJ GC EE KO
SUBJECT: (Continued)

2. Community Psychiatry.

In general, a premium is placed on direct unit and program consultation as the method of choice for practicing preventitive psychiatry and reducing psychiatric morbidity. In the Danang area, this is difficult because of the very complicated command structure of the numerous non-divisional units, often from distances involving much travel on the part of patients, commanders or mental hygiene staff. It has been made even more complicated because of the very erratic and often non-existant telephone service and continual difficulties in maintaining the detachment's vehicles.

The major focus of our community psychiatry efforts has been through the local dispensaries which are attached to the 95th Evac Hosp and who serve the various compounds and commands in the Danang area. The personnel of these units represent second echelon mental hygiene and commanders are encouraged to consult with their unit physician before a man is seen by mental hygiene. With this in mind, a close relationship is maintained with these dispensary staffs for educational purposes and for case detection purposes. From these sources command consultations are stimulated; and mental hygiene representatives, along with dispensary staff are frequently part of planning councils for drug, racial and morale problems.

Also newly created is a USARV stockade consultation program on once weekly basis which includes group sessions with stockade counsellors, plus consultation with the dispensary physicians and evaluation of confinees, this program involves one psychiatrist and two technicians and has proved valuable in reducing the number of required evaluations, accelerating the processing time of 212 and Chapter 10 action and reducing the turmoil and potential for danger caused by having prisoners and guards with weapons congregating in the MHCS clinic.

3. Views on Amnesty Program, are covered in Maj Cohen's paper read at the I Corps Medical Society meeting, 2 Jan 71 (sent to you seperately). In general, the only drug users which are admitted are those which we are fairly certain have a significant physiological addiction. Following hospitalization, or outpatient evaluation, they are referred back to command for consideration for the Amnesty program, or for Administrative/Judicial action with a report of the extent of the problem and treatment rendered.

4. Suggestions for the Future of Military Psychiatry in RVN.

A. Closer communication with MedCom and your office, particularly concerning USARV policies and documents which are pertinent or helpful to our mission.

B. A very thorough in-country briefing of new psychiatrists and social workers pertaining to the various facets of the mission and with specific suggestions and guddelines as to how these may most expediciously and correctly be handled. Not only is "the Army way" often quite unique, butthe added factors specific to RVN must be assimilated into the professionals theoretical framework.

AVBJ GC EE KO
SUBJECT: (Continued)

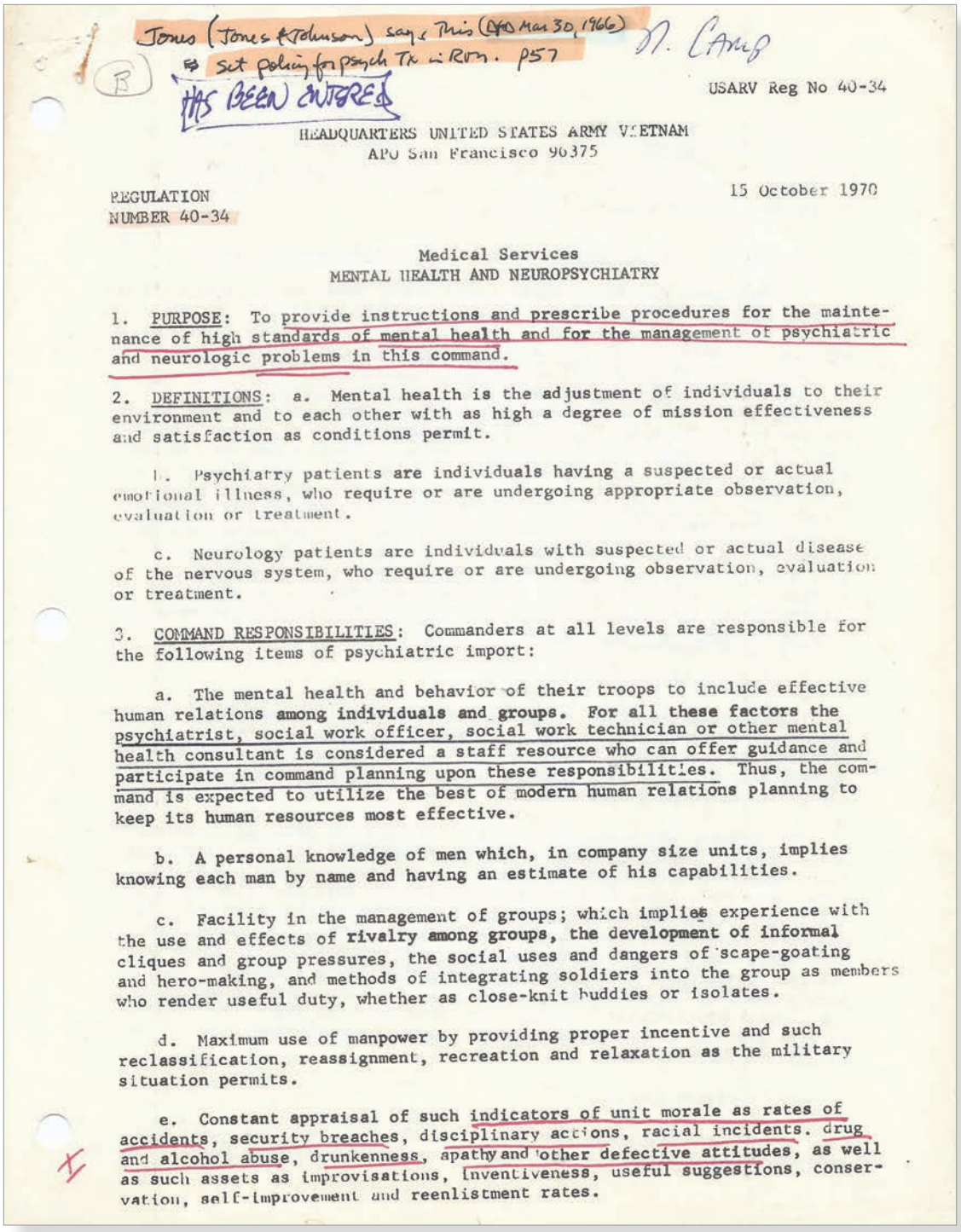
The orientation at Ft Sam is very helpful in getting off on the right foot, but the rapidly changing exiginces of Vietnam should be superimposed on that framework by those already in country and familiar with the problems and solutions or attempts at same. Along this line every effort at substantial overlap should be programmed into the replacement schedule.

C. More Army trained psychiatrists, or psychiatrists with a year or more of Army service should be sent to RVN in preference to drafted psychiatrists recently completing the MFSS basic course.

D. Also suggested is an additional slot under the Psychiatric Consultant for an experienced Army psychia trist solely devoted to helping the various psychiatrists in country develop community psychiatric programs. This special community psychiatric consultant would have no other duties and would be free to stay in a given area or Division for as many weeks as necessary to help set up viable and practical programs, and would make periodic visits to assess the worthwhileness of these programs. In most cases, psychiatrists fresh from residencies have little or no community psychiatry experience and beyond that are bewildered by the Army organizational structure and procedures.

E. I feel stabilized tours for the entire year are a vital necessity. Military and combat psychiatry bear little resemblance to other branches of medicine when it comes to community relationships, therefore the temptation to rotate psychiatrists should be resisted. The one year tour in itself does enough to sow the seeds of apathy in Army personnel without exacerbating it with an even shorter tour. It has been well documented that in any system, it takes a minimum of three months and often longer to become familiar enough with that system in order to develop those areas which need change. Therefore to rotate psychiatrists every six months means a minimum of six months of the 12 month tour is familiarization time.

Appendix 2 USARV REGULATION NO. 40-34



Jones (Jones & Johnson) says this (QMG Mar 30, 1966) set policy for psych Tx in RVN. p57 HAS BEEN ENTERED M. Camp

USARV Reg No 40-34

HEADQUARTERS UNITED STATES ARMY VIETNAM
APO San Francisco 96375

REGULATION
NUMBER 40-34

15 October 1970

Medical Services
MENTAL HEALTH AND NEUROPSYCHIATRY

1. PURPOSE: To provide instructions and prescribe procedures for the maintenance of high standards of mental health and for the management of psychiatric and neurologic problems in this command.

2. DEFINITIONS: a. Mental health is the adjustment of individuals to their environment and to each other with as high a degree of mission effectiveness and satisfaction as conditions permit.

b. Psychiatry patients are individuals having a suspected or actual emotional illness, who require or are undergoing appropriate observation, evaluation or treatment.

c. Neurology patients are individuals with suspected or actual disease of the nervous system, who require or are undergoing observation, evaluation or treatment.

3. COMMAND RESPONSIBILITIES: Commanders at all levels are responsible for the following items of psychiatric import:

a. The mental health and behavior of their troops to include effective human relations among individuals and groups. For all these factors the psychiatrist, social work officer, social work technician or other mental health consultant is considered a staff resource who can offer guidance and participate in command planning upon these responsibilities. Thus, the command is expected to utilize the best of modern human relations planning to keep its human resources most effective.

b. A personal knowledge of men which, in company size units, implies knowing each man by name and having an estimate of his capabilities.

c. Facility in the management of groups; which implies experience with the use and effects of rivalry among groups, the development of informal cliques and group pressures, the social uses and dangers of scape-goating and hero-making, and methods of integrating soldiers into the group as members who render useful duty, whether as close-knit buddies or isolates.

d. Maximum use of manpower by providing proper incentive and such reclassification, reassignment, recreation and relaxation as the military situation permits.

e. Constant appraisal of such indicators of unit morale as rates of accidents, security breaches, disciplinary actions, racial incidents, drug and alcohol abuse, drunkenness, apathy and other defective attitudes, as well as such assets as improvisations, inventiveness, useful suggestions, conservation, self-improvement and reenlistment rates.

Reg No 40-3A, HQ USARV, APO 96375, 15 Oct 70 (Cont)

f. Familiarity with procedures governing administrative separation contained in AR's 635-105, 635-206 and 635-212. Requests for psychiatric evaluation of individuals in the above administrative procedures will be forwarded to the psychiatrist by unit commanders or responsible agencies using the format in Appendix I as a guide.

4. PSYCHIATRIC AND NEUROLOGICAL EVALUATION AND TREATMENT IN USARV:

a. General: The mental hygiene unit's role involves prevention as well as treatment and includes close liaison with AMEDS members of the organization, as well as with unit commanders in order to prevent psychiatric problems from arising. Consultation with those responsible for the functioning of individuals and groups is emphasized over direct psychiatric care. Where some direct treatment is necessary, outpatient management is emphasized over inpatient. No psychiatric facility has as much ability to improve the functioning of a soldier for his natural duty as does his normal duty unit. Mental health consultants can help the unit commander work out ways to improve his influence on the members of the unit or utilize effectively some seemingly incorrigible individuals. Hospitalization is to be avoided except where patients are potentially dangerous to themselves or others, and then only because of mental illness. It is not to be used when personnel, who for administrative reasons or convenience, need only to remain overnight or await some administrative action. With rare exceptions, sociopathic soldiers (character and behavior disorders) are not to be admitted to hospitals. Medical facilities will not serve as substitutes for administrative action once the psychiatrist has recommended such action.

b. Organic psychiatric support:

(1) Psychiatric teams assigned to divisions and separate brigades provide consultation service, outpatient evaluations and treatment, and limited inpatient care. Soldiers whose condition requires consideration of out-of-country evacuation will be transferred to the appropriate in-country treatment center listed in para 4c(2), below.

(2) Organic psychiatrists and psychiatrists who serve as consultants to specific units hold a uniquely advantageous position in evaluating soldiers from their respective units. Frequently, they are intimately familiar with cases from their inceptions and are consistently best qualified to weigh the role stresses and other characteristics within both the unit and the patient. Accordingly, the command consultant's evaluation normally will be considered sufficient for courts-martial or board actions except in very special instances to be determined by the appropriate authority. When a sanity board is required (see para 5c) or a second opinion is requested, the nearest psychiatrist with qualifications equal to the first examiner will be employed wherever possible. A board of one physician only, a psychiatrist, is entirely proper.

c. Treatment facilities:

(1) Certain hospitals have a staff psychiatrist who has consultation contact with certain units, maintains an outpatient service, and to a limited

extent depending on local facilities and policies, provides inpatient care. Non-emergency inpatients may then be treated commensurate with the evacuation policy of the command.

(2) There are two psychiatry and neurology treatment centers in this command. One is operated by the 98th Medical Detachment (KO), 95th Evacuation Hospital at Da Nang, APO 96337, which serves all Army units in I and II N Military Regions. The 935th Medical Detachment (KO), located at the 93rd Evacuation Hospital at Long Binh, serves III and IV Military Regions. Additionally, the 483rd Air Force Hospital serves units in II S Military Region. These centers are staffed and equipped to provide evaluation, care and treatment for all types of psychiatric patients as well as neurological patients. All psychiatry and neurology patients whose condition suggests the need for out-of-country evacuation will be transferred to one of these centers for evaluation.

Choke points

5. ADMINISTRATIVE PROCEDURES, RECORDS AND REPORTS: a. General: Psychiatrists should be familiar with the AR's listed in para 3, as well as with TM 8-240, TM 8-244, and SR 40-1025-2. When psychiatric diagnosis is appropriate, psychiatrists will use only the standard nomenclature of the disease, as stated in AR 40-401, and give complete diagnosis with code, including description of severity, manifestations, predisposition, stress, LD and degree of incapacity, where applicable. Psychiatrists will forward reports of neuropsychiatric examinations for administrative separations or sanity findings to the requesting agencies within five days following examination. Format shown at Appendixes II and III should be used as a guide.

See also Appendix IV for "load" breakdown

b. Sanity Boards: Formal sanity boards, when required, will be initiated and conducted in accordance with para 121 of the Manual for Courts-Martial, United States, 1969 (Revised Edition); para 44, AR 40-3; para 19, TM 8-240; and para 11, TM 8-244.

c. Reports: Psychiatrists and neurologists are responsible for keeping accurate records of all outpatients and inpatients, and for coordinating with registrars so that accurate morbidity figures are obtained and forwarded. In addition to the aforementioned morbidity reports, USARV Form 55 (USARV Psychiatry and Neurology Morbidity Report) will be forwarded by courier in three copies through the commanding officer of the appropriate medical unit to this headquarters, ATTN: AVHSU-M, APO 96384, within five days following the end of each month. Reports Control Symbol AVHSU-31 has been assigned to this report (see Appendix IV).

d. Supplies: Psychiatrists and neurologists, through their unit medical supply officers, are responsible for maintaining adequate levels of medicine used in their practice, anticipating future needs and reordering when stocks are low.

6. REFERENCES: a. AR 40-3.

b. AR 40-401.

c. AR 635-105

Reg No 40-34, HQ USARV, APO 96375, 15 Oct 70 (Cont)

d. AR 635-206, misconduct

e. AR 635-212

f. SR 40-1025-2

g. TM 8-240.

h. TM 8-244.

i. Manual for Courts-Martial, United States, 1969 (Revised Edition)

(AVHSU-M)

FOR THE COMMANDER:

OFFICIAL:

CHARLES M. GETTYS
Major General, USA
Chief of Staff

[redacted]
Colonel, AGC
Adjutant General

4 Appendixes
I Format for Request for Psychiatric Evaluation
II Format for Psychiatric Reports for Administrative Type Separation
III Format for Psychiatric Report for Sanity Findings
IV Form for USARV Psychiatry and Neurology Morbidity Report

DISTRIBUTION:
B Plus
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1 MACV AG M&D Branch, APO 96222
1 AVHGF-M-(RCO)

USARV Reg No 40-34

APPENDIX I

FORMAT FOR REQUEST FOR PSYCHIATRIC EVALUATION

Request for Psychiatric Evaluation of

1. _____
NAME RANK SSAN

_____
ORGANIZATION ADDRESS DATE

2. Purpose of referral: ( ) Psychiatric Treatment, ( ) Psychiatric Evaluation for possible administrative separation under provisions of AR_____ ( ), Psychiatric Evaluation prior to _____, Court-Martial for charges of _____,

3. Personal Data: Years of Service_____, highest rank held_____, No. of Art 15's_____, of Courts-Martial_____, of reductions_____, of AWOLS_____, Latest ratings for conduct_____, efficiency_____, physical profile other than 1_____.

4. Commander's statement regarding individual's performance and behavior and rehabilitation potential._____

_____

_____

5. Commander's recommendations: ( ) Retention, ( ) Separation, ( ) Transfer, ( ) Other_____.

_____
Signature

_____
Title

USARV Reg No 40-34

APPENDIX II

FORMAT FOR PSYCHIATRIC REPORTS FOR ADMINISTRATIVE-TYPE SEPARATION

Heading - (Organization of Psychiatrist)

REPORT OF NEUROPSYCHIATRIC EXAMINATION

This is a report of neuropsychiatric examination in the case of (Name, Rank, SSAN, Organization) who was seen for (length of time) at (place and date). He was advised of his rights under Article 31, UCMJ prior to the interview.

Pertinent history: (State reason for referral, investigative or other reports available, and individual's account of the situation. Include pertinent past history).

Mental status: (Give symptoms and signs to substantiate diagnosis).

Physical examination: (Give only significant abnormalities).

Diagnosis: (Use Army Nomenclature, AR 40-401 and TB Med 15. When psychiatric diagnosis is indicated, give complete diagnosis).

Brief clinical abstract of findings: Examples:

1. This soldier gives a history of marked social unadaptability prior to and during service. He uses poor judgement, is not committed to any productive goals, and is completely unmotivated for further service. It is believed that he will not adjust to further military service and further rehabilitative efforts probably will be nonproductive.

2. There are no disqualifying mental or physical defects sufficient to warrant disposition through medical channnels.

3. Private Doe was and is mentally responsible, able to distinguish right from wrong and to adhere to the right, and has the mental capacity to understand and participate in board proceedings.

Comments: (optional)

Recommendations:

1. That individual be separated under provision of AR_____.

2. Other, if applicable.

USARV Reg No 40-34

APPENDIX III

FORMAT FOR PSYCHIATRIC REPORT OF SANITY FINDINGS

Heading - (Organization of Psychiatrist)

REPORT OF NEUROPSYCHIATRIC EXAMINATION

This is a report of neuropsychiatric examination in the case of (Name, Rank, SSAN, Organization) who was seen for (length of time) at (place and date). He was advised of his rights under Article 31, UCMJ prior to the interview.

Pertinent history: (State reason for referral, investigative or other reports available and individual's account of the situation. Include pertinent past history. State whether formal investigation data was reviewed).

Mental status: (Give symptoms and signs to substantiate diagnosis).

Physical examination: (Give only signs to substantiate diagnosis).

Physical examination: (Give only significant abnormalities).

Diagnosis: (Use Army nomenclature, AR 40-401 and TB Med 15. When psychiatric diagnosis is indicated, give complete diagnosis).

Sanity findings:

1. At the time of the alleged offense, the accused (was) (was not) so far free from mental disease, defect or derangement as to be able to distinguish right from wrong concerning the particular acts as charged.

2. At the time of the alleged offense, the accused (was) (was not) so far free from mental disease, defect or derangement as to be able to adhere to the right concerning the particular acts as charged.

3. The accused (possesses) (does not possess) sufficient mental capacity to understand the nature of the proceedings against him and to conduct or cooperate intelligently in his own defense.

4. The accused (was) (was not) capable of forming the specific intent to commit the alleged offense.

Comment: (optional)

Recommendations: (optional)

(It is usual to make a comment as to whether from a psychiatric point of view the member would eventually be expected to perform adequate duty or whether administrative or medical separation would be indicated).

APPENDIX IV

USARV Reg No 40-34

USARV PSYCHIATRY AND NEUROLOGY MORBIDITY REPORT (USARV Reg 40-34) PERIOD ENDING: REPORTS CONTROL SYMBOL AVHSU-31

THRU: TO: CG, USARV, ATTN: AVHSU Psychiatric Consultant APO 96384 FROM:

SECTION A - IN - PATIENT

LINE	CLASSIFICATION (final diagnostic category) (a)	ADMISSIONS DIRECT (b)	ADMISSIONS BY TRANSFER (c)	CONSULTATIONS (not NP Pts) (d)	IN-COUNTRY EVACUATIONS (e)	OUT-COUNTRY EVACUATIONS (f)	REMAINING	RTN TO DY (g)	MAN-DAYS IN HOSP (h)
1	PSYCHOTIC DISORDERS								
2	PSYCHONEUROTIC DISORDERS								
3	CHARACTER AND BEHAVIOR DISORDERS								
4.	DRUG ABUSE								
5	STRESS REACTION								
6	COMBAT EXHAUSTION								
7	OBSERVATION NP (7930)								
	NO PSYCHIATRIC DIAG								
8	TOTAL PSYCHIATRIC								
9	DISEASE OF NERVOUS SYS								

See over for definitions

SECTION B - OUT - PATIENT

LINE	CLASSIFICATION (a)	TOTAL NO OF PATIENTS (b)	EVALUATION (CERTIFICATES) (c)	TREATMENT VISITS (d)	RTN TO DY (e)	HOSPITALIZED (f)
1	PSYCHOTIC DISORDERS					
2	PSYCHONEUROTIC DISORDERS					
3	CHARACTER AND BEHAVIOR DISORDERS					
4	DRUG ABUSE					
5	STRESS REACTION					
6	COMBAT EXHAUSTION					
7	OBSERVATION NP (7930)					
	NO PSYCHIATRIC DIAG					
8.	COMMAND CONSULTATION					
9	TOTAL PSYCHIATRIC					
10	DISEASE OF NERVOUS SYS.					

USARV Form 55 Revised 22 Aug 70 PREVIOUS EDITIONS OF THIS FORM ARE OBSOLETE.

USARV Reg No 40-34

INSTRUCTIONS FOR USARV PSYCHIATRY AND MORBIDITY REPORT (USARV FORM 55)

Item #2 Psychoneurotic Reaction. Include psychophysiologic and psychosomatic reactions.

Item #3 Character and Behavior Disorder. Cases where drugs are responsible for inpatient/outpatient care should be listed in Item #4.

Item #4 Drug abuse, suspected or proven. Exclude cases where drugs are only incidental to care (outpatient/inpatient).

Item #5 Stress Reactions. Should include acute reactions not related to combat and those combat reactions not severe enough to be called combat exhaustion (as defined by Noyes and Kolb, American Handbook of Psychiatry, etc.).

Item #6 - Combat Exhaustion

Item #7 Observation Neuropsychiatric. Only those cases discharged with this diagnosis should be listed here. If admitted as observation N-P and a subsequent psychiatric diagnosis is made the case should show admission and disposition under that new classification only.

Item #8 (Inpatient) Total of all psychiatric evaluations.

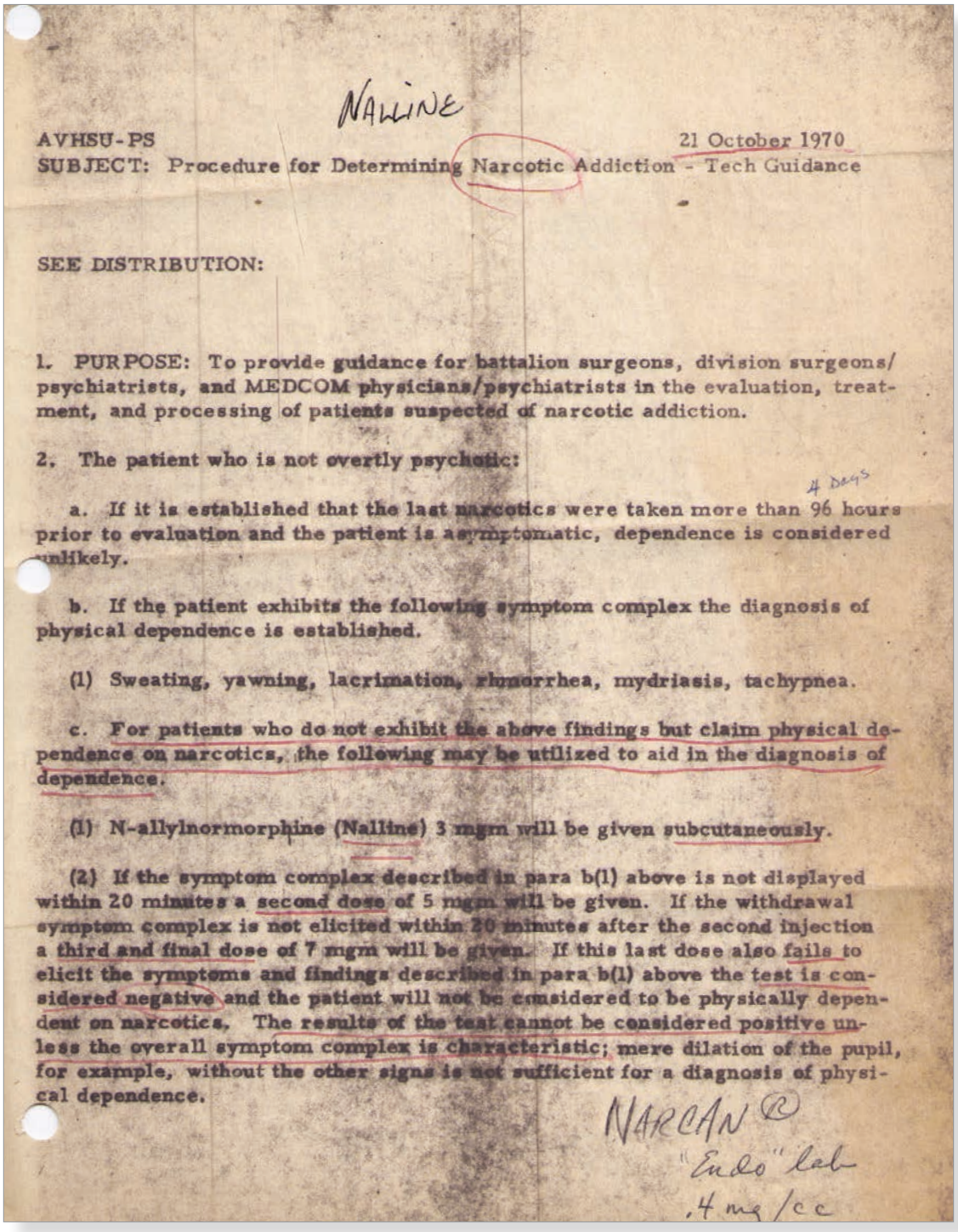
(Outpatient) Command Consultation to include evaluation for AR 635-200, 635-212, 40-501, etc.

Item #9 (Outpatient) Total of all psychiatric evaluations.

Inpatient Remaining. Those cases remaining inpatient at the end of the reporting period. Previously the total of admissions did not equal the total of dispositions.

Inpatient. Direct admissions should include (1) also those patients shown in "Hospitalized" under outpatient section B in addition to direct admissions and (2) only those patients admitted to the facility providing the report; a Medical Battalion if the reporting unit is a Division or a Brigade; a hospital if the reporting MHCS (e.g. if a division psychiatrist admits to a field or an evacuation hospital, then the inpatient report from the division will not include these patients). They should be reported by the hospital.

Appendix 3 PROCEDURE FOR DETERMINING NARCOTIC ADDICTION



NALLINE

AVHSU-PS 21 October 1970
SUBJECT: Procedure for Determining Narcotic Addiction - Tech Guidance

SEE DISTRIBUTION:

1. PURPOSE: To provide guidance for battalion surgeons, division surgeons/psychiatrists, and MEDCOM physicians/psychiatrists in the evaluation, treatment, and processing of patients suspected of narcotic addiction.

2. The patient who is not overtly psychotic:

a. If it is established that the last narcotics were taken more than 96 hours (4 days) prior to evaluation and the patient is asymptomatic, dependence is considered unlikely.

b. If the patient exhibits the following symptom complex the diagnosis of physical dependence is established.

(1) Sweating, yawning, lacrimation, rhinorrhea, mydriasis, tachypnea.

c. For patients who do not exhibit the above findings but claim physical dependence on narcotics, the following may be utilized to aid in the diagnosis of dependence.

(1) N-allylnormorphine (Nalline) 3 mgm will be given subcutaneously.

(2) If the symptom complex described in para b(1) above is not displayed within 20 minutes a second dose of 5 mgm will be given. If the withdrawal symptom complex is not elicited within 20 minutes after the second injection a third and final dose of 7 mgm will be given. If this last dose also fails to elicit the symptoms and findings described in para b(1) above the test is considered negative and the patient will not be considered to be physically dependent on narcotics. The results of the test cannot be considered positive unless the overall symptom complex is characteristic; mere dilation of the pupil, for example, without the other signs is not sufficient for a diagnosis of physical dependence.

NARCAN ®
"Endo" lab
.4 mg/cc

AVHSU-PS 21 October 1970
SUBJECT: Procedure for Determining Narcotic Addiction (cont.)

3. If physical dependence is established as outlined in para b(1) above, the patient should be hospitalized for treatment of withdrawal symptoms.

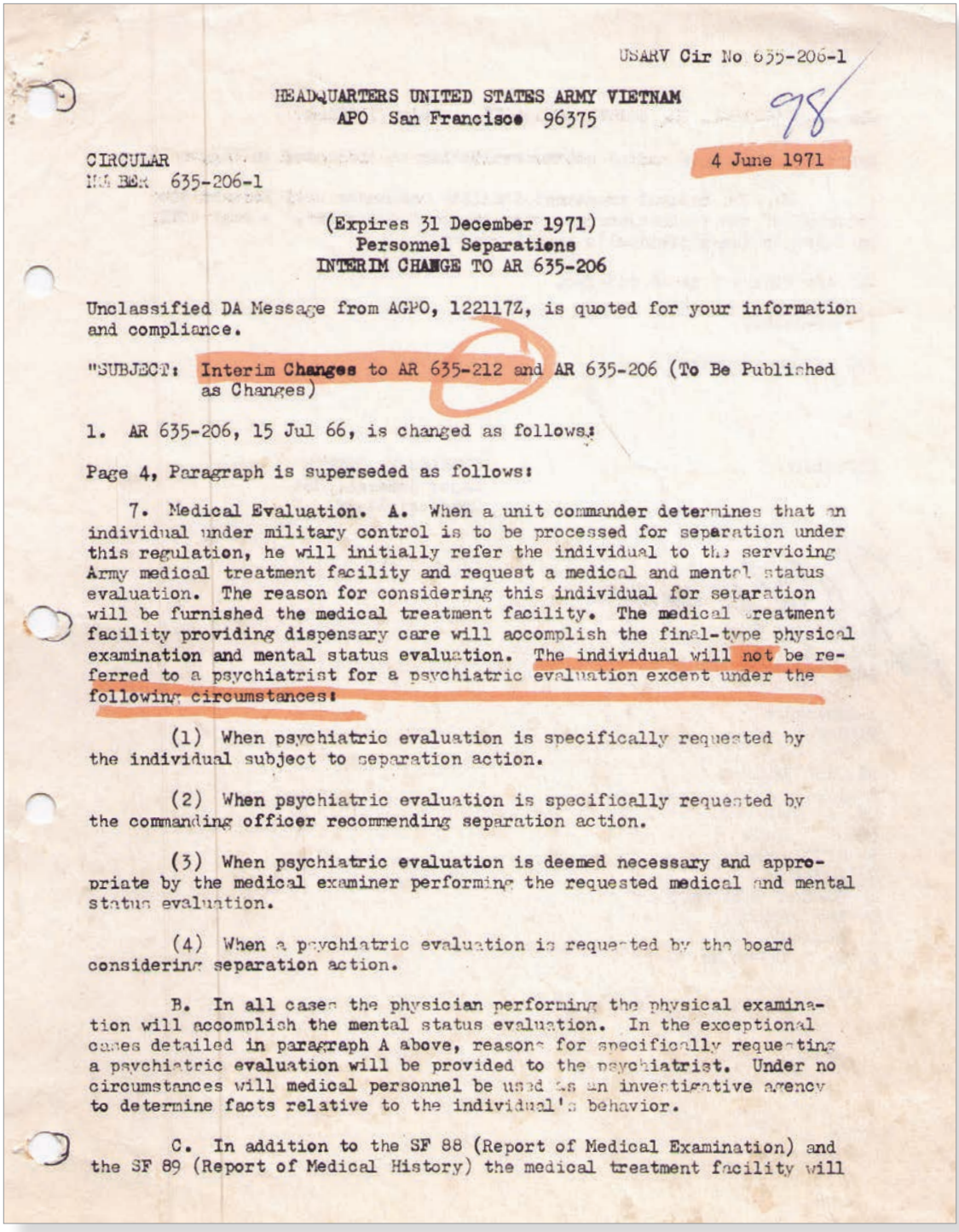
4. If physical dependence is not present the patient can be treated with tranquilizers and counselling on an outpatient basis, in consultation with mental health personnel as necessary.

FOR THE SURGEON:

[redacted]
COL, MC
Deputy Surgeon

DISTRIBUTION: A

Appendix 4 INTERIM CHANGE TO AR 635-206



USARV Cir No 635-206-1

98

HEADQUARTERS UNITED STATES ARMY VIETNAM
APO San Francisco 96375

CIRCULAR
NUMBER 635-206-1

4 June 1971

(Expires 31 December 1971)
Personnel Separations
INTERIM CHANGE TO AR 635-206

Unclassified DA Message from AGPO, 122117Z, is quoted for your information and compliance.

"SUBJECT: Interim Changes to AR 635-212 and AR 635-206 (To Be Published as Changes)

1. AR 635-206, 15 Jul 66, is changed as follows:

Page 4, Paragraph is superseded as follows:

7. Medical Evaluation. A. When a unit commander determines that an individual under military control is to be processed for separation under this regulation, he will initially refer the individual to the servicing Army medical treatment facility and request a medical and mental status evaluation. The reason for considering this individual for separation will be furnished the medical treatment facility. The medical treatment facility providing dispensary care will accomplish the final-type physical examination and mental status evaluation. The individual will not be referred to a psychiatrist for a psychiatric evaluation except under the following circumstances:

(1) When psychiatric evaluation is specifically requested by the individual subject to separation action.

(2) When psychiatric evaluation is specifically requested by the commanding officer recommending separation action.

(3) When psychiatric evaluation is deemed necessary and appropriate by the medical examiner performing the requested medical and mental status evaluation.

(4) When a psychiatric evaluation is requested by the board considering separation action.

B. In all cases the physician performing the physical examination will accomplish the mental status evaluation. In the exceptional cases detailed in paragraph A above, reasons for specifically requesting a psychiatric evaluation will be provided to the psychiatrist. Under no circumstances will medical personnel be used as an investigative agency to determine facts relative to the individual's behavior.

C. In addition to the SF 88 (Report of Medical Examination) and the SF 89 (Report of Medical History) the medical treatment facility will

Cir No 635-206-1, HQ, USARV, APO 96375, 4 Jun 71 (Cont)

prepare a report of mental status evaluation as indicated in Figure 3.

D. The medical treatment facility commander will forward the original of the evaluation report to the unit commander. A copy will be filed in the individual's health record."

2. Add Figure 3 to AR 635-206.

(AVHAG-PA(PS))

FOR THE COMMANDER:

OFFICIAL:

CHARLES N. GETTYS
Major General, USA
Chief of Staff

[redacted]

Colonel, AGC
Adjutant General

1 Inclosure
Figure 3

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Appendix 5 REQUIREMENTS FOR PSYCHIATRIC EVALUATION UNDER AR 635-212

DEPARTMENT OF THE ARMY
98th Medical Detachment (KO)
APO San Francisco 96349

AVBJ GC EE KO

SUBJECT: Requirements for Psychiatric Evaluation as part of elimination of enlisted personnel under the provisions of AR 635-212

I. In accordance with Sec III, Para 8, AR 635-212. Psychiatric evaluation of an individual at 98th Med Det (KO) will not be accomplished without a com-manding officer's report in letter form, furnishing the following:

a) Name, grade, service no., age, date of enlistment or induction, length of term for which enlisted and prior service.
b) Reason for action recommended, general, nondescript terms will not be used.
c) Armed Forces Qualification Test (AFQT) score, aptitude test scores and duty occupational military specialty (MOS).
d) Results of MOS evaluation testing, to include MOS in which evaluated and evaluation score.
e) Record of counseling
f) Description of rehabilitation attempts.(List assignments and duties under different officers and non-commissioned officers, in each organization or unit. Include duration of each assignment.
g) Conduct and efficiency ratings.
h) Record of trial by court martial.
i) Record of disciplinary action(include company punishments)
j) A statement by the individual indicating that he has been advised of his rights (para 10)
k) Any other information pertinent to the case.

II. This information is vital to the formulation of a psychiatric opinion regarding the individuals mental condition in relation to the conduct under consideration, and the probable effectiveness of further rehabilitative efforts as required by AR 635-212.

III. In accordance with USARV Suppliment 1 to AR 635-212. In the instance that psychiatric services are not readily available, particularly in non-di-visional units and where the service of a psychiatrist would require great distances of travel and loss of time in processing the AR 635-212 action, a medical corps officer who does not have specialized psychiatric training, but who is available locally to the unit, may complete the medical evaluation portion normally completed by a psychiatrist.

Norman M. Camp
NORMAN M. CAMP
MAJ, MC
Commanding

Appendix 6 ADMINISTRATIVE ELIMINATION UNDER PROVISIONS OF AR 635-212

98

DEPARTMENT OF THE ARMY
HEADQUARTERS, XXIV CORPS
APO SAN FRANCISCO 96349

AVII-CS

SUBJECT: Administrative Elimination Under the Provisions of AR 635-212

SEE DISTRIBUTION

1. The Commanding General desires that all commanders under his General Court Martial jurisdiction personally review the following references which outline problems which continue to plague the effectiveness of our program for administrative elimination of undesirable or unfit soldiers:

a. Letter, AVHAG-PA, Headquarters, United States Army, Vietnam, subject: AR 635-212 Eliminations for FY 1970, 5 December 1970, with 1st Indorsement, AVII-CG, this headquarters, 30 December 1970.

b. Letter, AVII-JA, this headquarters, subject: Administrative Eliminations, AR 635-212, 28 December 1970.

c. USARV Supplement 1 to AR 635-212, 23 April 1971.

2. The trend toward inappropriate elimination of drug abusers as "unsuitable" personnel, thus allowing the Board only the choice of an Honorable or General discharge certificate, appears now to be under control. Reports submitted to this headquarters by Special Court Martial convening authorities show that thus far this calendar year, no separations have been ordered for unsuitability by reason of drug abuse. Commanders must continue to give this point their personal attention to insure that past errors in this regard are corrected.

3. This headquarters provided the "Guide to Unit Commanders" for simplified interpretation of the subject regulations and stressed the urgent need for expeditious completion of these actions. To date, the average processing time in CY 71 for cases in which the respondent does not request a hearing before a board of officers is 26 days, compared with 40.5 days in the latter half of CY 70. This is an improvement -- but is not good enough. Elimination actions must be completed in the maximum of 20 days where no board hearing is requested, and in 35 days when a board of officers is convened. This time frame is computed from the date of the unit commander's letter recommending elimination to the date of final action ordering separation. All discharge actions will be reported to this headquarters with a specific explanation provided in cases which required more than the alloted 20 or 35 day cumulative time standards.

AVII-CS
SUBJECT: Administrative Elimination Under the Provisions of AR 635-212

4. USARV policy requires that the immediate commander review the service record of each soldier who has been administered three judicial and/or nonjudicial punishments, and consider at that time, whether to retain him, recommend rehabilitative reassignment, or recommend administrative elimination. Senior commanders must take positive action to insure that these requirements are met. While it is not suggested that a record of three disciplinary actions automatically dictates elimination, it is of paramount importance that this course of action be taken when warranted. In this regard, it has been noted with concern that in several cases referred to this headquarters for elimination for unfitness, a well documented record is provided of shirking and/or frequent incidents of flagrant disregard of orders and regulations, to include contemptuous behavior toward superiors. In these same cases, however, the unit commander reported without comment that no disciplinary action had been taken or was pending against the offender. To permit such misbehavior to go unpunished lessens the chances of rehabilitating a recalcitrant soldier and merely hastens the day when he must be eliminated from the service. Administrative elimination is not a substitute for professional leadership.

5. Rehabilitative reassignments are appropriate when it appears some improvement may be expected. When the soldier's attitude clearly demonstrates that this is not the case, the commander should request that this requirement be waived.

6. Retention of those men who have demonstrated their unsuitability or unfitness for continued service in the United States Army is a grave injustice to the majority of our dutiful young soldiers. Moreover, retention of such men often seriously impairs our combat posture and is detrimental to the maintenance of good order and discipline. It is imperative that the provisions of AR 635-212 be invoked where warranted and that commanders personally insure strict adherence to the requirements of the regulations and policies, to include expeditious processing and staying within the time standards imposed.

7. The "Guide for Unit Commanders," published by reference 1b, will be revised in the near future in consonance with the additional USARV guidance contained in reference 1c.

Robert C. Hixon
ROBERT C. HIXON
Brigadier General, USA
Chief of Staff

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Appendix 7 DIVISION PSYCHIATRY IN VIETNAM

Byrdy was assigned in Vietnam as the division psychiatrist with the 1st Cavalry Division (Airmobile), the first full division ordered into combat since the Korean War. He wrote this paper in 1967 shortly after his return to stateside civilian life. It is a candid and comprehensive overview of the challenges associated with the provision of psychiatric services within a newly deployed combat division during the buildup phase.

UNPUBLISHED PAPER: CAPTAIN HAROLD SR BYRDY, MEDICAL CORPS DIVISION OF PSYCHIATRY, VIETNAM

History

The division arrived in Vietnam in two separate groups, the air-transported advanced party of 1,040 which arrived within a week and the main body of the division which traveled by ocean and arrived in mid-September.[1] The base camp to be established was to be near an old French military installation at An Khe in the central highlands of Vietnam.

The division psychiatrist traveled with the advanced party. Some sixteen days after signing in at Fort Benning, Georgia, he was treating psychiatric patients [in Vietnam] under a tree near a temporary aide station. The first month was a period of rapid transformation of the area, of literally carving out a working area in the jungle. During this time the division circular defining policies and procedures of the Psychiatric Service was distributed and the psychiatric holding facility was established. The circular simply re-interpreted the basic Army Regulation 40-216. The several principles of military psychiatry were adhered to as closely as possible. Planned lines of evacuation were followed, by and large, except when tactical operations brought engaged units closer to extra-divisional medical facilities. The division strength of 15,000 men was supplemented by 5000 in attached units. The composition of the division which incorporated the 11th Air Assault Division and the 2nd Division had a large percentage of regular army men in the enlisted ranks. Further, since the previous base of operations was Fort Benning, Georgia, there was a large southern element. A non-official report by a personnel officer was that the division was an even 20% Negro in strength.

Psychiatric Role and Capability

As defined in regulation the division psychiatrist has a broad range of responsibilities, which for some cast him as the prototype of the community psychiatrist. In brief, he is responsible for whatever types of psychiatric patients are generated, combat or otherwise; he is responsible for advising command in matters of morale, of establishing a preventive psychiatry program and he is available for board and disciplinary action.

The actual facilities that were evolved were an office in Headquarters, Headquarters Company and a ward in Headquarters of the Medical Battalion. In the latter, the psychiatrist was assisted by a social worker and three technical specialists. Though the division's table of operations and equipment allows for other ancillary staff, these five effectively served to staff the mental health consultation service and in-patient

unit. After the psychiatric ward no longer handled the overflow of medical patients, we at no time had more than six in-patients.

Patient Source

Patients were referred either from any of the divisions' 44 physicians as "medical referrals" or were referred in through administrative channels. They were discouraged from presenting in any other way, that is, as self-referrals without going through their unit aide stations or by other agencies, such as special services or the chaplain.

The patients discussed here were seen between 30 August 1965, the date the first Vietnam patient presented, [and] 10 June 1966, a total of 252 days. During that period of time 503 patients were seen in 1,065 outpatient visits; 116 of these 503 were hospitalized.

Period of Adjustment

Flexibility, that oft magically invoked quality that is certain to carry many an American-trained psychiatrist through many ambiguous situations, was the hallmark in the execution of our services. Insofar as it was not clear how air mobility would effect the generation of psychiatric patients, no other orientation could be seriously maintained. Indeed, one unit commander expressed the opinion that a psychiatrist in an airmobile division was unnecessary because he felt that static tactical situations were remotely possible. That orientation overlooked the role of the Army psychiatrist as personnel officer. Eventually we evolved a service that combined the essence of a garrison mental health consultation service and a hospital, and which was to accommodate to any exigency that might present. With time, Camp Radcliff, as it was named, periodically manifested the temper of garrison life. During periods of heavy operations, the attitudes of the forward elements permeated the base camp. However, there were times when the units in the base camp would revert to the style of the garrison with its pre-occupation with polished boots and buckles. From the military standpoint, this reversion is entirely understandable; but from the standpoint of the trooper who had recently experienced contact with life threats and death, this seemed to some as bizarre. The lesson, presumably, is that obsessive rituals are not of equal value for all.

Military operations were in effect from the very beginning of troop arrival. However, the larger operations during the period in which these cases were collected were in the Ia Drang Valley and in the Bong Son region. The former was in October and November 1965 and the latter in February and March 1966. It was during these two periods that the majority of the cases of combat exhaustion were generated. Personnel had so planned the rotation of men from the theater so that changes would begin within several months after the division had arrived. It was intended that a massive rotation of troops at one time be obviated. The loss of men through battle casualties and rapid replacement of them facilitated this intention.

Operating in a new division in the fie1d were integrative as well as fragmenting forces. Promoting group identity which in the writer's mind is the true glue of any military unit of whatever size and whatever mission was the fact that the helicopter units had long trained together. There was a pervasive feeling of enthusiasm and expectation about what the new airmobile division could accomplish in combat. A centripetal force to the division's integrity was the fact that the official announcement of the division's formation occurred only six weeks before it moved out of the States, meaning that some units were rather abruptly incorporated into the division.

It was a clinical impression, on the basis of the arrival of the advanced party and then of the main body of the division, that the second week in the theater seemed to be the low point of adjustment to the situation. It seemed that then the novelty of the area wore off, the reality of a year's tour, and the incessant dangers became pre-occupations. However, with subsequently newly arriving troops this impression did not seem to be further substantiated.

Collection of Statistics

Unfortunately some of the conditions of being a new organization in the field preclude rigorously accurate and elaborate collection of psychiatric data. Indeed only through considerable effort was it possible to get rudimentary facts in a systematic way. Analysis of hospitalized populations must be more fruitful and in the history of the Second [World] War were the source of workable statistics. Certainly level of education, marital status, service category (Regular Army or draftee), and duration of duty (in the service and in the theater) would be illuminating social parameters to assess. The social parameters for the whole division

TABLE I. Analysis of Patient Population According to Rank

Pay Grade	Title	Number of Patients	Average age	% Negro	Number Hospitalized
E-1	Private	3	20.3	0	0
E-2	Private	51	22.2	41.2	4
E-3	Private First Class (-1)	199	21.3	21.6	46
E-4	Corporal (-1, 2)	108	23.2	20.4	32
E-5	Sergeant	80	29.5	26.2	20
E-6	Staff Sergeant	30	35.0	6.7	8
E-7	Platoon Sergeant or Sergeant First Class	8	34.1	0	3
E-8	First Sergeant or Master Sergeant	3	42.7	0	1
E-9	Sergeant Major	1	46.0	0	0
W 1-4	Warrant Officer	10	32.5	0	2
O-1	2nd Lieutenant	1	24.0	0	0
O-2	1st Lieutenant	5	24.2	0	0
O-3	Captain	3	29.3	0	0
O-4	Major	1	39.0	0	0
	TOTAL	503	24.7	21.7	116

1-lacks one designation of age
2-lacks one designation of race

would have been interesting, especially in light of congressional declination in modifying the draft laws. In psychiatric practice, at least, it became commonplace not only to encounter the high school drop out, but even the grammar school dropout.

Further we lack any substantial follow-up on the execution of our recommendations. Doubtless the percentage of those acted upon is different from that in garrison, but not necessarily much smaller as one might expect. Unit Commanders in the field, if they have time for the paper work, are eager to get rid of unpredictable personnel; whereas non-combat commanders, at times, unreasonably discourage the loss of manpower for any reasons, even for the most pressing.

Rank

93% of the patients came from the ranks E-2 through E-6 (see Table I), the greater burden, 61%, from PFC (E-3 and E-4). During the course of the year, some men were rapidly promoted because military policy in a combat area was conducive to rapid promotion. Further combat and medical losses within the individual units invariably opened "slots" for those remaining. Despite combat familiarity, some of these men had difficulty in leading rank juniors who were often age peers or seniors.

Ranks E-2 through E-6 included all of the Negro patients. It is not readily apparent why 41.2% of the E-2[s] are Negro when the general incidence of Negro patients was 21.7%. New troops, before they are rapidly promoted, have that designation as do many who are demoted for infractions.

Diagnosis

Table II lists the incidence for the general diagnostic categories. Incidence is based on troops strength of approximately 20,000, that is, the 15,000 organic to the division and 5,000 attached troops. In fact, during this period, approximately 8,000 additional troops rotated in the division because of combat and medical casualties and termination of service. The numerical incidence is in all likelihood exaggerated therefore. The figure of 2.2 evacuees per thousand per year jibes with Tiffany's and Allerton's statistic of less than 3 per thousand per year which was based on the theater statistics for January 1966.[2] The percentage of patients seen in the various

TABLE II. Analysis of Patient population according to diagnosis

Diagnosis	Number of cases	Average Age	% Negro	Number Hospitalized	Incidence per 1,000 per year
1. Acute brain syndrome -1	22	22.3	18.2	21	1.6
2. Psychosis	12	22.2	41.5	11	.8
3. Psychophysiologic reaction	24	24.1	25.0	7	1.7
4. Psychoneurosis -1, 2	70	26.9	14.1	13	5.1
5. Personality disorder	203	24.2	24.6	35	14.7
6. Combat exhaustion	22	23.5	27.7	13	1.6
7. Adult situational reaction	18	25.5	5.5	9	1.3
8. Miscellaneous	132	24.2	21.2	7	9.6
TOTAL	503	24.7	21.7	116	36.0
Evacuees [out of division]	30	—	—	—	2.2

1-lacks one designation of age
2-lacks one designation of race

diagnostic categories would not be similar to an analysis of an evacuation hospital and are not.[3]

Familiarization with the situation in the field brings the realization that the kinds of referrals depend on the tactical situation. Homosexuals and discipline problems are rarely referred in from units under engagement. Hausman and Rioch note that during the Korean War that the term "combat exhaustion" was used to designate all psychiatric casualties to minimize the damage to evacuees who might read their diagnoses.[4] We very early and very quickly abandoned this all-inclusive designation for the far less ambiguous and more specific standard nomenclature. The former system worked, presumably, because everyone knew the signals. In the Vietnamese situation, clearly they did not.

Of the 12 psychoses, one man was manic, 7 were acute undifferentiated schizophrenics, and 4 were paranoid. One man who shot himself in the leg was grossly psychotic.

Anxiety (35 cases) and depression (27 cases) were the two most common neuroses. Depression in the older soldier became more common in the sixth month of the tour. This co-incided roughly with the second major operation of the division. Of the phobias to flying, 2 could be said to be combat connected, while three others showed up in non-combatant men just prior to their rotation back to the states.

As might be expected, passive-aggressive personality was the most common characterologica1 diagnosis. A number of these patients were seen for psychiatric clearance in criminal action. These were just a fraction of those referred in for administrative boarding. To this writer's mind, there is little way of assessing the assumption that the passive-aggressive personality, a devil in the camp, is an excellent soldier in the field. There was no rule of thumb in recommending for this sort of referral. The sociopath, however, was generally recommended for boarding. It was held that group integrity and safety in the unit was jeopardized by a man with a strong anti-social history.

No systematic effort was made in chronicling suicidal gestures. Some self-inflicted wounds were sent for evaluation after they had healed and were ready to be returned to duty. Suicides fell into the province of the military police. Only once was an effort made to involve the psychiatrist in a post-suicide investigation. There were very few suicidal gestures that were directly referred into the psychiatrist.

A large group of cases (26.2%) were classified as miscellaneous. Included here are No Psychiatric Disease

and No Diagnosis Established. Medical problems, administrative cases needing psychiatric clearance, and referrals for counseling are the kinds of cases grouped here.

Disposition

Of the patients that were seen, an even 30 or 6% were evacuated "psychiatrically" from the division. This number included the 12 psychotics. Such patients as unresponsive combat exhaustion or those who merited further medical work-up, e.g., hypertensives, originally referred for headache, or seizure cases, would be evacuated. All others were returned to duty. Character disorders, the diagnoses most often invoked for administrative problems which were referred to the psychiatrist for disposition, did not routinely carry a recommendation for further administrative action, other than clearance. We quickly learned that there was no point executing our three day holding policy on psychotics. Two of these fellows were returned to the division, one the following day, the second after several months in a hospital setting. The latter again became fuminantly [*sic*] psychotic.

No patient was maintained as an out-patient on any psychotropic medication more potent than Librium. A consideration here was patient responsiveness in mortar attacks. Further, it was felt that if a patient merited Thorazine, he might best be accommodated in the psychiatric ward or out of the division.

The enuretics that were tried on Tofranil (Imipramine Hydrochloride) all failed to improve. Here again, discharge was not routinely recommended for enuresis. (It was for chronic encopresis). One man was referred in through his medic. He was three months shy of his three year tour and wet the bed frequently. He wanted some free medical help before he got out of the service. No one had known of his difficulty.

Of the 116 patients hospitalized, 27 were either acutely or chronically alcoholic. Unless these men were repeatedly hospitalized or were being considered for disciplinary or administrative action by their unit, they were merely 'dried out'.

Combat Exhaustion

The cases of combat exhaustion were engendered largely during the two major operations of the division. The average age of these men was 23.5 years. By initial diagnosis there were 32 cases. However, ten of these diagnoses were changed on sign out. Two were psychoneurotic. There were one psycho-physiological reaction, one schizophrenic, two alcoholic agitations, and four who manifested characterological difficulties in the subsequent contacts.

These men were treated with bed rest and tranquilization where necessary. In general they responded well to treatment. Three, however, were evacuated eventually. Of those evacuated, two were psychotic and the other irrevocably psychoneurotic. Two men eventually were transferred out of combat units.

Morale

Morale is an elusive issue. It is perhaps more easily influenced than accurately assessed. Insofar as much of the division saw itself as new and experimental in warfare, there was considerable enthusiasm. In the very early days of the division, the mail and the daily allotment of two cans of beer, usually warm, was a crucial issue which was quickly perceived by command. Though priority [mail] became fairly regular. The Stars and Stripes became available. Special services movies were instituted before the arrival of the main body of the division (The troops especially liked war films). Eventually there were Red Cross Services Network, Saigon with "doughnut dollies" and a local radio station relaying the Armed Forces Network from Saigon and also broadcasting its own programs. Camp followers, in a very well organized fashion, quickly moved into the area. Depending on the rather complicated desires of command, the troops variably had access to them. There was an in-country and out-of-country "rest and relaxation" system the functioning of which varied vastly from unit to unit and from rank to rank, but which could have only a salutary effect on the troops who were far removed from the coastal cities.

That the tour was for a 12 month period rather than "for the duration" facilitated morale and enhanced endurance.

Realistic personal danger varied tremendously among the units, the line companies, of course, being pre-eminent. Breakdown of psychiatric cases by units within the division show the line companies pathetically far in the numerical lead.

Preventive Psychiatry

The re-institution of the psychiatrist into the division during the Second [World] War was effected because many of the psychiatric problems could be anticipated and handled at the local level. The task of the division psychiatrist in its multiple ramifications is vast and almost by definition an impossibility. In garrison, with the assigned technicians in full strength, the psychiatrist may have a more direct source of information about troop attitudes, and further he may have competent men to handle problems locally. However, there is a strong hypothetical aspect to the smooth functioning of such an operation.

In the Cavalry, the psychiatrist was able to meet the 44 doctors at some time. Certainly he was never able to meet a large percentage of the unit commanders. This was not feasible though possibly desirable. Contacts with the general medical officers were intended largely to clarify referral policy and [were] didactic only on invitation. In general, there was little need to re-iterate the policy of referral, already issued in the division directive. However, physicians, overburdened with the humdrum of sick call, might abruptly refer ambiguous cases in. Often the patient who did not improve according to expectation (from perhaps gastritis or punji stake wound) would be referred in. The locus of the hang-up between patient and physician would be shifted and usually could be broken since the psychiatrist might be able to afford the luxury of taking a history or putting a partially ambulatory man with a poorly healing wound at bed rest. One man was referred in for exaggerated complaining and had been seen by two physicians whose physical examination did not include palpation. The man had an obviously fulminant punji stake abscess in his gastrocnemius.

Contacts with units were made whenever possible and nearly always with difficult cases through either the psychiatrist, the social worker, or a technical specialist, usually a social work specialist. However, these contacts were both relatively infrequent and almost always after the fact. A number of referrals from one unit at one time would invariably mean that the unit was "housecleaning" after returning from a mission, or that there was trouble in leadership. Three men, Negroes, were referred in from one unit. By the time the third man, whose eye was swollen, was seen, the brigade commander had seen fit to relieve the Commanding Officer and First Sergeant of the company and rectified the situation.

Personal contact with units was not facilely accomplished in any systematic way insofar as telephone communication took up to 45 minutes sometimes, if at all. Vehicular transportation depended on loan; and helicopter transportation which was difficult to schedule was generously or grudgingly offered, depending on the tactical situation. The difficulties of transportation were primarily time-consuming rather than impossible.

Essentially we practiced preventive psychiatry on the secondary level, that is, early diagnosis and rapid treatment, and we relied on the usual evacuation and referral channels for our patient population. In general, it was not policy to sell psychiatry to anyone. Availability when the need arose was ample justification for the service.

The few central principles of military psychiatry were practiced systematically. Hausman and Rioch state these succinctly "Immediacy, proximity, expectancy, . . . concurrence, and commitment."[4] In the Vietnamese war, heavy reliance on the first three seemed the most fruitful. Here the psychiatrist's efficacy is at its greatest when his identification with the group is most conducive to the immediate goals of the group, specifically, its integrity and self-preservation.

[*Post script: Byrdy, in correspondence with this author on 11 August 1982, said: "In contrast to news accounts of what subsequently transpired in military units in Vietnam, during my year the morale in the 1st Cav was remarkably high; however, in the course of that year there was erosion. Tiger beer was the main substance abused. There was marijuana available, but, as far as I know, very little in the way of hard drugs.*"]

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Appendix 8 LIEUTENANT COLONEL ARNOLD W JOHNSON JR

Lieutenant Colonel Arnold W Johnson served in Vietnam (July 1966–1967) during the buildup of forces as the senior Army psychiatrist in the theater—the Neuropsychiatry Consultant to the CG/USARV Surgeon. He provides a granular account of the growing complexity of the Army's combat role in Vietnam from the vantage point of the psychiatric challenges encountered in the early years of the war.

PANEL REMARKS: LIEUTENANT COLONEL ARNOLD W JOHNSON JR NEUROPSYCHIATRY CONSULTANT TO THE COMMANDING GENERAL/ US ARMY REPUBLIC OF VIETNAM SURGEON

. . . I do a certain amount of clinical work but I don't take too much time for that. Mostly the job consists of administrative and preventive work, staff work, working in terms of community psychiatry for all of the military communities in Vietnam and a great deal of traveling. I should be traveling about half the time in order to cover all of the obligations that are there. But there's a lot of office work, too, so sometimes it's hard to get away. The job is satisfying also from the point of view that the United States Army in Vietnam has an excellent level of morale and motivation. As far as my work is concerned, I get excellent cooperation not only from the medical people and the medical units, but also from the line people and the line units. In general, I think that the psychiatric system has been working well, and this also is satisfying.

. . . [I]n July of 1965 there were 31,000 troops in Vietnam, by January there were 128,000, by last July and August when I arrived there were about 170,000, and when I left the other day there were about 250,000 with more expected. It is growing very rapidly and will continue to grow for some time. You can begin to get some idea of the magnitude of the operation. . . . There are practical problems in Vietnam, things like communication, the telephone system. . . . The dial system that's been promised so long is gradually coming into being, but it's going to be a long time before telephone communication is very good. . . . Another practical problem is transportation. Land transportation is a little difficult. . . . I could travel out to see John Bowman at the 93rd Evac Hospital by car without too much difficulty, but he was about the only psychiatrist I could visit by automobile. In other cases I would ordinarily be flying. . . . Although the roads are passable and convoys go on satisfactorily, if you take a vehicle by yourself Charlie (Viet Cong guerrillas) is likely to stop you. Air transportation is good when you can get it, which depends on whether you have enough priority. I have enough priority so that I can usually get around without too much trouble, but once in a while I get bumped, too. The division psychiatrists, who are usually captains, sometimes have a great deal of difficulty getting the kind of transportation . . . they need to get them around to see the people whom they really ought to be seeing. As we get down into the Delta we'll probably be hearing more about water transportation. I think transportation in the Delta is going to be a problem; there won't be much land transportation down there.

For the last couple of months the climate has been pretty good. Sort of like fall, not terribly hot, but most of the year the weather is really quite hot, quite humid, quite wet and quite uncomfortable. There's a jungle with which to contend, and all the various kinds of fauna as well as flora.

One thing that must be getting clear to you by now from our conversations and from the pictures is that, differently from previous wars, all the hospitals are in permanent or semi-permanent buildings. The 93rd Evac is in Quonsets, the 3rd Field is in concrete permanent buildings and the 8th Field is in tropical, semi-permanent buildings, the 85th is in Quonsets, the 67th in some nice new concrete buildings, etc. The only exception is the 45th Hospital at Tay Ninh, which is the MUST unit made of inflatable buildings. Technically speaking, I suppose that makes them the only really mobile hospital. All of the others are being built in relatively permanent buildings. The rate at which they build hospitals is much better than it was in the days that John is describing, and they're learning something about holding off professional complement until things are sort of ready to go.

My job as consultant is partly an office job and partly a traveling job. The USARV Surgeon does not really command anything except a medical journal for Vietnam which General Wier, the USARV Surgeon, requested be established as a means of medical professional communication within Vietnam. Part of my job, along with that of the other Consultants who help me with this, is to get all the physicians around Vietnam to contribute the things that they ought to contribute in terms of communicating professionally within Vietnam. This puts me in touch with a lot of people besides psychiatrists, from my point of view as psychiatric consultant a very useful thing because it's an extra entree into a lot of areas that I wouldn't get into otherwise, or not as easily anyway.

I'm going to talk a bit more about the psychiatric aspects of this entire picture that I talked about before. We touched already somewhat on the evacuation system and I'm sure that you're aware that most of the medical evacuation is done by air, either by helicopter or by airplane. There is some land evacuation, but relatively little. There might be land evacuation under some circumstances from An Khe to Qui Nhon or from the Binh Son area to Qui Nhon, or from Saigon to Long Binh, or vice versa, from Di An to Long Binh. But by and large the roads that are really open and safe for an ambulance traveling alone are relatively few so that most of the medical evacuation is by air. Rather typically from a combat area a helicopter will pick up a patient and take him to a clearing station organic to the unit. If the patient needs to be evacuated further, a helicopter will then take him from the clearing station to the nearest hospital, perhaps a surgical hospital, perhaps an evac hospital. Then, if the hospital is in the forward area and the patient needs to be evacuated further, he'll probably be picked up by airplane, say from Pleiku or An Khe, and taken down to Qui Nhon to one of the evac hospitals there. Similar things go on in the Saigon area. Then, from Qui Nhon or Cam Ranh or Saigon, patients will be taken by airplane, sometimes directly to Okinawa or Japan, sometimes over to Clark Air Force Base in the Philippines and then trans-shipped to Japan or Okinawa from there, or perhaps sent directly back to the States. It used to be that all the psychiatric patients went either directly back to the States or to Clark and generally directly back to the States. Recently, however, this has been changed so that most of them are taken to Japan, given a certain amount of treatment there, and then sent back to the States later. There are about 3 hospitals in Japan that have psychiatric wards and a number of psychiatrists. . . .

The helicopter units that pick up patients are directly under the medical groups, the 55th Medical Group, the 43rd and the 68th. They are not assigned to the combat units. They don't have enough of them either, by the way, and as a result what usually happens is that the helicopters are assigned to cover a certain area, certain groups that are in that area. Hospitals also tend to cover an area. There are fixed hospitals; thus they can't follow any units around and they tend to cover the area that is close to them. Take as an example the helicopters stationed at Pleiku and the hospital at Pleiku. The helicopters will fan out and cover the combat units in that area. Transportation by air is simple if you can get it, but you can't always get it. Also, it's dangerous at times and this has contributed to the business of area coverage rather than medical care following the individual unit. As a result our psychiatric care has tended to become area coverage also. For instance, I have asked the division psychiatrist of the 4th infantry Division at Pleiku, Captain Randall, to cover the Pleiku area generally in addition to the 4th Infantry Division Headquarters and the 2nd Brigade of the 4th Infantry. Thus, he makes regular visits to the 18th Surgical Hospital at Pleiku, to the base camp of the 3rd Brigade of the 25th Infantry, and also support units of one kind or another that are based in the Pleiku area. In effect, he provides psychiatric coverage for all the Pleiku area. The psychiatrist at An Khe doesn't have quite as

extensive an area to cover, but he covers the An Khe area which is primarily the base camp of the First Air Cavalry and the 2nd Surgical Hospital to whom he provides consultation. The 4th Division psychiatrist arrived in-country, I believe in October, and his unit is going through all of the growing and building pains that were described by Dr. Bowman and Dr. Byrdy. The last time that I was up there they were operating out of a tent and were in the process of building a Quonset to house an MHCS-type of operation. They were locating, of course, within the base camp of the 4th Division, but they had managed to scrounge a jeep with which it was becoming possible to do the kind of area coverage for the Pleiku area that I felt should be carried out there. I might say at this point that the transportation for the division psychiatrist is a very difficult problem. In no case is there a jeep actually assigned to the division psychiatrist. They just aren't available. The division psychiatrist belongs to the division surgeon's office. The division surgeon's office has a couple of jeeps, but they're usually occupied by the division surgeon and others and the psychiatrist does not have one assigned to him. He has to scrounge transportation. Well, Captain Randall is quite an excellent scrounger, apparently, because he's the only division psychiatrist that has managed to get a jeep assigned to him so far. In some ways he's the one that needs it most because of the business of a little distance of 10 or 15 miles from his division up to the 3rd Brigade of the 25th. At An Khe the division psychiatrist walks, but the social worker has managed to get himself a little motor scooter. So he runs around the base camp doing consultations on a motor scooter. This sounds peculiar in a way but it's really a big help because the base camp is just too big to walk around, and other than that motor scooter they have to scrounge for transportation. It is possible to get helicopter rides out to the units that are away from the base camp, but you have to work at it as a captain. All of the division psychiatrists have complained that it's difficult to get the amount of transportation that they really need, so that they don't get out and visit as much as they perhaps ought to or might want to.

We talked about the problem of evacuation between An Khe, Binh Son and Qui Nhon. I think in the case of all four of the divisions that have worked with division psychiatrists so far, most of the psychiatric casualties probably go through the division psychiatrist, but a lot of them don't. One of the cases in point has been this situation in which numerous parts of the Cav for long periods of time have operated in the Binh Son area which as far as miles are concerned is actually a little closer to Qui Nhon, and besides which there's a mountain pass between them. Very often the evacuees have gone directly from the Binh Son area down to Qui Nhon to the hospitals there. The psychiatrists at Qui Nhon have often been the first ones to see the psychiatric patients from An Khe. This was a little bit of a problem because, of course, we would like to help the soldiers keep their unit identification if at all possible, if they're possibly going back to duty. Well, lately there's been the necessary kind of cooperation between the division psychiatrist and Captain Tischler at the 67th Evac. Captain Tischler sees a patient that comes from the 1st Cav who doesn't need to be in the hospital, he'll send him right up to An Khe to see the division psychiatrist to have him take care of the problem rather than keep him down at Qui Nhon for any length of time. Somewhat similar procedures have gone on in the Saigon area at times. The Qui Nhon area, as I said, is a big logistical area. When the psychiatrist there works, he sees some problems that come directly from the hospital, and he sees some problems that come from the Cav, but the bulk of referrals at Qui Nhon come from the military community in Qui Nhon. I've tried to get an estimate of how many troops are in the Qui Nhon area, and as far as I can tell it's similar to one of the large troop posts in the States in approximate size. At the moment there's one psychiatrist in Qui Nhon who has no help. He's rather swamped. Ordinarily we've had two psychiatrists up there but one of them has left and the replacement isn't in yet. The medical group commander there as well as the medical battalion commander who runs the medical support for Qui Nhon are interested in a mental hygiene-type facility for this area. Now there are no slots for such a thing in that area. The evac hospitals have slots for psychiatrists but not for social workers and social work technicians. One thing we've been talking about is that in addition to the concept of the large team that takes care of evac problems, etc., we probably need the concept of the small psychiatric team that gives the kind of area support that the division psychiatrist and his people are giving to Pleiku and to An Khe. We just don't have that kind of thing for Qui Nhon but we need it badly.

At Tuy Hoa the buildup is not very large yet, but it will probably grow. There is an evac hospital built there; there are probably 8 or 10,000 troops there now and

perhaps more are coming. We're looking forward to the time when, perhaps, they will need a psychiatrist at Tuy Hoa. They don't need one there quite yet. At Nha Trang is the KO team I mentioned. They are set up a little differently from the team at Long Binh. Historically they started out differently. The team at Long Binh early in the game got involved closely with the hospital, and both the ward and the clinic are in the hospital. The MHCS operates right out of the hospital. It has become so closely associated with the hospital that, as Dr. Bowman indicated, this causes a certain amount of problems because the interests of the hospital commander are not necessarily the interests of the KO Team commander who wants to provide community service to a large area outside of the hospital. The hospital commander can't always understand that this isn't just a hospital clinic. At Nha Trang the team started out totally separate from a hospital. It was established at a clearing company a couple of miles from the hospital, including the ward. The clinic, the ward, the MHCS-type operation, all operated completely separately from the hospital for some months. This worked pretty well, but they got into some administrative and logistical problems because the teams just don't have much in the way of administrative help organic to the team, and being separate from the hospital they really didn't get the kind of administrative and logistical support from the clearing company and from the medical battalion to which they were attached that they needed. More recently they've been attached to the 8th Field Hospital and have moved the ward into the hospital. The ward is in the hospital but the clinic and the MHCS operation are still out in the troop area a couple of miles from the hospital. At this point the team seems to have settled down into a reasonably good pattern of operation causing both the hospital and the team to be happy. They seem to be working quite effectively in the Nha Trang and Cam Ranh area. Mentioning Cam Ranh, there is no psychiatrist in the Cam Ranh area and yet there are tremendous numbers of troops. The team at Nha Trang sends a psychiatrist, social worker and a technician down and they spend Fridays holding a clinic at a clearing company at Cam Ranh which is very much appreciated by the people at Cam Ranh. I've talked with some of the doctors in the dispensaries there, and they feel that this is a great help to have this consultation. The number of troops in the Cam Ranh area is getting to be so large that just a visit once a week down from Nha Trang will soon not be enough. Here again the medical group commander of the 43rd Medical Group as well as the medical battalion commander at Cam Ranh, are asking for an MHCS-type operation to be set up at Cam Ranh. We have a situation somewhat like that at Qui Nhon in which ideally we would need a small psychiatric team, and soon. Cam Ranh is a very large area in terms of both expanse and number of people. There's an Air Force base there which has a hospital, housing two psychiatrists. They have a sizeable clinic operation and a sizeable ward; they have a forty-bed air-conditioned psychiatric ward which stays fairly full of patients all the time. Their clinic is busy also. Some of the patients that they see are Army patients from the Cam Ranh area. This is the only Air Force hospital in Vietnam; and, as far as I[']m able to tell, practically any Air Force psychiatric problem that arises in Vietnam gets evacuated to this Air Force hospital at Cam Ranh. They're increasingly busy just with Air Force people. They've been running about 40 patients on the ward ever since they opened up. The first time I was there in August they had about 25 Army patients with a lesser number of Air Force. The second time I was there they had 12 Army patients and they were still filled up to about 40 patients. LTC Murray, who's our social work consultant in Vietnam, was there recently and he said there were 6 Army patients but the ward was still full.

At Phan Rang there's really nothing much except, as I mentioned, the base camp of the l01st. There's a dispensary there, that's all. Some patients come up to the team from Phan Rang. Phan Thiet has one battalion, as I said. We do not have a psychiatrist at the 36th Evac Hospital in Vung Tau. The only large combat unit being served directly by the hospital at Vung Tau is that of the Australians, and the Australians have a certain amount of organic medical support. We just don't seem to get many psychiatric referrals from them. I don't know what they do with them, but we don't seem to get them. By and large the psychiatric referrals from the Vung Tau area have been sent up to Saigon or to Long Binh, either to one of the hospitals in Saigon or to the team at Long Binh. The division psychiatrist of the 25th Division at Cu Chi gives area service to the area taken care of by the 25th Division. He not only has a clinic there at the medical battalion, which is in the base camp along with Division headquarters, but he also provides consultation to the 7th Surgical Hospital and to the 12th Evac Hospital which are at the base camp of the 25th Division. His also is the place to which the 196th Light Infantry Brigade evacuates psychiatric patients,

as well as the 3rd Brigade of the 4th Division which is at nearby Dau Tien. These units are controlled by the 25th Division which renders medical support, including a psychiatrist. I just want to mention one thing. In general, the 25th Division has had very few psychiatric casualties; that is, the rate has been quite low, slightly lower than that which Dr. Byrdy described for the Air Cav. But this doesn't mean that they don't have any; they do have some. Operation Attleboro, as you remember, was one of the big operations last fall. Up at Tay Ninh at the medical clearing company of the 196th Brigade there's a social work specialist by the name of Mann, the only mental hygiene-kind of personnel in Tay Ninh. He has operated in such a manner that the medical people at Tay Ninh have gained all kinds of confidence in his ability to screen and work with psychiatric patients. Whenever a psychiatric casualty comes to attention in Tay Ninh, the medical people there have Mann see him. Mann has gained quite a reputation. He submits a report to me every month on the patients he sees and the work that he does. I talked with him about what happened during Operation Attleboro. We've mentioned the fact that there isn't any combat fatigue, etc. It isn't that there isn't any combat fatigue, there just hasn't been as much of it, and much of what has occurred has not been as severe as some that we've seen in the past. Either that or it's been handled much better. At the height of Operation Attleboro there were two companies of the 25th Division up in that area who got hit rather hard. Inside of a couple of days or so, Mann processed about 12 or 14 fellows from these two companies who essentially were a form of combat fatigue or combat exhaustion. These companies were hit very hard with a lot of casualties and a lot of people's buddies got killed. They worked hard during that period also. The way Mann described it, these were rather typically "shook up," and anxious, frightened and exhausted kids. He treated them in conjunction with the doctors there in the classical textbook fashion for combat exhaustion with a little rest, a little ventilation, a little reassurance, a little food, and sleep overnight. After 24 hours they all went back to duty and, as far as he could tell, they all did fine. So it isn't that these cases don't happen; it's that to some extent they are being handled perhaps better than they have at times in the past. This is a credit to the other physicians in the area, too, that they understand this process and are able to cooperate with it. At other times I've talked with individual physicians who understand this process very well all by themselves without any help from any psychiatrists or social workers. At Di An is the 1st Infantry Division psychiatrist and perhaps this division has had more of what you might call combat fatigue right along than any other. They've had some operations which were lengthy in which the fellows stayed out in the jungle for long periods of time, and right along they've had, not a large number, but maybe up to 6 or 8 a month, a steady trickle of cases that they call combat fatigue, which has gotten back to the psychiatrist. There have been more that have been taken care of in the medical companies, sometimes by the social work technicians in conjunction with the doctors. But the psychiatrist will often receive them and take care of them for 2 to 5 days in the medical battalion, back at his headquarters, and then return them to duty. Very rarely do they actually get back as far as the hospital at Long Binh, although there have been a few. The team at Long Binh has trained some social work technicians. They've trained at least one for the 173rd Airborne Brigade at Ben Hoa and another one for the Cavalry. . . .

[Next,] I . . . want to show you some figures. [The] . . . trouble with these figures is that, as Captain Byrdy mentioned, the rates and figures are very difficult to arrive at in a situation like this. These figures, for instance, refer only to reports that I've received from psychiatrists. When you say this is the rate seen by the psychiatrist or these are the admissions done by the psychiatrists at the psychiatric facilities, they aren't really complete. The evacuation figure is perhaps more accurate than any, because this represents the rate for patients who have been evacuated by our psychiatrists. There have been a few that haven't, but we've evacuated a few of those of other services, too, so it probably comes out about even. The morbidity rate is a little more problematical because this is the figure that is reported by all of the registrars from all of the medical facilities around the country that have registrars. I found errors in that at times. On the other hand, I found errors in all these figures at times. You can't take this as gospel, but it gives you an idea as to how the rates go. You'll notice that the out-patient rate stays relatively the same. There was a little drop, probably representing a period when there were 2 or 3 of the psychiatrists out at the same time during which time a couple of the clinics weren't operating. While this rate has stayed in the same ball park, the population in the country has been rising steadily causing the number of outpatients to rise steadily. The psychiatric admission rate as reported

by the psychiatric facilities at least stays roughly in the same general area but the number has been rising as the population in the country rises. You roughly double the population in the country and the numbers that are admitted to our psychiatric wards roughly doubles. The evacuation rate out of country was a little lower last summer than it has been for the last four months, but you'll notice how closely the evacuation rate has been the same for the last four months, quite low, around 2 per thousand per year. This figure is the percentage of the total evacuees out of country for the month. I didn't get the figure for the total December evacuations so I couldn't figure the percentages, but I have reason to think that the percentage of evacs for December is about the same as for November. Perhaps about 3 percent of all evacs were psychiatric. The morbidity is essentially lost time due to psychiatric diagnoses as reported by all the registrars. You'll notice that this rate is generally a little larger than the admission rate reported by psychiatrists. This you can expect because other people besides psychiatrists will make admissions for psychiatric reasons, and they won't all get to a psychiatrist necessarily. I think that these figures are slightly small but they're probably comparable to the figures that are reported in the command health report from the Department of the Army in which the CONUS rate for the first six months of 1966 varied from about 9 to 11, and the Army as a whole varied from about 9 to 11. Bill Allerton was telling me that the CONUS rate is up now. If you look at this you can see that, although we aren't having any unusual problem with combat fatigue, we aren't having any unusual problem with more psychiatric cases for any reasons in Vietnam than you might expect, yet we are having an amount of business that is comparable to the business that you get on a troop post in the United States. Perhaps this is not quite as high as a rate that you get out of a basic training camp; but it isn't that there aren't any psychiatric problems in Vietnam, it's just that the rate is not particularly unusual.

[A question-and-answer period followed Johnson's comments]

[Johnson, responding to a question.] I think there are many different factors involved in the psychiatric rate in Vietnam. The leadership by command in Vietnam is excellent and I'm sure that's a part of the picture. I'm sure that many of the facilities that have been established for troops in this situation which weren't established in previous situations as well are a part of the picture, too. For instance, the mail situation is much better than that I experienced in Korea. Also, there are things such as the Armed Forces Radio, for any soldier in Vietnam who carries a little pocket radio can listen to the news and find out what's going on. The food is excellent in general. Often I'll travel up to the 4th Infantry Division in Pleiku and go out to a mess tent and eat a meal that is just as good as anything that I can get in Saigon . The leadership has established for the troops other things that make for good morale generally. I think another factor is the one-year rotation. I think that the trooper generally has the feeling that one year is a short while; and, if he can make it for a year he'll have it made and will sort of prove himself. I think this is a definite factor—the combat isn't endless. If one can make it for a year, he can get out of it. It isn't the hopeless feeling that one has when the combat is essentially endless and he expects that the unit is going to disappear entirely including himself. I think I have not answered your question well at all. I think there are many different factors, including the morbidity of the troops. I think on the positive side is the fact that one doesn't just sit in a defensive position and stand off attacks. Our units generally are on the attack all the time. They go out and attack and then come back and rest and then go out and attack. The rest between the periods of attack is important.

. . .[Johnson, responding to a question about slightly increased incidence of psychiatric evacuations in September of 1966.] Well, I think it refers to a lot of things. I think that at this point there were a lot more replacements arriving. The 4th Division was arriving at that time, but in addition there were a lot of others. You see, the big build-up started the previous summer and by September of 1966 a lot of the troops that had volunteered to come over here or were organic to a unit were being replaced by individual replacements some of whom were volunteers but some of whom were not necessarily volunteers. This increased replacement situation started in about September. I think this had something to do with the little jump in rate at that time.

[Johnson, responding to a question as to the low casualty rate in units arriving with good unit integrity; ie, soldiers who had served in the same unit for some time.] Definitely a factor. This, I feel, has been part of the thing about the low rates in the 25th Division and the 1st

Cav in the past which, I think, changes as the individual replacements begin to come in.

[Johnson, responding to the question, "If that's true, then why are some of the units split up so much? This seems like asking for trouble. I know this is a command problem; they've got some of the soldiers in three different spots."] The only thing I can say about the fact that the divisions are split up the way they are is that this was done because of military necessity. The divisions are built out of brigades specifically so that they can be flexible in response to military requirements. [Comment by another participant]: The three brigades conduct themselves quite independently from one another. Indeed, our major field problems envisage that they would be separated. One brigade would have no difficulty to go out into the field for a long period of time quite independent of the other two brigades and having its own internal cohesiveness and morale, which is, I think, pretty much separate from one another. They could go out into the field for a long period without the feeling that the division was fragmented. . . .

[Johnson, responding to the question, "[M]orale seems to be so high over there and [yet there is] the paradox [of] the activities [antiwar riots] at Berkeley. It would appear as though they're [the soldiers] getting either screened information or else they're getting all of it and handling it very well."] No, there's no screening of the information. The fellows over there just laugh about it, as far as I can tell.… On the plane on the way back I was listening to some of them talking and they were making jokes about the guys at Berkeley.

[Panel member comment]: . . . [I]n my experience with the divisions naturally we had no information for several months. We got a radio tape, I think, in the four months there. Mail service as yet hadn't had all the wrinkles ironed out, people really had to rely on letters from home and clippings from home for the first half of our tour. And then, our two sources of information, the troop sources of information, were the radio in Saigon and the *Stars and Stripes*. These radios told everything that was worthwhile, including rock and roll records. The *Stars and Stripes*, comparing it with clippings from the *Times*, tended to tone down somewhat the disclaimers of the war.

[Johnson, responding to a question as to U.S. soldiers being adversely affected in morale by Vietnamese intransigence.]: I don't really believe so. It seems to me that in most cases the relationship between the American troops and the Vietnamese people is quite good. I've made a number of friends among the Vietnamese myself and I observe many other people that do. I observed that the Privates and PFC's do also, and I observed very little in the way of real friction.

[Panel member comment]: In our division we were really isolated pretty much from the civilian population. Our base camp was set up in such a way as to be quite separate and maintain a large degree of integrity until those times when we thought that the integrity should be broken down somewhat. However, I think that many people have an attitude of unusual suspiciousness toward the local civilian population. In our division this was based on a number of incidents in which the local brush cutters laid out little signs about installations and that sort of thing. I think that we kept things going in an insulated manner mostly, but the attitude of suspiciousness prevailed and I assume that at least in our area it must still prevail.

[Johnson]: Let me say one more thing about the information business. By this time there are PX's in every unit around the country, and one can go into the PX to buy a *Time Magazine* or *Newsweek* or *Observer*, or whatever he wants. He can read anything that he wants to read. Sometimes it's a week or two late, but it isn't as it was back in September when it was two months late. In addition to which, particularly in Saigon, there are daily papers. I buy a paper every morning and read the news. The Vietnamese government censors some of the military news, but they don't do anything to censor the news that comes out of the United States. All of the draft card burners and Berkeley protesters are featured in the news over there daily, and I think it makes no particular problem.

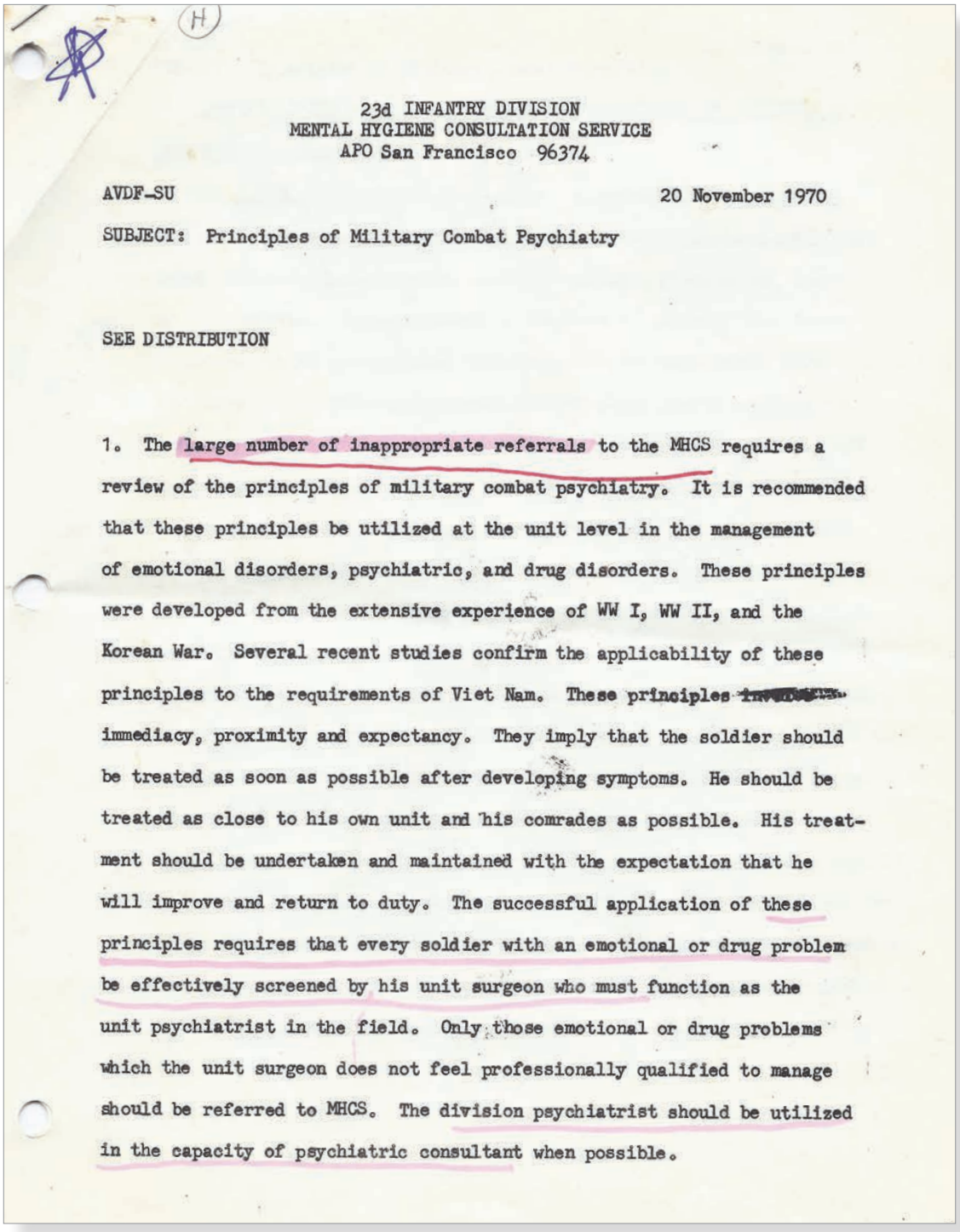
[Johnson, responding to a question comparing troops in Korea with those in Vietnam]: . . . [O]ne of the factors in Korea is that it is essentially a defensive position. It was essentially a situation of sitting still and waiting for something to maybe happen. Also, it is essentially a garrison-type of situation with a certain amount of rigidity, "spit and polish," and so forth. We find that in Vietnam in the base camps when the soldiers are there

for a while and things get a bit more rigid, there's more acting out. The troops enjoy being out in the field more. One would think that the rates would go up when they go out in the field to try to find Charlie, but that's when the rate goes down and everybody seems to feel quite good with relatively few problems. The problems return when they return to the post.

Source: Jones FD, ed. *Proceedings: Social and Preventive Psychiatry Course, 1967*. Washington, DC: GPO; 1968: 41–46, 73-76. [Available at: Alexandria, Va: Defense Technical Information Center. Document No. AD A950058.]

In: *Overview of Army Psychiatry in Vietnam, Soc and Preventive Psy Course*, Washington, DC, 1967

Appendix 9 23RD INFANTRY MENTAL HYGIENE CONSULTATION



23d INFANTRY DIVISION
MENTAL HYGIENE CONSULTATION SERVICE
APO San Francisco 96374

AVDF-SU 20 November 1970

SUBJECT: Principles of Military Combat Psychiatry

SEE DISTRIBUTION

1. The large number of inappropriate referrals to the MHCS requires a review of the principles of military combat psychiatry. It is recommended that these principles be utilized at the unit level in the management of emotional disorders, psychiatric, and drug disorders. These principles were developed from the extensive experience of WW I, WW II, and the Korean War. Several recent studies confirm the applicability of these principles to the requirements of Viet Nam. These principles [redacted] immediacy, proximity and expectancy. They imply that the soldier should be treated as soon as possible after developing symptoms. He should be treated as close to his own unit and his comrades as possible. His treatment should be undertaken and maintained with the expectation that he will improve and return to duty. The successful application of these principles requires that every soldier with an emotional or drug problem be effectively screened by his unit surgeon who must function as the unit psychiatrist in the field. Only those emotional or drug problems which the unit surgeon does not feel professionally qualified to manage should be referred to MHCS. The division psychiatrist should be utilized in the capacity of psychiatric consultant when possible.

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2. SPECIFIC PRINCIPLES OF MANAGEMENT OF PSYCHIATRIC OR EMOTIONALLY DISTURBED PATIENTS:

a. PSYCHOPHYSIOLOGICAL REACTIONS: hyperventilation, syncope, vomiting, incontinence, eneuresis, headaches and HYSTERICAL REACTIONS: pains without organic disease, panicky feelings, freezing up, sleep-walking, nerves. The management of the bulk of patients with these disorders can be accomplished effectively at the unit level. Treatment consists of emotional support, reassurance, the opportunity to ventilate, and a tranquilizer (e.g. Mellaril 25 mg bid). The patient should not be allowed to obtain secondary gain, such as coming out of the field or relief from duty, which only serves to fix his symptoms rather than relieve them. The further this type of patient is evacuated towards the rear, the more difficult will be his rehabilitation and return to duty. A frequent problem with this category of disorder concerns a judgement on the potential hazard of the soldier to his unit. Such patients when evaluated by the MHCS, ordinarily will be returned to their units for duty. Exceptions to this policy may be the individual whose symptom manifestations have been documented as hazardous to his unit. Thus hyperventilation after a firefight will not warrant a profile limitation. The same reaction during a firefight, which jeopardized the safety of the unit, would justify a profile limiting field duty. However, such reaction should be substantiated in the individual's health record prior to referral to the mental hygiene consult. Service decisions by

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the MHCS on profile limitations are based on what the patient has done and not on what he says he might do.

b. CHARACTER AND BEHAVIOR DISORDERS INCLUDING DRUG DEPENDENCE: The major portion of these disorders can be managed effectively in the unit by appropriate rehabilitative and disciplinary action. Those individuals on the Drug Amnesty program can be provided support as described in the SOP on the Amnesty program. Supplementary use of tranquilizers may be indicated such as Mellaril, 25 mg bid-tid. Those who are considered physically dependent on barbiturates or narcotics should be referred to MHCS for withdrawal over a 5-8 day period.

c. PSYCHOSES: Delusions and/or hallucinations not related to drug intoxication and SEVERE NEUROSES: hysterical paralysis, mutism, amnesia, and compulsions which impair the ability of the individual to function. Patients with these disorders should be referred to MHCS where a specific treatment plan and/or limitation of duty will be recommended.

3. NON-PSYCHIATRIC EMOTIONAL PROBLEMS:

a. FEAR OF THE FIELD: Fear of the field is a normal reaction. It can be managed effectively by unit measures such as the "buddy system", which keeps the individual close to an experienced soldier or NCO during the initial period in combat action. It is important that the soldier who manifests such fear joins his unit in the field as soon as possible. The unit surgeon must reassure the soldier that his fear is normal and can be overcome. Tranquilizers should not be prescribed if symptoms of anxiety (outlined in b below) are not present.

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b. ANXIETY: No one should expect to feel comfortable and relaxed in the combat field. Headaches, abdominal cramps, poor sleep, poor appetite, are normal symptoms in combat, and do not justify evacuation. Again, the unit surgeon must reassure the soldier that most combat soldiers at some time experience some or all of these symptoms and that they are not indicative of emotional illness. In these cases, however, tranquilizers (e.g. Mellaril 25 mg b.i.d.) may be prescribed to help control the overt anxiety.

c. REFUSAL TO GO TO THE FIELD: When a soldier who has been in a combat area refuses to return because of psychiatric reasons, he should be evaluated by the unit surgeon to determine fitness. If he has been able to perform his field duties in the past without presenting a hazard to his unit, he is considered fit for field duty. He should be managed administratively. When a man who has never been in the combat field before refuses to go, he cannot claim psychiatric unfitness. Psychiatric evaluation of fitness is based upon actual performance in the field. A trial of field combat duty is necessary before any determination of fitness can be made.

4. MHCS REFERRALS: Most referrals to the MHCS will be accomplished by the unit surgeon. Administrative referrals may be made directly to MHCS by the unit commander for the following: 212, CO status, or court martial proceedings. In such cases Americal Form 49 should accompany

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the individual to MHCS.

Larry E. Alessi

LARRY E. ALESSI
CPT, MC
Division Psychiatrist

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1-Surg, 1-1 Cavalry
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Appendix 10 PSYCHIATRIC EXPERIENCE AT THE 3RD FIELD HOSPITAL

Captain Arthur S Blank Jr, Medical Corps, was a civilian-trained psychiatrist who served in Vietnam (October 1965–1966) during the first year that ground troops were deployed. He was initially assigned with the 1st Infantry Division, then with the 935th Neuropsychiatric Detachment (KO), and finally with the 3rd Field Hospital in Saigon. The comments below center on his experiences as a solo psychiatrist assigned to the 3rd Field Hospital (April–September 1966).

PANEL REMARKS: CPT. ARTHUR S BLANK JR. 3RD FIELD HOSPITAL, SAIGON

During my first few months in Vietnam I was the de facto First Division Psychiatrist in as much as Captain Perito did not arrive until the beginning of January 1966. After that the KO Team arrived and we worked together until I moved to the 3rd Field Hospital in Saigon in April 1966. I'd like to devote most of my comments to that latter six months which I spent at the 3rd Field Hospital. In doing so, I think I'm talking about an experience which is fairly typical for the psychiatrist who is stationed at an Evac or Field hospital where there is not a KO Team, not a psychiatric ward as such, and essentially no other psychiatric personnel. The 3rd Field and the 17th Field Hospitals in Saigon provide directed medical support for the 25,000, maybe now 30,000, troops in the Saigon area, our support troops, and also provide, along with the 93rd Evac Hospital, direct support for support and combat troops in the Delta, such as there are.

The work load was manageable, although I want to hasten to make the same points that Dr. Byrdy did, that matters of administration and communication take much longer in Vietnam than they do, I think, anyplace else in the world. We're going to have to take this into consideration. I would also say about these general statistics that these would represent roughly one-half of the business in Saigon during this period. Captain William Kenny is at the 17th Field Hospital. He was seeing approximately the same number of patients as was I, although not quite as many inpatients.

What I have in mind here is to demonstrate the kind of patients that are admitted to what might be considered a "middle-level" psychiatric facility, between field stations and the clearing company on the one hand, and the evac hospital or field hospital with the KO Team on the other hand. All the schizophrenic patients admitted during this period were eventually sent to the 93rd Evac Hospital and eventually evacuated from there. With exceptions of the few severely neurotic, severely depressed or severely anxious neurotic patients, the patients listed here as neurosis, situational reaction and combat exhaustion were admitted to the hospital by me. This was occasionally my procedure calculated to facilitate the evaluation. Many of these were patients from the Delta or from units out of town who could not be seen as outpatients. Also, some of them were admitted to be started on drugs. Now the patients with character disorders, chronic alcoholism and acute alcoholism were admitted by other people besides me to my service, and discharged by me as quickly as possible. I do not have a figure for the average length of stay down here but it was in the order of under 5 days. It was not substantially different for any particular diagnostic group.

On page three I have some numbers about where these patients came from. I think this will help to give you an idea of the complexity of evacuation channels in Vietnam and give you an idea of the fact that things really don't follow the traditional model so much in that, with certain exceptions, any medical facility tends to get patients from anywhere. As you see, I've got patients from battalion surgeons in the field, dispensaries in Saigon shipped to doctors off the coast, flight surgeons from aviation battalions in the Delta, and so on. Only two patients in the entire six months came in from clearing companies. These same proportions apply to my outpatient statistics for that period. Under the lower half of page three I have some miscellaneous comments about the patients admitted. Well, let's make the following additions. First of all, there was one successful suicide in a chronically depressed alcoholic, which, interestingly enough, generated two other outpatients who both were seen for some time. In one, the suicide of this sergeant precipitated a classical obsessional neurosis, while the other patient had a fairly severe transient anxiety reaction.

I'd like to add a couple of other things. From these 61 patients admitted, 8 had been previously psychiatrically hospitalized anywhere from 1 to 4 admissions and all of these hospitalizations had been before they came to Vietnam. In addition, another 17 of the 61 had had some kind of contact with a psychiatrist, ranging anywhere from one evaluation to extended outpatient therapy as a civilian before coming into the military. In all of these cases the previous psychiatric contact was before they came to Vietnam. I wasn't particularly conscious of this as I was seeing the patients over there, and I want to go into this in looking over my outpatients. It raises an interesting question about screening. I do not know what the baseline figures would be in this area. Even though these numbers are small and they're all from one facility, I wonder if the question is not raised here. Since these were patients who ended up in the hospital in Vietnam, perhaps attention should be paid particularly to previous psychiatric hospitalization and also outpatient contact as part of the screening process for deployment. I simply don't know what's being done along that line, and I would be interested to hear about it. Another fact I'd like to add concerning these inpatients is that there was in relation to their time in Vietnam, a small peak around 4 weeks in-country. But the largest group of them had been in Vietnam about 5 months. I'm really not sure what this means; the time curve for outpatients at 3rd Field was studied by my predecessor there, Ed Huffman, and also by me; and most of the outpatients come in around 4 to 6 weeks in-country.

Finally, on the back page, there are some numbers about inpatient consults. These are patients referred to me during the six-month period by the medical and surgical services. What I mean by this is that initially the patient had been admitted for some sort of physical symptoms or some apparently organic problem. After the medical or surgical work up was completed and I saw the patient it was clear that it was a psychosomatic problem or a straight psychiatric problem that had been the reason for his admission into the hospital. This was the case in 12 out of 33 of the patients and in 18 out of the 33 it turned out that the psychiatric problem was either not existent or was incidental to what they had been admitted to the hospital for. Three of the patients were diagnostic problems who were subsequently evacuated from the country by the medical or surgical services for further work up. In going over these statistics, I found that I had recorded none of these 12 patients as psychiatric admissions. I remembered sometime early after arriving in Vietnam to monitor the discharges from other services in the hospital particularly for psychosomatic problems. I bring this up now because I suspect that this may be happening at other facilities and may be the experience of other psychiatrists besides myself. There may be in this area a certain percentage of covert psychiatric casualties. In the case of this six-month period at 3rd Field these 12 patients represent about 18 percent of the psychiatric admissions. The numbers refer only to the 12 consults whose admission was determined by psychiatric problems, and I don't think they need any particular explanation at this point.

I'd like to make a few general comments about the outpatients seen. Clinically the group of 300 or so outpatients fit closely with the kinds of problems described by Dr. Byrdy with the exception, of course, that in my situation the percentage of combat troops was only about 20 percent. Transient situational reactions were predominant. In addition, I saw a goodly number, probably around 70 or 80, out of this group of support troops who clearly had a passive dependent character and who had an anxiety syndrome in 4 to 6 weeks after they arrived in Vietnam. It appeared in

most cases that these individuals were reacting to a combination of the stress of being there and particularly of the heavy work load which many of them had--12, 14, or 16 hours a day, 7 days a week. A combination of this kind of stress and the separation from their mothers, or their wives toward whom they related as a child to a mother. In general I found them to be eminently treatable. These were passive dependent characters who came to see the psychiatrist largely because of their discomfort, not because of somebody's dissatisfaction with their behavior. Some of them were treated with a combination of one or two interviews and thoroughly large doses of Librium which I used quite regularly and found extremely effective with this kind of person.

Well, I'd like to move on to some other topics about which I want to comment just briefly and perhaps about which we can talk more in the discussion. During the six-month period I saw 50 of the AR 635-212 cases, almost all of whom were from the Saigon area. It's interesting to compare this with my only other experience in the military, which has been at Fort Dix since I returned. It's interesting to compare the kinds of behavior patterns of administrative cases we see there with these 50 in Saigon. The majority of these 50 in Saigon had engaged in overtly hostile behavior. Instead of passive aggression a lot of it was aggressive aggression, and consisted of either directing repeated incidents of either verbal abuse toward superiors or all-out physical assault on superiors, usually while armed and often appearing with some degree of intoxication, but not always. I'm interested in the group and I'm trying to study my records on them. I don't have much of an idea of what they were like psychologically. In general, they had been in the service for a while, were RA and had a reasonable record as far as I could determine with reference to disciplinary problems and general performance before they came to Vietnam. Furthermore in the large majority of them there was a clear-cut absence of, or an infrequent presence of, the father's role in their development. I guess this is a common feature in certain groups of behavioral cases anyway. I had the impression there was something about being in Vietnam, something about the situation, something about the war, something about the invitation to violence, which was implied by the contract that had really changed the course of their re1ationship with the military.

I'd like to mention now something about terrorism. During the period 1 April to 30 September three major terrorist incidents occurred in Saigon—two mortar attacks in the Tan Son Nhut area, one in April and one in August, and the plastic explosion at the Victor BOQ in downtown Saigon in April. Additionally, the period April through June was relatively significant by reason of agitation by Buddhist groups and agitation by Catholic groups. In general the city was more tense during this three month period than it was any other time I was there. This resulted in an increase in the usual level of minor terrorist incidents—grenades thrown in jeeps, occasional sniping, burning of vehicles and so on. However, throughout this entire period only one patient was admitted to either hospital in Saigon in which the psychiatric syndrome was attributable to experience with a terrorist incident. This was a captain who had a transient psychotic reaction following the Victory blast and who was admitted to 17th Field Hospital for a few days. He cleared up quite rapidly. I saw two other patients myself during this time whose problems were in part attributable to terrorist activity—one fellow who had been chronically anxious for six months during his residence somewhere down in the Delta and who had an exacerbation of this just as he was about to return home. Shortly after arriving in Vietnam the other had been sniped at outside the Tan Son Nhut gate; it isn't clear by whom. He was upset about this. It seems clear that at least during the period I'm talking about there was really no direct connection between psychiatric admissions or psychiatric outpatient visits and terrorism. Bill Kenny did a questionnaire study of the officers at the Victory BOQ in April and found that a large majority of those near the blast reported subjectively experiencing anxiety and some preoccupation with the blast, all the usual symptoms of a mild traumatic state, for about two weeks afterwards. Interestingly, I made the same kind of observations in a more informal way. I observed the 3rd Field Hospital staff following the two mortarings at Tan Son Nhut. It was a jumpy one or two weeks afterwards with an increase in alcohol intake and so on. I'm not sure what the experience of others in the country has been, perhaps we can get into this later, but I think it's an important point that the terrorist activity of the VC has not generated any significant clinical problems as far as we're concerned.

I would like to close with a few brief and probably not very profound comments about the whole question of

the war and its relationship to our work over there. I found that I've been asked many times what kind of patients does one see, what kind of problems does one see in relation to the political ambiguities of the war, the dissension of this country about it, and so on. Is there any connection? Does this seem to be a problem? Do the ambiguities of the war seem to be a problem for the soldiers? The answer to this is very simply, "No." I did not see single patient in whom I felt that any kind of conflict about the war on any level was primary in precipitating his visits to me or his admission to the hospital. A few patients happened also to be preoccupied with the question of the war and the politics involved, etc. In one way or another many patients and personnel, probably representing about the same proportion as that which one would find in the general public in this country, were less than enthusiastic about our national effort there. But again, this seemed to have no connection, really, with what was troubling them psychiatrically.

[*Reference is made in the proceedings to an incident in which one of Captain Blank's patients brought a grenade into his office and exploded it after warning Captain Blank to leave. The patient sustained some frontal lobe damage but lived, and Captain Blank was uninjured.]*

In: Johnson AW Jr, Bowman JA, Byrdy HS, Blank AS Jr. Panel discussion: Army psychiatry in Vietnam. In: Jones FD, ed. *Proceedings: Social and Preventive Psychiatry Course, 1967*. Washington DC: Government Printing Office; 1968:41-76. [See also Alexandria, VA: Defense Documentation Center (Document AD No. 950-058, 1980).]

Appendix 11 RECENT EXPERIENCES IN COMBAT PSYCHIATRY IN VIETNAM

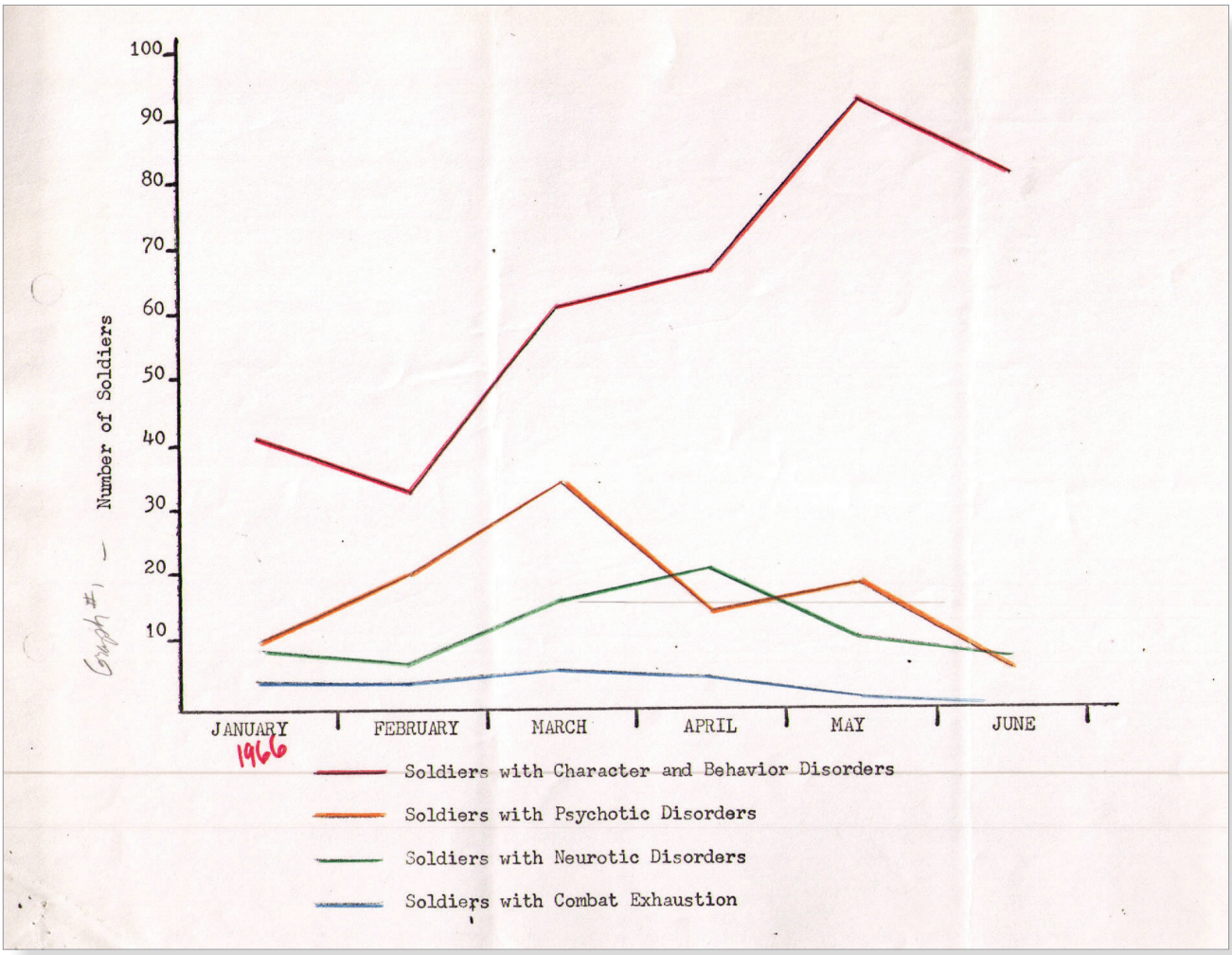
This paper (unpublished) provides an overview of the experiences of the 935th Neuropsychiatric Medical Specialty Detachment (KO), which was attached to the 93rd Evacuation Hospital on the Long Binh post 20 miles northeast of Saigon. It was written by its first commander, Major John A Bowman, Medical Corps, who was Army-trained in psychiatry, and spans between January 1966, when the 935th first deployed in Vietnam, and the following June. Bowman wrote this soon after he returned to the United States after completing his assignment in Vietnam. This material is published with the expressed permission of the author. Minor edits have been applied to the original.

UNPUBLISHED PAPER: JOHN A BOWMAN, MAJOR, MEDICAL CORPS
935TH NEUROPSYCHIATRIC MEDICAL SPECIALTY DETACHMENT

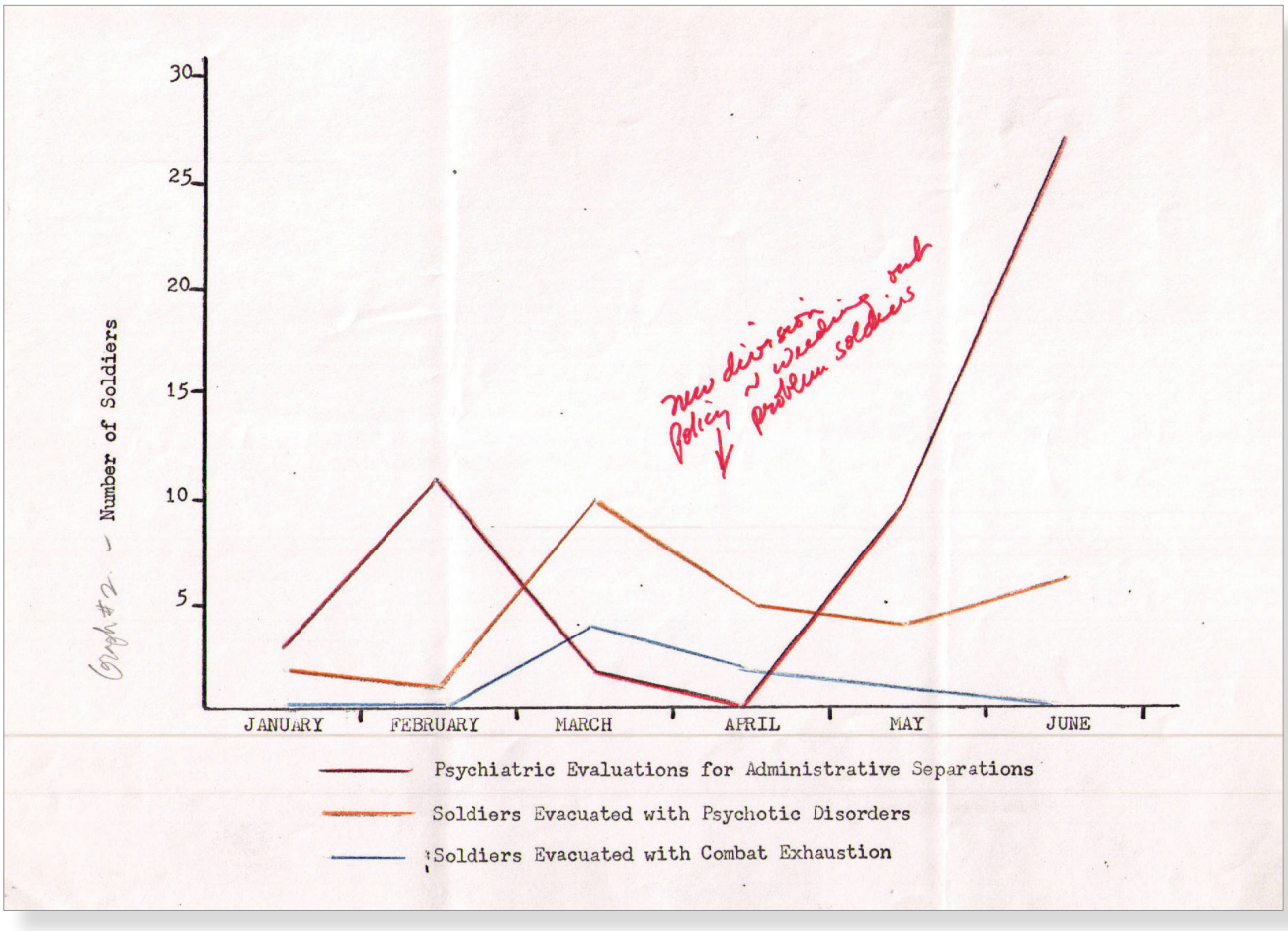
The author, a Regular Army psychiatrist, served in Viet Nam from December 1965 to November 1966 as the Commanding Officer of the Psychiatry and Neurology Treatment and Evacuation Center [The 935th Medical Detachment (KO)]. This center was composed of a professional complement of three psychiatrists, one neurologist, two social workers, one clinical psychologist, and one male psychiatric nurse. Twelve to 15 enlisted men of various training, that is, social work specialists, clinical psychology technicians, and neuropsychiatric specialists, were members of the KO Team, thereby totaling 20 to 23 men.

The mission of the KO Team was to establish a center where soldiers in Viet Nam could receive psychiatric and neurological consultation and treatment for up to 30 days as inpatients, if necessary, prior to evacuation to the continental United States [CONUS] or return to duty. The KO Team served as the evacuation center for all Army psychiatry and neurology casualties in Viet Nam. To accomplish this mission the team was assigned to the 93rd Evacuation Hospital and functioned in Quonset buildings in an area 20 miles northeast of Saigon in close proximity to the "D" War Zone. A second function or mission soon became to establish an MHCS [mental hygiene consultation service] type facility for the many thousands of soldiers in the surrounding area who had no psychiatric services organic to their respective units. The combat units the KO team provided care for were the 25th Infantry Division, the 1st Infantry Division, the 1st Cavalry Division (Airmobile), and the 173d Airborne Brigade of the 101st Airborne Division. These were primarily Regular Army professional soldiers who were well motivated and skillfully led.

The purpose of this paper is to present a few of the experiences of the Combat Psychiatry Team (KO) operating in Viet Nam. The 935th Medical Detachment (KO) was activated at Valley Forge General Hospital in October 1965 and trained as a unit for combat before overseas deployment on 29 November 1965. Arriving in December 1965, the team became operational in January 1966. The statistics presented herein represent the six-month period from January through June 1966. This period was characterized by mass movements of personnel into Viet Nam and also by many search-and-destroy type combat missions, both of which may account for monthly variations in the psychiatry and neurology [P&N] morbidity reports. The data and statistics, therefore, are presented to reflect the type and amount of work accomplished, and we do not attempt to interpret the monthly fluctuations of various diagnostic categories or the total number of referrals evaluated. Overall it can be said that we encountered a very low rate of combat exhaustion and an increase in character and behavioral disorders as time progressed.



The type of psychiatric referrals seen in Viet Nam deserve special consideration. There were, of course, a small number of soldiers, less than 5% of all referrals, who presented with a well defined psychosis, usually a paranoid schizophrenic or a manic depressive reaction, and who presented no diagnostic or dispositional problem. In contrast to World War II or the Korean Conflict, combat exhaustion was rarely seen, and represented less than 2% of all referrals. [The author uses two criteria in the diagnosis of combat exhaustion: (1) actual exposure to combat, ie, under hostile fire; and (2) the presence of fatigue, whether produced by physical causes such as exertion, heat, dehydration diarrhea, and loss of sleep, or by psychological causes such as anxiety and insomnia.] Combat exhaustion was rarely seen because combat was usually short-lived as the VC [Viet Cong guerrillas] did not choose to "stand and fight" very often; adequate food and rest were usually available to our troops. Nevertheless, a tremendous psychological stress was always present, as no area was considered safe from ambush, terrorist activities, or sniper fire. Exhaustion states, however, were usually secondary to the extreme heat, dehydration, diarrhea, and toxic diseases. Uncomplicated cases of combat fatigue were usually treated at the battalion aid station and few were returned to the P&N Center. A high morale among the combat troops also contributed to the low rate of combat exhaustion and more generally to a low P&N casualty rate. Otherwise, the critical time period between the time a soldier arrived in Viet Nam and the time he was first seen for psychiatric evaluation peaked at 1–2 months. Of 491 soldiers referred for evaluation, it was our prediction that a very high percentage of high school dropouts would be referred for administrative separation, but this did not prove true. Only about

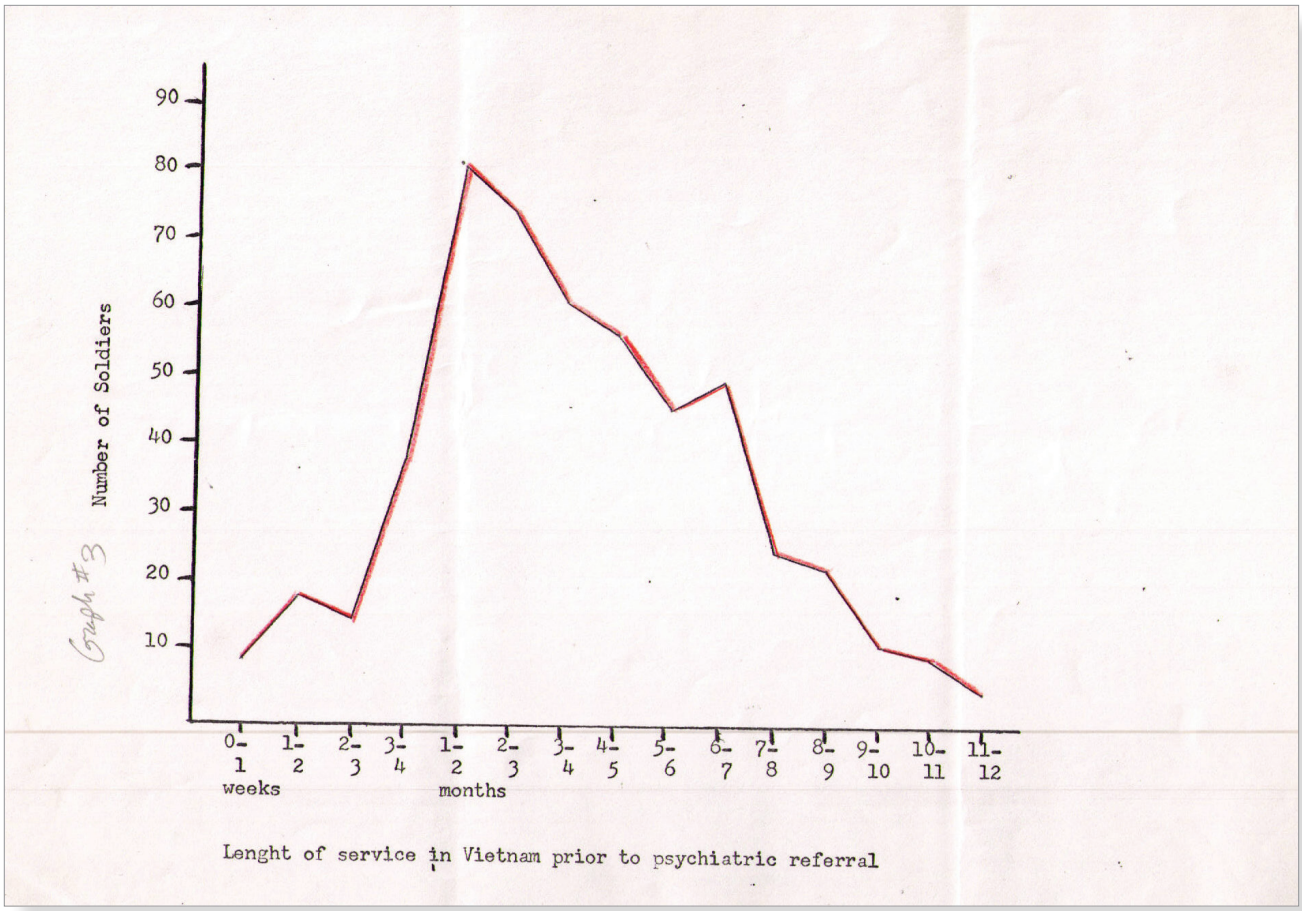


31% of the high school dropouts referred to the P&N Clinic were referred for administrative separations, and the remaining 69% of the high school dropouts were referred for other reasons.

The majority of soldiers referred to the KO Team presented either behavioral difficulties or somatic complaints of a specific nature. The somatic complaint was one that usually temporarily removed the soldier from the stresses he was experiencing in an honorable way, [that is], the complaint or symptom did not cause him to receive an Art. XV or courts-martial. For example, a soldier on guard duty may be referred with symptoms of narcolepsy or sleep-walking.
A soldier on a search-and-destroy mission where silence was sometimes life-saving may present symptoms of sleep-talking or nightmares in which he would shout out, thus endangering his whole unit. The symptom, therefore, not only rendered the soldier ineffective but also sometimes even made him a liability to his unit.

We wish to discuss in detail some of the symptoms seen in soldiers under stress in the combat zone in Viet Nam. For the sake of brevity and clarity the symptoms most often encountered in the soldier under stress in Viet Nam are divided into two categories: symptoms seen in nonwounded soldiers and symptoms seen in wounded soldiers. The symptoms are not listed in order of prevalence.

A. Stress Symptoms Seen in Nonwounded Soldiers:
   1. Somnambulism.
   2. Anxiety dreams with talking or shouting.
   3. Syncope and vertigo.
   4. "Narcolepsy" like complaints.
   5. "Seizures"—not proved to be grand mal or petit mal.
   6. Musculoskeletal type complaints, such as low back pain where the orthopedic examination is negative.

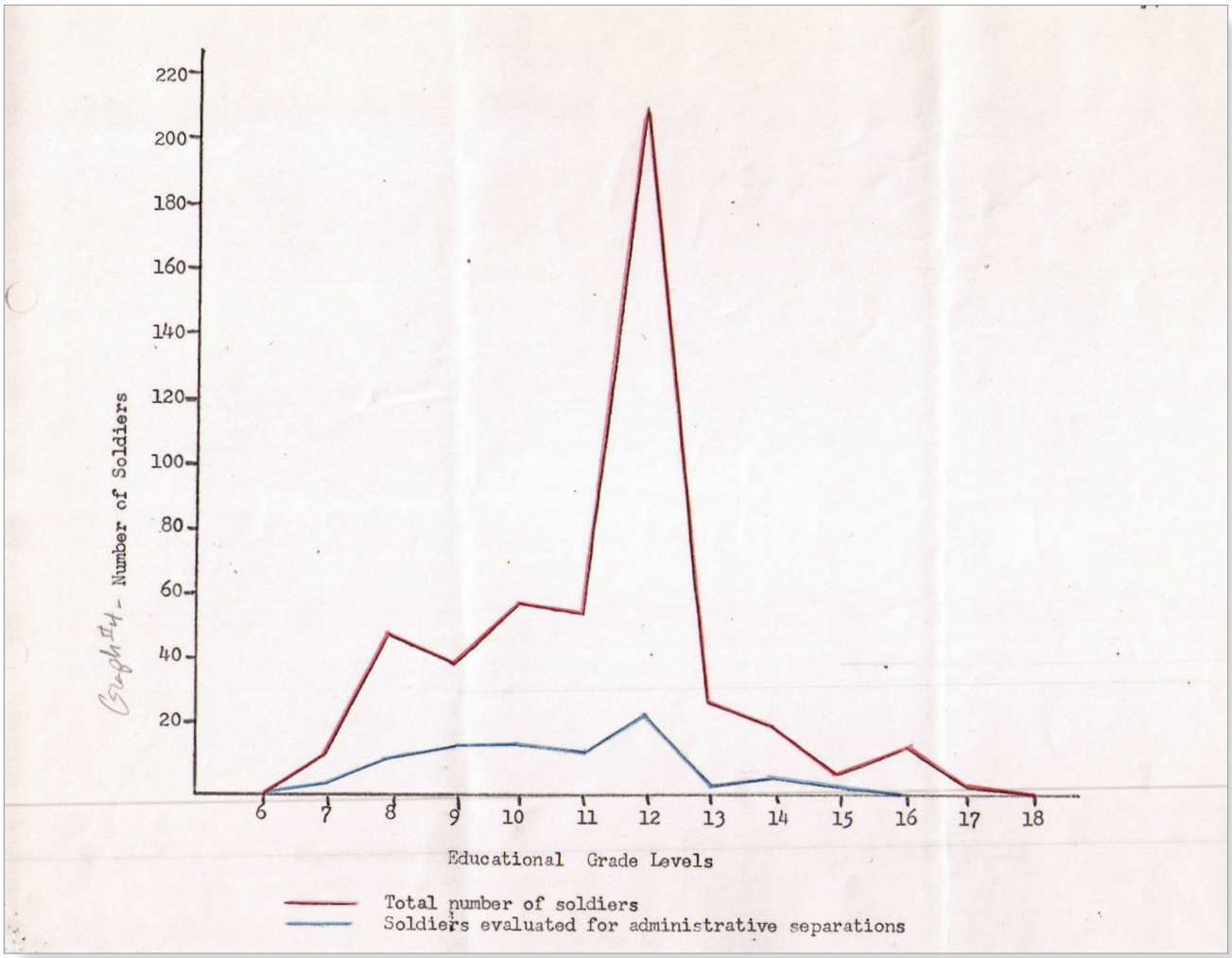


7. Amnesia, especially following exposure to explosions (mortar, artillery, or mines) but having no concussion.
8. Blurred vision—when the ophthalmologist can find no visual defects.
9. Stuttering, especially following exposure to loud noises or automatic weapons fire.
10. "Aphonias" or other speech disturbances, such as speaking with a whisper.
11. Persistent nausea or abdominal pain in which no GI [gastrointestinal] disease could be demonstrated by the internal medicine service.
12. Headaches, atypical but severe, persistent and disabling, most often diagnosed as "tension headache."
13. Loss of hearing—in which ENT [ear, nose, and throat] examination could find no hearing loss.

B. Stress Symptoms Seen in Wounded Soldiers—The disabling symptoms of wounded soldiers usually developed after hospitalization, or if present when hospitalized, the symptoms persisted or became more severe, requiring neuropsychiatric consultation:

1. Persistent anxiety dreams.
2. Pain in wounded extremity following complete healing.
3. Sensory defects in which the patient claimed hypesthesia and weakness of an extremity but the neurological examination was negative.

There was a very close liaison between the psychiatric staff and the medical and surgical specialties, since we both lived in one BOQ and worked together in the same clinic building. Consultations were frequently accomplished on an immediate and informal level, but even formal consultations were completed in 24–48 hours. There was a standard operating procedure for handling these psychiatric referrals. The soldier's symptoms were considered real by both the referring physician and psychiatrist. A physical examination and the appropriate X-rays and lab studies were ordered



when necessary. When the referring physician was sure there was no organic etiology to the complaint, the soldier was directly questioned about his feelings about returning to duty (after he had been reassured there was no organic illness present). Frequently the soldier/patient felt relieved to know that "nothing serious was wrong" and desired to return to his unit. Occasionally the soldier ventilated concern to the nurse or doctor about returning to duty. In refractory cases or when tranquilizers were thought necessary, the physician referred the soldier for psychiatric evaluation. The soldier was allowed to ventilate feelings, especially fear of death or fear of derangement [*sic*] of his body image, but the contract between the consultant (psychiatrist/social worker), the consultee (soldier), and the referring agency (CO [commanding officer] or physician) was well-defined in one respect: The presenting symptom would not be allowed to be used as a lever [for the soldier] to be relieved from duty or evacuated from Viet Nam. It took repeated contacts with the referring agencies by the KO Team personnel to keep the above communication concerning the intent of the consultation intact. The KO Team personnel would work to the best of their abilities to help the soldier with his problem, but the presenting symptom was rarely considered sufficient reason to evacuate the soldier from Viet Nam unless, of course, upon evaluation the soldier proved to be frankly psychotic. In most cases the soldiers gave up their symptoms and returned to duty asymptomatic or with less severity of symptoms. There were few recurrences. Occasionally mild sedatives were used, but tranquilizers were seldom prescribed. It was the staff's feeling that tranquilizers would tend to reinforce the soldier's concept of being ill.

Occasionally a soldier asked forthrightly to be relieved from combat because he was "too nervous." Some were vehement and demanding, some tearful, some agitated, and some emotionally labile. Too, some pleaded to be given a noncombatant assignment (often the request was to be a medic and work in the hospital). The staff did not allow evacuations from the combat zone or transfers within the combat zone unless it was medically indicated or militarily feasible. Due to our rigidity on evacuation policy our colleagues in the BOQ [bachelor officers' quarters] frequently referred to us as "tough guys" and whimsical but pointed remarks about "Catch 22" were aimed in our direction.

Indeed it was difficult to return to duty a soldier who had seen considerable combat, or had been wounded, or a soldier who had seen his best friend killed. After a period of grief, catharsis, or rest we found many of the soldiers ready for duty. In spite of mild to moderate anxiety, the soldiers for the most part did function effectively when returned. Frequently the members of the KO Team turned to each other for support when we returned a soldier to duty who may have narrowly escaped death or injury and was now reluctant to go back to combat. Without our own intra-group support a firm policy on evacuation could not have existed.

Another large group of referrals to the outpatient clinic were soldiers whose behavioral difficulties led to punitive or administrative action. The three most frequent behavioral problems were:

1. frequent or repeated AWOLs [absence without leave];
2. regressive behavior: excessive drinking, loss of pride in personal appearance; and
3. aggressive behavior: indiscriminate firing of weapons, insubordination, assault, and threats of violence to NCOs [noncommissioned officers] and commissioned officers.

In most of these administrative referrals the soldier usually acknowledged that he wanted either out of the unit or out of the Army. After a unit command consultation we decided whether to recommend administrative separation or to attempt further counseling with the consultee.

Consideration must be given to our administrative separation policies. Certain behaviors that would have been punished in CONUS were often condoned in combat, such as a soldier's being unshaven or having a dirty uniform or unpolished boots; one can understand this after experiencing the monsoon season in Viet Nam.

Most referrals to the P&N Clinic for administrative separation resulted from AWOL, insubordination, and aggressive or regressive behavior. The CO's lament was, "I have to fight a war. I am too busy with plans for our next operation to spend time with soldiers who don't work for me." The CO's point was reasonable; he really needed his time for fighting the war. The Commanders of support and logistical troops, however, did have more time to work with their problem soldiers and the MHCS representative. The marked increase of 208–209 cases in May and June 1966 was first thought to reflect the large numbers of replacements who had been drafted and sent to the Republic of Viet Nam. Further evaluation suggested that it represented a change in command policy in one of the local large tactical units. The policy in essence became to weed out any soldiers who got into difficulty [that] came to the attention of command.

During the first six months of 1966 we averaged about 300 referrals per month and a daily inpatient census of 10–12 patients. The therapeutic approach to hospitalized soldiers on the psychiatric ward included brief psychotherapy, both ventilative and supportive, tranquilizing drugs, and most important, the use of the milieu principle. Soldiers were admitted, given clean clothing, a shower, a warm meal, and sedation when appropriate. The soldier/patient was expected to keep his area clean and to assist ward personnel in maintaining an orderly ward. For example, the soldier/patient washed windows and policed the ward area inside and out. A patient NCOIC [noncommissioned officer in charge] was appointed to direct ward details and to manage the "buddy" system. The soldiers helped each other and exerted controls on their own behavior. The soldier not considered well enough to be off the ward alone was assisted by a convalescent patient to the mess hall, latrine, shower, or Red Cross lounge. Soldier/patients were required to stand for ward rounds and to display the same military courtesy to their attending physician that they would to their commanding officer. At all times the soldier was reminded that he was a part

of the US Army in a combat situation and was expected to behave accordingly.

The practical reality in Vietnam was that the entire country was a hostile area, there were no traditional "front lines," and there were great distances between tactical units and hospital facilities. However, the goal of maintaining unit identity was generally feasible because of the helicopter. When a soldier was admitted to our psychiatric ward at the 935th, we requested the parent unit to make regular visits to him, to bring him his mail, and to pay him on the ward. The line commanders well understood the need to maintain contact with their men in the hospital and cooperated to the fullest with our visitation program. No soldier, therefore, could feel lost or separated from his unit when hospitalized, even though his unit was 250 miles away. The use of the above principles of milieu therapy, the "buddy" system, and frequent unit contacts greatly decreased the amount of acting-out behavior, and consequently the number of soldiers requiring medical evacuation was reduced. Thus in effect, we were able to apply the principles of combat psychiatry (eg, treating the soldier as close to the combat area as possible and returning him to duty as soon as possible were effectively applied) and it was possible to return to duty about 90% of all hospitalized soldiers referred to the Psychiatry and Neurology Treatment and Evacuation Center (935th KO team).

Appendix 12 INTERESTING REACTION TYPES ENCOUNTERED IN A WAR ZONE

UNPUBLISHED PAPER: CAPTAIN H SPENCER BLOCH (MD)
DIRECTOR OF THE PSYCHIATRY AND NEUROLOGY INPATIENT SERVICE
935TH PSYCHIATRIC DETACHMENT (AUGUST 1967–1968)

Although the main interest in orientation of military psychiatry since WWII [World War II] has been in the direction of community psychiatry, nevertheless it is probable that the most valuable and lasting contributions of psychiatrists in the military to understanding of psychological processes has come from the clinical studies from WWII. Works such as Grinker and Spiegel's *Men Under Stress* remain as comprehensive classics of reaction types and treatment of the effects of stress and strain on men. In fact, in the current war zone [Vietnam] psychiatrists are hard-pressed to find psychiatric casualty types which were not reported in *Men Under Stress*. Nevertheless, in an overview of a large number of psychiatric casualties seen and treated in Vietnam, certain reaction patterns or types of response to stress were noted that may help to elucidate further our understanding of human psychodynamics. Not withstanding that distinction made by Grinker and Spiegel between certain types of reactions which are seen in ground forces and are not seen in personnel who fly, one has the impression comparing present day material with that seen during WW II of an increasing tendency towards reaction patterns which capitalize upon essentially alloplastic defensive adaptational techniques as opposed to autoplastic ones. Certainly a large number of psychosomatic and psychophysiological responses, as well as anxiety states, are seen in Vietnam today. Nevertheless, one is impressed by the degree to which externalizing defenses and the paranoid positions are adopted in setting of stress there. The degree to which this is related to the nature of the stresses of people serving on the ground as opposed to the degree to which it may reflect alterations in personality structure are as yet unanswered questions. In another recent communication an overview of army Clinical psychiatry in Vietnam was presented with some representative case histories that were included to convey a spectrum of the nature of hospitalized psychiatric patients seen there. This paper presents several case histories which serve as prototypes of certain reaction patterns seen in Vietnam. The cases chosen are ones which demonstrate the point to be made quite graphically and are presented with illustrating the kind of phenomena that could be frequently seen in other patients in which these presenting symptomatology was not as dramatic or graphic. The purpose in presenting these cases is to add further data to our understanding of human response to stress and strain.

THE CONCEPT OF INFANTILE REGRESSION

Case #1: A 20 year-old single PFC rifleman with 13 months active duty service and 8 months in Vietnam, was apparently sitting on guard duty with his combat unit in

the field one night. The unit was not actively engaged in fighting. At that time he was noted by his companions to become kind of "crazy." That is, he became confused, disoriented, unable to answer questions coherently, and was allegedly hallucinating, though this was not described in the referral note. No precipitant was discernible. He was taken to the medical clearing station and kept there overnight. The next morning he was mute and was flown to the psychiatric ward which was about 20 minutes away. He was admitted at that point, and on admission he was sucking his thumb constantly and alternately nodding and shaking his head. He seemed bewildered and appeared frightened. He would not talk initially and neither gentle nor forceful efforts by the ward corpsmen induced him to stop sucking his thumb, which he did incessantly. When [his] sadness was [confronted] he burst into tears and said in baby talk that his mommy had told him that his father was dead and that now he wanted to see his brother. Later he said "bumble bees sting . . . today." And he pointed to his ankle around which a bandage was wrapped and under which was found no evidence of any sting or other injury. The type of interest that he seemed to manifest in this and other body parts suggested that his body was very much hypercathected. His only other activity was to awkwardly write a few words on paper with his left hand in response to questions (for example his home of residence and "no" was written in response to questions about the presence of any psychotic manifestations in his thinking). All the while he sucked his right thumb.

Physical examination was within normal limits and he was put to sleep with Thorazine for approximately 24 hours after being told that he would be better when he awoke. Upon awakening he was asymptomatic and was progressively mobilized in the ward milieu during the second 24 hours of the hospital stay. He remained completely amnesic for the episode and wondered what had happened. He denied any drug usage, confirmed the fact that his father had been killed by an automobile when he was very young and that he did have one brother. He was right handed. He was returned to full duty at the beginning of his third hospital day and never again seen at the psychiatric facility.

Comment: Although there is a paucity of anamnestic material available in this case, it is included because it demonstrates so clearly reversion to literal infantile behavior and attitudes in a classic manner, presumably related to some internal or externally perceived distress. More frequently reversion to infantile or child-like attitude was more prominent1y viewed in stress situations than reversion to concomitant behavior, though that was also seen. The next case gives a demonstration of this latter point.

Case #2: Was a 27-year old Army physician, a Captain, who had been a battalion surgeon with 4 months of active duty service and 2 months in Vietnam. He was referred to the psychiatric ward by his division Psychiatrist after he had developed self-referential ideas and perhaps loosely formed, delusional, ideations in the setting of intensified fears of bodily injury or death.

He was the son of a meat cutter and dominating mother who he claimed always wanted him to achieve more. He was raised in lower middleclass Jewish surroundings in an urban area. He recalled a long-standing history of fears in his childhood including of dogs (he would cross the Street to avoid them), fears when showering in the bathroom with soap in his eyes (that someone would come in and hurt him), consciously recalled fears of injury to his penis, fears of going into his room at night (he would check under the bed in the dark), feeling that it was crazy but "I couldn't help it." He described a relative social isolation during his growing and college and medical school years in response to his fears. Despite this he remained conscientious, eager to always do a good job, and competent in his work as a physician. He was fearful about his assignment to Vietnam, and his fears became markedly activated with some realistic basis when he was assigned as a battalion surgeon. To combat extreme anxiety while he served in that capacity he took morphine once and 30–40 Librium on another occasion for insomnia and anxiety. He was hospitalized briefly then and then put to work in a clearing company hospital where he functioned reasonably well. He was then returned to his own battalion headquarters where he worked in a medical company and did well for several days. However, then, in a setting of having to go out into civilian villages with the Med Cap Team plus with the death of another battalion surgeon by hostile fire, his fears increased markedly, not only that he was going to be injured or killed, but that the people around him in command were trying to kill him by making him go out into the field this way. He began to think that a dream he had had of having communicated with God was,

in fact, true; that he had to stop the war by no longer working and by letting the world know "what was really happening" in Vietnam. Also, as noted, he felt that people were trying to get him killed. In this setting he was referred to the psychiatric ward.

At admission he was frightened, sullen, withdrawn, suspicious, and thought he had been betrayed by people who had sent him there. He was not psychotic but operating from a stance of childish or infantile regression to the point of projecting and externalizing the basis of his distress. Over the course of the next several days, intensive individual psychotherapy was undertaken wherein he was urged to review his present day fears in light of his long-standing concerns about bodily injury or death. He described the intensity of his fright in his unit and his concomitant feeling of hopelessness. He specifically related to the fact that he could do nothing about his fear, could trust no one, in fact, he could not even trust himself at that point. Despite the seemingly overwhelming quality of his desire and necessity of fleeing the situation and adopting the paranoid defense, the part of himself that really stated in a very small voice that he really wanted to do a good job and didn't like to be the way he was, was not only heard by the therapeutic personnel but implicitly fostered, acknowledged, agreed with, and supported at the same time the intensity of his fears were accepted by the psychiatrist. After these clarifications had been made in an attempt to decondition his fear of not being able to control himself, that is, not be able to control his reaction (fear), he was readily mobilized to work in the hospital area as a physician and subsequently assigned to another hospital where he completed his tour of duty in an exemplary manner. At times of imminent danger from enemy attack he would contact the psychiatrist by mail it to briefly express his fears as well as his hopes of continuing to do a good job—which he did.

Comment: This case illustrates an important point, both I think in understanding and in management of reactions to stress. The presenting phenomenology in the case, and the impetus from the man's unit, was that he was experiencing a significant paranoid reaction, perhaps paranoid schizophrenia and that he should be evacuated from the war zone. Such a disposition and label would probably have influenced significantly and adversely this man's future career, his feelings about himself, and potentially his life.

When the phenomena were viewed as a kind of reversion to a type of infantile attitude at a time of fright, treated that way—as a child blaming others because he could not cope with the intensity of his fear—then the patient was readily able to reconstitute to his premorbid level of functioning and gain himself a modicum of self-esteem in the process. Needless to say, having the motivation to go on and conduct oneself appropriately and beneficially is important in the success of this type of management. But focusing back on the psychodynamic factors involved, this case shows reversion to infantile attitudes with concomitant behavior emerging in response to stress. Never quite disorganized, though becoming that way, and more ominous than the type of symptoms exhibited in case #1, because our general thinking is that the paranoid defense is more ominous than the hysterical one. This may or may not be true as we will see in the next case.

Case #3. I first saw JM, a 21 y.o., sing1e, negro Pfc who worked as a stock clerk in a supply and service company (13 months in the Army and 8 months in RVN) when he was transferred to us from a surgical hospital following an overnight admission for "agitated, combative, and unmanageable behavior." He was reported by the referring physician (not a psychiatrist) to be a marijuana user, and it was alleged that he had smoked pot that evening and had developed delusions of death and persecution. He was unresponsive, sullen, and unwilling or unable to communicate when admitted to the surgical hospital. He was given Thorazine and Seconal overnight and transferred to us the next day. An MP [military police] escort was required in transit.

He was lethargic and drowsy when admitted to our ward, but he could be aroused quite readily and was oriented, a little defensive, but cooperative. When interviewed after the effects of the sedation had worn off, he adamantly denied recent or past marijuana usage. He explained his recent symptoms as a "nervous breakdown", though he professed amnesia for the events leading up to his hospitalization. He claimed that 3 weeks earlier while sitting tower guard with another EM [enlisted man] he had heard voices of other members of his family, though he couldn't distinguish what they were saying. These voices had not recurred but subsequent to hearing them he had experienced the onset of a generalized mistrust of people plus a pervasive

suspiciousness with referential ideation but apparently no true delusions.

Background information was not particularly revealing, though he was guarded in imparting biographical data. He was the 4th of 5 children born to a couple who raised him, though 2 of his sisters were raised by a grandmother. He described himself as extroverted though moody during his growing years. He denied neurotic traits or difficulty in his interpersonal relationships. He had spent 8 months in reform school, allegedly for his first offense (breaking and entering). Upon graduation from high school he held one job in a knitting mill for 3 years before being drafted. He had two Article 15's during basic training when he wanted to get out of the service; however, after deciding to fulfill his service obligation he had no further administrative actions against him.

During his next two days in the hospital he remained asymptomatic without evidence of psychosis or severe neurosis. He eventually suggested that the episode resulted from a buildup of feelings of boredom and frustration associated with the routine, repetitious, and confining nature of his job in supply and his life in Tay Ninh. He said that he wanted out of the Army and to go home. He was discharged and went to the 90th Replacement Battalion to await transportation to his company area, only to be brought into our Emergency Room late the same night by MPs. He had been assaultive at the 90th Replacement Battalion and had been found wandering around looking for a certain buddy. The following morning he was asymptomatic and indicated that he had been drinking the night before, though he denied the use of marijuana. He was discharged and returned to his unit. The next day he was sent from the same surgical hospital with a note indicating that he had a 3–4 week history of bizarre behavior, hallucinations and delusions, and aggressive behavior. These symptoms included seeing himself as dead and being mourned by his family, praying at the feet of his buddy, thinking that his buddy was God, and imagining that his friends were physically attacking him and trying to kill him. The referring physician indicated that he was not fit to serve in an area where weapons were available. The KO team psychiatrist who admitted him from the clinic noted the man to be "slightly confused, rather loose and concrete, oriented, reading the Bible, and checking his penis while expressing, fears of losing his "nature." However, once again his ward behavior was completely unremarkable except for a running dialogue he held with several other Negro patients. This involved having sold his soul to the Devil. This dialogue seemed primarily in the service of provoking another patient who was very much obsessed with good and evil as personified by God and the Devil. A diagnostic\therapeutic trial of Thorazine was begun (75mg q.i.d.) but PFC JM promptly became somnolent on this relatively small dose, so it was discontinued. A full battery of psychological testing was performed and resulted in perhaps the most normal profile we have seen in a ward patient. There was evidence of sociopathic and hypomanic features in his personality but no suggestion of psychosis.

After 6 days he was returned to duty with a certificate clearing him for administrative action. Because the concern of the referring physicians was justifiable it was recommended that the EM see the neighborhood division psychiatrist if necessary in the future, so that symptoms could be observed at their source. This had been suggested twice previously.

Apparently the next night the EM was found strangling a buddy in his bunk. He was admitted to a division clearing station facility, claiming not to remember what had happened. However, upon questioning he told a corpsman that he had been strangling another man. A few minutes later a former KO team psychiatrist who had known the patient on our ward before he joined the division came by, recognized the patient, and asked him what had happened. The patient avowed vehemently that he didn't know and couldn't recall. When confronted with the fact that he had just told a corpsman about trying to strangle a friend he became defensive and claimed that the corpsman had made it all up. The patient was returned to his unit for administrative action and placed in the stockade where he has presented no problem, although he did visit the Social Work Officer there once to express concerns about the Devil. The defense lawyer for the case claims that everyone involved, including the prosecuting attorney, is convinced that this man is mentally deranged, and they are all loathe to try the case in a Court Martial.

Comment: Let me say at the outset of my discussion that I don't know what this man's diagnosis is. It's not my intent to try to convince you one way or the other

about it. The case is complicated by the fact that he may well have been a marijuana user. But I present it because it illustrates dramatically the type of patient that causes us so much trouble in diagnosis and disposition. I will make some general observations about them, some dynamic speculations, and a few comments about my experience in managing them.

From several cases that we've seen I have noted:

1) Many if not most of these men are Negro.
2) They almost always present as behavioral problems in their units of gradual, rather than acute, onset. This is often in the form of intransigent, disobedient, or resistive behavior. They either have been violent or their units fear aggressive outbursts from them.
3) Hallucinatory or delusional phenomena, when present, usually involve a communication with God and have some religious significance related to Good and Evil. Interestingly enough, when two or more of these types are on our ward at the same time they seem to understand these symptoms in each ot`her without surprise or difficulty.
4) In interviewing them the primary psychotic-type manifestation in their thinking is the prominent use of projection as defense mechanism in conjunction with their anger. This projection is rarely well-organized; rather is pervasive and not accompanied by a great deal of denial. It does not have a bizarre quality. Rather, it appears to be an accentuation of a preexisting character trait, or more accurately the emergence in more vivid form of a latent character trait which has been mobilized under stress.

To conceptualize, I think that we are dealing with a group of action-oriented young men whose usual style for handling tension and frustration is discharge through physical activity. Their frustration tolerance is low, depression is not well-tolerated, and in civilian life both aggressive and sexual tensions are dissipated in the streets, so to speak.

Most of them are in non-combatant jobs, and their tension has at least three sources:

1) The tedium and boredom in their work without sufficient diversionary opportunities,
2) The ever-present fear of death, and particularly of mutilation, that is experienced by everyone in the combat zone,
3) The crowded, all-male living conditions, which predispose to activation of adolescent homosexual concerns.

Their psychological structure has little resiliency and few outlets for coping with these tensions other than discharge of them, and this is limited by the confining aspects of military structure. In this setting projection emerges as an adaptational mechanism to accommodate the pressure from the upsurge of these instinctual tensions. At this point they are often referred to psychiatric sources.

I do not feel that these men are borderline characters. They don't demonstrate any particular fluidity of defenses with a tendency to utilize a variety of defense mechanisms to accommodate the stress of everyday living. Nor do they usually show a typical pattern of psychotic regression under stress. Rather these men use projection to handle their anger and frustration, and any behavioral outbursts don't stem from the projection as much as from feelings of narcissistic entitlement to discharge their tension.

Nor do I think that these people are experiencing one of the forms of transient infantile regression seen quite frequently here. This latter group usually responds dramatically to a 24–48 hour period of sleep treatment with Thorazine.

In approaching these potential patients I suggest diagnosing their projection first; is it evidence of severe regression which they can't handle, or is it a less ominous character trait? Next, in as fearless a way as possible, confront the aggression to determine its relative danger. Then consider a brief (1-2 day) trial of Thorazine, keeping the man in his company area or at the division level if his unit is very scared of him, treating him similar to a combat reaction but using Thorazine in an attempt to leech out some of the anger. I believe that maintaining the expectation that the man perform his duties or take the administrative consequences is vital; for there are two dangers: (1) The first is that the man receives the communication that his sick behavior has tangible rewards. This motivates secondary-gain factors which perpetuate his symptoms. (2) The other danger is that the man receives the communication from us that he is in fact dangerous. That is—that he has been relieved of his responsibilities

because he is a feared person. Such a message causes these men to unconsciously become frightened of their own uncontrollability, and they get worse (via panic). I feel that we have a more difficult time reconstituting them than workers at a more forward echelon, and I urge that vigorous but short-lived treatment always be tried before sending this type patient rearward to us. Once again, I present this material, not as a definitive explanation, but as observations and temporary conclusions for your consideration as we try to find the most effective ways of dealing with these difficult problems in diagnosis and management.

Comment: This case represents a not infrequently seen and perplexing group of patients who often appear much differently in their units than they do when they arrive at the hospital, which is often no more than 5 miles away. Some general observations about this latter group of patients will be made, but it is included as the 3rd of this triumvirate of cases because it contains both the kind of hysterical features suggested in the first case and also the use of projection in more ominous kinds of defenses in times of stress in settings that are not really quite clearly delineated. It was unclear in this group of cases whether we were primarily dealing with the emergence of projection that represented a kind of latent character trait that emerged under stress in a certain group of young men, and, as such, was more analogous to the situation of case #2, or whether we were primarily seeing transient psychotic reactions at times of stress in certain predisposed, characteriologically-disordered soldiers. My inclination would be to view these two phenomena on a spectrum with the more seriously disordered ones showing the capacity to disorganize briefly under certain stresses which will be delineated subsequently.

In line with the nature of the regressive phenomena being talked about in response to stress, namely a reversion to behavior (case #1), attitudes (case #2), or a combination in varying severity (case #3), the following case illustrates the reversion to a fantasy that represents an unresolved developmental conflict. In addition it bridges the gap again with adoption of both hysterical and paranoid phenomena, and points out some of the difficulties that professionals have in dealing with patients who know they are only separated by about 5 miles of physical distance.

Case #4: A 21-year-old Sp4 who had functioned effectively as a mortar man in a weapons platoon for 6 months began showing up at sick-call because of low back pain. When he continued to return to sick call after several negative physical examinations, he was referred to the division psychiatrist who cleared him and sent him back to duty. However, the night before returning to the field, while lying in a bunk he hallucinated a big man holding an open-mouthed snake coming after him. He ran out in fear, panicked, wild-eyed, and certain of the hallucination. He hallucinated the man and snake on several occasions and was seen again by the division psychiatrist who referred him to the psychiatric ward with the diagnosis of schizophrenic reaction.

On the night of his arrival on the psychiatric ward, he experienced one episode of hallucinating the man with the snake while going outside to the latrine. However, from that time on he remained symptom free without evidence of psychoses. Amnestic material revealed a stable pre-service adjustment, though he had a long-standing fear of snakes, and there seemed to be good evidence of unresolved castration fears. After several days he was returned to his unit via the division psychiatrist with a note elucidating the psychodynamics which had been uncovered and with the diagnosis of hysteria. At the divisional level his symptoms recurred almost immediately after learning that he would be sent to zone company area. He was treated at the division level for a week where, in addition to recurrence of hallucinations, he also experienced several bizarre episodes of dissociation and derealization in which he exhibited strange behavior for which he remained amnesic. He was sent back to psychiatric ward with a note indicating that, although the dynamics which had been postulated were interesting, they were not really relevant to this man's situation or to this case. The pertinent facts were that the enlisted man had functioned well until receiving a minor gunshot wound in the arm approximately one month before his back pain developed. Subsequent to that injury, he had been ineffective to the point where the above noted symptoms developed. The division psychiatrist indicated that the man was ineffective, psychotic, and should be treated though medical channels. The division psychiatrist's point was well taken, but also, the data that he added confirmed the postulated dynamic issues. They offered corroborative evidence of castration fears to his body

image that had been activated. Once again, the patient showed no symptoms in the psychiatric ward setting and was eventually returned to the care of the division psychiatrist. At that point both psychiatrists agreed that the man should be transferred to a non-combat unit for a trial of duty. Accordingly he was transferred from infantry duty to work at the docks and remained symptom free for the remaining 6 months of his tour of duty.

Appendix 13 LETTERS OF COLONEL (RETIRED) MATTHEW D PARRISH

Lieutenant Colonel Matthew D Parrish, Medical Corps, served in Vietnam (July 1967–July 1968) as the third Neuropsychiatry Consultant to the Commanding General, US Army, Republic of Vietnam Surgeon. He was deployed during the period of the most intense fighting in Vietnam, which included that surrounding the enemy Tet offensives. Following his assignment in Vietnam, Parrish was assigned as Psychiatry and Neurology Consultant in the Army Office of the Surgeon General. He had served over 20 years as an Army officer before his assignment in Vietnam, including a tour in World War II as a bombardier, and one in Korea during the war as an Army psychiatrist. He received his psychiatric training at Walter Reed General Hospital in the early 1950s. The following are excerpts from correspondence with the author 17 years after his service in Vietnam.

EXCERTS FROM CORRESPONDENCE: LIEUTENANT COLONEL MATTHEW D PARRISH THIRD NEUROPSYCHIATRY CONSULTANT TO THE COMMANDING GENERAL (JULY 1967–JULY 1968)

From what I experienced, heard and read, I concluded that VN [Vietnam] was the easiest war of the century—shorter battles, better medicine, better food, better respite, entertainment, even weather, though some of this may be a matter of taste. Korea, in all those ways, was much tougher. Even Pentagon support seemed worse [during the Korean War].[1]

My personal records of Vietnam are rather poor with regard to most of the questions you ask. I did send tapes back to some people, . . . I published some articles in USARV [US Army Republic of Vietnam Medical Bulletin] and one in JAMA [Journal of the American Medical Association], but that one was on surgery.[2] I was officially advised in the combat zones of WW II [World War II], Korea, and Vietnam that I should keep no diaries or personal records (because of possible capture).[3] I hope you can teach the full literature and the history [of Army psychiatry in Vietnam] to those who, like me, had part-experiences [there]. Otherwise, those who served in one place and time will not see the meaning and relative importance of their own experience.[1]

The military historians in Long Binh told me that every major unit incountry was monitored by a military historian. Commanders were required to write up any engagement within three days of the event. The theory was that if the commander waited 30 days to write, he could get away with more lies—as Julius Caesar did. Yet there was no such monitoring of the psychiatric work of each major unit. It doesn't have to be "real research." A psychiatric team's reports would be a checkup on other reports and research. There seems to be fear in the upper echelons, however, that the local team might use such a report to make complaints or to persuade higher staff that some unreasonable action should be taken. In 1967–68 there were several studies on drug abuse in the psychiatric units of hospitals and divisions. I myself thought they should be transmitted to SGO [Surgeon General's Office] or WRAIR [Walter Reed Army Institute of Research] but the USARV surgeon's office, and I think even MACV [Military Assistance Command Vietnam], tried to suppress them at first. Eventually they encouraged some local reports to counter the unsavory statistics of the first study (by Sokol et al) which by then was demanded by SGO. The theater Neuropsychiatry Consultant always sent a monthly statistical report to SGO. That report was obtained in part from the psychiatric units, and in part from USARV. The USARV statistics also contained interesting statistics from Air Force and Navy which showed much higher psychiatric evacuation rates than the Army.

. . . It appeared to me after I got back to SGO that WRAIR would be a better place than SGO to "archive" the reports and journals produced in VN. SGO sometimes cleans out [old] papers.[1] Crude [psychiatric] counts were acceptable in Vietnam because Vietnam was fought as a management war. It set measurable goals and measured the progress toward those goals—counting bodies, friendly villages, shells, gallons, pills, calories, hours and dollars, not . . . technical skill, improvisation, persuasiveness, leadership, language fluency, transcultural understanding, political forces, group cohesion. Most loved was any measurement [that] could be expressed in dollars.[1]

The TET offensive [which took place while Parrish was in Vietnam], of course, was only incidentally directed at the troops in VN. It was primarily aimed, through the media, at the highest command echelon of the US military—the American people and their politicians. The Saigon chief of police, Mr. Loan, unwittingly cooperated by shooting that Charlie in the head with a .45 while on TV. Half the people in the US saw that man's head bounce with the bullet. Very spectacular. [General Westmoreland] unwittingly set up TET by announcing in January that victory was just around the corner. Soon after the 1968 Martin Luther King riots in Washington I was eating at the Division Commander's table near Pleiku. A California congressman was at the table. He expressed surprise to find that the damage in Saigon was so slight. When he took off from National Airport in Washington he had seen the whole length of H Street ablaze or smoking from downtown to the Anacostia River—much worse than TET in Saigon. Furthermore he had read in *Time Magazine* that TET had destroyed Peiku. But now he found that not a shot had been fired there. In May a *Time* correspondent interviewed me, so I asked him why *Time* had said Pleiku was destroyed. He said, "Oh, some colonel in MACV told us that." [I asked,] "Why didn't *Time* retract it in the next issue?" [His reply,] "Oh it wouldn't have been news then." Again, we cooperated nicely with the enemy. . . .[1]

But should the individual soldier be knowledgeable of the current history he is helping to create? In the traditional military of the past centuries the yeoman soldier was either kept dumb or he was fed the kind of propaganda that would keep him properly motivated against the enemy and for the Fatherland. . . . The poorly controlled media in the wars of our lifetimes have made something of a mess of that. Back in the mid-sixties Marshall McLuhan predicted that, solely because of TV, the US could not win the Vietnam War or any other prolonged conventional war. But by the time of the VN war every American soldier was high tech . . . [and the] Army trusted him pretty well. The PX [Post Exchange] sold the John Birch literature as well as *Ramparts* and other super liberal or even Marxist magazines. The US soldier was no illiterate yeoman. Some theories of military management consider that a disadvantage. But then didn't the psychiatrist need to understand the social and political situation that the soldiers (and he himself) faced?[4]

[Regarding] psychoactive drugs. At Letterman years ago Douglas Kelly (psychologist who examined Goering and others) reminded us that WW II in Europe was fought with gasoline and alcohol—even cognac. The Army in [Vietnam] made it easy for most troops to get all the alcohol they wanted—cheap. Neuroleptics were less addicting, probably relieved more anxiety, may have been no more impairing, probably set up no tardive dyskinesia in the time and dosage frame allotted them. Hospitals, civilian and military, should develop more skill in controlling behavior and even relieving anxiety without dangerous drugs. . . . [Neuroleptics and the assumption that medication is a cheaper alternative] had a profound effect on psychiatrists—making them into diagnosis and medication doctors. They control behavior and other symptoms by physical and chemical means, less often by psychological [ones]. . . . In VN, however, the 9th Infantry Division and some others utilized auxiliary corpsmen gleaned from the soldiers who had gotten 3 purple hearts and been excused from combat but who knew about re-motivating combat fatigue subjects.[1]

[The] training [of psychiatrists deployed in Vietnam] could have been better, but numbers were close to proper. Because of travel problems and Murphy's Law we were chronically one or two psychiatrists short.[3] [I] f the theater consultant can see the [newly deployed] psychiatrist on the day of his arrival in Vietnam, can orient him when he is ready to be 'imprinted," can walk him to his division Surgeon and CG and to his division psychiatry unit, then the new psychiatrist performs well for troops.[1]

I think "treating" a [soldier] patient meant for Gentry Harris [Army psychiatrist in Korea] a long psychoanalytically oriented relationship. [Preferable is] "managing" [refers to] the practical enmembering of patient into a functioning group. (If your squad accepts you, the Army will accept you. If it doesn't, you must get another squad to accept you or else get out of the Army.)[1]

The psychiatrist helps the soldier to "Stay committed to the welfare of his combat unit. . . ." In a good combat team . . . the welfare of the individual DEPENDS on the welfare of the unit. For an experienced combat soldier the most terrible fear comes from being assigned to a poor team. Even to work with a good team you are not used to is bad enough. The problem then is that your mind is not a part of the team mind. You are not sure what everyone else is up to. The psychiatrist helps to keep these soldier-unit covalent bonds from breaking.[4] Psychiatric residencies today do not emphasize community psychiatry or even group therapy—only individual psychology: humanistic psychoanalytic work, or dehumanized behavior mod[ification] (which need not be dehumanized).[1]

The Theater Consultants in psychiatry advised SGO that the Consultant should always be a full colonel because he or she could then most easily obtain the country-wide transportation so essential to doing true consultation. The LTCs [lieutenant colonels] had to get special standing orders [that] allowed them to ride on almost any passenger plane going their way. Sometimes they rode in a Caribou or a C-130 which was carrying migrating Vietnamese or perhaps just freight. Sometimes they rode as an extra passenger on a light plane or helicopter some colonel had requested for the day. But another great advantage is that a full colonel can more easily talk with generals—Division Commanders. . . . On the other hand, a Colonel is just as accepted as a [Lieutenant] Colonel when it comes to conferring with Corpsmen, and other soldiers as well as company commanders.[4]

My tour in Vietnam certainly gave me a lot of experience, learning and contacts. I thought that I had been trained about as well to do the job as anyone. I was irked however, that I was not allowed to finish and put together my work at WRAIR [before I was sent] and also that I had had two hardship tours already while many other had had none. A year later, having finished WRAIR, for better or for worse, I would have had much less objection. . . . My thought was that the Army should have a dozen persons who had been so trained. And I thought, perhaps erroneously, that VN could be a training ground . . . [but] apparently others thought . . . that it was best to keep using the same one or two experts over and over.[5]

But I found out that assignments of the [USARV] Consultant were not made on the basis of rank and probably not on the basis of skill or of proper career development but rather on the basis of what influential psychiatrists wanted to be assigned in Hawaii or to Letterman [General Hospital in San Francisco], or wanted to get out of DA staff work.[4]

It seemed to me that [some deployed psychiatrists] had a good time in Vietnam—professionally, personally, even politically. But I doubt if it would be smart for [them] to advertise that now. I think this is true of a lot of us. It's not a question of, "Did I benefit by going to Vietnam?" rather it is, "SHOULD I have benefited?"—given today's view of history.[4]

Source

Written comments from Matthew D. Parrish to Norman M. Camp; dated: (1) 24 July 1985: first installment of a lengthy response to early chapter drafts; (2) 23 February 1983 cover letter returning survey; (3) 21 February 1983 comments in survey; (4) 1 August 1985: second installment of the response; and (5) 17 August 1985: third and final installment of the response.

Appendix 14 COLONEL CLOTILDE D BOWEN, MC, END OF TOUR REPORT

Colonel Clotilde D Bowen, MC, served in Vietnam (July 1970–71) during the drawdown phase as the sixth Neuropsychiatry Consultant to the CG/USARV Surgeon—the senior Army psychiatrist in the theater. In her role as the Army's chief psychiatrist in Vietnam, Colonel Bowen oversaw the work of the deployed psychiatrists and allied mental health personnel. She was also responsible for planning and coordinating the Army's rapidly developing drug and race relations programs in Vietnam and often was called upon to brief congressmen, visiting foreign dignitaries and ranking officers, and news media about the eroding morale and mental health of the troops.

AVBJ-PS END OF TOUR REPORT: COLONEL BOWEN/DH/481
SIXTH NEUROPSYCHIATRY CONSULTANT TO THE COMMANDING GENERAL
(8 JUNE 1971)

1. **Organizational changes and impact on mission accomp1ishment:**

a. Early in FY 71, the psychiatrist in the Cam Ranh Bay area was detached from the South Beach MHCS and attached to the 483rd AF Hospital. The Air Force had two psychiatrists on TDY from out-of-country. Thus the attachment of the Army psychiatrist afforded needed additional help and aided in the successful return to duty, out-of-country evacuation and administration actions for Army patients. In August, the 483rd AF Hospital was the first to report an Army death due to heroin overdose proven by autopsy. In October 1970 this hospital was receiving the largest number of Army personnel with drug problems. The Cam Ranh MHCS was manned by a social work officer and psychology/social work specialists until April 1971 when the clinic was discontinued at DEROS of the two remaining personnel. With the continuing draw down of Army personnel in the Cam Ranh area, the psychiatrist was reassigned to the 935th KO Detachment in May 1971. When the 67th Medical Group Headquarters moved from the 95th Evacuation Hosptial premises to Camp Baxter in August 1970, the 98th KO team took over these buildings and remodeled them to suit a MHCS. They began to function more efficiently in October when a new, permanent commander arrived, Maj. Norman Camp.

b. In April 1971, the in-patient portion of psychiatric service and the neurology clinic of the 935th KO team were moved from the 93rd Evac Hospital to the 24th Evac Hospital on Long Binh when the former hospital closed. In addition the MHCS was moved to the old admission portion of time 93rd Evac Hospital while the 32nd Medical Depot took over the major portion of the 93rd buildings. This has resulted in the same type difficulties experienced a year ago when the 98th KO moved from Nha Trang to Da Nang. Much engineer work will be necessary before the EEG area in properly shielded.

c. Both the 4th and the 25th Infantry Divisions stood down in Nov and Dec respectively, freeing the MHCS staffs. Dr. Jeppsen from the 25th was reassigned to the 23rd (Americal) Infantry (Mobile). He was reassigned to the 935th KO team in June 1971, as a replacement. Dr. Cushman of the 4th Division covered the 3rd Field MHCS psychiatrist for 6 weeks while the latter enjoyed a 30 day extension leave, then was reassigned to the 101st ABN at Camp Eagle for the remainder of his tour. There was much disorder to these stand downs with loss

of morale esprit de corps, and credibility among the enlisted mental health specialists who were reassigned, often times outside of their mental health specialist MOSs.

d. The MHCS of the 23rd Div at Chu Lai received both in-patients and out-patients from the 91st Evac Hospital and the 27th Surgical as well as from non-divisional support units. This was an excellent arrangement for all concerned.

2. Technical & professional advances:

a. In January 1971, the 935th KO team, augmented, opened a ha1f-way house, called Cross Roads, at the 24th Evac Hospital. This is essentially a detoxification center for heroin drug addicts. As of June, 1971, it is being reorganized and staffed with personnel from other Long Binh Post activities under the direction of the post commander.

b. As early as September 1970, all division MHCS's were setting up beds of 6-25 for the treatment of heroin drug addicts. Starting with that month, all psychiatric activities began to include with their monthly reports, a list of EM by name, rank, unit, drugs used and amount. Many drug abusers were admitted to psychiatric words of MEDCOM Hospitals until late December 1970, when numerous Amnesty-Rehabilitation programs took over these functions.

c. The lack of psychiatric coverage at the lst/5th Mech Brigade near Quang Tri had resulted in the loss of at least 200 men-days per month. Through the 67th Medical Group and XXIV Corps Surgeon arrangements were made to have a psychiatrist and/or social worker from the 98th KO team in Da Nang visit the 1/5 Mech Brigade weekly. This arrangement was continued until the onset of heavy monsoon rains in October and November. The brigade surgeon, a board certified psychiatrist, assumed these responsibilities at this time.

d. Medical Technical Guidance, Drug Abuse, was written by Maj. Eric Nelson, C.O. of 935th KO Detachment with help of Medical Consultant as a 'crash' project early in September l970. Upon critical review by the NP Consultant it was revised and re-published on 15 October. This manual has been distributed to all physicians as they arrive in-country since January 1971, along with a short briefing on the RVN drug problem and its solution.

e. Revision of USARV Reg No. 40-34, pertaining to Mental Health & Neuropsychiatry, was published on 15 October 1970 with changes in the morbidity report form (USARV Form 55) and explicit instructions. Even with this revision it was evident that the entire psychiatric reporting system was poor: (1) personnel admitted to medical services for treatment of alcoholism, drug abuse, psychosomatic conditions, etc. are reported to MRO as neuropsychiatric disease. Thus, the NP report forwarded to the consultant does not give a true picture of psychiatric morbidity. In addition, services other than psychiatry have evacuated patients out-of-country with NP diagnoses.

f. Revision of USARV Supplement to AR 635-212 on 27 October 1970 by TWIX provided guidance for the psychiatric portion of the medical evaluation to be performed by general medical officers when a psychiatrist was not readily available. On 12 April 1971 this was made an Army wide policy by CGUSAMC Wash D.C.

g. NP Consultant worked with USA MEDCOMV DC/S P&0 in setting up better recording system for drug abuse. Worked with Medical Consultant & 9th Medical Lab to set up better processing of autopsies in suspected drug deaths and urinalysis for drugs. Worked USARV Special Personnel Actions Division and Information Office on defining drug programs and press releases concerning drugs.

3. Personnel, logistics, and other problems encountered:

a. On 1 July 1970 there were 20 psychiatrists in-country. Eighteen DEROS'ed during the year. At present there are 15, including a husband and wife. Ten will DEROS in June, July and August 1971, including the NP Consultant. Replacements for nine will not arrive until a week to 10 days after the last DEROS's in August.

b. One psychiatrist who was to DEROS in Jan 71 extended until August 1971. He is a flight surgeon and was transferred to the 23rd Division on 4 June 1971 as interim division surgeon. The psychiatrist assigned to the 3rd Brigade of the 1st Cav is reassigned to the formers' position at the 3rd Field Hospital.

c. Of the ten projected 3129's in August 1971, six are fully trained. The four D 3129's should be sent to the field as 3100's and the six partially-trained physicians already in-country placed in KO detachments.

d. Plans are in progress to integrate KO detachments into the 95th & 24th Evac Hospitals as psychiatric services, as a space saving maneuver.

4. Recommendations for future action:

a. Dissolve KO detachments and reassign personnel to two evacuation hospitals

b. Re-assignment of D 3129's already In-country to hospital psychiatric services under a fully-trained, preferably RA, chief of psychiatry.

c. Assignment of Social Work Consultant to Professional Services Division USAMEDCOMV.

d. No extensions beyond regular DEROS should be considered for psychiatric personnel. During the last seven months the person is entitled to a 30 day leave, a one week leave, and an R & R. Because of these frequent breaks and other psychological factors, work performed is less than satisfactory.

e. That reports from psychiatric services to NP Consultant be considered informational, at best. No statistical reports should be generated from these reports; they indicate trends only. The best way to track of psychiatric services is frequent liaison visits.

f. Consideration should be made to assign MHCS's to support units and/or combine MHCS's of division and support units in a geographical area. Support units usually have more psychiatric problems than divisions.

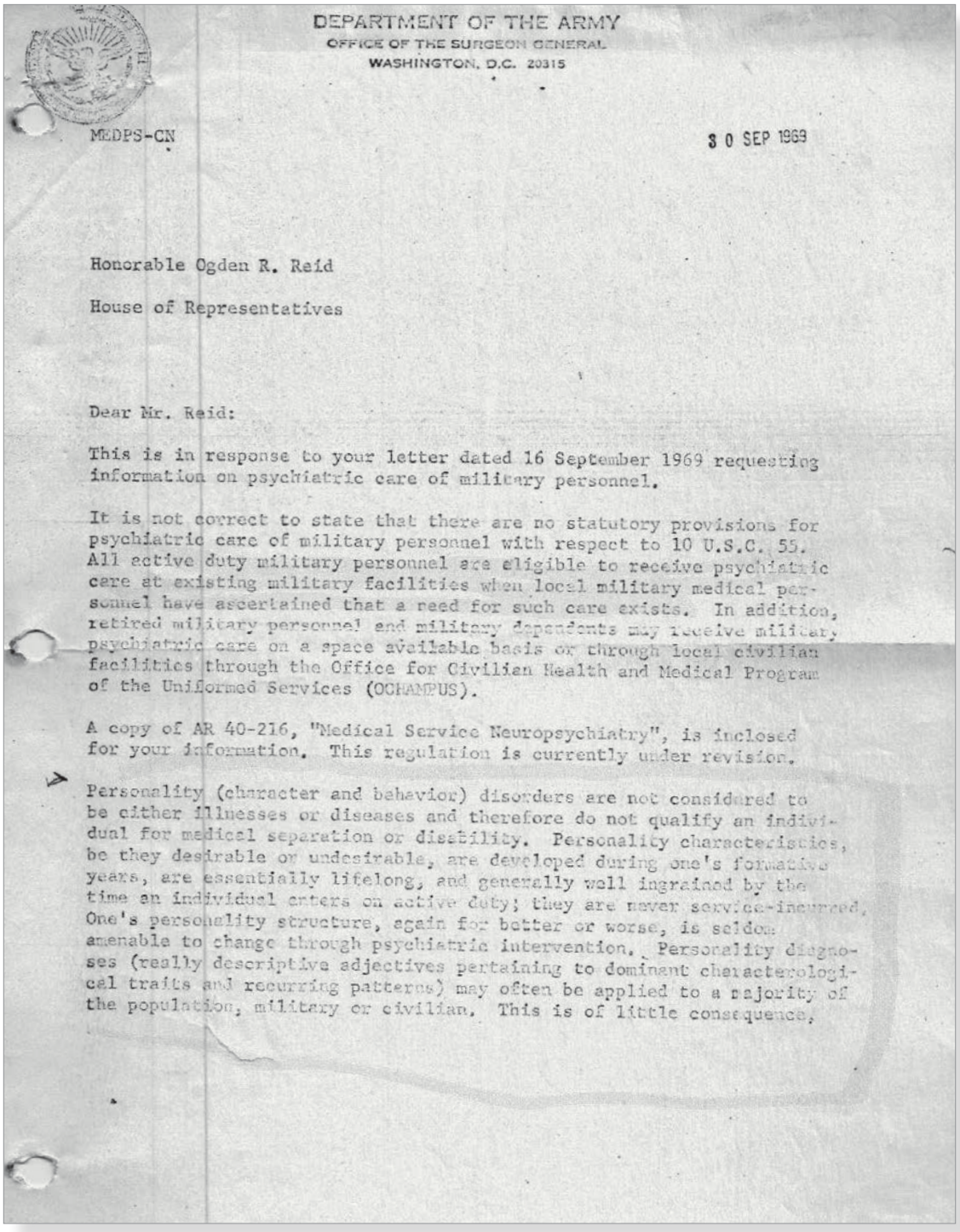
g. Psychiatric personnel should continue to be consultants to drug and alcohol programs rather than running programs. They should provide educational assistance to commanders, chaplains and other physicians involved in drug & human relations problems.

h. Efforts should be made to combine Human Relations & Drug-Alcohol Abuse programs, at least conceptually.

i. A means for better communication between command and staff of divisions and the division psychiatrist should be improvised. At present the Army has many morale, racial and E.M. problems which era in the purview of the psychiatrist and which the division surgeon does not accurately convey to command. Consideration should be made for psychiatrists to have equal status with surgeons in divisions.

CLOTILDE D BOWEN
COL, MC
Neuropsychiatric Consultant

Appendix 15 LETTER TO HONORABLE OGDEN R REID



DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
WASHINGTON, D.C. 20315

MEDPS-CN

30 SEP 1969

Honorable Ogden R. Reid

House of Representatives

Dear Mr. Reid:

This is in response to your letter dated 16 September 1969 requesting information on psychiatric care of military personnel.

It is not correct to state that there are no statutory provisions for psychiatric care of military personnel with respect to 10 U.S.C. 55. All active duty military personnel are eligible to receive psychiatric care at existing military facilities when local military medical personnel have ascertained that a need for such care exists. In addition, retired military personnel and military dependents may receive military psychiatric care on a space available basis or through local civilian facilities through the Office for Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS).

A copy of AR 40-216, "Medical Service Neuropsychiatry", is inclosed for your information. This regulation is currently under revision.

Personality (character and behavior) disorders are not considered to be either illnesses or diseases and therefore do not qualify an individual for medical separation or disability. Personality characteristics, be they desirable or undesirable, are developed during one's formative years, are essentially lifelong, and generally well ingrained by the time an individual enters on active duty; they are never service-incurred. One's personality structure, again for better or worse, is seldom amenable to change through psychiatric intervention. Personality diagnoses (really descriptive adjectives pertaining to dominant characterological traits and recurring patterns) may often be applied to a majority of the population, military or civilian. This is of little consequence.

MEDPS-CN
Honorable Ogden R. Reid

however, since we are not talking about disease or illness. Motivation is generally the major factor in determining whether or not such individuals successfully complete their obligated military service. The vast majority of individuals with characterological defects do, in fact, complete their Service obligation. The Army's method of dealing with unsuitable characterological types is not particularly unique. If a civilian employee is confronted with an individual whose personality characteristics make him an unsuitable or undesirable employee, his services are terminated (he is "fired"); he is not discharged for medical reasons, nor is he given a pension. Similarly, if a soldier's personality characteristics repeatedly bring him into conflict with the Army and attempts to motivate him toward more satisfactory service are non-productive, the Army has a way of "firing" him (administrative separation under the provisions of AR 635-212). In this case the final decision regarding the quality of his work and, therefore, the need for the termination of his services should and does rest with his employer, i.e., the Commanding Officer, and not with medical authority. Both psychiatric and medical evaluations are obtained prior to separation, however, to rule out the presence of any unfitting psychiatric (psychosis, neurosis) or medical condition.

There are approximately 330 psychiatrists currently on active duty, or about one psychiatrist per 4,500 active duty soldiers.

It is recognized that there is a large area of disagreement between the military psychiatrist and an ever-growing number of active duty soldiers and their civilian counterparts; the former maintaining the expectancy that a soldier should become a member of his military group and do his best to participate and further the group effort, the latter being more concerned with avoiding his military obligation by any and all means at the disposal of his ingenuity. This is seen as a reflection of the times and not as a manifestation of psychiatric illness.

I trust this information will be helpful to you in answering questions from your constituents.

Sincerely yours,

1 Incl
AR 40-216

HAL B. JENNINGS, JR.
Brigadier General, MC
Deputy Surgeon General

CF
The Surgeon General
OTSG Record Room
Dir, Prof Svc
RETURN. P&N Cons Br
ROOM 6B-044

2

Appendix 16 VIETNAM STUDY

Franklin Del Jones was assigned as an Army psychiatrist to the 3rd Field Hospital in Saigon (September 1966–January 1967) during the second year of the war. On 29 August 1977, Jones made a presentation in Honolulu, Hawaii, to the World Psychiatric Association, titled "Reactions to Stress: Combat Versus Combat Support Troops." Included were results of a field study Jones conducted at the 3rd Field Hospital. The study presented here provides the only systematically collected data comparing combat and non-combat personnel in Vietnam regarding psychiatric and behavior problems.

REACTIONS TO STRESS COMPARING COMBAT AND SUPPORT TROOPS
FRANKLIN DEL JONES, PSYCHIATRIST
3RD FIELD HOSPITAL, SAIGON (SEPTEMBER 1966–JANUARY 1967)

From September 1966 through December 1966, Jones saw 120 consecutive patients for whom enough data is available to classify their status as CT [combat troops] or CST [combat support troops] and to determine their symptomatology. **Table [1]** lists their demographic features and number of patients on whom the data is based.

Demographic variables tended to separate CT and CST only with regard to age (median for CT was 23 and CST was 29) and marital status (CT were 65% single, CST were 49% single). Both groups were about equally represented in percentages of officers and Blacks, and the median rank for enlisted in both groups was E-4 (corporal).

Table [2] taken from the records of 98 CST and 22 CT casualties and four in which status was not known (total 124 patients) seen by Jones at the Third Field Hospital, Saigon, From September through December 1966, reveals some of the symptomatology found in the 120 CT and CST subjects.

A surprising disparity is seen in numbers of patients having symptomatic alcoholism in CT and CST, only 1 in CT and 26 in CST, roughly 5% in CT and 25% in CST or a five-fold difference. Drug abuse was absent in CT and present in 5 of CST. Another surprise was the relatively high incidence of homosexuality in CST 9% but none in CT. Psychosis accounted for about 8% of CST but none in CT. Often there was an involvement of drugs or alcohol in these psychotic cases; at least two occurred in soldiers who had just smoked marijuana and two occurred in alcoholic soldiers. Character and behavior disorders (CBD) were found in about half the CT and over one-third of the CST, while anxiety and conversion symptoms occurred in about the same proportion, ie, half the CT and over one-third of the CST. Psychophysiologic symptoms (usually gastrointestinal or headaches) were present in about 20% of the CT and 15% of the CST.

In only 47 cases (20 CT, 27 CST) could the type of conflict be determined with some degree of certainty as seen in (**Table [3]**). Thirteen of 22 CT and five of 98 CST had a primary conflict over being in a combat zone. Security Clearances, usually based on previous psychiatric contact, were requested on 13 (1 CT, 12 CST), only one of which was recommended to be denied due to a severe personality disorder. Most of them had seen a psychiatrist years before for minor situational anxiety problems.

TABLE 1. Demographic Variables

DEMOGRAPHIC VARIABLE	COMBAT TROOPS (number of patients)	SUPPORT TROOPS (number of patients)
Median age	23 years old (20)	29 years old (93)
Percentage Caucasian	79% (19)	80% (94)
Percentage Single	65% (17)	49% (92)
Percentage Enlisted	84% (19)	88% (92)

TABLE 2. Symptomatology

SYMPTOM OR BEHAVIOR	COMBAT TROOPS (n=22)		SUPPORT TROOPS (n=98)	
	Primary Symptom*	Secondary Symptom**	Primary Symptom	Secondary Symptom
Alcoholism	1	0	19	7
Character and Behavior disorder	7	3	18	18
Anxiety	4	1	16	5
Homosexuality	0	0	8	1
Psychophysiologic Symptoms	3	1	7	5
Psychosis	0	0	6	2
Conversion Symptoms	5	1	5	2
Drug Abuse	0	0	4	1
Depression	0	0	6	2
Other	1	4	3	7
None (Security Clearance)	1	0	5	0
TOTAL	22	10	98	50

* Primary Symptom refers to the most prominent symptom or behavior bringing the soldier to psychiatric attention (one per case)

** Secondary Symptom refers to additional symptoms present in the soldier (one or more per case)

TABLE 3. Postulated Conflicts

TYPE OF CONFLICT	COMBAT TROOPS (n=20)	SUPPORT TROOPS (n=27)	UNKNOWN (n=1)
Being in a combat zone	13	5	
Marital problems	4	16	1
Family problems	1	5	
Job problems	2	1	
None (Security Clearance)	(1)	(12)	

When overlapping, about equally distributed symptoms are eliminated, the CST casualty stands out as being very much more likely to be alcoholic, homosexual and psychotic. These findings are in striking conformity with those of Tureen and Stein (1949) during World War II. Their report, one of the few contrasting combat with combat support troops, stated that soldiers with "constitutional psychopathic states" constituted 10% of admissions when the hospital operated in a rear base section (combat support) but only 1.8% in a forward base section (combat). These "constitutional psychopathic states" consisted primarily of "chronic alcoholism, sex perversion, criminalism [sic], inadequate personality and emotional instability."[1]

SUMMARY

Military psychiatry has essentially solved the problem of handling combat psychiatric casualties with a program of immediate, forward, simple treatment involving rest in an atmosphere of expectation that the soldier will soon return to combat. The problems of combat support troops, involving complex self-destructive behavioral responses to separation from loved ones and demoralization with loss of unit integrity, will require more complex solutions. Most important is restoration of unit identity, perhaps by keeping units cohesive from basic training to combat and perhaps by rotating entire units. Drastic disorders may require drastic remedies. Another attack point would be to make combat support experience more like the positive appeal of combat experience; ie, goal-oriented with little time for boredom. Finally, drug abuse or other such behavior, such as failure to take antimalarial tablets or failure to prevent frostbite [as seen during the Korean War], must not be allowed to become an "evacuation syndrome" removing the soldier from the combat zone.

REFERENCE

1. Tureen LL, Stein M. The base section psychiatric hospital. In: Hanson FR, ed. *Combat Psychiatry*. Washington, DC: U.S. Government Printing Office; 1949:105–134. [Also published as a Supplement to *Bulletin of US Army Medical Department*, 1949, 9.]

Appendix 17 MENTAL HYGIENE BULLETIN NO. 1

DEPARTMENT OF THE ARMY
935th Medical Detachment (KO)
APO 96491

MENTAL HYGIENE BULLETIN NO1 20 February 1968

SUGGESTIONS IN THE MANAGEMENT OF ALCOHOLISM

Management of alcoholics and excessive use of alcohol continues to plague commanders who have responsibility for all aspects of this problem except for its medical complications. For this reason we would like to offer some additional suggestions to supplement those outlined in a previous memorandum.

As noted previously, AA remains the most effective group treatment approach for alcoholics. The unit on Long Binh Post continues to meet on Monday evenings at 1900 hours at the 93d Evacuation Hospital Chapel. It is recommended that new members be brought to the first meeting by the unit's first sergeant or some superior. No other (preliminary) proceedures are necessary in making a referral to AA.

It has been our experience that when an alcoholic's drinking becomes uncontrolled, he needs strong and firm help from others to regain his ability to cope more successfully with his desire to drink. At such times, it is both appropriate and therapeutic for a commander to take such measures as:

1) barring the alcoholic from all clubs under threat of administrative action.

2) invalidating that part of his ration card having to do with alcoholic beaverages.

3) requiring him to report to the ISG or some superior each day before work to make sure that he is sober and fit for duty.

4) assigning the man sufficient duties to keep him busy and occupied.

5) insuring attendance at AA if there is an AA unit available.

In conjunction with such steps, the dispensary physician or the batallion surgeon can collaborate with the commander's efforts by prescribing a mild tranquilizer such as librium (10 to 20 mg four times daily) for those alcoholics who are experiencing undue anxiety.

If measures of this type are undertaken by the commander with the conviction that there is value in inducing the alcoholic to stop drinking, and with willingness on his part to back up his orders with administrative or judicial action, then many of these men will regain some self-control over their drinking, as well as considerable self-esteem. If these measures fail, then it can be concluded that all appropriate rehabilitative measures have been tried. At that point administrative separation should be strongly considered without regard to grade, age, or length of service.

Appendix 18 EXCERPTS FROM THE BAKER/HOLLOWAY REPORTS

Between 22 February and 23 March 1971, Colonel Stewart L Baker Jr; Chief Psychiatry and Neurology Consultant, Office of the Surgeon General, US Army, conducted an official inspection tour of the primary drug treatment and rehabilitation programs in the Pacific Theater Command (PACOM), including South Vietnam. Two months later, between 28 April and 28 June, Colonel Harry C Holloway, research psychiatrist with the Army Medical Research and Development Command, conducted a more extensive tour, including the programs visited by Baker. Baker and Holloway ultimately produced the report CINCPAC [Commander in Chief, Pacific Area Command] Study for Evaluation of PACOM Drug Abuse Treatment/Rehabilitation Programs, which combined their findings in the Vietnam theater with those from visits to other US military installations in the Pacific theater.

CINCPAC STUDY FOR EVALUATION OF PACOM DRUG ABUSE TREATMENT/REHABILITATION PROGRAMS
1 SEPTEMBER 1971

VIETNAM: REPORT SUMMARY AND CONCLUSIONS

(1) Drug abuse in the US military forces represents a significant threat to effective combat readiness and jeopardizes the very survival of the traditional concept of the military as a vehicle of national policy.
(2) Efforts at drug use suppression and treatment/rehabilitation to date in Vietnam have failed.
(3) Any drug abuse control program must concentrate sufficient resources and be of such a massive scale that success can be reasonably predicted.
(4) In-country treatment and on-the-job rehabilitation provides the most feasible and effective method for dealing with the incidence of drug use.
(5) Whereas an individual identified as a drug user must be immediately removed from his unit (to guarantee reduction of prevalence, to decrease social contagion, and to prevent the disruption of organizational integrity and discipline), evacuation of all identified drug users from the command is unacceptable (both from the standpoint of military manpower management and from the viewpoint of minimizing the reinforcement/fixation of failure in the individual drug user).
(6) Chemical monitoring is absolutely essential to proper management of troops undergoing withdrawal (detoxification) and of rehabilitees being followed in field units.
(7) The entire population in Vietnam should be subjected to urine screening within each 90 days by means of mobile collection teams, and rehabilitees and counselors in units should be tested at least twice each week.
(8) Actual rehabilitation of the individual must take place on the job through the use of locally trained unit counselors and is ultimately the responsibility of the commanding officer.

VIETNAM: DETAIL OF BAKER'S OBSERVATIONS FOLLOWED BY SUMMARIES OF HOLLOWAY'S SUBSEQUENT FINDINGS

The following excerpts provide detail from Baker's report regarding his observations of drug treatment and rehabilitation programs in Vietnam. Each is followed by a summary of Holloway's observations [in *italics*] of the same programs roughly two months later. It should be noted that the programs described below were the primary Army programs in Vietnam at that time, but there were numerous smaller ones as well as programs of other service branches, most of which were visited by Holloway and also addressed in his report.

935th Neuropsychiatric Medical Specialty Detachment (KO)/24th Evacuation Hospital on Long Binh Post: 9 March 1971

. . . The 935th (KO) operates a 30 bed drug abuse rehabilitation center ["Crossroads"], which serves the Long Binh area [near Saigon]. Arrivals are screened by social work technicians, including ex-users, to evaluate motivations for admission. The patient, if accepted, is stripped, searched, and given a shower (necessarily cold water), then entered into the ward area, which is located inside a barbed wire enclosure. A staff of eighteen 91-Bs and 91-Fs, including two former users, man the unit. Methadone withdrawal technique is used, initially 30 mgm. per day, decreasing thru the first three days. Compazine is used for nausea and vomiting. Lomotil is used for diarrhea. By the 3rd day the patient is off drugs. The amnesty support provided is a one time opportunity. In the event of any relapse, the patient is refused readmission. The average stay is five days. Toxicology is provided by the 3rd Med Lab.

Drug free statistics appear to vary with the man's parent organization, perhaps a reflection of aftercare attitudes and practices:

- In one organization, 6 of 35 graduates have returned to drugs
- In another organization, 9 of 11 are back on drugs

During the month of February, there were 150 admissions, 64 of these left AMA [against medical advice] (less than 4 days in the program). Follow-up data indicate 40–50% of those completing the 5 day rehab program remain drug-free. The number of those leaving AMA who remain drug free is not known. In general there is great shame associated with being labeled a "junkie," and this is frequently one's experience on returning to his unit following detoxification. It is often noted that those who fail in the rehab program express strong criticism of it, alleging no care was given, minimizing the quality of the group encounter sessions, etc., as though a paranoid defense against further guilt.

. . . It is the impression of those involved in drug rehab efforts that a number of men volunteer for RVN [Republic of Vietnam] in part because of the easy access to drugs, and that some extend their tour in part because of this ready availability. Most volunteers for amnesty program attentions have less than 90 days before DEROS [date expected return from overseas]. Other motivations apparently propelling soldiers toward the center include a drug death in the unit, or the news of an admission for drug overdose. Survey of admissions during the last 6 months indicates that most drug abusers start such behavior in RVN before the end of their 3rd month there. There is a formidable group or peer pressure which greets a new arrival and identifies his drug attitude. . . . One is expected to either declare himself by joining the drug practices of a core group or declare himself in opposition. This same pressure greets the amnesty program graduate, who is seen as "square" or a potential "stoolie" on return to his unit unless he rejoins his former associates in drug abuse behaviors.

Holloway observed later (13 May and 20 June) that this medically based treatment facility, which was housed in a former prisoner of war ward, limited its focus to detoxification and a group therapy. It was not staffed sufficiently to operate at full capacity and did not receive sufficient line command support in terms of resources and personnel.

USARV confinement facility ("LBJ") on Long Binh post—9 March 1971

The 935th (KO) supports the Long Binh stockade, where there are 375 prisoners with 45 days average stay there. Reportedly, most serious crimes seen in RVN are associated with drug abuse, particularly binoctal. A section of G-1 is collecting data on the long series of fraggings which have occurred within the past two years, and will forward this data to DCSPER, DA [Deputy Chief of Staff for Personnel, Department of the Army] in the future.

Holloway observed later (13 May) that there were a number of prisoners who required detoxification, and that medically supervised withdrawal and rehabilitation counseling was provided in confinement cells. Also, it was widely rumored that drugs were readily available within the facility, and ex-guards were regularly incarcerated for heroin offenses.

18th Surgical Hospital and the 1/5th Infantry Brigade (Mechanized) at Quang Tri near the DMZ—10 March 1971

At the time of my visit the esprit de corps appeared high throughout the area, clearly reflecting the satisfaction and confidence with the military actions going on in nearby Laos. . . . The general morale appeared in clear contrast to that of units I visited later, far from the northern hub of activity. Lower morale

seemed more characteristic of the units involved in passive defense activities, particularly in the south.

The 18th Surgical Hospital had provided a [heroin] rehab program since November 1970, offering amnesty and medical support. A general medical officer had directed this effort until late February 1971, when the staff in support of this program became somewhat depleted by requirements in support of the Laos incursion. Two social work technicians had carried the responsibility of the program almost alone for several weeks. Reflecting the movement of troops to the west, and decrease in staff, the number of patients seen in this program had declined from 85 patients (240 visits) in November, 1970, to 20 patients (90 visits) in February, 1971. During recent days the number of patients had begun to increase again. . . . Currently the drug rehabilitation program is entirely outpatient, employing Valium and Donnatal to assist withdrawal. No follow-up was attempted within the units. No ex-abusers were employed. The Laotian incursion had occurred quite suddenly, with little alerting of the troops. The quick move to Khe San and the border had interrupted personal pipelines for heroin supplies, so a number of soldiers experienced withdrawal reactions during the first day or two. Within several days, however, drug supplies were beginning to arrive in the Khe Sanh area, reportedly brought by the GI truck driver who hauled supplies, and withdrawal reactions were no longer observed [in the field]. . . .

The clinic staff felt drug usage was quite high particularly among supply and transportation personnel, estimating that approximately 80% of the group use heroin. The access to drugs was quite difficult to control in this group, since their duties provided them access to villages en route to various destinations. Several deaths due to heroin overdoses were described.

Holloway observed later (6 May and 20 May) that following Baker's visit an extensive heroin problem emerged within the 1/5th Infantry Brigade (Mechanized), forcing them to establish their own 10-bed treatment ward, which was staffed by four technicians and a partially trained psychiatrist. However, the detoxification process was not effective as heroin could not be kept off the ward. Follow-up efforts were spotty and no valid statistics were available. Trips to nearby fire bases verified that heroin was being used in the field and on patrol, and heroin use had infiltrated every level of the brigade structure including the medical battalion. Two drug treatment "hootches" in company-sized units were also observed, but the lack of sufficient resources, particularly trained personnel, clearly limited their effectiveness.

101st Airborne Division in the Hue-Phu Bai area—10 March 1971

The Drug Center of Camp Eagle employs a ward area for initial admission and drug withdrawal. This unit is led by [a physician with] one year of psychiatric training. Morphine is used to medically support the patient during withdrawal. Both to facilitate referral of drug abusers and to develop follow-up support for ex-users, a number of Battalion Drug Teams have been developed. A Drug Team is composed of the Battalion Surgeon, Battalion Chaplain, and one or two enlisted members in Grade E-6 or below. [The team] is available on a 24 hour basis. Following return to duty, the drug rehab graduate may be seen daily at first, then less frequently. A recently initiated Assay of Intake at the Drug Center (n = 64) indicates that the average admission has a history of self-abuse with multiple drugs [although] heroin dependency was the reason for admission in 98% of the cases. [Of those] 48% stated they shot it by needle and the remainder described they chose to sniff it. There was no follow-up data available to determine the effect of the program.

Holloway observed later (6 May) that the program sought to withdraw 150 to 200 soldiers per month for heroin dependence, but because this took place under outpatient circumstances programmatic success was limited because drugs were readily accessible. The division had made systematic efforts to regulate the Vietnamese nationals within its compounds without measurable effects. In fact inspections of fire support bases demonstrated, as in other combat divisions, that heroin was available and being used in the field.

95th Evacuation Hospital and the 98th Neuropsychiatric Medical Specialty Detachment (KO) at Da Nang—11 March 1971

[The] account of the psychiatric team's operations indicated [that there was] no formal drug rehab program developed here; the referrals were all evaluated and treated within the outpatient area except when admission for treatment of withdrawal reaction was required. The focus on amnesty was not a major one, and the number of patients self-referred for this was not very large. In fact

. . . the staff expressed concern regarding the tradition of openness in the psychiatric referral system, and felt that this . . . renders it vulnerable to manipulation.

Holloway observed later (5 May) that the Da Nang Area Support Command reported a high level of heroin dependence in all subordinate units. Whereas line officers complained that they were not receiving adequate support from medical facilities, the psychiatric team expressed the strong position that the drug abuse was primarily a neglected leadership/command problem.

23rd Infantry Division at Chu Lai—12 March 1971

. . . Since September 1970, more than 200 persons had volunteered for the amnesty program at the Medical Battalion level. Slightly more than 50 of these were hospitalized there for withdrawal. In less than 4 days they were returned to duty, with recommendation that they find a buddy, preferably an NCO, to assist them in remaining off drugs. Each of the four medical companies has its own drug abuse program, separate from the medical battalion activity. Most amnesty cases undergo drug withdrawal at medical company and dispensary level.

Holloway observed later (6 May and 27 May) that the division's drug program mostly emphasized troop education and vigorous drug suppression/enforcement efforts, and there was no structured program for rehabilitation and follow-up of amnesty volunteers. Recent arrests of dispensary staff for drug possession demonstrated the difficulty of establishing a "drug-free environment" for withdrawal. Visits to fire support bases revealed little difference in drug use from the other divisions.

67th Evacuation Hospital in Qui Nhon—13 March 1971

This hospital supports a port facility and supply area.

The drug abuse program employs methadone for withdrawal, three days hospitalization and then outpatient clinic appointments for three scheduled follow-up visits. In addition, a letter is regularly forwarded to the man's unit, requesting unit-based counseling, and the institution of a buddy system to respond to the patient's aftercare needs.

A number of severe marijuana cases have been hospitalized, with history of use of 15–20 joints daily for three to six months. These cases have strong organic brain syndrome characteristics.

. . . A number of cases are known in which the soldiers "crash" themselves with binoctal, a barbiturate, to come off heroin. This is obviously a dangerous practice.

Holloway observed later (8 June) that in terms of outcome, the heroin rehabilitation program here, consisting of traditional outpatient care with a few general medical beds allocated for inpatients, resulted in only 10% of referrals achieving withdrawal.

II Field Force Headquarters on Long Binh Post—14 March 1971

Pioneer House was activated in August 1970 by General Davidson. It was clear following the Cambodian campaign that drug abuse was increasing at an alarming rate. [An earlier] directed drug program delivered by educational "teams" visiting the various areas did not appear to reach the troops effectively. An emergent leader in the person of an aggressive social work technician proposed a new format, a nonmilitary-nonmedical model, led by enlisted men, primarily by ex-drug abusers. Obtaining a trailer and locating it in the area, this small group of enlisted men began a hard-line, low professional profile program which concentrated on the hard drugs, especially heroin, and minimized marijuana. Personnel admitted to Pioneer House had it banged into their heads that heroin kills, and themes such as "where's your head? If it's off on smack, bad" were stressed. Ex-drug abusers were preferred as staff because of the concern about personal commitment . . . of trained professionals, who might feel it was just another job. . . . The program was intense and motivational.

Withdrawal was accomplished with thorazine and probanthine. Lately, Valium has also been employed. [M]ost admissions are for heroin abuse. An open door policy permitted admission of literally anyone who arrives…. Since amnesty was originally considered to call for anonymity, there were no records kept in the traditional medical form . . . therefore, statistics were initially quite poor. An analysis of the last 100 graduates of the program, however, gives a somewhat surprising profile of the hard drug user, when compared to [civilian addicts]: his average age was 20; 25% of the time he's married; in 90% of the instances both parents are alive, and in

75% of the instances the parents are neither separated nor divorced; 50% of cases had no record of Article 15 [disciplinary action], and another 25% have had one Article 15; 60% of the admissions arrive within four months of their DEROS. . . . In summary, the profile of the potentially rehabilitatible drug user was described as: strung out on heroin, but you don't know it—he's doing his job.

. . . Pioneer House accepts a man back when he relapses to drug abuse. It is locally held that, as in problem drinking, often a truly rehabilitatible man will fail at least once.

. . . The modus operandi of the activity [12–15 patients]: for the first 48 hours no one may leave. . . . A medical technician stays with the new admission, checking blood pressure and pulse, to watch for a strong withdrawal reaction following a recent "hit." Much is made of the touching of patients during this withdrawal crisis, holding them, rubbing the back, in essence giving concern and love. Initially, the staff man will try to get a relationship going with the new admission, and then will emphasize that [his drug use is volitional and it is his responsibility to abstain]. The ex-user is skilled in helping the patient identify his motivational attitudes. The regimen of withdrawal was "cold turkey", with some medical support as described. The withdrawal symptoms become fairly strong 18-24 hours after admission, on the average. About 25% of cases have mild symptoms and 25% have quite severe symptoms. The rehab center is not considered to be a medical facility per se, so the hard reactions are taken to the hospital for management of the medical crisis. About the third day many participants begin to waver. Basically they want heroin. This is quite a vulnerable period. . . . Currently the practice is to return the patient to duty around the fifth day, with the request for another ex-user in the unit area to help him readjust there in a non-drug culture.

. . . Followup data is quite incomplete in this activity. There is evidence that 30% of the graduates are still drug free, another 30% have relapsed to drug use, and there is no information about the remaining 40%, many of whom have DEROS'd to CONUS [continental United States].

Holloway observed later (14 May) that ex-drug users on the staff had subverted the program by supplying drugs to the participants. As a consequence it had recently been restructured using a lieutenant and enlisted man with non-drug use backgrounds.

3rd Brigade, 1st Cavalry Division (AMBL) Bien Hoa—14 March 1971

The 1st Cavalry Division is about to be deactivated in Vietnam. A sizeable morale problem associates to the impact of unit stand-downs which causes large numbers of troops to be transferred as excess. . . . This is felt to aggravate the tendency toward drug abuse. A drug abuse ward was developed in October 1970, at the 1st Cav MHCS [mental hygiene consultation service], directed particularly toward heroin abuse. A medical officer in attendance provided for controlled withdrawal from drugs. At the present time admissions are increasing to this unit, reflecting predominantly men approaching their DEROS, and others being transferred to another divisional unit with worry about the new unit's attitude and drug supply. Most of these patients are described as fairly healthy persons who "wandered" into drugs, with better prognosis for recovery than the drug addict stereotype.

Holloway observed later (15 June) that because of rapidly rising heroin use levels the brigade established its own drug treatment center. It operates under the authority of the Brigade Surgeon and uses medical personnel exclusively, and it is housed in a group of buildings surrounded by a high fence to facilitate drug-free detoxification. Amnesty volunteers were segregated from the other soldiers undergoing treatment and rehabilitation for drug abuse. Also, because the Vietnamese living in the area adjacent to an outlying firebase were a ready source of heroin, the brigade established a "customs house," which was used to search troops arriving or leaving the base for drugs and contraband. Success measures for these initiatives were not available.

164th Combat Aviation Group south of Saigon in Can Tho in the Mekong River delta—15 March 1971

[Project Rebuild] is an eight week program which ordinarily follows the individual's involvement in an outpatient group while awaiting admission: Week one—withdrawal ward; week two—rebuild platoon; week three—daily counseling; week four through eight—weekly counseling. Nothing is placed in the official medical record. Necessary records are kept in the Chaplain's office. This is a heavily invested, multidisciplinary, highly professional model [staffed by

physicians, a social worker, a nurse, chaplains, medics, ex-users, full-time and part-time officers]. . .

Project Rebuild is a balanced, well considered program whose statistics are equal or better to those of other programs. Screening of individuals is vigorously pursued. The balance of credibility of the program is further evidenced in the training curriculum which emphasizes alcohol "highs" as well. There is a model of team leadership in each rebuild platoon, conjointly between medical officer, chaplain and platoon leader. Substitutions for hard drug use by marijuana, alcohol, or other practice are not supported. The concept of rehabilitation has more to do with increased understanding than with any sense of mastery or arrival, as from a medical illness. The client is educated to his drug problem much as Alcoholics Anonymous proposes that for him the drug will remain a special problem, requiring special and unrelenting vigilance and personal adaptations.

Holloway observed later (5 June) that despite strong command support and the application of the most well structured and professionally competent therapeutic techniques observed throughout Vietnam, follow-up statistics could verify only 15% effectiveness. Also, north of Can Tho at Vinh Long, a sister program was in operation under the auspices of 7/1st Air Cavalry unit and experienced similar results.

Cam Ran Bay and the 483rd AF Hospital—17 March 1971

[The 483rd AF Hospital] is an attractively located, though aging hospital. . . . The drug rehab program [which serves large numbers of Army patients] is carried through on the psychiatry ward, and involves requirement that the soldier turn himself in first to his CO [commanding officer], be sent to the hospital, be given a four day detoxification, and then returned to duty. [A] letter was sent to each man's CO following his discharge, requesting follow-up information, but after four months of no response this was terminated. It would appear that no aftercare structure has been possible from this location.

Holloway observed later (10 June) that since the 483rd AF Hospital had stopped treating Army patients in their program, Support Command was forced to establish its own drug rehabilitation facility, "Operation Guts." This program was an example of an exclusively command organized, supported, and maintained program that featured a well-planned physical facility and a detailed operational plan; but it lacked trained counselors and medical support. Personnel included a lieutenant colonel in charge, a 1st Lieutenant project officer, three NCOs, including one administrative sergeant with Alcoholics Anonymous experience, and a number of EM with a variety of MOSs [military occupational specialties] (including two medics and one ex-user). The staff was mainly characterized by enthusiasm and inexperience; they were developing their skills as care-givers on the spot. However, the program and related education and enforcement efforts failed to slow the extensive heroin use in the Cam Ranh Bay area.

Appendix 19 THE PROFESSIONAL CONSULTATION MODEL

The distribution for this document is uncertain, but apparently it was intended to integrate the 935th Psychiatric Detachment's outreach and consultation services with the primary care medical dispensaries, post chaplains, and other Army agencies in their catchment area, primarily the sprawling Long Binh Post and nearby units. It is in the form of a position paper and explains their rationale for emphasizing secondary preventive activities (the promotion of early detection of developing psychiatric conditions and behavior problems among soldiers and their management as outpatients) over primary preventive activities (efforts devoted to influencing the conditions under which soldiers live, work, and fight so as to reduce the incidence of maladjustment and the occurrence of new psychiatric conditions).

UNPUBLISHED: PSYCHIATRIC CONSULTATION IN THE WAR ZONE
CAPTAIN H SPENCER BLOCH (MD)
DIRECTOR OF THE PSYCHIATRY AND NEUROLOGY INPATIENT SERVICE
935TH PSYCHIATRIC DETACHMENT (AUGUST, 1967–1968)

I would like to present two ideas briefly:
Our experience and perspective have led us to two conclusions upon which our current program of psychiatric consultation is based. The first is that emotional reactions and symptoms are harder to prevent than they are to adapt to and live with. The second is that, in a war zone, one should do the least intervention that is necessary to enable a man to function effectively in his unit.

DISCUSSION

To elaborate on these points let me begin by mentioning that the general orienta-tion and emphasis of military psychiatrists since WW II has been in the area of preventive psychiatry. Practitioners of this approach feel that there are principles of preventive psychiatry that can be conveyed to the leaders of units, and when these principles are put into practice, somehow psychiatric symptomatology and illnesses can be significantly aborted within a unit. This has been the rationale for psychiatrists and other mental health [professionals] spending much of their working time visiting units, meeting and consulting with key people (COs and NCOs) and somehow, in the process, accomplishing the transmittal of concepts and actual plans that will effectively prevent psychiatric illness from developing within the unit.

Our own perspective and experience has led the staff of the 935th to a different conclusion and approach. Namely, we believe that everyone is probably better off if we leave unit leaders alone to conduct their mission in the best way they have been taught and have learned. What general principles of preventive psychiatry that may exist are known by most leaders and are generally common sense.
The numbers and kinds of variables within and between units probably make it impossible to formulate any specific principles for preventive psychiatry anyway. Rather, we can best be of most help when specific problems arise. And we can best bring our knowledge and suggestions to bear through channels of professional consultation. In this way COs get their suggestions through their close associates and advisors, such as dispensary or battalion surgeons or unit chaplains. To this end we encourage such professional service people to consult with us about problems that have come their way from units they support. Often the natural reaction from the unit and then from the first professional who sees him (like the primary care physician or the chaplain) is that "This man needs help—more than I can give him—(ergo), please take him off our hands; he's ineffective and bothersome and

sometimes frightening—or at least anxiety-provoking." This is a natural reaction, especially if a person is exhibiting behavior that is not readily understood.

Our general approach in consulting with such personnel is to guide them in helping the unit both to manage their behavior or symptoms and also to help the unit to become more tolerant and accepting of behavior that is somewhat aberrant. So that, rather than trying to prevent emotionally-induced symptomatology and behavior (which we think is impossible to do), we attempt to increase the unit's toleration for variation and idiosyncrasy. Certainly some people must be removed and hospitalized, and this is done when necessary, but usually it isn't. When we have combated the unit's panic about deviant behavior by not being overwhelmed by it ourselves and through aiming at an understanding of it, then we can help the unit do the same and help the individual get back closer to the norm.

From what has just been said it can be seen how our first premise (i.e., that it is usually easier to live with and manage psychopathology than to prevent it) relates to our second one (i.e., in the war zone where our interest is in supporting the unit's mission, we, of necessity, wish to do the least that is necessary to enable a man to function effectively in his unit—to make the fewest and most innocuous adjustments that are required to achieve compatibility and enhanced efficiency between the deviant man and his group). We don't mean to imply either laziness, dereliction of responsibility, or second class professionalism on the part of the advisors and treators. One doesn't stint, but rather one thinks small rather than in the more grandiose terms that psychiatrists often do in trying to remake a person's character structure. As you are well aware, the vast majority of patients that we see are operating with mechanisms they've been using for years to handle certain typed of situations and stresses. We don't want to alter this radically now. We just presume that most of these folks have gotten along adequately until the time when we see them, that something has shoved them over the line into ineffectiveness, and our interest is in determining what we can recommend to help them pull themselves back over that line into the realm of acceptable functioning. These principles govern our approach in advising people like you who are the closer confidants and advisers of unit leaders.