

US Army Psychiatry *in the* Vietnam War

New Challenges in Extended Counterinsurgency Warfare

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Note to the readers. This volume utilizes some materials that are not available either in print or online. Several colleagues gave me access to their personal journals kept during their tours in Vietnam. Other colleagues shared papers they had written either during their tours in Vietnam or after their return home, but had never published. Other unpublished sources of information include handouts or other materials I received at various times during my Army career: when I attended Officer Basic Course, when I completed my residency, when I deployed to Vietnam, and after my return. None of these materials are considered “sensitive” by the military. I have included some of these materials as exhibits in the chapters, attachments to the chapters, or appendices to the volume. They are also listed in the references for each chapter, followed by a note that the document is available as indicated in this volume.

Physicians serving in Vietnam were provided a wide array of psychotropic medications, especially including newer neuroleptic and anxiolytic tranquilizing medications and the tricyclic antidepressants, for use with soldiers with psychiatric symptoms. In the field these were most often referred to by their brand names and not their generic names. I have followed suit in this book, only indicating the generic names when physicians used those names.

There were very few female military personnel in Vietnam, most of whom were assigned as nurses. Thus, unless noted otherwise, the experiences and observations chronicled in this book are those of men, and the use of pronouns reflects this reality.

There are references in this work to many important and timely articles that appeared during the war in the *USARV Medical Bulletin*, which was published from 1966 to 1971 to provide useful information for Army Medical Department personnel throughout the theater. This collection is archived at the US Army Academy of Health Sciences, Stimson Library, Fort Sam Houston, Texas. Complete PDF versions of articles can be accessed via the Internet at <http://cdm15290.contentdm.oclc.org/cdm/landingpage/collection/p15290coll4>. Individual articles can be searched using the author's last name. —Norman M Camp

About the Author



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DURING THE CREATION AND COMPLETION of this volume, Norman M Camp, MD brought a unique blend of training and experience to the task of making sense of the many political, environmental, institutional, social, and psychological strands that interacted to ultimately create a morale and mental health crisis among US ground forces in Vietnam. Pivotal was his service as psychiatrist and commanding officer of the 98th Neuropsychiatric Medical Specialty Detachment (KO) in Vietnam from October 1970 to October 1971—the period of greatest demoralization and dissent—for which he received the Bronze Star for Meritorious Achievement. Before going to Vietnam he completed his general medical internship at Letterman Army Hospital in San Francisco, California, and his general psychiatry residency at Walter Reed General Hospital in Washington, DC. After his return he completed child and adolescent psychiatry fellowship training at Letterman Army Hospital/University of California, San Francisco and psychoanalytic training with the Baltimore-Washington Institute for Psychoanalysis.

Additional familiarity with social sciences research came through his assignment as research investigator with the Department of Military Psychiatry, Walter Reed Army Institute of Research (WRAIR) in Washington, DC, from 1980 to 1985, where he had the opportunity to conduct a survey of veteran Army psychiatrists who served in Vietnam regarding their professional activities in the theater. His WRAIR assignment also resulted in his publishing (with Stretch and Marshall) an annotated bibliography of the psychiatric and social sciences literature pertaining to the effects of the war on troops serving in Vietnam, and later a long overdue exploration of the potential confusion of military psychiatric ethics arising during war. Practical augmentation of these experiences came through Dr Camp's assignments as Chief of Psychiatry of an Army hospital in Germany, Chief of the Community Mental Health Activity at a post in the United States, and as a member of the teaching faculty at Walter Reed Army Medical Center.

Dr Camp retired as a colonel from active service in 1988. He was awarded the Army Surgeon General's "A" Proficiency Designator as having attained the highest level of professional achievement recognized by the Army Medical Department. After his military retirement, Dr Camp relocated to Richmond, Virginia, where, in addition to maintaining an active clinical practice of psychiatry and psychoanalysis, he steadfastly directed his professional energies to the education and training of the next generation of psychiatrists. As Clinical Professor of Psychiatry at the Medical College of Virginia/Virginia Commonwealth University, he served for almost two decades as the Director of Psychotherapy Training for the psychiatry residency-training program.



Foreword

[Opposite] M42 Duster self-propelled anti-aircraft gun, “The Peace Maker.” The name given this particular M42 Duster by its crew apparently associates its formidable firepower to the iconic Army Colt .45 Peacemaker revolver from the late 1800s. However, in this photograph, taken in 1970 during the second half of the war, there are decorations flanking the name, that is, the international peace symbol and the hand sign for peace, which were emblems that had been adopted by the Vietnam War protest movement in the United States. These markings are consistent with the growing confusion of values among the replacement troops sent to fight in Vietnam as the war lengthened, which in turn appears to be linked to the morale, discipline, and mental health crisis that developed.

When this war is over it will be a brighter day.

When this war is over it will be a brighter day.

But it won't bring back those poor boys in the grave.

JJ Cale and Eric Clapton

FIFTY EIGHT THOUSAND DEAD, 300,000 wounded, and \$189 billion spent to process the Vietnam War from 1965 to 1972. America went into this war incrementally, sliding down a slippery slope. Our decision to become involved and our strategy to win the war were flawed. Looking out on a post-World War II landscape, we saw communism running rampant and the Cold War heating up. Vietnam presented an opportunity to stem the “Red Tide,” so we came to the aid of our South Vietnamese allies. Unfortunately, the South Vietnamese government was weak, autocratic, and corrupt. It represented the last vestiges of three centuries of colonialism.

Our initial strategy was to fight a short war with overwhelming force. The enemy strategy was to conduct a prolonged, low-intensity counterinsurgency regardless of casualties. We misunderstood and underestimated the resolve of our enemy. As many times before and since, we did not heed the lessons of history. Domestic issues of the day influenced overall strategy. During the 1960s, our government was focusing on large social programs and wanted our intrusion into Southeast Asia to have minimal impact on the American public—a “guns and butter” policy. Crucial strategic decisions that would ultimately affect the conduct of the war were made with domestic policy in mind.

The National Guard and Reserves were not mobilized. A selective draft was initiated, which targeted poor and disadvantaged single males in rural and urban areas, and was echoed in pop culture—Creedence Clearwater Revival’s “I ain’t no Senator’s son. . . .”

Troops were sent to Vietnam under a 1-year rotation policy. This approach ultimately led to a breakdown in unit cohesion and disrupted continuity of leadership. Further breakdown of morale, discipline, and effectiveness occurred during the rise of social unrest at home with the civil rights movement and the counterculture youth movement. Soldiers were keenly aware of these events and of the public’s ever increasing feelings against the war and the troops themselves—the “baby killers.” All these events played out on television. The war was conducted in the living rooms of America night after night, ultimately leading to a decline in the national will to support the war.

To further add to the US military's problems in country, our South Vietnamese allies introduced readily available heroin, and a drug epidemic ensued among the troops. With the culmination of these many forces swirling about, it should be no surprise that our soldiers' behavior was affected in a negative manner manifested by low morale, disobedience, antimilitary aggressive behavior, distrust, and a lack of respect for leaders and the "Green Machine" in general.

To make sense out of psychiatry in the Vietnam War is a daunting proposition. Mental health personnel were caught up in the same environment as the troops. Very few of the 135 psychiatrists deployed to Vietnam were unaffected by the war. Many had strong conflicting emotions surrounding the war. Some psychiatrists were overwhelmed, had a sense of helplessness, and felt they were being used as a trash bin for ineffective soldiers. They too felt victimized by the Green Machine.

Meanwhile in America, the psychiatric community was extremely polarized, with large numbers strongly against the war. Many stateside physicians openly criticized their colleagues serving in Vietnam for supporting the Army Medical Department's primary mission—to conserve the fighting strength. Feelings ran high and active duty physicians were in effect told by their colleagues, "Don't treat the wounded to send them back to their units; medevacuate as many as possible out of the country." As a newly minted psychiatrist serving in Vietnam with the 1st Cavalry Division, I felt betrayed by my own specialty, but their feelings did mirror those of the American public, which ultimately lost all national will to conduct the war. No war can be won if your citizens are against it.

In the aftermath of the war the American public, the military, and civilian leadership collectively breathed a sigh of relief to see Vietnam recede in the rear view mirror. Our first counterinsurgency war in the 20th century was an embarrassment and a failure.

People just wanted to forget it, particularly the behavioral issues. It is interesting that the psychiatric literature pertaining to the war is often contradictory and misleading. The psychiatric records and data that came out of Vietnam were very spotty, fragmented, and

incomplete. The Army eventually "lost" most of the primary source material. There has never been a study of "what went wrong" or an official history written of Army psychiatry in the Vietnam War.

Colonel Mike Camp, US Army (Retired), is to be commended for undertaking the daunting task of collecting a composite of published and unpublished articles, reports, and survey Army documents pertaining to mental health issues during the Vietnam War. Dr. Camp had boots on the ground as commander of one of two neuropsychiatric teams (KO) and has walked the walk. The culmination of his efforts is a highly readable, interesting, and valuable account of troop behavior, leadership issues, and historical events ultimately leading to our failure in Vietnam. He divides the war into two phases: 1965–1968, an idealistic time, and 1968–1972, a war inexorably careening awry; as you read you will understand why.

This history is a virtual goldmine of material pertinent to mental health issues in counterinsurgency warfare. Important lessons learned then are as pertinent today as they were 40 years ago.

It is a must read for civilian and military leadership as well as mental health professionals. Since Vietnam, the United States has fought two counterinsurgency wars in the Middle East. Some problematic issues have been addressed, and support of our military is very positive. However, today, even with an all-volunteer Army, there are challenges to be met—discipline problems, suicides, domestic issues, and multiple rotations.

In the end, mental health must be recognized as a command issue from the very top down. Leaders involved with strategic and operational planning must always keep in mind the effects of their decisions on troops placed in harm's way. Colonel Camp's worthy efforts to construct a history of mental health during the Vietnam War fill an important gap that is long overdue. It is an insightful and valuable archive of the many lessons learned relative to our present and future.

Major General Richard D Cameron
US Army (Retired)

Preface

International peace symbol over a trail outside Da Nang. This photograph was taken during the second half of the war. The peace sign was likely painted by some US military group. Its unambiguous message is one of opposition to the war, an increasingly popular attitude among replacement troops assigned in the theater. Photograph courtesy of Richard D Cameron, Major General, US Army (Retired).



THE AMERICAN GROUND WAR IN VIETNAM (1965–1973) was a “low intensity,” “irregular,” counterinsurgency/guerrilla war that became prolonged, socially condemned, and ultimately produced great national agony and incalculable cultural aftereffects. Even now, four decades after the last troops were withdrawn, arguments still remain as to whether America was defeated, failed to achieve its military and political objectives, or withdrew prematurely because a liberal media convinced the public that the war could not be won at any reasonable cost. Regardless of the position one chooses, the war was extremely costly in terms of casualties—including psychiatric casualties—and the loss of American resources and international prestige.

Also indisputable, the US Army suffered a severe breakdown in soldier morale and discipline in Vietnam—matters that are at the heart of military leadership and overlap with the mission of Army psychiatry. More specific to psychiatry, the psychosocial strain affecting the troops and their leaders in Vietnam produced a wide array of individual and group pathologies that thoroughly tested the deployed psychiatrists and their mental health colleagues.

No single statistic can reasonably characterize the Army’s shifting, as well as accelerating, psychiatric and behavioral challenge in Vietnam. Psychiatric attrition through the course of the war—the incidence of soldiers hospitalized or excused from duty status—ranged between 12 per 1,000 per year and 16.5 per 1,000 per year.^{1–3} Although this record appears very favorable compared to rates for the Korean War (73/1,000/year)⁴ and World War II (28–101/1,000/year),⁴ it is misleading. Not only does this rate address only one measure of soldier psychological and behavioral dysfunction, but in averaging 8 years of experience it also minimizes the fourfold increase in the last few years of the war and disguises the problems that ultimately emerged. In fact, if the increases in

psychiatric conditions through the second half of the war are combined with similar increases in behavioral problems (skyrocketing rates for judicial and nonjudicial punishments, racial incidents, combat refusals, attacks on officers and noncommissioned officers, and casual heroin use)—problems that are mostly not included in psychiatric statistics—an incontrovertible truth emerges: the US military ultimately sustained a debilitating psychosocial crisis in Vietnam that, in addition to its humanitarian costs, jeopardized combat readiness. When there is acknowledgment of the extensive morale and discipline problems, there is a tendency to dismiss them as consequences of the emergent drug culture of the times as if the Army, especially in Vietnam, did not unravel from within but was literally infected by a toxic agent that has since been eradicated.⁵ Most important, and quite surprising, there has been no official history written about Army psychiatric and behavior problems in Vietnam nor has there been a systematic study by the Army of what happened.

The Army mental health personnel who served in Vietnam brought with them a confidence in principles of combat psychiatry derived from hard-fought pragmatic experiences in World War I, World War II, and Korea. These were handed down by those who served in those wars through systematic efforts at reconstruction and analysis. For example, following both world wars, veteran psychiatrists worked with the US Army Medical Department's historical unit to elaborate a review of the structure and role of Army psychiatry in support of the nation's combat activities.⁶⁻⁸ The results were an exceptionally thorough and scholarly series that became classics in military psychiatry.

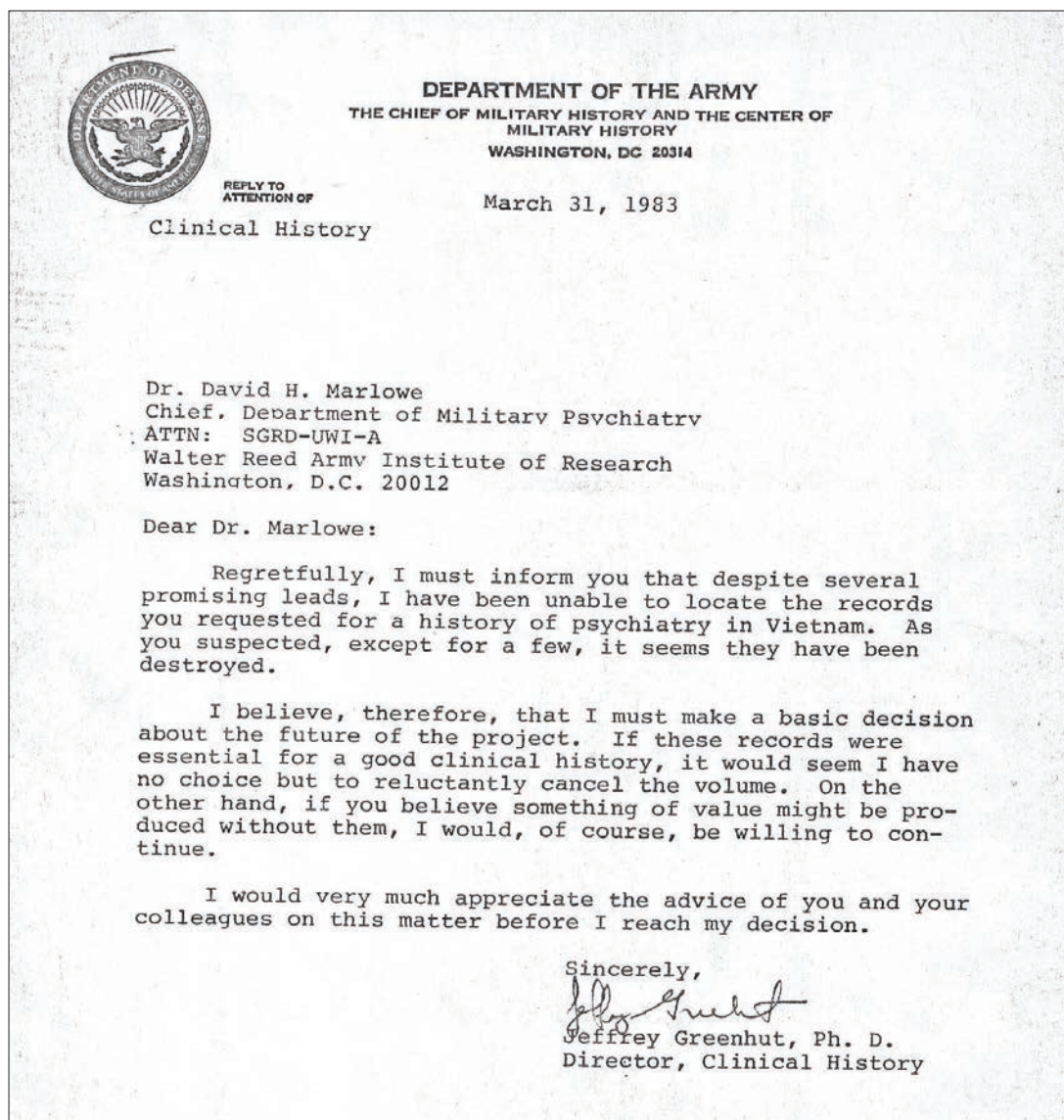
The Army evidently planned to sponsor publication of a similar history of psychiatry after the Korean War. Regrettably, this effort was suspended in 1983 because of the death of the principle author, Colonel (Retired) Albert J Glass. In the late 1990s, his colleague, Colonel (Retired) Franklin Del Jones, took steps to salvage the progress that Glass had made, and the results of this collaboration reside on the server at the Uniformed Services University of the Health Sciences (<http://www.lrc.usuhs.edu/Archivex/pdf/CombatPsych.pdf>). A partial history of psychiatry in the Korean War also exists in Glass's publications,⁹⁻¹² which are augmented by those of other psychiatrists who either served in Korea,¹³⁻¹⁵ conducted investigations there,^{16,17} or sought to review the record years later.¹⁸

Taken together, these accounts summarize the psychiatric dimensions of those wars and document the evolution and utility of combat psychiatry. They highlight the considerable challenges faced by Army psychiatrists and the limits of their available psychiatric resources, their achievements, and at times their failures. They also reveal how the changing circumstances within each war altered clinical presentations, treatment approaches, and therapeutic results, as well as led to changes in the preparation and training of mental health personnel who followed. Most importantly, they underscore the necessity that Army psychiatry work closely with military planners regarding potential threats to morale, cohesion, and force resiliency.

However, with regard to the experience in Vietnam, the record has remained fragmented and confused. In the immediate aftermath of the Vietnam War, the Army Medical Department apparently intended to sponsor the creation of a history of Army psychiatry in the war along with other medical specialties,¹⁹ but that project was never begun. The Walter Reed Army Institute of Research (WRAIR) made a tentative effort in the early 1980s under the leadership of Jones. Although WRAIR convened a group of representative psychiatrists who had served during the war, they abandoned the project, evidently because of how much time had lapsed since their service in Vietnam and because the documentation that could have served as primary source material could not be located by the Army (Figure 1).

There have been a few publications that provide summaries of Army psychiatry in Vietnam, but they are limited because they primarily focus on observations from the advisor period and the first half of the war.^{4,20-22} In 1975, after the withdrawal of US forces, Jones and Colonel Arnold W Johnson Jr. published a preliminary overview of Army psychiatry in Vietnam when Johnson was serving as the Psychiatry and Neurology Consultant to the Office of The Surgeon General, US Army.¹ They described common clinical entities and provided gross data demonstrating rising prevalence patterns in the theater, which they associated with changing military circumstances and policy features of the war. However, they left greater detail and synthesis for other accounts, which unfortunately were never published—a blind spot repeated even in Jones' otherwise excellent later reviews of the history of military psychiatry.^{23,24}

FIGURE 1. Letter to Dr David Marlow



Other circumstances also help explain the absence of a more complete Vietnam military psychiatry history. Until it was forced to study heroin use among soldiers late in the war,²⁵⁻²⁷ the Army undertook relatively little formal psychiatric research in Vietnam after regular forces were committed in 1965. Notable exceptions were the study of physiologic, psychological, and social correlates of stress by Major Peter Bourne and his WRAIR colleagues conducted in 1965 and 1966,²⁸ and the surveys of illegal drug use in 1967 by Captains Roger A Roffman and Ely Sapol,²⁹ and in 1969 by Captain M Duncan Stanton.³⁰ Also, there were visits to

Vietnam late in the war to investigate the drug abuse epidemic by Colonel Stewart L Baker Jr³¹ and Colonel Harry C Holloway,³² senior military psychiatrists, as well as Norman Zinberg, MD,³³ a civilian psychiatrist, which produced informative reports.

Anecdotal accounts published by psychiatrists who served in the war are also a useful source of information.³⁴ Regrettably, considerable skew is introduced because, of the 28 psychiatrists who served with the Army and who published accounts, 23 (82%) were assigned there during the first half of the war. The few

articles by psychiatrists that served during the drawdown phase of the war, when psychiatric attrition rates were highest, are limited descriptions of local patterns of drug abuse or drug treatment programs. Also, of 46 publications from the entire group, half appeared only in the *US Army Vietnam Medical Bulletin*—a nonjuried publication that was produced and circulated in Vietnam and discontinued in early 1971.

Thus, it was with these features in mind—the rampant psychiatric and behavioral disturbances in the second half of the war, followed by decades of institutional disregard for this unprecedented, dangerous state of affairs—that the author set out to create *US Army Psychiatry in the Vietnam War*. The methodology utilized was that of assembling and synthesizing information drawn from a wide variety of available sources to document the successes and failures of the deployed Army psychiatrists and allied mental health and medical personnel. This approach was augmented by data from the author's 1982 survey of the veteran psychiatrists who served with the Army in Vietnam.^{35,36} Whereas this review was intended to serve as a historical record, it is not the comprehensive history that should have been developed by the Army. Nonetheless, it does define many of the most salient “lessons learned” with respect to the variables that affected the morale, discipline, mental health, and performance of the troops deployed in Vietnam, as well as those bearing on the mental health specialists sent to support them.

This work will undoubtedly evoke questions that cannot be readily answered; but hopefully it will help shape thought and discovery by others regarding future conflicts. Certain features of the Vietnam theater, that is, a counterinsurgency/guerrilla war that became protracted and politically contentious at home, may more be the nature of US wars in the future than the relatively popular, main force warfare that characterized the earlier wars of the 20th century.³⁷

It should be acknowledged from the outset that this work has favored data actually observed in Vietnam or as proximate to the experience there as possible. For a variety of reasons, time and distance from a combat theater are notorious in producing revisions of memory. Furthermore, apart from various exceptions, this review only nominally mentions the other Army mental health professionals (nurses, social workers, psychologists) and

paraprofessionals (enlisted specialists) who served side by side with Army psychiatrists in Vietnam throughout the war. It also does not do justice to the considerable numbers of nonpsychiatrist physicians who found themselves in Vietnam bearing the full weight of the psychiatric challenge in their area. In addition, the work also omits discussion of the many psychiatrists and allied personnel in the military evacuation network beyond Vietnam who received (and were challenged by) the most seriously affected soldier-patients from the war. The essential roles these groups played and the sacrifices they made are worthy of their own historical record.

Regrettably, because of the absence of data, this review does not specifically address additional stressors that may have been associated with serving in specific assignment types or situations in Vietnam (eg, officers and noncommissioned officers, elite troops such as Rangers and Special Forces, Army aviators, helicopter crewmen, scouts, tankers, healthcare professionals and paraprofessionals, chaplains, graves registration personnel, explosive ordnance disposal personnel, long-range reconnaissance patrol personnel, advisors, snipers, so-called tunnel rats). On the other hand, although there was extensive study of POWs following their release,³⁸ the findings pertaining to psychiatric effects of captivity were felt to be tangential to this review. The work also does not include the psychiatric experience of allied military forces in Vietnam or attempt a systematic comparison of the Army with other branches of the US military. Regarding the latter, in selected instances references to the published works addressing the experiences of Navy physicians, including psychiatrists, who provided care for the Marines serving in Vietnam are utilized because of the overlapping nature of the Marine mission with that of the Army.

This account also does not address neurological problems specifically or the deployment of neurologists in Vietnam, although the medical specialties of neurology and psychiatry share a developmental history, and “neuropsychiatry” was commonly used as a synonym for psychiatry throughout the war. In fact, a position for one neurologist was included in the Table of Organization and Equipment of the two Army neuropsychiatry specialty medical detachments that were deployed in Vietnam beginning in 1965; however, by 1970 that connection had been dissolved.

A full review of the important matter of postwar psychosocial effects on those who accepted America's call to service in Vietnam is well beyond the scope of this work. Because, by policy, the majority of personnel assigned there served a single deployment, typically 12 to 13 months in length, concern for long-term psychological effects was of secondary importance among the active service branches during the war. However, during the latter years of the war and the decades to follow, growing evidence of an apparently high prevalence of delayed psychiatric and behavior symptoms among veterans brought increasing clinical and research interest in the negative effects associated with service in Vietnam.³⁴

Finally, the reader should view the psychiatric treatment philosophy and clinical approaches represented in this work through the lens of the Army medical and psychiatric doctrine of the 1960s and early 1970s and the applicable civilian standards of care of the times. In this respect it is notable that following the war, the American Psychiatric Association's diagnostic nomenclature, the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition (DSM-III [1980]), underwent a radical and controversial revision that, for the first time, required explicit phenomenological criteria for the diagnosis of psychiatric conditions. In time this sea change in the field of psychiatry powerfully affected how society viewed mental health.³⁹ It also generated a dominant, empirically grounded, biobehavioral psychiatry that in many respects supplanted the decades-old model favoring intrapsychic and psychosocially based etiologic assumptions for psychiatric conditions that had prevailed throughout the war. Within the military, the combination of this paradigm shift and the postwar establishment of the new diagnostic entity, posttraumatic stress disorder (PTSD), redefined levels of acceptable risk for soldiers exposed to the psychological hazards of combat deployment in more conservative terms. This in turn lowered the tolerance levels for psychological risk for combat soldiers within military medicine and psychiatry (This will be discussed in Chapter 12, Exhibit 12-1, concerning post-Vietnam challenges to the forward treatment doctrine.)

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