PROLOGUE

A Psychiatrist's Experience During The Drawdown in Vietnam: Coping With Epidemic Demoralization, Dissent, and Dysfunction at the Tipping Point

Change-of-command ceremony for the 95th Evacuation Hospital in the winter of 1970. Such a demonstration of military order and purpose was intended to inspire the medical personnel assigned to the hospital as well as US military and Vietnamese patients who were observing from the adjacent wards. Photograph courtesy of Richard D Cameron, Major General, US Army (Retired).

Telling the story of the Army's psychiatric problems in Vietnam requires that one start at the end so that the beginning and middle have context. As for the bitter end, the war in Vietnam came to a dramatic close on 30 April 1975, when America's ally, the government of South Vietnam, surrendered to the overwhelming military force of North Vietnam. For the United States this represented a resounding strategic failure, if not a tactical one. Although American combat personnel had been completely withdrawn 2 years earlier, it must be acknowledged that this was in response to great opposition to the war at home[1]; widespread demoralization in the theater, which was often expressed in psychiatric conditions and behavioral problems (see Chapter 2, Figure 2-2 and Chapter 8, Figure 8-1); and a military leadership that was on its heels. This degradation of military order and discipline, as well as a general compromise of the mental health of the force, was unprecedented and mostly unanticipated because American troop strength had been dropping steadily since

mid-1969, and the numbers of US combat casualties had been falling proportionally.

In an effort to document the psychiatric dimensions associated with these calamitous circumstances, I begin here with selected recollections and impressions from my service from October 1970 to October 1971, roughly year 6 of the 8 years of the ground war, as psychiatrist and commanding officer of the 98th Neuropsychiatric Medical Detachment (KO), one of the US Army's two specialized psychiatric treatment and referral centers in Vietnam. Most of what follows was written during the decade after I returned from Vietnam. It was augmented with my official Report of Activities of the 98th Medical [Psychiatric] Detachment (KO) covering the last quarter of l970 (Appendix 1 to this volume) and recently cross-validated with my psychiatric colleagues who served with me at the 98th KO Team. Inclusion of my subjective reactions is consistent with psychiatry's time-honored recognition of the value of the participant-observer approach to data gathering and interpretation.

PREDEPLOYMENT PSYCHIATRIC TRAINING AND PREPARATION

American ground forces were committed in the Republic of South Vietnam in March 1965,[1] in opposition to a communist takeover of that country by indigenous guerrilla forces (Viet Cong) and regular units from the North Vietnam Army (NVA). When I arrived in the fall of 1970, midway through the drawdown years of the war (1969–1973), peace negotiations were being haltingly pursued with North Vietnam, and the earlier US offensive strategy of attrition had been replaced with a defensive one that sought area security and "Vietnamization" of the fighting (ie, turning the fighting over to the South Vietnamese). Still, we were very much at war in Southeast Asia, casualties continued to mount, and public opposition had become impatient and strident.[2]

Despite having many reservations, I volunteered to serve in Vietnam as my next assignment after residency training in psychiatry at the US Army's Walter Reed General Hospital in Washington, DC. Early in 1970, at the time I agreed to an assignment to Vietnam, over 400,000 US troops were still there[3] (from a peak of 538,700 in mid-1969[3]), and I felt it was the right thing to do. However, I also thought I was destined to be sent anyway because I was one of only two in my graduating class of eight without children.

Overall, my education and training in psychiatry at Walter Reed was excellent. Yet, as far as preparing me specifically to serve as a military psychiatrist in Vietnam, it fell short in three important regards. First, there is the matter of military identity and indoctrination. Like most of my classmates, before beginning the program in psychiatry in 1967 I had completed 5 weeks of Medical Corps Officer Basic Training at the Medical Field Service School at Fort Sam Houston in San Antonio, Texas. However, this was quickly overshadowed by the clinical experience at Walter Reed, a large, busy medical center located in the midst of a densely populated urban area and geographically isolated from the larger Army. Even though my classmates and I wore Army uniforms beneath our white clinical coats, and many of our patients were casualties from Vietnam, we preferred to believe that our training (3 years) would outlast the war, and that we were serving as neutral caregivers who were functioning on the sidelines. This is even more remarkable considering that we were training in the nation's capital and directly exposed to the wrenching social tumult of the late 1960s, especially events associated with the increasingly bitter struggle over the war.

As for the specialized training in psychiatry, our didactic curriculum at Walter Reed did include specific references to combat's high potential to be psychologically traumatic. It also addressed more generally the uniquely stressful influences associated with military environments and circumstances (social as well as physical). However, as I only appreciated after serving in Vietnam, the training was biased in favor of forms of psychological disturbance *within* the individual patient, including soldiers engaged in combat. This training provided only limited practical experience regarding pathogenic group dynamics that can form within military populations and that warrant a "community psychiatry" model. This shortcoming was despite programmatic intentions to the contrary.[4] We mostly studied the principles of prevention and treatment of combat breakdown among soldiers exposed to sustained combat as was seen in earlier wars. And quite strikingly, there was no evident feedback loop to our training program from the Vietnam theater that could have alerted us to the accelerating social, psychiatric, and behavioral problems there—problems not primarily linked to combat exposure. In short, we literally prepared to fight the last war.

Finally, totally absent from our curricula at Walter Reed was acknowledgment of the combat psychiatrist's potential, and most exquisite, ethical dilemma. This refers to situations when clinical decisions become burdened by a clash between military priorities (centered on ostensible collective values) and those of the individual soldier (centered on ostensible individualist values). Although this is not unique to military psychiatry, it ultimately became very pointed in Vietnam and greatly complicated the deployed military psychiatrists' role requirements with implications both for the individual soldier and military force conservation and preparedness.[5,6] This subject will be explored in Chapter 11.

In the spring of 1970 my training at Walter Reed concluded, my assignment in Vietnam loomed, my denial of the personal relevance of the war dissolved, and I felt increasingly unsettled as I made my way to Travis Air Force Base in California for my flight to Southeast Asia. As circumstance would have it, this was a period of reintensification of the war protests in the United States in response to the May incursion into Cambodia by US forces and its allies and the associated riots and student shootings at Kent State (four deaths) and Jackson State University (two deaths) by National Guard troops.[2] It also roughly coincided with an upsurge in alienation of draft-eligible men as a consequence of the Nixon Administration's revision of the selective service procedures eliminating draft deferments and the introduction of a draft lottery system that would be implemented in calendar year 1970.[7,8] These events only served to further heighten opposition, or at least doubt, among the soldiers who were sent to Vietnam as replacements. After 5 years of this war, most Americans had become thoroughly disheartened, impatient with the peace negotiations and the pace of troop withdrawal, and mistrustful of the government and the military.[2] And the mental health of the Army appeared to be unraveling as a consequence,[9,10] especially in Vietnam.[11(p96)] Worst of all, the public seemed to condemn anyone connected with the war, including those whose duty it was to serve there—as if the only honorable attitude for the soldier would be one of opposition and avoidance.[12]

Nonetheless, when I joined the plane full of other replacements on their way to Vietnam on 4 October 1970, my training at Walter Reed had led me to assume that for each individual soldier whose fate it would be to face (directly or indirectly) his counterpart in combat, his reservations or hesitancy could result in his becoming a casualty, physical or psychiatric. If such misgivings were shared by enough of his comrades, the potential also existed for entire units to fail. More specifically, I had confidence in combat psychiatry's doctrine of forward treatment I'd been taught: that brief, simple treatments applied in the vicinity of the soldier's unit and accompanied by the clear expectation that he will soon resume his military duties serve to limit his disability, and, by extension, protect his unit from associated reduction in its combat effectiveness.[13,14]

In other words, as I saw it, a vital part of my job in Vietnam was to support the soldier's inclination to see his military duty through and to oppose the natural aversion of soldiers to combat risks—the "loss of the will to fight" that had been posited to be at the heart of combat stress reactions.[15] However, as I learned soon enough, I was operating under a flawed assumption. By fall 1970, most of the soldiers sent to Vietnam—the majority of whom were either draftees or volunteered to join the Army because they were told it would lower their chances of facing combat—had little sense of duty about serving there. I was not able to anticipate the corrosive psychosocial impact that society's opposition to the war in Vietnam would have on the thousands of soldiers who shared America's war weariness yet still would be sent as replacements to defend its cause under circumstances of increasing moral ambiguity.

THE MISSION, STAFFING, AND STRUCTURE OF THE 98th MEDICAL (PSYCHIATRIC) DETACHMENT

I was assigned to serve as commander of one of two specialized US Army psychiatric referral and treatment centers in Vietnam. Throughout my year the 98th Psychiatric Detachment was attached to the 95th Evacuation Hospital, which was located along the northern coast of South Vietnam near the city of Da Nang. The 95th Evacuation Hospital consisted of a 320-bed "general" hospital and five outlying dispensaries. It was staffed with 65 physicians, representing all medical specialties; 65 nurses; and over 300 enlisted corpsmen. Its mission was to provide a broad range of medical services to the 50,000 to 60,000 American military and civilian personnel in the surrounding area as well

those of allied forces. Because the Da Nang Airfield was located on the other side of the city from the hospital and was heavily used by US aircraft, the 1st Marine Division and innumerable smaller US military units (primarily combat support) provided security for the region and a safe haven for our hospital compound, even though the hospital itself was surrounded by a large population of displaced Vietnamese. The 98th Psychiatric Detachment was configured and equipped to be "semimobile" and theoretically could have moved elsewhere to meet changing psychiatric needs; however, it remained physically and organizationally attached to the 95th Evacuation Hospital throughout the year.

Our detachment had a professional complement of four fully trained psychiatrists—one more than we were authorized (in addition to myself, Majors Nathan and Barbara Cohen [married], and Henry [Gene] Robinson—all of whom had just completed their psychiatry training in civilian programs). They likewise remained assigned to the 98th Psychiatric Detachment for the entire year. Later in the year Captain Leslie Secrest, a partially trained psychiatrist, transferred in from his previous assignment near the demilitarized zone with the 1st Brigade, 5th Mechanized Infantry Division. We also had one social work officer assigned (one less than authorized), as well as several psychiatric nurses (one was authorized) who staffed our 15-bed inpatient ward. Although also authorized, we did not have a psychologist assigned. Finally, exceedingly important were the 15 to 20 enlisted corpsmen (neuropsychiatric specialists) who were assigned and who had Army training in social work or clinical psychology.

The mission of the 98th Psychiatric Detachment was to provide specialized hospital-level treatment (up to 30 days) for troops evacuated from all Army units in the northern half of South Vietnam as well as to serve as one of two out-of-country evacuation staging centers for patients needing additional care. The 98th KO Team also provided mental hygiene consultation service (MHCS) capabilities for the large number of nondivisional units from the Da Nang area and scattered along the northern coast of South Vietnam. In effect, our clinical assets were organized around provision of three primary services: (1) definitive inpatient care, (2) assessment and treatment of outpatients, and (3) administrative and forensic evaluations. We also offered psychiatric consultation to the other medical and surgical services of the 95th Evacuation Hospital and its outlying dispensaries as well as provided on-site consultation and staff training within the Da Nang Stockade. Episodically we provided consultation to command elements of units that came to our attention as referring an inordinately high number of soldiers or whom we learned had sustained some unusual event, for example, a suicide, racial incident, or a "fragging" (term adopted to refer to incidents of soldiers assassinating other service members, including superiors, using fragmentation grenades or claymore mines).

THE INFREQUENCY OF CLASSIC COMBAT EXHAUSTION

Regrettably I did not collect and retain numerical data on the types of patients we evaluated and treated at the 98th Psychiatric Detachment during the year. It was Army policy that all medical records (inpatient and outpatient) remain at the medical treatment facility and in the soldier's personal health record. US Army Republic of Vietnam (USARV) headquarters did collect monthly counts of psychiatric inpatients within a limited taxonomy: psychotic disorders, psychoneurotic disorders, character and behavior disorders (ie, personality disorders), stress reaction, combat exhaustion, and observation-no psychiatric diagnosis.[16] (This is detailed in USARV Regulation 40-34, *Mental Health and Neuropsychiatry,* a complete copy of which is provided in Appendix 2 to this volume.) However, evidently these records were not brought back to the United States or, if they were, they were not archived after the war.

With regard to classic combat exhaustion cases—combat soldiers disabled by psychophysiological reactions to combat—those were seen only occasionally. By design, this should have been the case. As will be explained in Chapter 7, the majority of the combat-generated cases should have been treated at lower medical treatment echelons by each division's medical and psychiatric personnel and returned to duty. As a referral facility, the 98th Psychiatric Detachment was structured to mostly provide extended care for refractory cases (so-called 3rd echelon care).

In fact, throughout the war and throughout the theater, there was a lower incidence of psychiatric and behavior problems generated by combat exposure and risk than had been anticipated from earlier wars. This was attributed to a collection of stress-mitigating factors in the Vietnam theater such as sporadic combat, tours typically limited to 1 year, and various technological

advantages held by US troops. Additionally, by 1970 the Army of the Republic of Vietnam (ARVN) was more likely to do the fighting ("Vietnamization" of the war). The enemy had also reduced the overall pace of the fighting.[11(p97)] Furthermore, in the last few years of the war, American troops seemed quite willing to avoid contact with the enemy when possible, even to the point of faking patrols.[11]

However, we, along with other medical personnel assigned to the 95th Evacuation Hospital, did treat many outpatients with less dramatic stress symptoms stemming from combat exposure, or from anticipation of combat. These ranged from psychological symptoms such as anxiety, depression, or aggressive outbursts; to psychophysiologic symptoms such as gastrointestinal irritability or insomnia; to psychosomatic conversion symptoms such as "helmet headache" or "rucksack paralysis" (exaggerated complaints of numbness, tingling, or weakness of the arms from the weight of the pack).

I recall particularly well two soldiers who had acute, disabling reactions to combat. The first I saw within the first few months of my tour. He resembled many of the reactions reported in earlier wars:

CASE 1: Sergeant With Acute Combat Stress Reaction and Partial Paralysis

Identifying information: Sergeant (SGT) Alpha was a single, white E-5 who was evacuated by helicopter to the 95th Evacuation Hospital with other casualties following a nearby firefight.

History of present illness: He complained of numbness and paralysis from the waist down following a near miss by an enemy rocket.

Past history: None obtained.

Examination: Within a relatively brief period of time and in the setting of the hospital's receiving area, I confirmed that he was not otherwise psychiatrically impaired and that there was no physical explanation for his symptoms.

Clinical course: After I listened to his rather bland account of becoming overwhelmed by the combat situation, I told SGT Alpha that he was suffering with an expectable and temporary reaction from the stress of his ordeal and that soon the numbness of his legs would wear off and the strength in his legs would recover. Although he claimed he could not sit, with effort and my assistance he was able to sit on a stool. I gave him a pair of sawhorses to hold on to for balance and reassured him that he could return to his unit when he felt ready to walk. I also instructed him to seek help from his battalion aid station if his symptoms recurred after he left the 95th Evacuation Hospital. I further instructed the nurses on duty to be matter-of-fact about his imminent recovery and resumption of duty function and to express curiosity about how the rest of the members of his platoon had fared—a group to which he clearly felt committed. When I checked back later I learned that he had walked out of the hospital after about an hour.

Discharge diagnosis: Conversion reaction—paraparesis (ie, a form of combat-induced, acute stress disorder).

Disposition: Returned to duty to be followed by his battalion surgeon.

Source: Case drawn from memory of author in 1980.

I learned no more about SGT Alpha except that he was not returned to us for further psychiatric attention. At the time I was satisfied that this rapidly applied management of conversion symptomatology was effective and in keeping with the previously mentioned forward treatment doctrine for fresh combat-generated psychiatric conditions. The other combat-related case I saw in my last month in Vietnam, and it was different in some important respects.

CASE 2: Private With Disabling Anxiety During His First Firefight

Identifying information: Private (PVT) E-2 Bravo was a young, white, first-term enlisted soldier who was new to Vietnam, had never before been in a firefight, and was brought to me by the military police after he had been arrested for desertion under fire.

History of present illness: While he was being processed into the stockade, he complained of acute anxiety and demanded to see a psychiatrist.

Past history: None obtained.

Examination: PVT Bravo was found to have no wounds or other physical problems. He was intelligent and without cognitive impairment. He became agitated as he described how scared and panicked he had become when the fighting erupted, his opposition to the war, and how, naturally, he had boarded the medevac helicopter that had darted in to retrieve the seriously wounded. Even though he was clearly quite afraid—initially of the fighting, and now of confinement and prosecution—he did not demonstrate a psychiatric disorder. It was especially notable that the patient indicated little or no affiliation with members of his unit or commitment to their military mission (compared to SGT Alpha, Case 1).

Clinical course: I felt I had little to provide him other than compassion and reassurance that he did not have a mental disorder. I acknowledged his courage in acting on his convictions but stated that I believed he would probably pay some price for it.

Discharge diagnosis: No disease found.

Disposition: PVT Bravo was psychiatrically cleared and released back to the military police authority.

Source: Case drawn from memory of author in 1980.

PVT Bravo left me with a vivid and uncomfortable memory because he was so direct and naïve in expecting me to save him from the consequences of having made a seemingly rational choice, at least to him, in a seemingly irrational situation. He evidently stirred an ethical conflict within me. However, I felt some consolation in knowing that at least the price he would pay would not include death or becoming wounded, nor the guilt of participating in a war to which he felt morally opposed. Parenthetically, I also wondered how I would have handled his situation.

DRAWDOWN PHASE
DEMORALIZATION AND ALIENATION

Far more demanding of our unit's professional time and energy was the deluge of referrals for whom combat exposure was not a central factor and who expressed symptoms and behaviors associated with disillusionment, despair, dissent, and dysfunction. In that the 98th Psychiatric Detachment was the psychiatric treatment facility of last resort for soldiers from units throughout the northern half of South Vietnam, we were in a unique position to appreciate the bigger picture. What was striking was that most of the soldiers we saw had been previously functional in the United States. This strongly suggested that in becoming symptomatic in Vietnam, especially in such large numbers, significant pathogenic influences were operating at the group or social level. In other words, they had become overwhelmed by a complex interaction of circumstantial stressors and individual characteristics. Whereas our soldier-patients were the more symptomatic individuals, they were the leading edge of a far wider and more ominous demoralization and alienation that was distorting the US Army in Vietnam—a social breakdown of the military organization itself.

Demoralization and Alienation Beyond the Clinic

Demoralization was glaringly evident with practically every encounter with a service member we had, in or out of clinical settings, and mostly irrespective of rank. Depression and depressive equivalents were ubiquitous. Signs and symptoms included sleeping and eating disorders, irritability, inefficiency, social withdrawal, and psychosomatic symptoms, as well as various regressive behaviors that were attempts to ease these painful feelings, for example, covert or passive antiauthority behaviors, self-medication with drugs or alcohol, and sexual hyperactivity.

In 1967, early in my training at Walter Reed, I had periodically heard soldier-patients repeat a boast they had adopted in Vietnam, "Yea though I walk through the valley of the shadow of death, I will fear no evil—For I am the meanest son of a bitch in the valley." (This play on the 23rd Psalm of David derives from the "infamous Special Forces prayer."[17(p251)]) As time passed and Americans became increasingly opposed to the war, this was replaced with "It's not much of a war, but it's the only war we have." By the time I had

arrived in Vietnam in the fall of 1970, cynicism among the replacement troops was even more evident in their "Who wants to be the last man killed in Vietnam?" When I left at the end of my year there, it had become frankly despairing in "If I ever look like I give a fuck, call a medic!"

Especially conspicuous were the provocative behaviors of the younger black enlisted soldiers who would congregate in large clusters and seemed to relish the considerable commotion generated by their prolonged, ritualized handshakes (the "dap"). When passing one another they would exchange the "black power" salute (a raised fist), and many wore black pride jewelry, modified their uniform (eg, having "Bro" embroidered in front of their last name), or wrote slogans on their helmet (ie, "No gook ever called me Nigger"[18(p66)]). Whereas in one sense these were understandable expressions of black pride and solidarity consistent with the rising civil rights movement in the United States, they also easily edged over the line in conveying dissent, and in some cases menace, in the racially charged context of Vietnam. In earlier years the military in Vietnam sought to suppress such group expressions of solidarity among black soldiers through regulations, but these had subsequently been dropped as racial tensions had become increasingly incendiary.[19] Open expressions of racial provocation were not as prominent among the white soldiers, but it was not uncommon to see the Confederate battle flag on display. Although this may have been intended as an expression of regional pride, it was universally interpreted by the black soldiers as racist.

More critically, there existed a spirit of solidarity among lower-ranking soldiers, irrespective of race, centered on strong antimilitary sentiment. Personalized, nonregulation decorations of hair or uniform by enlisted members (EM) openly declared these attitudes. ("Penciled on helmet camouflage bands and chalked elsewhere were such graffiti as peace symbols, slogans such as 'Re-up? I'd rather throw up,' 'Power to the people,' 'Kill a noncom for Christ,' . . . and 'The Army [or Westmorland, or some selected person or outfit] sucks.'"[18(p66)]) Furthermore the challenges to military authority seemed implicitly enforced by the weapons that they carried (or to which they had easy access).

The reciprocal for this spirit of provocation by the enlisted soldier was the apathetic or indifferent reaction of the noncommissioned officer (NCO) or officer. His resigned, inattentive attitude apparently reflected his reaction to intimidation and the uncertain authority that characterized the Army in Vietnam at that time.

Demoralization and Alienation on the 95th Evacuation Hospital Compound

The world of the 95th Evacuation Hospital compound seemed to be a microcosm of the theater. Upon my arrival in Vietnam I was informed by the senior Army psychiatrist in Vietnam, the USARV Psychiatry and Neurology Consultant, Colonel Clotilde Bowen, that I would be assuming command of the 98th Psychiatric Detachment because my psychiatry training had taken place in an Army medical center, and I was presumed to be loyal to military goals and authority. She considered this necessary because the 95th Evacuation Hospital commander, Colonel Jerome Weiner, had threatened to evict the 98th KO Team because some members of its professional staff had been encouraging antimilitary attitudes among the hospital's personnel and patients. (I only came to fully appreciate a decade later why Colonel Weiner was so negative toward the mental health team when I read Shad Meshad's published account of his antiwar, antimilitary advocacy when he was assigned to the 98th Psychiatric Detachment as a social work officer before I arrived.[20])

Upon arriving at the 95th Evacuation Hospital, I learned that it was not uncommon for the Army doctors there to be threatened by patients if the doctors did not agree to evacuate them out of Vietnam. In fact, I was told that shortly before I arrived, our unit's neurologist had been stalked by an armed patient and was required to go into hiding until the soldier was apprehended. (I have not seen further documentation of this particular application to military doctors of the intimidation that enlisted soldiers used against authority figures at that time in Vietnam. However, in an unpublished thesis, David J Kruzich, a social work officer with the 1st Cavalry Division in Vietnam the same year, provided examples of fraggings [or attempts] and included: "A soldier attempted to frag the division psychiatrist who refused to remove him from duty status for psychiatric reasons. The frag bounced off of a screen covering the clinic window and detonated outside."[21(p34)])

On the other side of the issue, however, many of the physicians I came to know at the 95th Evacuation Hospital strongly sympathized with the soldier-patient's wish to have a medical excuse to leave Vietnam. As a matter of practice, these doctors would exaggerate the diagnosis as far as they thought they could to justify

the soldier's medical evacuation and felt satisfied that they were contributing to ending the war. (I have not seen further documentation of this either; however, in *365 Days*, RJ Glasser's fictionalized reflections from his service as an Army doctor at an Army evacuation hospital in Japan in 1969, this perspective was echoed. Chapter 1 centered on moral and ethical conflicts in a drafted doctor who sought to manipulate the Army return-to-duty rules so that his recovering patient did not have to resume his tour of duty in Vietnam.[22])

I also learned upon my arrival that one of the 95th Evacuation Hospital's barracks had been claimed as the exclusive territory of the black enlisted soldiers and was barred to others. Periodically Colonel Weiner and his staff would cautiously stage a "health and welfare" inspection of this barracks in search of unauthorized weapons and soldiers who were absent without leave (AWOL). Furthermore, although we were aware of fragging incidents among the nearby support units, several days after my arrival, matters became more personal when a grenade, which apparently had either failed to explode or was intended to serve as a warning to someone, was discovered laying near the doctors' quarters.

Clinical Expressions of Demoralization and Alienation

The enormous volume of psychiatric referrals we saw who had debilitating demoralization and smoldering animosity toward military authority indicated to us that the US Army in Vietnam was indeed at war with itself. Regardless of presenting symptoms, whether it was bitterness and drug use by the younger soldier or depression and alcohol abuse by the older NCO, the reciprocal hatreds and resentments across the superior–subordinate line were easily surfaced (officers were seen less commonly by us, often because of their worry that it could damage their military career).

Modal Presentation for the Enlisted Soldier Seen at the 98th Psychiatric Detachment

Identifying features:
- Lowest ranks, white, drafted, 18 to 22 years old
- Between 5 and 7 months into his 12-month tour
- Not usually assigned to a combat unit—may have seen some action

Impetus for referral:
- Command-referred: either for psychiatric clearance in conjunction with processing the soldier for administrative separation from the Army for repeated discipline problems, or regarding court-martial proceedings for UCMJ (Uniform Code of Military Justice) violations
- Self-referred: seeking rescue from military authority while insinuating threats of loss of impulse control (with weapon used against NCO, injure himself, or by getting "hooked" on drugs)

Background:
- From small town and intact family (happy + or -)
- High school graduate or almost a high school graduate
- Preservice history of social drug use, pre-Vietnam service record was satisfactory
- Has, or had, a girlfriend at home (waning contact)

Clinical observations:
- Quite self-preoccupied, especially regarding release from Vietnam
- Not too disturbed about having been drafted
- Not too passionate about the morality of the war
- Quite passionate in blaming the "lifers" (immediate superiors) and wanting to be free of military control
- Casual about admitting to drug use in Vietnam; references to "close" drug-taking cohorts
- Often fixated/agitated regarding feeling needed at home (eg, to help a sick family member)
- Quite bored and impatient with passage of time
- Painfully aware of unfairness in "the system" (eg, others with safer or more comfortable situations, others leaving Vietnam early as a "drop" [an early release from Vietnam])

Our soldier-patient invariably blamed all of his distress on his circumstance in Vietnam and especially his closest military leaders. The NCO or officer was disdainfully dismissed as a "lifer" or "juicer" (implying alcohol abuse), and was portrayed as an incompetent and malignant authority who was "hassling" him—typically regarding drug use. The soldier-patient, feeling he had nothing to lose, claimed he would not hesitate to destroy his military leader if the warnings went unheeded. Among our caseload, it was extremely common to hear the disgruntled soldier conclude his tirade about his sergeant or officer with "and if he

doesn't stop, one of these days somebody's going to frag him!" The allusion was that, if provoked far enough, the disgruntled soldiers in the unit would draw straws for the job of executioner (with a pooled bounty as reward). Furthermore, we knew that fragging could be more than a wishful fantasy as victims from the Da Nang area were brought to our hospital for emergency care. This subject of fragging will be explored more fully in Chapter 2 and Chapter 8. Whereas at this point in time, the US public was not aware of soldier assassinations of their leaders, information we collected informally from nurses who worked in the receiving area of the 95th Evacuation Hospital indicated that such events were not uncommon. It became evident to us that both the prevalence of this defiant threat and the alarming frequency of such acts revealed that lower-ranking soldiers shared extreme feelings of impotence, despair, betrayal, and desperation. Furthermore, the requirement that we assess the level of risk among those we saw was particularly difficult because the threat was often phrased ambiguously.

Modal Presentation for the Noncommissioned Officer Seen at the 98th Psychiatric Detachment

Identifying features:
- White, 30 to 42 years old
- Between 3 and 6 months into second tour in Vietnam
- May have seen some action in first tour but not in this one
- Satisfactory to commendable career performance before this tour

Impetus for referral:
- Self-referred: bitter, depressed, reduced appetite and sleep, acknowledged alcohol abuse
- Command-referred: for ineffectiveness, unreliability, effects of alcohol abuse, low morale

Background:
- Career soldier
- From a small town
- Married with children; no Vietnamese girlfriend
- Waning communications from home

Clinical observations:
- Quite self-preoccupied
- Fearful that he was not needed at home
- Lamenting the absence of military structure and discipline in Vietnam compared to his first tour
- Bitter complaints of lack of support from unit's officers
- Very aware of defiance of enlisted soldiers generally and specifically through heroin use
- Scared to assert authority over oppositional, menacing soldiers (either had been threatened with violence or knew a fellow NCO who had been)
- Evidence of alcohol dependence
- Looking for a (situational) way out; hoping for rescue by the mental health team

The NCO could hardly contain his rage at having his authority challenged by the young soldier and feeling betrayed by his lieutenant who was perceived as too lenient with the restive troops, with the explanation offered that he was closer to their age and typically not a careerist.[18] Furthermore, the NCO feared that attempts at responsible leadership risked his being "blown away" (eg, "fragged").

The Heroin Problem

Coinciding with the bottoming morale, the problem of heroin use by lower-ranking enlisted soldiers also erupted during our year and became enormously disruptive for the military in Vietnam. None of us at the 98th Psychiatric Detachment were surprised to find high drug use among the soldier population during our tour because the rising tide of drug use in the American youth culture was well documented, a very influential phenomenon that will be explored in Chapter 1. What we weren't prepared for, however, was the extremely high proportion of soldiers who were preferentially utilizing heroin (or, in a minority of instances, other drugs with serious addictive potential, such as barbiturates and amphetamines). In early 1970, a few months before my arrival, a very efficient Vietnamese heroin distribution system spread throughout South Vietnam, and our soldiers became eager customers. A carton of cigarettes costing a soldier $1.80 could easily be exchanged for a vial of heroin (250 mg, 95% pure[23]) that would have had hundreds of dollars of American street value. As a consequence of it being available in such a pure and inexpensive form, soldiers commonly used heroin recreationally and socially, usually through smoking with tobacco or snorting.

As heroin use spread, the assessment and management of affected soldiers increasingly dominated our

psychiatric team's resources. The information we gained from patients and others suggested that 30% to 40% of the enlisted solders in our catchment area, especially noncombat troops, were using heroin, at least sporadically. These informal estimates coincided with those shared by colleagues at our sister unit in the south, the 935th Medical (Psychiatric) Detachment near Saigon. These estimates were collected informally during a psychiatric drug abuse conference held at Cam Rahn Bay in November 1970, which was arranged by Colonel Bowen, the USARV Psychiatric Consultant. For the better part of a year following the beginning of the heroin market, except for monitoring arrests for drug possession, or drug overdose cases, the US military authority in Vietnam could only approximate the extent of heroin use among soldiers, but by any measure it was a rapidly worsening situation.

Drug Rehabilitation/Amnesty Program

In response to rising numbers of soldiers using addicting drugs in Vietnam and an urgent demand for containment of the problem, on 29 December 1970 USARV headquarters published the "Drug Rehabilitation/Amnesty Program"[24] letter (nicknamed the "amnesty program") as a theater adaptation of Army Regulation 600-32.[25] In addition to outlining the procedures and conditions regarding amnesty, the letter directed commanders to provide the following elements for the purpose of drug rehabilitation (as noted in AR 600-32, "for restorable drug abusers, when appropriate, and consistent with the sensitivity of the mission"[25(¶2-5)]). First, the unit commander was to direct any drug-using soldier to the nearest medical facility for whatever acute care medical personnel would determine was necessary. Upon release, the commander was instructed to assess the soldier's potential for successful return to previous duties and responsibilities and, if suitable, enroll him in the unit's Drug Rehabilitation/Amnesty Program. This included informing his direct supervisor of his "key role in the rehabilitation of the soldier"[24(¶6C (4))] and linking the rehabilitee with a counseling "buddy"—a peer who could "act as a positive influence, and . . . provide counseling and supportive assistance in the soldier's endeavors to remain free of drugs."[24(¶6C(2)a(2))] The program was also to provide the soldier with group therapy "wherein [he] may receive support from ex-drug abusers, associate with others who are attempting to stop using drugs; and receive professional counseling from the unit surgeon, chaplain or qualified visiting professionals."[24(¶6C(3))] Finally, the commander was to destroy all records of the soldier's participation in these programs (ie, amnesty and rehabilitation) when the soldier departed the unit.

Unfortunately, establishing an effective drug treatment and rehabilitation program turned out to be far harder than drafting a policy. During the 9 or so months between when the heroin market began to thrive and the implementation and standardization of the urine drug-screening procedures, there was great confusion as to how to identify drug-using soldiers, how to manage (medical, administrative, or judicial) their drug use or drug-related misbehavior, and how to ultimately decide if they were fit for further duty, in Vietnam or elsewhere. Furthermore, word-of-mouth dissemination of news of an "amnesty program," which initially seemed to exist in name alone, implied judicial carte blanche to soldiers and promises of medical magic to commanders.

The urgency of the problem meant that major Army units were forced to draw upon the resources at hand to improvise facilities and programs intended to offer drug treatment and rehabilitation. These typically had whimsical, unmilitary names (ie, "Sky House," "Highland House," "Operation Guts," "Head Quarters," "Pioneer House," "Crossroads," and so forth), were spawned from the imaginations of those involved, usually individuals with little or no experience treating substance abuse, and often were staffed with counselors who claimed to have kicked the habit themselves.

With rare exception, these programs achieved only marginal success in keeping enrollees from returning to heroin use (unless the soldier was within a few weeks of the end of his tour in Vietnam) and often faded away because of discouragement in the staff or the unit's command, exposure of drug dealing or use by the staff, or the departure of key staff members who were rotated home from Vietnam. Finally, in June 1971, over halfway through my tour, reliable urine drug-screening technology came on line in Vietnam and allowed the US military to identify drug users (but for the first 5 months this was limited to soldiers departing Vietnam) and monitor detoxification in controlled centers; but it had only a modest effect on soldier use (see Chapter 9).

Throughout this stormy period, the 98th Psychiatric Detachment was often at cross purposes with those commanders who chose to interpret the USARV Drug Rehabilitation/Amnesty Program to

mean that the management of these soldiers was to be solely in a hospital-based, medical program. Typically with no notice and little or no documentation, soldiers by the truck full arrived at our hospital, often after a trip of many hours and without having received any prior medical attention, for hospitalization, (presumably) detoxification, and rehabilitation or evacuation out of Vietnam. Furthermore, the soldiers themselves were eager to be hospitalized by us—they hoped indefinitely—to get relief from duty and military authority. In innumerable instances, the soldier had waited until he was in legal jeopardy before demanding that he be admitted to the amnesty program—in clear contradiction to the regulation.

Our assessments often utilized a narcotic antagonist to measure the extent of physical dependency. This approach was recommended in a Technical Guidance Letter (see Appendix 3)—"for battalion surgeons, division surgeons and psychiatrists, and MEDCOM (Medical Command) physicians/psychiatrists in the evaluation, treatment, and processing of patients suspected of narcotic addiction"—distributed by the 67th Medical Group (21 October 1970), the command authority over Army medical units in the northern half of South Vietnam. This medically supervised challenge test consisted of the subcutaneous administration of increasing doses of Nalline [N-allyl-normorphine] to suspected opiate-dependent soldiers to bring out objective signs of withdrawal (which, if induced, would then be treated supportively).[26] This test was only positive for about one out of every 10 soldiers,[27] primarily those who had resorted to intravenous use or snorting. For the remainder, we assumed that their continued use of heroin should, in large part, be considered volitional (ie, misconduct), and we returned them back to their units for further rehabilitative, judicial, or administrative considerations—to be medically monitored by their dispensary physician. In our estimation, this manner of triage was consistent with USARV Regulation 40-34[16] (*Medical Services: Mental Health and Neuropsychiatry*), which stipulated that outpatient management should be emphasized over inpatient, and hospitalization was to be avoided when possible, especially in the case of soldiers who primarily needed custodial care; but it did make us unpopular with the drug-using soldiers and with many commanders.

By way of a case example, the following material (disguised) is from the record of a psychiatric contact at the 95th Evacuation Hospital.

CASE 3: Attempted Murder Suspect Seeking Exoneration Through the Drug Amnesty Program

Identifying information: PVT Charlie was a 25-year-old, single, black E-2 who was assigned as a sentry dog handler and who was in the process of being charged with intent to commit murder.

History of present illness: He was brought to the 98th Psychiatric Detachment by his first sergeant prior to pretrial confinement because he complained that he was addicted to heroin ("snorting two caps per day") and was demanding to be admitted to "the amnesty program." According to accompanying documents, the patient shot another soldier in the stomach after he had confronted the patient with his failure to stand guard duty earlier. The patient's excuse at the time was that he could not perform guard because he had ingested four capsules of Binoctal (a French barbiturate), snorted heroin, and smoked marijuana. As he chased the other soldier and shot him with his pistol, he was heard screaming, "I'm going to kill you, you white bastard!"

Past history: PVT Charlie was raised in Alabama as the youngest of three sons. His parents separated about the time of his birth and he rarely saw his father. His mother died of a heart condition when he was 12. At 15, he was sent to a juvenile confinement facility for burglary. Upon release 2 years later he lived briefly with his father, produced an erratic employment record, and then enlisted in the Army. During a prior tour in Vietnam he received two Article 15s (for AWOL and failure to obey an order). During his current assignment he received three Article 15s (for AWOL), and a bar to reenlistment.

Examination: In the receiving ward of the 95th Evacuation Hospital, the patient presented as a tall, thin, young man who was calm, fully alert, oriented, and in no distress. His manner was provocatively unmilitary, punctuated with gestures and phrases of the black culture. His mood and thought processes were normal. He appeared of average intelligence, and his judgment and insight were fair. He was blasé about the interview and blamed his shooting of the other soldier on his drug habit.

Clinical course: Monitored administration of Nalline failed to demonstrate physical dependence to opiates.

Discharge diagnosis: The examining psychiatrist concluded that the patient did not warrant a psychiatric diagnosis but should be considered to have strong antisocial tendencies. He also expressed the opinion that PVT Charlie should be considered fully accountable for his behavior regarding the shooting incident, but that his apparent heavy drug use, if substantiated, could be considered a mitigating circumstance.

Disposition: The patient was cleared for duty and for administrative or judicial proceedings.

Source: Report of psychiatric evaluation prepared for the Office of the Staff Judge Advocate.

Given the circumstances, it is not surprising that PVT Charlie was not seen subsequently at the 98th Psychiatric Detachment.

CHALLENGES FOR THE 98th PSYCHIATRIC DETACHMENT

As the year progressed our clinical resources and stamina were increasingly taxed by such referrals. The following review of the professional components of the 98th Psychiatric Detachment and the 95th Evacuation Hospital will be illustrative.

The Inpatient Service

Our inpatient facility and staff permitted us to offer a level of care equivalent to a stateside military psychiatric unit, and we were typically very busy delivering milieu-centered care and pharmacotherapy for soldiers who manifested a broad range of psychiatric disorders. Our relatively low rate of admission compared to the extensive prevalence of maladjustment among the troops was in large part a consequence of our intention to distinguish medically treatable illness from command issues of morale and discipline. In compliance with USARV Regulation 40-34, we applied the principles of combat psychiatry, that is, returning the soldier back to duty as soon as medical treatment issues subsided. However, we were frequently challenged by commanders who insisted we admit soldiers who, by our assessment, did not have a psychiatric disorder. These soldiers did possess the capacity to perform their duties (or discontinue drug use, or conform to properly executed military orders, etc) and consequently warranted a custodial setting instead. We often lost these battles and, to our distress, our ward's treatment milieu became predictably disrupted by these soldiers.

In the cases of those we did admit for detoxification, our program results were often uncertain because, despite our best efforts, it was impossible to keep our psychiatric ward drug-free, and, for most of the year, we had no reliable laboratory capacity to monitor withdrawal. Vietnamese boys stood patiently outside the hospital's barbed-wire perimeter day or night ready to supply the demand for drugs, and emptied plastic heroin containers were commonly found among our hospital's waste. Probably the most disconcerting element for us was that the majority of soldiers we saw did not agree they had a problem. They typically rationalized their habit by either denying that the use of heroin was disabling or dangerous, or by blaming the Army for forcing them to serve in such an impossible situation as Vietnam, or both.

The Outpatient Service

In our outpatient clinic, we did see a very small proportion of soldiers who genuinely sought treatment for their inability to adjust, that is, those who did not blame something outside of themselves for their difficulties and wanted assistance in shoring up flagging personal resources. More commonly, we performed an endless series of evaluations of discontented, dysfunctional soldiers for whom command sought either administrative separation from the Army or counseling in conjunction with the USARV Drug Rehabilitation/ Amnesty Program. These soldiers were often sullen, resentful, and obstreperous. The majority of them were determined to manipulate the system so as to obtain relief from their discontent through being eliminated from the Army (and presumably sent home from Vietnam) as quickly as possible, even if it meant they would receive a prejudicial discharge.

In October a change to AR 635-212,[28,29] the Army regulation for underperforming soldiers who were being processed for discharge from the Army, eliminated the requirement that a psychiatrist evaluate every soldier for whom a commander recommended administrative separation from the service (see Appendix 4). However,

the flow of these referrals continued to accelerate because if the commander was in a hurry to get rid of a contentious soldier who was failing to perform, he could bypass a lengthy process requiring documentation of failed rehabilitation efforts if he could get an Army psychiatrist to label the soldier a "character and behavior disorder" (ie, a sustained, especially preservice, pattern of maladjustment). This was very trying work for us because we, too, often felt caught in the middle. We sought to execute our duties responsibly and felt loyal to the Army, even while we were eager for the war to end (and even more eager for our year in Vietnam to end).

More palpable, however, was our commitment to the relief of suffering in our soldier-patients. We felt empathetic with their antiwar feelings, if not their antimilitary ones. We also were respectful of their self-protective instincts. However, in the majority of cases they did not manifest a psychiatric condition, including a character and behavior disorder, and we believed that administrative or judicial Army agencies, and not medical authorities, held primary responsibility for their disposition. In this regard, we attempted to reduce the numbers of inappropriate referrals of soldiers for simple insubordination and indiscipline through the dissemination of a memo to local commanders reiterating the specifics of the Army regulation for administrative separations for unfitness and unsuitability (Appendix 5, 98th Medical Detachment (KO) Memo: "Requirements for Psychiatric Evaluation as Part of Elimination of Enlisted Personnel Under the Provisions of AR 635-212").

(After I left Vietnam I read that just across Da Nang harbor from us, Lieutenant Commander HW Fisher, Navy psychiatrist, was having similar difficulties with the command referrals from the 1st Marine Division.[30] According to Fisher's report, of 1,000 consecutive referrals, he diagnosed 96% having character and behavior disorders. [See Chapters 2 and 9 for a further discussion of his referrals.])

Technically we had the option of offering psychiatric treatment or proposing other rehabilitative steps that the commander might implement. However, in the majority of instances these soldiers reacted to us as if we were agents of a persecuting Army and would not cooperate. Also, by this time, commanders had little spirit for attempting further rehabilitative efforts as well. They were having their own morale crisis.[10,31] This can be illustrated in the memo to all subordinate commands from Brigadier General Hixon, Chief of Staff, XXIV Corps, some time in the spring of 1971 (Appendix 6, "Administrative Elimination Under Provisions of AR 635-212"). XXIV Corps was a major component command of Headquarters, US Army Republic of Vietnam (USARV) and controlled all US ground forces in I Corps Tactical Zone, which comprised the five northernmost provinces of South Vietnam. In the memo General Hixon commended the leadership for reducing the numbers of soldiers with drug abuse patterns who were inappropriately recommended for Honorable or General Discharge and urged commanders to further shorten the time lag in the administrative processing of undesirable or unfit soldiers. Remarkably, however, he also commented that,

> [I]t has been noted with concern that in several cases referred to this headquarters for elimination . . . 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. . . .

As the year progressed there was increasing emphasis through the Army chain of command in Vietnam on communicating leadership principles to commanders and urging them to take a moderate stance toward troop complaints and provocations. Guidance letters came regularly from USARV headquarters instructing commanders and their staffs how to participate in "rap sessions" with unit Human Relations Councils. One example, dated 10 February 1971 (Subject: Human Relations),[32] which offered advice regarding how to lead seminars with soldier groups, encouraged commanders to: relinquish traditional symbols of authority, such as entering the room last or using a speaker stand or stage; "Be prepared to admit that error or injustice has occurred"; "recognize the fact that [it] may be a result of your own ignorance or misinformation"; and share "some intimate, personal experience . . . in order to become a member of the group."[32]

Finally, it is not possible to overemphasize how valuable our enlisted corpsmen (neuropsychiatric specialists, commonly referred to as "psych techs" or simply as "techs") were in the assessment and treatment of this difficult population. They served as the primary

counselors for approximately 80% of referrals. Not only did these corpsmen prove to be extraordinarily capable and committed to the mission and the soldier-patients they saw, but they also had an enormous advantage over the professional staff in working with soldiers because, being comparable in age and rank, they were more likely to be trusted.

Command Consultation

Primary prevention outreach activity in military psychiatry (eg, providing advice to commanders regarding matters that may be negatively affecting soldier morale and psychological fitness) falls under the heading of command consultation and has a rich professional heritage dating back to World War II and the Korean War. Psychiatric support in the military context also insinuates that clinical assistance includes efforts to mediate between the symptomatic soldier and his primary group, that is, the small unit to which he is, or should be, a member (secondary prevention). "Group" refers to his enlisted cohorts as well as to his more immediate military leaders (NCOs, officers) and presumes the primacy of the military mission. However, during our year, the psychiatrists with the 98th Psychiatric Detachment had limited success with these social psychiatry activities for several reasons.

First and most obvious, our time and energies were consumed with performing evaluations and providing care for the huge volume of referrals. Also, the units with whom we might liaise—typically nondivisional, noncombat units—were scattered widely across the northern half of South Vietnam, and we faced formidable transportation and communication obstacles to interact with them. In addition, because I was the only one of the four psychiatrists with the 98th KO Team with any pre-Vietnam military experience, the others were far less confident leaving the clinical setting to deal with line commanders and NCOs. Furthermore, on those occasions when I sought to provide consultation to a unit that was referring unusually high numbers of solders to us, I more often than not came away discouraged. I either encountered despondency among leadership elements similar to what we saw in our soldier-patients, or found my interest and expertise to be unwelcome. I was treated as an outsider by both officers and NCOs, and I had the strong impression that they feared I was there to expose their failures.

One consultation I do recall took place on the USS *Oriskany,* an aircraft carrier. I probably remember it because it was dramatic in nature and because I was invited to intervene and not treated as a threat.

Example of Command Consultation (Secondary Prevention)

In March 1971, I was flown offshore to the USS *Oriskany* at the invitation of the senior medical officer who wanted my help in responding to a suicide pact made by six sailors who worked in the boiler room. These men complained that requiring them to work in the extreme heat there was inhumane, and they had threatened to jump overboard if they weren't relieved of that duty. Once aboard, I conducted clinical interviews with each of them in the boiler room (140°F —disturbingly hot) and then met collectively with them to listen to their grievances. Not surprisingly, many were diffuse complaints about authoritarian military regulations and so forth. I also had an extensive interchange with the medical staff and the sailors' supervisors. I concluded that these were not cases of clinical depression but of dispirited sailors. I supported command in keeping these sailors at their jobs but encouraged command to devise a system of special incentives (eg, shorter shifts, more breaks, additional perks) that could compensate for those elements of the boiler room environment that were beyond the stress level of other jobs aboard the ship. I also suggested that if there was a suicide attempt, that it be regarded as misconduct rather than as a symptom of mental illness, and that these sailors be informed of that before the fact.

Later I informally heard that one of the sailors had jumped off the stern of the carrier, in the daylight, in front of witnesses. The sailor was safely retrieved, held in sickbay for a day for observation, and ultimately placed in the brig to await administrative proceedings. There were no subsequent incidents of this nature afterward, and command was satisfied with this outcome. I had no information as to how the men experienced it.

REDEPLOYMENT

Consequent to nothing more momentous than months, weeks, hours, and minutes ticking by, I packed up my things and left Vietnam on 4 October 1971, exactly 1 year after I arrived. By then, US forces still numbered over 200,000 and soldiers were still dying or becoming wounded in combat, even if at a reduced

rate. The end of the war was promised but not yet in sight. By then, all three of my original psychiatrist colleagues had rotated home after their year was over, and I was involved in orienting replacement staff for the 98th. As an aside, my physical safety was never in serious jeopardy in the course of the year, but that is the sort of thing one dared not acknowledge until your DEROS flight left the tarmac. I don't regret that I went to Vietnam, and I am very proud to have served my country. However, I left Vietnam deeply troubled by what my psychiatric unit faced during our year.

Clearly the long drawdown from the protracted, stalemated, and bitterly controversial war had substantially and negatively affected the US Army in Vietnam. By the time we arrived late in 1970, the requisite military culture of commitment and cohesion had retrogressed into a pathological, antimilitary one with features suggesting a class war between lower ranks and their superiors—an inversion of military morale. From our vantage point, the consequent psychiatric challenges were truly staggering—with respect to our stamina and resources, and regarding our feelings about the work. In other words, we had our own demoralization with which to contend. Instead of providing a therapeutic function for our soldier-patients, or an educational/consultation one for their leaders, we were far more often relegated by circumstances to serving as sorters, medicators, processors, and too often custodians for the psychological casualties of a seriously dysfunctional military organization.

Consequently, perhaps with the exception of our inpatient service, the 98th Psychiatric Detachment served a limited and, more often than not, quite unsatisfying role—unsatisfying to the majority of soldiers who sought relief through us, unsatisfying to the commanders who referred them, and unsatisfying to ourselves. As for our patients, we listened to a flood of anguish and made our best efforts to provide empathy, support, and occasionally antianxiety or antidepressant medication. We ultimately, necessarily, returned the soldier, or the NCO, to the same situation from which he came and were powerless to alter him or it. For a series of reasons our attempts at primary and secondary prevention through command consultation were equally unsatisfying: we could not influence the social pathology affecting our soldier-patients and their leaders as the greater strain was at the "macro" level; our psychiatric detachment was organizationally only adjunctive to the military units we were responsible for serving; and we favored the individual model of psychopathology that had been the basis of our training.

Despite all this, I did derive some consolation from the knowledge that the deterioration of morale, discipline, and mental health in the theater did not exceed the tipping point, that is, widespread institutional failure, riots, mutiny, dereliction of duty, or outright sabotage, and American combat preparedness was not seriously tested by the enemy. Furthermore, when I recalled specific soldiers who were clearly better off because we were there, I felt some satisfaction as well.

POST-VIETNAM SYNTHESIS

In the decade that followed my service in Vietnam, I found myself increasingly frustrated with the Army's failure, including that of Army psychiatry, to study the serious, and in many respects disabling, morale and mental health problems that became so widespread in the theater. Fortunately in 1980 I was assigned to Walter Reed Army Institute of Research (WRAIR) and had an opportunity to explore these matters in more depth. Following an exhaustive review of the psychiatric and social science literature surrounding the war[33] and extensive discussions with colleagues, including FD Jones, who served in Vietnam during the buildup phase, I delineated the following set of socio-environmental features that I believed were so corrosive to the troops serving in the drawdown in Vietnam.

PATHOGENIC PSYCHOSOCIAL STRESSORS AMONG LOWER RANKS DURING THE DRAWDOWN

Summary of the Demoralizing Stressors Borne by the Replacement Soldiers of 1970 and 1971

Encounters with enlisted soldiers at the 98th Psychiatric Detachment and elsewhere taught us a great deal about the stressors that led them to feel so dispirited, angry, and desperate. They can be divided into the following six categories. Because there is considerable overlap, and in that it is difficult to distinguish cause from effect, there is no assumption of order of importance. It is again underscored that it was our sense that these psychosocial stressors affected all service members in Vietnam to varying degrees in 1970 and 1971, not just our patients.

Feeling Purposeless

There was a predictable morale-depleting effect when the US switched from a more active, offensive strategy in Vietnam to a defensive one ("Vietnamization"). This left the soldier feeling little purpose in his risk and sacrifice. Instead, according to the soldiers we saw, they felt they were only marking time while waiting for America to carefully extricate itself from the region. Such deterioration in military espirit and conduct during a withdrawal has been seen in previous American wars.[34] Apparently, as long as the military objective has been perceived as still having meaning, the austere, regimented, and dangerous living and working conditions, including the combat itself, have been mostly tolerable. But following even a clear victory or negotiated truce, much less an ambiguous conclusion like in Vietnam, reactions associated with demobilization arose. It was our impression that in drawdown Vietnam, military personnel, especially those who were not careerists, demonstrated through behaviors and, at times, psychiatric symptoms, their reluctance to take risks and make further personal sacrifices, especially forced remoteness from loved ones and from previous social roles.

Feelings of Shame

The soldier assigned in Vietnam in the drawdown phase also had to contend with the sense of being blamed by Americans at home. As the war progressed it was increasingly common for returning soldiers to be greeted by war protesters with jeers and taunts like "baby killers,"[35,36] and even allegedly spit on.[11,37] By 1970, much of the stateside media as well as sentiments from loved ones[38] seemed of one voice—that participation in the war was dishonorable and that true patriots were individuals who avoided service there or openly opposed the military. Although he wanted to believe that his activities in Vietnam "don't mean nothing!" because "the World" was only what existed outside of Vietnam, it was our impression that the soldier serving late in the war was nonetheless deeply troubled by the condemnation he personally sustained by cooperating, no matter how passively or partially, with the US military effort. Some have argued[39,40] that the personnel who fought in Vietnam were unaffected by the controversy because they were apolitical; however, from our experience, many clearly struggled with contradictory feelings—for example, opposed to the war yet critical of war protesters in the United States.[12]

Feeling Increasingly Vulnerable

As soldiers experienced a diminishment of the shared, combat-centered goals, there was a rising concern for personal safety. In Vietnam in 1970 and 1971, every soldier we spoke to was reassured to learn of the declining troop numbers and casualty rate. However, he perceived that the US resolve for fighting the war was dissipating and that the original rationale was questionable at best. He might have found it tolerable to be there if he could believe his war might end soon—safely for him—through a negotiated truce and a troop withdrawal; but this prospect remained elusive and distant. He felt especially tormented when he heard of other soldiers who suddenly—seemingly randomly—received a "drop" (early return to the United States), or of whole units that left on short notice. This would be especially hard for the soldier who remained behind and was assigned to combat duty because, although everyone seemed to agree that a ceasefire was imminent, he and his buddies were still sent on missions. To him, therefore, these were meaningless missions that could lead to contact with enemy forces. Thus, there was little impetus to be a bold warrior, and his attention necessarily became focused around trying to influence factors that might reduce his exposure and increase his survival odds.

Feeling Excessive Hardship

Soldiers had to make do with less in the culture of "(relative) deprivation."[41,42] The late Vietnam soldier morale also seemed eroded by the prevailing attitude among US forces centered on the attainment of individual status and comfort, which had replaced an earlier one of collective purpose and individual sacrifice.[43] Upon his arrival in Vietnam, the new soldier rapidly became aware that various individuals, usually those with the opportunities of rank or position, seemed to suffer appreciably less with respect to hardships, deprivations, or risk than others in this retrograding circumstance. The traditionally disadvantaged, that is, racial minorities and the underclasses, were the ones most likely to have to get along with less[43]—the men with the most to risk and the least to gain. Perceived disparities especially included who was most likely to become a combat casualty or suffer greater exposure to the inhospitable environment. Particularly vexing was to be deprived of otherwise quite ordinary, but precious, commodities (air-conditioners, flush toilets, etc) and opportunities (to socialize with Western women or

freely transport oneself to post exchanges, recreational areas, or other facilities, etc). Furthermore, we saw that the soldier that was new to Vietnam was quickly warned by his fellow soldiers that those with rank and seniority had status, comfort (relative), and limited risk. Even worse, any tendency for these leaders to promote their careers through combat enthusiasm could result in unnecessary casualties.[31]

The Effects of Prolonged Confinement, Boredom, and Isolation

It is impossible to exaggerate the combined longing for home and loved ones and the search for a justifying meaning for his risk and sacrifice that preoccupies a soldier sent to fight in a foreign setting. The soldiers we treated in Vietnam repeatedly shared these same kinds of yearnings and concerns with us. Thus, adding to his feeling impotent, exploited, and shamed was the soldier's boredom in reaction to inactivity and isolation. In the Saigon area many US personnel found ways to have judicious, off-duty contact with the Vietnamese outside of military boundaries despite the lack of authorization, and in so doing some may have found opportunities to learn about the Vietnamese and their culture and discover meaning in their experience. However, for most soldiers South Vietnam outside military compounds was "off limits,"[44] and contact with the indigenous Vietnamese was through limited interactions with day laborers hired by the military to perform menial jobs on the bases or brief, mutually exploitive transactions with prostitutes when the opportunity arose.[44,45] The week of rest and recuperation ("R & R") leave, which was enjoyed by all personnel at some point in their tour, served as a highly valued form of psychological decompression; but in the long run it represented a minor exception. As a result, thousands of American troops were sequestered in small, isolated, and heavily guarded compounds or firebases. The only way to venture out for any reason, such as a trip to the post exchange or even to an appointment at the hospital, was in one of a very limited number of military vehicles or aircraft. Consequently, opportunities to escape the embrace of the immediate military setting and authority were rare. This predictably fueled "island fever" (ie, heightened interpersonal conflicts and intolerance) among the troops stuck in these small cantonments.

Feeling Debased and Oppressed by Military Authority

Many a soldier recounted to us how his initial willingness to serve out his military obligation in Vietnam, despite hardship and risk, was quickly replaced by a bitter disillusionment as he experienced the actual conditions in the theater. Apparently this conversion arose once he was fully cut off from previous ties and identities. He then became a participant—no matter how indirectly or passively—in the socially condemned war. He was immersed in the inverted and adversarial culture of the Army in Vietnam, surrounded by the antimilitary attitudes of his peers. Although it was not likely that someone with rank would openly debase a soldier in Vietnam, the prevalent status and privilege system in a culture of relative deprivation and risk powerfully implied stigmatization and devaluation. Throughout the war, soldiers who faced little or no combat risk were referred to by the combat-exposed troops by the disdainful term REMF—"*rear echelon mother f--ker*." Furthermore, by this point in the war, this distinction was greatly heightened because the troops challenged most combat objectives. The prospect of cohorts risking being killed or wounded signified the most explicit form of debasement possible in their eyes. Reactions of those feeling victimized readily fueled latent tensions between other subgroups (ie, racial minority vs white, disadvantaged vs social mainstream, and younger vs older), which periodically clashed as a displacement for anti-institutional passions. Especially prevalent were tensions between enlisted soldiers and military leaders regarding drug use and possession.

Soldier Shame, Despair, and "UUUU"

The stressors outlined above were compounded by many others such as:

- the impairment of pre-Vietnam bonding with fellow soldiers, leaders, and the military mission (so-called commitment and cohesion) because of the random, individualized, 1-year tours in Vietnam;
- disruption of ties between soldiers and their small unit officers because of the theater policy of rotating officers from command to staff positions after 6 months (to increase opportunities to command);
- racial and "generation gap" tensions brought to the combat theater from the increasingly fractious stateside culture;
- the extremely inexpensive heroin that was efficiently marketed by the Vietnamese almost no matter where a unit was located;

- popular press publications exposing corruption by high-ranking Vietnamese and opportunistic Americans,[18(p150),43,46] as well as allegations of combat atrocities, a subject that will be explored in Chapter 6; and
- the persistent possibility of attack by an enemy who might become bolder as the US troop strength declined and defenses thinned.

As a consequence, lower-ranking soldiers bonded around antimilitary sentiments as if victims of a tyrannical regime. The resultant collective state of mind was especially reflected in the popular graffiti "UUUU" (which stood for: "We are the unwilling, led by the unqualified, doing the unnecessary, for the ungrateful").[18(pp44,111),46,47(p10)] This slogan expressed the collection of elements that comprised the soldier's acute sense of moral conflict and betrayal. Referring to himself as the "unwilling" alluded to a sense of impotence and of feeling coerced. "Led by the unqualified" referred to feeling misled by his most immediate leaders, as well as insinuates the danger he faced in combat. "Doing the unnecessary" condemned the war's rationale and, by implication, those with ultimate authority (civilian and military). And, "for the ungrateful" revealed his feelings of alienation from fellow Americans and his consequent disdain. This soldier's lament included no specific reference to feeling blamed and stigmatized, but such feelings were in fact the source of the slogan's paradoxical components, that is, it was a collection of psychological efforts that served to proclaim his innocence and find others more deserving of blame and shame.

Soldier Adaptations and Symptoms

The projections and rationalizations noted above apparently provided only limited relief because we saw many types of individual and group efforts, some more adaptive than others, to reduce this painful state. The most common of these are what sociologist Erving Goffman called "removal activities" and "release binge fantasies," that is, activities useful at killing time or awareness of circumstance that have been described in settings of forced confinement such as prisons or mental institutions.[48] The soldier in late Vietnam ritualistically marked his "short-timer's calendar," searched the sky to sight "freedom bird" flights to the United States, and generally had prolonged and rapturous discussions with peers about desires to be fulfilled in abundance once he was released from "Nam" back to "the World." Whether through legitimate activities, such as shopping at the post exchange, watching movies, attending USO (United Service Organizations) shows, or recording cassette tapes to send home, or more questionable ones, such as drug and alcohol use or frequenting prostitutes, the pursuit of such avenues was obviously highly valued. It takes little additional data to understand the degree to which the soldier experienced himself as miserable and isolated from life and the living, and, like the prison inmate, felt that time had to be "done."

Soldiers also chose to relieve pent-up tensions through various "counterauthority" behaviors. These consisted of episodic, peer-group-sanctioned, passive but inherently aggressive behaviors that were designed to preserve a sense of individual autonomy through some form of forbidden activity that would frustrate military authorities yet avoid real risk. Behaviors such as "search and avoid" combat missions[11]; "shamming," that is, the pretense of activity but without productivity; and especially, habitually getting "stoned" (intoxicated, but with illegal drugs) served this end. The great popularity of heroin use by soldiers in Vietnam can be explained on the basis that it allowed the maximal fulfillment not only of the goals of "removal" (from place and circumstance) and "counterauthority" (the sense of thwarting the institution and its authorities), but also of two other simultaneous goals: submersion in an affirming affinity group and relief of individual psychological tension.

Especially alarming was the growing popularity of the idea of peer group-sanctioned, anonymous assassination of leaders, which at times was a real threat. (Open defiance and threats toward officers and NCOs were far less common but still occurred.) These incidents were more often committed by characterologically predisposed soldiers whose inhibitions were lowered by alcohol or drug use. Desertion and AWOL were a proportionally less common solution because of the alien surrounding environment. Finally, a minority of the enlisted patients we saw, but still an extensive number, became clinically depressed with either agitated or retarded (ie, lethargic) features, usually including preoccupation with concerns of breakthrough of violent impulses (suicidal or homicidal). A much smaller number became totally disabled with psychosis.

PATHOGENIC PSYCHOSOCIAL STRESSORS AMONG OFFICERS AND NONCOMMISSIONED OFFICERS DURING THE DRAWDOWN

Officer/Noncommissioned Officer Search for Meaning and Motivation

We also learned about the sources of anguish, adaptations, and symptoms among officers and NCOs, but much more came from exchanges outside of the formal clinical setting. Although not disheveled or undisciplined appearing as were many of the young enlisted soldiers, any clinical or social contact with an officer or NCO in 1970 and 1971 revealed him to be equally stressed and miserable in his role of caretaker authority. To a large degree he bore some of the same hardships and deprivations as did everyone who served in Vietnam (risk of attack by the enemy, remoteness from home and loved ones, inhospitable environment, alien cultural surroundings, etc). Like the enlisted soldier, he, too, lacked conviction in an overriding, valid rationale for US military activities in Vietnam. Aspirations for victory shared by those serving earlier in the war had long since been replaced with a simple desire to survive the assignment as safely and as comfortably as possible, and, for the officer/NCO, with as few as possible casualties among his men. To a considerable degree, his sentiments echoed the younger soldier's "UUUU" lament, but he was resigned to his career commitment to the military—right or wrong—and conducted himself accordingly. However, as leader/authority he suffered a sense of corporate impotence regarding military operations in Vietnam (it was a common assumption in 1970–1971 that the South Vietnamese regime could not hold off the communist forces after the US forces departed) and had some appreciation for the decline in the integrity of the military as an institution. Furthermore, having also recently arrived from the midst of American stateside culture, like the lower-ranking enlisted soldiers, he, too, had witnessed its reversal in attitude toward the war in the United States and directly or indirectly felt society's blame of those who served there; but beyond that he had to withstand the stigmatization of his military career. On the other hand, unlike the enlisted soldier (as well as many of the young lieutenants who were just serving out their obligation), the individual with higher rank could at least have some comfort in believing that his career goals might be advanced by service in Vietnam.

Regarding the demoralization and alienation affecting his unit, the officer/NCO believed he was a victim of circumstance (ie, beginning with the bad luck of getting assigned to Vietnam during the drawdown period); had inherited a bad situation from those more truly responsible (such as military and government policymakers or fellow officers who preceded him in Vietnam); and had little enthusiasm for trying to correct the problems related to his angry and undisciplined troops. Nonetheless he was greatly stressed by the hostility and provocation of these soldiers and also morally torn.

Officer/Noncommissioned Officer Adaptations and Symptoms

As with the young enlisted soldier, the career officer or NCO sought relief from this collection of stressors. However, in his case he had some options only available to those with rank. He also generally wished to avoid confronting his resentful troops. One common and often harmful adaptation was the tendency of many officers to overly defer to their NCOs to enforce that degree of discipline that was unavoidable. This may have been especially true for leaders of platoon-size units where young 2nd lieutenants were more sympathetic with the antiwar, and, to a certain degree, antiauthority values of the soldiers than were their career NCOs. Also, to me and my mental health colleagues it seemed that too often commanders defaulted to medical channels to avoid their own obligation to respond to these pernicious morale and discipline problems. When this happened, our availability for those who more truly needed us was compromised, and more appropriate legal or administrative processes became delayed and confused.

Emotional blunting and escaping time and situation constraints through the use of alcohol was the most commonly used personal relief mechanism for officers and NCOs, similar to the marijuana and heroin use by the enlisted soldiers. However, compared to the enormous attention devoted to drug use among lower-ranking soldiers, alcohol abuse, especially among those with rank, was mostly overlooked in Vietnam until the individual became frankly dysfunctional. From our point of view, alcohol dependency and addiction was as individually disabling as was the use of illegal drugs, but it was much less provocative to the Army, the media, and the public at home.

Of course some officers and NCOs suffered with frank psychopathology, especially variations of depression. This was far more common among the NCOs who had no recourse but to continue to engage with the restive soldiers. Most officers and NCOs seemed to believe that morale was near the flashpoint and elected to bend as far as possible. Some, however, did not and perhaps were targeted for fragging. Likewise the enlisted soldiers noted that they got little or no opposition on most issues, that a minimum was really expected of them, and that open defiance without imperative cause would in all likelihood delay their departure from Vietnam—a most dreaded prospect.[49] Thus, a sort of uneasy stalemate prevailed, but one with many provocative incidents, enormous numbers of psychological casualties, and, perhaps, substantial jeopardy to military preparedness.

THE WALTER REED ARMY INSTITUTE OF RESEARCH VIETNAM PSYCHIATRIST SURVEY

Finally, there are the results from the Walter Reed Army Institute of Research survey of Army psychiatrists who were veterans of the Vietnam War that was mentioned in the Preface and will be more fully described in Chapter 5. This research permitted me to test the generalizability of my experiences, observations, and conclusions, as well as those of other psychiatrists who published their accounts, through the systematic collection of the experiences of all who served. Findings from this survey will be utilized to amplify the subjects covered in Chapters 6 through 11.

In conclusion, despite the late date I believe that through the window of psychiatric experience and sensibilities, important elements explaining the deterioration of morale and mental health in Vietnam can be illuminated with this review. In particular I anticipate that in elaborating and synthesizing this complex history as I have sought to do, the difficulties faced by veterans can be more readily comprehended by those who wish to help and support them. It is also my hope that the results will serve to encourage policymakers and military leaders to appreciate more fully the limitations of human nature under these specific conditions of war and deployment (especially from the standpoint of the social psychology of military groups) and plan accordingly for the future.

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