

Preventive Social Psychiatry and Command Consultation: Who Is the Patient—The Soldier or His Military Unit?

. . . [U]nit commanders rely heavily on the psychiatrist to assist them in removing problem [soldiers]. The removal of the characterological is necessary to the functioning of the unit. From one standpoint the referral to the psychiatrist means a breakdown of group integrity. Sometimes it is not clear whether the patient does not feel a part of the group or whether he is not perceived as such. The passive aggressive, of course, was our stock in trade. With these referrals I had to consider whether the referral was honestly made. I think this is an important point because with time people's secret motives become apparent. . . . [For example, it] was quite commonplace for a unit to refer an alcoholic because he had said or done something while under the influence of alcohol. . . . [T]here were many referrals in which the [first] sergeant was angry, felt that he had to do something, and a compromise was to send them to the psychiatrist [as punishment].¹

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Vietnam (August 1965–June 1966)

Armed two-and-a-half-ton truck with rebel flag. In this 1971 photograph, both the name on the side of the truck (“The Fugitives”) and its Confederate battle flag, which was predictably a racist taunt to black troops, are consistent with the morale and discipline crisis that faced the Army in Vietnam during the last years of the war. Photograph courtesy of Norman M Camp, Colonel, US Army (Retired).



The subject of this chapter—social/community psychiatry, prevention, and command consultation—is a natural extension of the two preceding chapters: Chapter 8, which reviewed the psychiatric problems in Vietnam that were not specifically combat related, especially those associated with the radical decline in soldier morale and discipline, and Chapter 9, which examined the epidemic drug and alcohol problems that evolved. Taken together these two chapters not only described accelerating rates for psychiatric conditions and behavior problems among individual

soldiers, but they also indicated that over time a social/institutional crisis developed within the US Army in Vietnam—a dangerous decline in soldier identification with their unit, its members, and its mission, along with a failure of military leaders to devise countermeasures. They also suggested that under those deteriorating circumstances (1) many of the referred soldiers who did not have evident preservice character defects could have been thought of as (combat theater) deployment stress reactions in addition to whatever conventional psychiatric diagnoses they warranted, in order to take into account the unique and generally overwhelming collection of stressful circumstances in the theater; and (2) many of the units from which they were referred could have been thought of as having inverted morale (ie, morale had dropped so low that military “commitment and cohesion” had fragmented and was replaced with cliques based on opposition to military authority as well as heavy drug use and other forms of misconduct and defiance).

After the war some senior psychiatric leaders concluded that the rock-bottom morale and the sheer volume of psychiatric and drug abuse casualties jeopardized combat readiness in Vietnam as much as the high incidence of combat stress casualties in earlier wars.² Military psychiatry planners certainly did not anticipate this outcome in the years preceding the war. In fact, they were quite confident about the future based on the cross-fertilization that had developed between the traditional principles of military psychiatry, which were reviewed in earlier chapters, and the growing community psychiatry movement (also referred to as social psychiatry) in civilian psychiatry^{3–6}—a movement that was shifting psychiatry away from its traditional emphasis on individual psychopathology to one that identified the patient as someone who was unable to adapt because of a pathological transaction with his “community.” This new model suggested that the most effective military psychiatrist was somewhat less involved in providing traditional direct services to the symptomatic soldier (ie, through diagnosis and treatment) and more involved in providing indirect services (ie, through supervision and consultation) to those individuals, especially military leaders, who could have a wider effect on soldier maladjustment and associated social/community failures. As it turned out, the Vietnam War presented a rich opportunity to test this model.

This chapter explores the available psychiatric literature pertaining to mental health consultation/

liaison with healthcare providers, commanders, and other military leaders in Vietnam. Regarding command consultation specifically, it also draws from the Walter Reed Army Institute of Research (WRAIR) psychiatrist survey data in an attempt to fill in missing information.

BACKGROUND

In the decade between the Korean War and the Vietnam War, Army Regulation (AR) 40-216, *Medical Service: Neuropsychiatry* (dated 18 June 1959)—the Army regulation governing psychiatric care—was issued, which directed psychiatrists and allied mental health professionals to aid command in conserving the mental health of Army personnel.⁷ This regulation further stipulated that the responsibilities of psychiatrists included the provision of prevention, diagnosis, and treatment of emotional and personality disorders, mental illness, and neurological diseases; specialized leadership for allied health professionals and paraprofessionals; and consultation to commanders regarding factors affecting the morale and mental health of their troops. Within the regulation’s directives the primacy of prevention, the idea of the pathologic community and the premium placed on command consultation are distinguishable from direct treatments. These mutually reinforcing elements were drawn from three conceptual streams:

1. preventing the occurrence of conditions is more efficient than treating them after they have formed;
2. utilizing mental health personnel as consultants to military leaders and agencies has more impact in prevention than waiting for cases to arrive at a treatment facility; and
3. within the relatively healthy military population, applying a community psychiatry approach is more effective than one based on individual psychopathology.

Preventive Psychiatry and Military Populations

Even though the concept of prevention in psychiatry sounds intuitive, it can be confusing because the Army has historically considered that all activities of Army psychiatrists fall into one of three levels of prevention: primary, secondary, and tertiary, a concept that was borrowed from civilian psychiatry.⁸

Primary Psychiatric Prevention

Primary psychiatric prevention refers to efforts designed to reduce the generation of psychiatric conditions through advice to military leaders regarding overall morale and stress reduction. This is true prevention and takes the form of program-centered command consultation. According to Brigadier General William C Menninger, senior Army psychiatrist and Psychiatric Consultant to the Surgeon General of the Army during World War II,

The most important functions of military psychiatry are primary preventive: to give counsel and advice regarding the attitude of military men toward their jobs; to minimize environmental stresses which tend to impair the efficiency of the personality; [and] to increase environmental supports to the personality.^{9(p337)}

More about command consultation will follow.

Secondary Psychiatric Prevention

Secondary psychiatric prevention refers to early intervention and treatment designed to minimize symptoms for affected soldiers, with the goal being that of the prevention of greater disability. The model of secondary prevention would include the Army's traditional doctrine for management and treatment of combat stress casualties, which was reviewed in Chapter 7 (ie, proximity, immediacy, expectation, and simplicity, also known as "PIES"). To reiterate, this doctrine emphasizes the principles of prompt treatment of the symptomatic soldier as near his unit and the fighting as possible ("proximity" and "immediacy"), coupled with a treatment approach that encourages him to adapt to his combat environment and circumstance and reinforces his identity as a soldier and his loyalty to his military comrades ("simplicity" and "expectancy"). In instances when treatment personnel have established a liaison with an affected soldier's command cadre, this has been referred to as case-centered command consultation.

Tertiary Psychiatric Prevention

Tertiary psychiatric prevention refers to the treatment of psychiatrically disabled soldiers out of their duty setting, as in hospitals or other medical treatment facilities, with the goal being that of rapid recovery and return to duty function and the prevention of chronic disability.

Joining Community Psychiatry and Military Psychiatry

Since World War I and World War II, Army psychiatry has emphasized the importance of psychiatrists and allied mental health personnel developing an active liaison with unit commanders. Appreciation of the importance of the soldier's (small) group in stress reduction derived especially from experience in World War II. The following are conclusions drawn by Menninger:

The psychiatrist who worked in the field had to know the Army and its mission; he had to be able to identify himself closely with the Army; he had to reorient from his interest in treating one person to the prevention of mental ill health in groups; he had to attempt to apply the best of his psychiatric knowledge to the social situation in which he worked.^{9(p487)}

Also, according to Albert J Glass, senior Army psychiatrist and military psychiatry historian, the most important psychiatric problems in military populations—again, with the model being that of combat breakdown—were "situationally induced emotional disorders" (in contrast to endogenously derived civilian disorders). He wrote:

The most significant contribution of WW II [World War II] psychiatry was recognition of mutually supportive influences by participants in combat or other stress situations. WW II clearly showed that interpersonal relationships and other external circumstances were at least as important as personality configuration or the assets and liabilities of the individual in the effectiveness of coping behavior. For example, the frequency of psychiatric casualties seemed to be more related to the characteristics of the group than the character traits of the individual . . . [ie,] the social determinants of adaptation.^{10(p507)}

Incorporation of the community psychiatry perspective—one that located the symptomatic individual within his social and circumstantial context—was defined more broadly during the Korean War to include the causes of other types of soldier symptoms that might come from dysfunctional groups or units.⁴ The community psychiatry model was found to be especially apropos

both because military populations are composed of relatively psychologically healthy individuals, and because the military is a closed social system, that is, members are not free to quickly move in and out at will as are civilians. Thus behavioral determinants based on personality features, while significant, were believed to rarely be decisive in pathogenesis.¹⁰

Codification of the command consultation model especially took root when psychiatric expertise was extended to military trainers at stateside posts during World War II through a system of mental health consultation services (MHCS) for the purpose of “aiding newly inducted soldiers to adjust to separation from family, lack of privacy, fragmentation, unaccustomed physical activity and other deprivations and changes incident to the transition from civil to military life.”^{10(p505)} The MHCS model seemed validated by the fact that psychiatric disability was considerably reduced among the troops served by the new system.¹⁰

Principles of Command Consultation in the Vietnam Era

Command consultation especially included the process of apprising commanders of factors that reduced soldier morale and motivation—circumstances that often led to psychiatric conditions and discipline problems, in other words, primary prevention.¹¹ It also included (as secondary prevention) outreach activities that fostered early and more effective intervention for dysfunctional soldiers: the case-centered consultation. To mediate between the soldier and his primary group, that is, his enlisted cohorts as well as his more immediate military leaders, the proficient psychiatric consultant needed to understand the soldier’s military environment. Effective consultation also required that the consultant appreciate the fact that the commander was ultimately responsible for the well-being of his troops and retained the prerogative of ignoring the consultant’s advice.¹² According to AR 40-216, *Medical Service: Neuropsychiatry*:

The majority of factors which affect the mental health and morale of troops fall within the responsibility of command, [for example], providing proper leadership, training, assignment, reassignment, incentive, motivation, rest, recreation, and elimination of the unsuitable, inept, and the unfit.^{7(§1,3b(1),p1)}

Particularly useful in program consultation would be an epidemiological or public health perspective involving collecting and monitoring various data pertaining to problematic behaviors that may signal lowered morale. Examples would include rising rates for disciplinary incidents, trainee maladjustment, accidents, diseases, and other indicators of unit and individual dysfunction. Regarding accidents and diseases, certain actions, or inactions, by soldiers that increase their odds of having these can represent conscious or unwitting efforts to exempt themselves from participating in combat, that is, as “voluntary casualties”^{13(p52)} (similar to Jones’ “evacuation syndrome”—soldiers who are motivated to manipulate the system to get relief from foreign deployment and, perhaps, combat risks¹⁴). And the onus is on command to prevent all of these. Thus through the epidemiologic approach, the consultant could provide a commander guidance regarding military policies and planning, screening, indoctrination and training, physical conditioning, morale and leadership, enhancement of social supports, and even decisions surrounding combat tactics.^{15–17} Although it was difficult to prove that earlier prevention efforts produced favorable results, a wide-ranging review of existing programs among all service branches by the Group for the Advancement of Psychiatry in 1960 concluded that soldier ineffectiveness had been reduced, even if there was not evidence to indicate that emotional difficulties had been reduced.¹⁸

VIETNAM

As noted in Chapter 3, specific guidelines regarding the provision of psychiatric services for Army personnel operating in the combat theater of South Vietnam was contained in US Army Republic of Vietnam (USARV) Regulation 40-34, *Medical Services: Mental Health and Neuropsychiatry*¹⁹ (Appendix 2 to this volume). This regulation served to reinforce and extend the principles found in the aforementioned Army regulation, AR 40-216, pertaining to psychiatric care, and both had been influenced by the preventive/community psychiatry movement in civilian and military psychiatry. USARV Regulation 40-34 indicated that the function of the mental hygiene unit was to prevent psychiatric problems from arising, as well as treat them if they did. Consultation with unit commanders was to be emphasized over direct psychiatric care. When direct

treatment was necessary, outpatient management was preferred to inpatient management, if at all possible. These stipulations were consistent with the Army's belief that the soldier's unit had greater ability to help him recover than did a psychiatric treatment facility, and that it was the mental health consultant's role to help the commander "improve his influence on the members of the unit. . . ." ^{19(¶4a,p2)} In this regard commanders were urged to monitor various indicators of failing unit morale (ie, rising rates of "accidents, security breaches, disciplinary actions, racial incidents, drug and alcohol abuse, drunkenness, [and] apathy and other defective attitudes" ^{19(¶3e,p1)}).

USARV Regulation 40-34 reiterated the fact that the commander was primarily responsible for the management of the personnel within his unit to include "effective human relations among individuals and groups." ^{19(¶3a,p1)} To accomplish this he needed to have:

. . . facility in the management of groups; which implies experience with the use and effects of rivalry among groups, the development of informal cliques and group pressures, the social uses and dangers of scape-goating and hero-making, and methods of integrating soldiers into the group as members who render useful duty, whether as close-knit buddies or isolates. ^{19(¶3c,p1)}

Psychiatrist Preparation

During the war newly commissioned psychiatrists attended the medical officer's basic training at the Medical Field Service School (MFSS) and received the handout "Introduction to Military Psychiatry." This document reminded participants of the often-dangerous circumstances faced by soldiers and informed them of the fact that the soldier's commanding officer was primarily responsible for his mental health. It also encouraged them to expand their etiologic considerations for soldiers to include pathogenic social dynamics:

In the highly integrated social system of the Army, the early detection of emotional problems and mental illness has special significance. The close association and inter-dependence that is characteristic of the system make the epidemiology of psychiatric symptoms a more urgent consideration. The capability of soldiers to employ tremendously destructive forces also adds to the requirement for early recognition.

Since mental health is a command responsibility, detection of severe emotional problems is also a necessary part of this obligation . . . and employing such resources for the early detection of mental illness is a function of the psychiatric service.

Psychiatric symptoms and emotional problems are not the exclusive property of the individual but are the result of a transaction or process with the environment [emphasis added]. Consequently, the problem may often be dealt with as a problem of this transaction, or of the environment, rather than as a problem of individual pathology. In the latter instance, the emphases should be on evaluation of what is going on between the soldier and his environment, and [as treatment], environmental manipulation may have its greatest effectiveness—to reestablish a more healthy communication. Many times the group focuses its problems on a scapegoat. Other times poor management makes simple problems complex; malassignment and utilization are not especially rare and unit leaders have been known to be sadistic or inept. The question often arises as to who has the problem? Over and over again, the troubled soldier is a symptom of the pathology of the group, poor leadership, or detrimental policies or procedures. [Consequently] the psychiatrist must be thoroughly familiar with [the soldier's] "community." ^{20(pp2-3)}

Finally, to be an effective consult/liaison psychiatrist in the context of the Army, participants in the medical officer's basic training at MFSS were instructed to be fully aware of "any situation concerning policy, procedure, or practice within an organization or between organizational elements in which human behavior was a principle concern." ^{20(p11)}

Obstacles in Providing Command Consultation

On a practical basis, several potential problems existed for the psychiatrist who would undertake to provide program-centered and case-centered command consultation in Vietnam.

Inaccessibility of Senior Commanders to Psychiatric Opinion

As Army Regulation 40-216 indicated, division psychiatrists were not on the commander's staff but on that of the division surgeon:

[The Army psychiatrist was] *to assist the surgeon in advising the commander* [emphasis added] in matters pertaining to the morale of troops and the impact of current policies upon the psychological effectiveness of troops.^{7(p1)}

This meant that organizationally he was not in a position to directly address command but was required to pass his advice through the division surgeon, who may or may not agree. It is uncertain from the available literature from Vietnam whether deployed division psychiatrists felt stymied by not having direct access to division commanders, but Colonel Clotilde D Bowen's End of Tour Report (Appendix 14 to this volume) from the period 1970 to 1971 did include the recommendation that the (staff) status of the division psychiatrist be elevated to that of the division surgeons. This suggested that there was a tendency for division surgeons to oppose or minimize the influence of their division psychiatrists.

In a similar vein, throughout the war mental health specialists had no direct organizational connection to the commanders of nondivisional combat and noncombat support units. Furthermore, no organizational modifications in this misalignment were made, even though they outnumbered the troops in the divisions by a factor of 2 to 3 and it was becoming increasingly apparent that support troops were sustaining higher psychiatric casualty rates.

Opposition of Commanders to Programmatic Psychiatric Attention

A subtle and usually not acknowledged factor is that many line commanders have a tendency to be wary of psychiatric input because they believe it has the potential to "weaken the fighting man."^{21(p154)} By way of illustration, midway through the war, an article was published in *Military Medicine* and disseminated in Vietnam through the *USARV Medical Bulletin* by General William Westmoreland, the commander of the armed forces in Vietnam (US Military Assistance Command, Vietnam or USMACV) entitled "Mental Health—An Aspect of Command." Amidst General Westmoreland's otherwise encouragement of commanders to utilize behavioral science theory and military mental health support, he included this curious and clearly ambivalent passage:

Your psychiatrist should be encouraged to socialize every opportunity they get with the commander, the lower unit commanders and the other members of the staff. Let them see he is not the "weirdo" the comic books sometimes lead us to believe. Frankly, some commanders and many soldiers are leery of anyone or thing that smacks of "head shrinking." The psychiatrists I have met appear to be ordinary fellows (although I am not a psychiatrist) who do have specialized skills and knowledge and are trying to contribute to the conservation and utilization of manpower.^{12(p213)}

Insufficient Preparation and Training in Command Consultation

A large proportion of the psychiatrists in Vietnam had no working familiarity with the Army before their assignment. As noted in Chapter 5, during the first half of the war, almost a quarter of psychiatrists arrived in Vietnam shortly after completing their civilian residency training. In the second half of the war, the percentage jumped to over half. Furthermore, the program at the MFSS, where they received their initial Army training prior to their first assignment, included neither instruction nor training as to how to obtain entrée to a unit as a consultant. As noted by McCarroll et al, development of command consultation skills requires an apprenticeship under an experienced psychiatrist.²¹ In addition, the WRAIR survey data indicated that roughly half of the participants began their assignment in Vietnam with no overlap with the psychiatrist whom they had replaced. In an effort to remedy the situation, Lieutenant Colonel Robert L Pettera, a division psychiatrist in Vietnam, published an article in the *USARV Medical Journal* in early 1968 providing very basic advice as to how to develop a dialogue with unit leaders to facilitate primary and secondary command consultation²²; however, its distribution in Vietnam at the time is uncertain, and it does not appear to have been circulated among the cohorts of replacement psychiatrists in the years that followed.

Case-Centered Command Consultation in Vietnam

Overview

From their vantage point of reviewing the theater-wide trends in Army psychiatry over the first two-thirds of the war, Colbach and Parrish touted the preventive mental health emphasis in Vietnam. However, according

to their description, the record seemed mixed. (“Some mental health personnel have been quite effective in going into a unit, finding areas of interpersonal friction and correcting them before members of the unit become psychiatric casualties, [but] in the area of racial problems . . . this technique has been underused.”^{23(p340)}) In particular they chided the hospital-based psychiatrists for being more like traditional civilian psychiatrists (“hospital- and office-oriented rather than field-oriented”). According to Colbach and Parrish, “The large numbers of small support units have had much less group identity than the combat divisions, and mental health personnel have responded to this in part by staying in their offices. Although there have been exceptions, preventive psychiatry has been at a minimum at this level.”^{23(p336)}

In fairness to the nondivision psychiatrists, Colbach and Parrish also described how practicing preventive psychiatry in the combat divisions followed easily:

. . . For those [soldiers] returned to duty, follow-up has been easy because of the scattering of mental health personnel throughout the division.

Because of their many contacts throughout the division, mental health personnel at this level are quite adept at preventing problems before they arise. They generally have the power to manipulate the environment in many different ways and probably their main contribution has been in the area of preventive psychiatry.^{23(p335)}

Reports From the Field

The psychiatrists’ reports (again, almost exclusively from the first half of the war) generally indicated that in the divisions, mental health consultation with battalion surgeons and other medical personnel, as well as with unit leaders, was a regular activity that appeared to effectively reduce psychiatric attrition and morbidity. On the other hand, perhaps validating the observation by Colbach and Parrish, there is little information available to indicate that the psychiatrists with the hospitals and psychiatric specialty detachments functioned similarly. Intriguingly, 15 years after Colbach published with Parrish, he wrote another piece in which he agonized over his experiences in Vietnam:

In fact we did not do a whole lot of command consultation [at the 67th Evacuation Hospital and the 935th Psychiatric Detachment]. Being

hospital based, we were somewhat isolated. Also I don’t think we really knew how to do command consultation, and we weren’t exactly deluged with request for this from various commanders.^{24(p259)}

As for the division psychiatrists, Byrde, who served with the 1st Cavalry Division during the first year of the war (1965–1966), described feeling uncomfortable in “selling” mental health services to unit commanders (“as though we were drumming up business”^{1(p47)}), even though he did take pains to become acquainted with them. In fact, he found some commanders were dismissive based on their prediction that there would be negligible psychiatric casualties in the division because it was Airmobile (and that he and his staff were “unnecessary baggage”). However, once cases began to appear, case-centered command consultation began to follow. (“[M]ore complicated cases were best handled when some closure was affected by personal contact with the unit. This might be a telephone call, a visit by me or the social worker to the CO [commanding officer] or the XO [executive officer], or a visit by a tech.”^{1(p50)}) But elsewhere he said:

We lacked any substantial follow-up on the execution of our recommendations. Doubtless the percentage of those acted upon is different from that in garrison, but not necessarily much smaller as one might expect. Unit commanders in the field, if they have time for the paper work, are eager to get rid of unpredictable personnel; whereas non-combat commanders, at times, unreasonably discourage the loss of manpower for any reasons, even for the most pressing.^{25(p5)}

Over the course of the following year, functional relationships between division psychiatrists and commanders in Vietnam became more fluid, at least the case-centered command consultation approach. Perhaps this occurred because by then the divisions had established their operational bases and patterns of functioning in the novel environment and knew what types of casualties to expect and the value of the mental health advice and support. Captain John A Bostrom, who served with the 1st Cavalry Division a year or so after Byrde (1967–1968), touted the unit consultation approach they utilized, but he did not mention primary prevention. He used two hypothetical case examples (one a soldier with psychosomatic back pain and the

EXHIBIT 10-1. Command (Program) Consultation to a Combat Unit by an Enlisted Social Work/Psychology Technician

This is Part 2 of a set of observations by Specialist 6th Class Dennis L Menard, an enlisted social work/psychology technician, from his consultation work with a 1st Infantry Division battalion in November 1967. This was undertaken because of an unusually high mental hygiene referral rate, and it entailed a week-long study of "the morale, interactions of the men, and the difficulties of the unit in the combat situation." (Part 1: Troop Living Conditions in the Field is in Chapter 1, Exhibit 1-2.)

[Besides the high mental health referral rate], the courts martial rate was very high . . . about 15 in the past month. Offenses included AWOL [absent without leave] and desertion, disobeying movement orders, refusal to go on ambush patrol or listening post, and careless handling of weapons resulting in personal injuries.

Consultation with a platoon leader was made about his relationships with the men . . . concerning how a good, confidence-inspiring leader can function on the level of his men [so as to] build trust, respect and friendship. This platoon leader does try to work and play with his men, and he avoids appearing that he is a rigid, aloof, and a demanding type of officer. He offered an explanation for some of the battalion's problems. It has had three commanding officers in the past 8 months. The first was described as very aggressive, aloof, and "hard core"; trying to make garrison troops of his men and following regulations to the letter. The men disliked him and his policies. The second commander was portrayed as just the opposite . . . a passive leader who was not a good decision maker. The men feared his shortcomings, which generated mistrust and low morale. The new commander is a young "Kennedy type." He is a dynamic, knowledgeable, and inspiring leader who makes sound tactical decisions. In addition, he lends an ear to his more experienced and proven officers and allows them to advise and suggest. He insists on discipline and has been "cracking down," giving Articles 15 and Courts Martial like they were "going out of style." But the men are somewhat apprehensive about him; fearing him as the unknown. Will he get them in more trouble . . . more inappropriate fire fights? Can he handle a crisis situation? From the standpoint of the average soldier . . . they consider him still unproven and are waiting and testing.

In general, soldiers bitch a lot when frequent moves require work . . . digging in, filling sandbags, etc. Nerves get tense and emotions reach explosive heights, and the men find it hard to take orders. Men complain in all wars about improper dissemination of information. Just not being informed about movements and operations may generate fear and dissension.

In the past there seemed to be a low morale in this battalion stemming from bad leadership, lack of faith in commanding officers, lack of identification with their unit, which resulted in an "I don't give a damn" attitude. This attitude can, of course, be a foundation for ineffectiveness and a low fighting spirit as exemplified in a high sick call rate prior to an operation and general shamming [pretending activity but without productivity] type complaints just before a patrol. If the morale is low and the men can find an escape, they tend to direct their efforts at avoiding duty. Of prime importance is the fact that any type of manipulating or "a way out" must be avoided and stopped as near the front as possible. Too many people being sent back for administrative or marginal sick call complaints tend to be detrimental to the "hardcore" soldier.

Conclusions: (1) Lack of confidence from past leaders. (2) Apprehension about the new battalion commander. (3) Irregularities in the battalion aid station felt to be the responsibility of the MSC [Medical Service Corps] officer. This promoted shamming and compromised medical care within the battalion. Results: The Division Psychiatrist made a field visit to check out the above formulation. As the Battalion Commander was so new, it was decided to pass over those aspects of the morale situation due to change in command. Regarding the problems at the aid station though, the Division Psychiatrist spent time with the Battalion Surgeon reviewing the administrative aspects of his job and discussing ways in which the MSC Officer had contributed to the aid station's problems [*Camp—ie, resulting in "evacuation syndromes"*]. The Battalion Surgeon "took charge" of the situation, which has since ceased to be a problem.

Source: Menard DL. The social work specialist in a combat division. *US Army Vietnam Med Bull.* 1968;(March/April):56-57.

other a "troublemaker") to demonstrate the effective use of case-centered unit consultation by his enlisted social work/psychology technicians.²⁶ That same year, Captain Gerald Motis with the 4th Infantry Division (ID), described an ambitious and effective program of forward-deployed enlisted social work/psychology

technicians whom he supervised regularly in the field, but apparently their consultation efforts were mostly with the battalion surgeons.²⁷

The aforementioned article by Pettera was especially descriptive regarding the field consultation and treatment program implemented in the 9th ID the same year as

Bostrom and Motis.²² He estimated that through their preventive approach they reduced psychiatric attrition in the division by a factor of three to five, but he provided no specifics on primary prevention interventions; his efforts apparently remained mostly centered on the management of emergent cases. Pettera described various types of defensive resistance exhibited by commanders, and he proposed strategies designed to achieve credibility and reduce obstacles to candid dialogue about cases and associated unit problems.²² However, it must be assumed that Pettera's higher rank (lieutenant colonel) and military background enabled him to much more confidently liaise with the division's command cadres than Byrde, Bostrom, and Motis (all with the rank of captain), who were civilian-trained psychiatrists.

Finally, Douglas R Bey, the division psychiatrist for the 1st ID (April 1969–April 1970) during the transition phase of the war, reported that he and his staff were very active in case-centered consultations with the command cadre who were responsible for the patients they treated (see a summary of Bey's activities in Chapter 3).

Several Army social work/psychology technicians provided reports indicating that they were very active in case-centered command consultation. Case 7-2 in Chapter 7, Staff Sergeant (SSGT) Victor, treated by SP6 Dennis L Menard (who worked with Edward L Gordon, the division psychiatrist with the 1st ID), illustrated the invaluable role played by that division's social work/psychology technicians in bridging between the symptomatic soldier and his unit's command cadre. In the same respect, Chapter 3 includes descriptions of the work of SP5 David B Stern with the 9th Infantry Division, who described the technician-level psychiatric support he provided to two of the division's combat battalions that were part of the Mobile Riverine Force; SP5 Paul A Bender with the 11th Infantry Brigade (Light), who provided a critical link between the primary care medical system and the division psychiatrist and between the medical and psychiatric system and the soldier's unit; and SP5 Smith, who, with Bey, extended both primary and secondary psychiatric prevention activities to various 1st ID units. (Case 6-11, SP4 Papa, in Chapter 6 demonstrated how Smith provided both therapeutic counseling to a traumatized patient and effective consultation to his unit's command cadre and battalion surgeon.^{28(p365)})

Program-Centered Command Consultation in Vietnam

Of course, the individuals who served as Neuro-psychiatry Consultant to the Commanding General, US Army, Republic of Vietnam (CG/USARV) Surgeon practiced pure program-centered, command consultation in the course of carrying out their duties. Otherwise, except for the few examples described below, the available professional literature from Vietnam, both from the psychiatrists assigned to the combat divisions and those serving at the hospitals and with the psychiatric specialty detachments, did not document program-centered, primary prevention activities. During the first year of the war, Byrde, with the 1st Cavalry Division, complained that practical impediments, especially transportation and communication obstacles, doomed his primary prevention efforts. ("The net result was that we responded to crises rather than 'heading them off at the pass.'"^{1(p50)}) However, during the ensuing years in Vietnam, additional factors likely served to limit primary prevention activities such as the increased pressure to provide direct treatment of soldiers or supervise allied mental health and medical personnel (for an example, see Alessi in Appendix 9, "Principles of Military Combat Psychiatry").

Program-Centered Command Consultation by Division Mental Health Personnel

Menard, a social work/psychology technician who served with the 1st ID during the peak phase of combat intensity, provided detailed documentation of his unit consultation that was a model of primary prevention activity by an enlisted specialist.²⁹ According to Menard's report, in November 1967, he spent a week becoming familiar with each company in an infantry battalion in order to search for systemic causes for higher than expected mental health, medical, and disciplinary problems (Exhibit 10-1).

The innovative command-consultation work by Bey and his staff in the 1st ID 2 years later exemplified primary prevention activities by division psychiatry personnel and set a standard in this regard. Their publications are rich in particulars, such as their routine of monitoring selected parameters of the division's battalions (eg, sick call and mental hygiene referrals as well as rates for nonjudicial punishments and courts-martial, Inspector General complaints, accidents, venereal disease, and malaria) in order to select at-risk units for a formal organizational case study and unit

EXHIBIT 10-2. Command (Program) Consultation by Division Psychiatry Personnel

This is a postwar account by Douglas R Bey, who served in Vietnam as Division Psychiatrist for the 1st Infantry Division (April 1969–April 1970).

We kept records of our cases and noted that periodically we would receive several referrals from the same unit at approximately the same time. We also monitored the number of chaplain visits, accident rates, sick call rates, mental health visits, Inspector General complaints, Article 15s, court-martials [sic], and malaria rates (this was a command indicator because it reflected unit discipline—if men didn't take their pills as ordered they got malaria). When the stress indicators for a unit increased, we contacted the battalion commander and battalion surgeon about the unit and [made] arrangements to meet and discuss our observations. If command concurred that there were problems in a specific company we would meet with the company commander and the executive officer. If it appeared that further evaluation was warranted, we would interview members of command and assign a [social work/psychology] technician to the unit to live and work with the enlisted men while gathering information about the unit's stresses. Afterwards we would report back to the unit starting at the top in written and oral form. Sometimes we could give specific recommendations to try to help reduce the unit's stress and in other situations, the process itself seemed to help the unit focus on the emotional aspects of the organization and solve the problem.

By graphing the stress indicators for each unit and by going to units to discuss organizational factors that were producing stress within the units we were able to identify a few organizational stress periods. For example, one unit that stood out was a dump truck company that had a high incidence of drug related problems such as referrals to sick call, referrals to psychiatry, arrests, and Article 15s. We consulted with the key members of the company and [social work/psychology technician] Specialist 5th Class Smith stayed with the unit to gather information. He found that the company commander put his own promotion above the welfare of his men and refused to give the men breaks or even Christmas Day off. There was also a chronic shortage of tires and spare parts which motivated drivers to steal the needed equipment from neighboring units. The unit did not have safety cages to protect men working on high pressure tires, and one driver was killed as a result. Armed guards were not provided to protect the truck convoys and drivers had to keep their M-16s in plastic bags to prevent them from getting jammed by dust. The AK-47s used by the VC [Viet Cong] did not jam with dust and the VC would use the dust as cover when mounting ambushes. The drivers were frightened and jumpy and had killed some Vietnamese children who were digging into an old well near the road. Although the children were looking for food and salvageable items in the [Army] trash, the drivers thought they were withdrawing hidden weapons from a cache. Another problem was that the first sergeant of the unit was a chronic alcoholic who was hard on drug users. When the findings, largely obtained from Specialist Smith's investigation, were conveyed to command some positive changes took place. New spare parts and a steel cage were ordered for the unit. The commanding officer was replaced and the first sergeant was medically evacuated for chemical dependency treatment.

Reproduced with permission from: Bey D. *Wizard Six: A Combat Psychiatrist in Vietnam*. College Station, Tex: Texas A & M University Military History Series, 104; 2006: 166–167.

consultation (Exhibit 10-2). Particularly notable are their efforts at educating unit commanders and others about special combat group stress points (ie, change of command and the introduction of a new unit member) as well as common stressors affecting individual soldiers (ie, “short-timer’s syndrome” and soldiers having less education, being foreign born, or having a language handicap).

With respect to noncombat troops, Bey noticed that the morale of the support unit soldiers appeared to suffer compared to that of the combat troops. When he studied the psychiatric referrals from one support company, he discovered that most had character and behavior problems, and a high percentage were high school

dropouts. This led to a morale-boosting collaborative effort with the Army Education Center that helped 26 soldiers pass their general educational development (GED) test.³⁰

However, Bey also underscored the potential difficulties in providing primary prevention in a combat division:

From a practical point of view most field units want to get the job done and most [commanders] realize that the psychiatrist probably doesn't know his way around the military and will help him carry out his job. However, unless the psychiatrist has the support of key officers who understand the military

EXHIBIT 10-3. Command (Program) Consultation by Specialized Psychiatric Detachment Personnel

This is an account written by John A Bowman, a military-trained psychiatrist who served in Vietnam as the first commander of the 935th Psychiatric Detachment (KO) near Saigon (December 1965–October 1966).

The area that the 935th [Psychiatric Detachment] moved into [on the large US Army post at Long Binh, 30 miles outside of Saigon] was sparsely populated when we got there (January 1966). There was the 93rd Evac Hospital, the 616th Clearing Company, the 624th Quartermaster Company, 3rd Ordnance, and a few scattered engineer companies up and down the highway. By the time I left a year later, there were 131 different units there. And this necessitated our developing a mental hygiene consultation-type approach. I broke the [psychiatric detachment personnel] into two levels in the two sections in the outpatient clinic. Both were headed by social work officers. One social work officer and several enlisted men would make trips to the nearby military units in jeeps. The reason I say “nearby” is that there were many places which were unsafe to go to; but, to those areas that were unrestricted and to which we had free travel, we would make unit contacts in the field. The second social work officer and other social work specialists worked primarily in the clinic and they saw the many ‘walk-ins’ there. The reason we had ‘walk-ins’ was that helicopters were used to transport these patients from outlying units or inaccessible areas and the helicopter would bring 3 or 4 orthopedic or surgical cases to the hospital and also would put a psychiatric case on the helicopter and bring him as well. This worked out quite well for us. In the units that we were able to study in the surrounding area there were a few problems of morale and leadership that were reflected in the rate of psychiatric evaluations. We discovered this by having our men go out to the units. An example was a place at which there was an engineer unit. We were getting a very high rate of referrals from the unit. On a visit our social work officer found that as a matter of routine newly arriving men reporting into that engineer unit would report to the commanding officer. He had footprints drawn on the floor where these men would stand and then he would chew them out. This was on arriving in Vietnam! In working with the commanding officer and trying to help him become less rigid, we were able to lower the referral rate.

In another unit, a signal unit, we’d got quite a few of their senior-ranking NCOs [noncommissioned officers]. I think that when you get senior-ranking NCOs coming in, it’s good evidence that there’s something wrong in the unit. Well, what was going on? This was a newly-arrived unit in Vietnam and the commanding officer had posted on the troop bulletin board that he wanted each man to work so hard that at the end of the day he’d be so exhausted that he would never ask for any post pass to go into the nearby town. Then a couple of his men who were on post pass got into difficulty. They were picked up at an Off-limits area, so he said, “From now on post passes are eliminated because I will not give post passes until the men in the unit learn how to deal with the Vietnamese culture and also the American military rules.” The men in his unit reacted by saying, “How can we learn about military rules or about the Vietnamese culture unless we’re given post passes and are allowed to go out?” Those caught in the middle, the NCOs, were the ones that developed the symptoms. They would come in with depressions, frustrations and anxiety. This was the unit that fell under Second Field Forces (Field Forces II) which had its own medical unit. I was able to work through the Second Field Forces surgeon, working in the field with this signal battalion, until eventually their referral rate fell off.

Source: Bowman JA. In: Johnson AW Jr, Bowman JA, Byrdy HS, Blank AS Jr. Panel Discussion: Army psychiatry in Vietnam. In: Jones FD, ed. *Proceedings: Social and Preventive Psychiatry Course*, 1967. Washington, DC: Government Printing Office; 1968: 63–64. [Available at: Defense Documentation Center, Alexandria, Virginia, Document AD A950058, 1980.]

he is very likely to find himself frustrated and unable to carry out his job. Thanks to the medical officers in our division . . . we did not have these difficulties and in fact can say that no program or effort on our part to provide new programs or additional services to the men in our division were ever thwarted because of red tape or lack of support from the medical battalion.³¹(ChapV,pp6–7)

Although Bey is the only division psychiatrist who described primary prevention as a discrete professional activity,^{28,32} it could be said that, apart from some unique

preparatory experiences he had before his assignment in Vietnam, he might have had more time for these activities because of the somewhat lower combat intensity by that point in the war.

Program-Centered Command Consultation by Psychiatric Personnel Assigned to the Hospitals and Specialty Detachments

Exhibit 10-3 provides an example of program consultation during the first year of the war by John A Bowman, an Army-trained psychiatrist, and the personnel assigned to the 935th Psychiatric Detachment.³³

Bowman's unpublished account of his experience with the 935th team, "Recent Experiences in Combat Psychiatry in Viet Nam," also underscored the clinical importance of a working liaison with the soldier/patient's unit leaders (Appendix 11 to this volume).

Two years after Bowman's year-long rotation was completed, John A Talbott's "community psychiatry" team, which was also based out of the 935th Psychiatric Detachment, offered outreach services and consultation (primary and secondary prevention care) for the USARV Stockade, 10 primary care medical dispensaries, the post chaplains, and commanders, primarily of support units and related agencies, most of which were located on and around the Long Binh post. The team was composed of six mental health professionals (psychiatry, psychology, and social work) and 10 enlisted social work/psychology technicians. They especially targeted units (and their supporting dispensaries) who showed unusually high rates for psychiatric referral, sick call visits, and stockade confinement.

Talbott's team's orientation was community-centered, that is, based on a belief that a soldier's problems often reflected difficulties within the military unit, and they offered recommendations regarding how a unit might better "structure the environmental situation"^{34(p1235)} and reduce the incidence of psychiatric conditions and behavior problems. Although there were no outcome measures, the consensus seemed to be that this demonstration project had been effective in reducing case incidence and disability. Of note, however, Talbott added that the "successful practice of community psychiatry required considerable enthusiasm and interest, and persons not interested will not succeed."^{34(p1235)}

It is interesting that contemporaneously with Talbott, Jack R Anderson, a Lieutenant Colonel with many years of Army experience and the commanding officer of Talbott's unit, argued that the social psychiatry/unit consultation model had proved only marginally successful in Vietnam compared to the patient-oriented, professional consultation model. However, his focus was on the division psychiatrists, and he opined that they would be more effectively utilized if they were reassigned to the hospitals and psychiatric detachments to provide tertiary echelon care.³⁵ H Spencer Bloch, who worked with Anderson, seemed to agree that primary prevention efforts proved to be inefficient at best (see Appendix 19, "Psychiatric Consultation in the War Zone: The Professional Consultation Model").

Finally, following his service in Vietnam and his publication (with Johnson) of the overview of the psychiatric problems in the Vietnam War, Jones concluded that primary preventive activities with the noncombat troops was even more important in Vietnam, especially during the drawdown. This was because the types of disorders that typically occur in that population—disaffection, indiscipline, and dysfunction—are more difficult to treat than combat stress disorders. According to Jones, commanders of support units should emphasize discipline and morale-enhancing activities for their troops as well as provide ample recognition of their critical role. In addition, a relationship should be established between support troops and the combat troops they support; and support troops should be allowed temporary assignments to combat units. More controversial, he also posited that disciplinary infractions could be dealt with through *forward* (in the direction of the fighting), rather than rearward, evacuation in order to minimize secondary gain from misconduct.³⁶ Somewhat in support of Jones, Spector, a military historian, reported that some commanders in Vietnam sought to get support troops more involved in activities related to combat to diffuse these tensions, that is, they were included in reaction squads or perimeter defense, and that this improved morale and lowered the rate of incidents.^{37(p55)} However, overall there is no evidence that any of these ideas were institutionalized in Vietnam, and there is no documentation that the deployed psychiatrists were utilized as consultants regarding these matters.

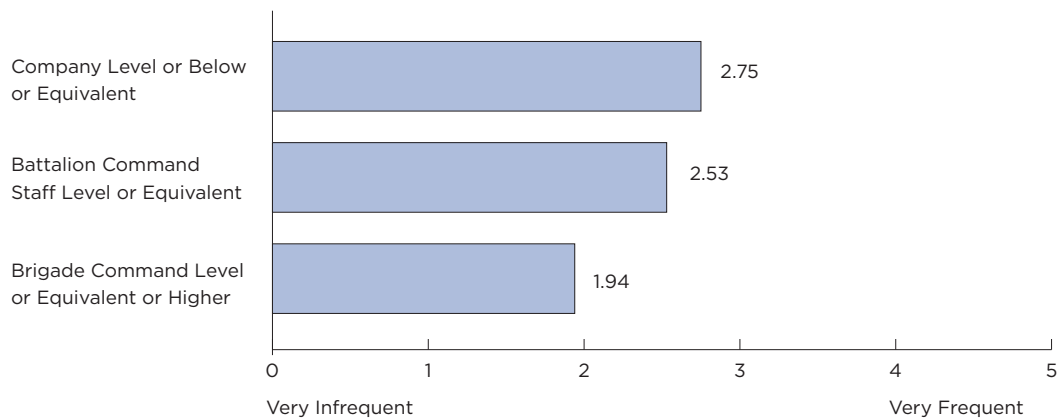
WALTER REED ARMY INSTITUTE OF RESEARCH PSYCHIATRIST SURVEY FINDINGS: COMMAND CONSULTATION/SOCIAL PSYCHIATRY ACTIVITIES IN VIETNAM

The following extends the summary of findings from the 1982 WRAIR postwar survey of Army psychiatrists who served in Vietnam that was begun in Chapter 5. Specifically, it presents findings from responses to survey questions that explored participants' impressions of the extent to which they engaged in command consultation, apparent results, and potential impediments.

Frequency of Command/Program Consultation Efforts and Success

The preceding material highlighted the evident value of command consultation as a means by which

FIGURE 10-1. Estimated frequency of command consultation efforts: mean extent of survey psychiatrists' agreement on 1-to-5 point scale from 1 = very infrequent to 5 = very frequent for three questions [N = 61-83].



the military psychiatrist or other mental health specialist can apply principles of social/community psychiatry to military groups in order to reduce the occurrence and severity of soldier maladjustment or psychiatric conditions. The WRAIR survey psychiatrists were asked to estimate the frequency of their efforts in command consultation, as well as perceived success, with small (company level or below), medium (battalion command staff level), and large units (brigade command staff level or higher).

Figure 10-1 presents response means from questions regarding survey participants' estimations of the frequency they or their staff made efforts to provide command consultation to units according to three levels of unit size (company or lower, battalion or lower, or brigade or higher). The results suggest a trend in which the higher the level of the command, the less frequently psychiatrists provided command consultation. A similar set of questions asked about frequency of success in command consultation ("perceived some reduction in anticipated psychiatric casualties") for each of these command levels and the results were almost identical to the values for the items regarding frequency of command consultation efforts. Taken together these results suggest that command consultation was a relatively low priority (all means were less than 3), and furthermore, that the results from these activities were uncertain. Indications of low priority are consistent with results presented in Chapter 5, Figure 5-2 showing that survey psychiatrists estimated they devoted a limited percentage of their professional time to command consultation (12.1%

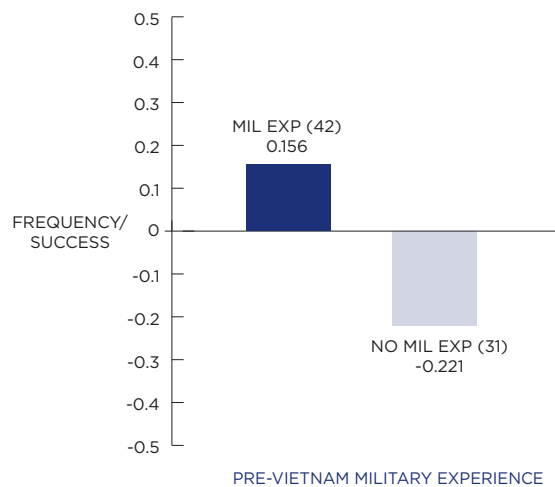
when they served in the combat divisions and 10.7% as hospital psychiatrists).

Survey psychiatrists' answers to four questions (ie, pertaining to their recalled efforts, and to their perceived success, in command consultation with small [company]- and with medium [battalion]-sized units) correlated substantially with each other. These items were subsequently combined into one four-item factor, and a regression analyses was conducted using three principle psychiatrist dichotomous variables: (1) phase of the war served (early vs late); (2) type of assignment in Vietnam (with any combat unit vs only with a hospital); and (3) the presence or absence of pre-Vietnam military experience. (This is a variation on the civilian vs military-trained distinction used in earlier analyses. Participants designated as "military experience" are those who had either Army psychiatric residency training or a military assignment before Vietnam, and those designated as "no military experience" had neither). The regression model included the main effects of these three predictors as well as all first-order interactions between them.

Two statistically significant main effects involving this factor were found and presented in Figures 10-2A and 10-2B (the factor is scaled such that a value of "0" corresponds to average or the "typical" psychiatrist's score). They accounted for 10% of the variation in the "efforts and successes" composite outcome.

Figure 10-2A depicts the relationship between reported frequency and success in command consultation and military experience before assignment in Vietnam. A high score implies greater frequency and greater success

FIGURE 10-2A. Factor analysis results of Survey Psychiatrists' estimates of frequency and success in command consultation, by pre-Vietnam military experience ($p < .06$). Low score indicates low frequency and success.



MIL EXP: presence of predeployment military experience (a psychiatrist with either Army psychiatric residency training or a military assignment before Vietnam) (number of respondents)

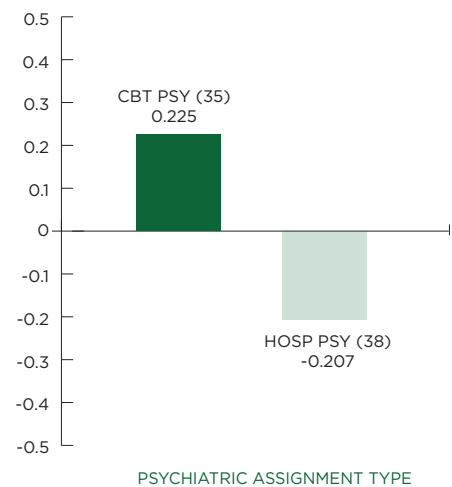
NO MIL EXP: refers to absence of predeployment military experience (a psychiatrist who had neither Army psychiatric residency training nor a military assignment before Vietnam) (number of respondents)

in command consultation. These results suggest that psychiatrists with military experience before assignment in Vietnam report greater frequency and success in command consultation than do psychiatrists without military experience before assignment in Vietnam. (Psychiatrist rank differences were unlikely to explain these findings and those that follow because, apart from a few exceptions, the “military experience” group generally did not outrank their colleagues who had no pre-Vietnam military experience)

Figure 10-2B similarly depicts the relationship between frequency and success in command consultation and assignment type in Vietnam. These results imply that psychiatrists had greater frequency and success in command consultation if they served in a combat unit assignment as opposed to those who had only hospital assignments.

The higher estimates of perceived efforts and success in command consultation for both of these groups (ie, psychiatrists with either Army psychiatric

FIGURE 10-2B. Factor analysis results of Survey Psychiatrists' estimates of frequency and success in command consultation, by assignment type in Vietnam ($p < .07$). Low score indicates low frequency and success.



CBT PSY: at least one combat unit assignment in Vietnam (number of respondents)

HOSP PSY: no combat unit assignment in Vietnam (number of respondents)

residency training or a military assignment before Vietnam and psychiatrists who had at least one combat-unit assignment in Vietnam) appear to coincide with impressions from earlier wars. They suggest that through either of these experiences, the psychiatrists who served in Vietnam were more likely to identify with the military and its goals and more regularly and successfully serve as consultants to commanders (see discussion in Chapter 5).

Factors Perceived as Interfering With Command Consultation Efforts or Success

Survey psychiatrists were also asked to speculate regarding instances when command consultation was not successful. They were asked to indicate the extent of their agreement for a series of forced-choice statements about factors perceived as interfering with command consultation. The results are presented in Table 10-1.

Visual inspection of the findings presented in Table 10-1 indicates that the majority of means for individual items lie just above the midpoint of the response scale

TABLE 10-1. Factors Perceived as Interfering With Command Consultation

Factors Interfering With Command Consultation	Mean
(8) Leaders were not receptive to inquiry and advice from outside of their chain of command	3.35
(2) Leaders feared the consultant would reveal and broadcast their deficiencies	3.27
(7) Leaders were not receptive to consultants who were unfamiliar with, or unidentified with, the military culture	3.18
(1) Leaders were not interested in a behavior science perspective from any source	3.17
(4) Consultants were not trained in community psychiatry or military psychiatry	3.08
(3) Psychiatric opinion had limited usefulness under the circumstances	3.08
(6) Leaders denied most of the problems within their unit	2.85
(5) Leaders were not committed to their troops or their problems	1.97

Mean extent of survey psychiatrists' agreement along a 5-point scale with 1 = very infrequent and 5 = very frequent (N = 61-83). (Numbers) refer to order of the item in the survey questionnaire.

(3) and are tightly clustered around this midpoint. Taken together, these means suggest an absence of strong feelings among the survey participants regarding factors interfering with command consultation. More complex statistical approaches were avoided because of small sample sizes. Nonetheless, from a purely descriptive point of view the trends warrant some comment. The two leading factors interfering with command consultation, items 8 and 2, suggest either command parochialism (ie, commanders would be unreceptive to advice from outside the unit's chain of command) or suspiciousness (ie, commanders would fear the consultant would broadcast their real or imagined deficiencies).

To some degree, the next lower item (7), lack of receptivity to the outsider consultant, may stem from the same source, but it could also suggest a communication problem shared by both consultant and consultee. Still, these three items (8, 2, and 7) appear to define the barrier consultants could have faced if they were not part of the organization ("organic") to which they would offer consultation. In this regard, although not tested, it is natural to assume that the psychiatrists who served in the combat divisions would have encountered these obstacles less often than the hospital and psychiatric specialty detachment psychiatrists, which would be consistent with findings presented in Figure 10-2B.

The second set of three items, 1, 4, and 3, appear to center on ignorance of the value of social psychiatry, which could reside in either the consultant or the consultee. Either would surely be regrettable, but they are

potentially solvable through education and training. In consideration of the consultant psychiatrists, although the extent of their training in community psychiatry and organizational consultation during their pre-Vietnam psychiatric training was not explored in the study, it can be said that mastery of these skills was not generally a standard educational requirement in psychiatric training programs of the times. Also as noted, the Army provided no system-wide program for training them in command consultation either. Fortunately, the remaining two prospective obstacles (6 and 5), which could be seen as command denial and lack of commitment, clearly ominous, are ranked by the survey psychiatrists as the least likely to have been influential.

In conclusion, the low level of command consultation activity represented in Figure 10-1 and the extent of endorsement of various impediments presented in Table 10-1 are only suggestive. However, considering that preventive and social psychiatry had been emphasized by senior Army psychiatrists in the decades leading up to the war, these results imply that more could have been done to promote command consultation in Vietnam, that is, to train mental health personnel in situ, ensure receptivity by commanders, and monitor outcomes.

SUMMARY AND CONCLUSIONS

Army psychiatrists have historically been exhorted to support commanders by sharing their expertise through command consultation regarding risk factors for

individual and group psychopathology. It was believed that a psychiatrist–commander dialogue could promote the conservation of manpower through prevention of soldier ineffectiveness and psychiatric disability. Such an approach was consistent with the commander’s primary responsibility for minimizing the various environmental and situational stress factors that could lower the morale and mental health of his troops. It also rested on theories regarding the powerful stress-buffering potential of the soldier’s community, that is, the small military unit with which he related and from which he drew his self-esteem.

At the time America entered the war in Vietnam, principles of program-centered (primary prevention) and case-centered (secondary prevention) command consultation were well established in the literature of military psychiatry and in the regulations governing Army psychiatrists and the provision of mental health-care. However, endorsing the community psychiatry/command consultation model does not ensure that the deployed psychiatric personnel are skilled or committed to command consultation, nor does it guarantee their entrée to a unit’s command cadre. This chapter reviewed the available literature in order to explore the implementation of command consultation in Vietnam and evidence of its utility. The following summarizes the more salient findings:

- At least through the buildup phase of the war (1965–1968), there is ample evidence from the available literature that the psychiatric personnel in the combat divisions, that is, professionals and paraprofessionals (social work/psychology technicians), actively and productively engaged in case-centered command consultation with unit leaders (officers and NCOs) and medical personnel in the interest of minimizing soldier disability from psychiatric and related problems.
- With regard to nondivisional combat and combat support/service support units, which constituted the majority of Army personnel in Vietnam, there is little evidence from the literature of case-centered command consultation by the psychiatric personnel responsible for the care of these troops. This appears to be corroborated by the WRAIR psychiatrist survey finding in which the psychiatrists who were assigned only to hospitals reported lower frequency of effort and success in command consultation than did the psychiatrists who had combat unit

assignments. Apparently both the solo psychiatrists at the evacuation and field hospitals and the psychiatric personnel at the psychiatric detachments functioned more often in a reactive mode, responding to clinical demand from their hospital base.

The first requirement of these professionals was to provide 3rd echelon, hospital-level treatment. When possible, they also provided 2nd echelon, outpatient evaluation and treatment services. Evidently, most often they communicated with unit leaders and dispensary medical personnel through patient health records and other formal means. Likely explanations for their limited case-centered, command consultation include:

- geographical remoteness was compounded by transportation and communication obstacles;
 - solo psychiatrists at the evacuation and field hospitals did not have specialized staff to pursue active liaison with units;
 - personnel at the psychiatric specialty detachments were often pressed to provide 3rd echelon care for troops who had been evacuated a long distance from their parent unit, and as a result they had little time and capability to provide unit consultation; and
 - organizational divergence led to both formal and functional separateness.
- Apart from some noteworthy exceptions, the available literature suggests that the more specialized program-centered command consultation was not routinely undertaken by psychiatrists and other mental health personnel in Vietnam. Furthermore, the WRAIR survey responses suggest that overall the psychiatrists assigned in Vietnam were uncertain as to whether they had anything to offer the commander of a military unit on a programmatic level and likewise whether the commanders would welcome their advice. The question of whether commanders in Vietnam were trained to utilize the expertise of the available military psychiatrists and welcomed their input is unanswerable; however, explanations bearing on the psychiatrist side of the equation may include the following:
 - most assigned psychiatrists had not received formal training in community psychiatry;

- the majority of psychiatrists had no military background and no training in consulting with a (nonmedical) line unit. The pertinence of this was suggested by the WRAIR survey finding that psychiatrists with no pre-Vietnam military experience reported lower frequency of effort and success in command consultation than did the psychiatrists who had some pre-Vietnam military experience; and
 - roughly half of the psychiatrists had no overlap with their predecessor in Vietnam and had little opportunity for on-the-job training by the leaving psychiatrist.
- **Many of the activities of the nine USARV Psychiatry Consultants would certainly meet the definition of program-centered, primary prevention; however, there is almost no surviving documentation of their efforts or results.** By extension, considering the fact that the war became a drawn-out, unconventional/ guerrilla war—and one to which the American public became increasingly opposed—the available evidence indicates there were no associated field studies or research regarding the impact of these stressors on the replacement troops and their units that would have guided the Psychiatry Consultants in providing consultation at the central, that is, USARV, level. At the very least, an epidemiologically based system for monitoring the various (changing) indices reflecting the widespread and growing demoralization and dysfunction in the theater should have been utilized. Such a dedicated preventive medicine approach could have informed command of stressors progressively undermining the force, which in turn could have led to timely command consultation by the psychiatric contingent to smaller units regarding possible psychosocial remedies. It also could have provided grounds for modification of the system of mental health resources and the selection and preparation of replacement psychiatrists for Vietnam. Compounding these matters, as noted in Chapter 4, during the final 2 years in Vietnam, when morale and drug problems reached extreme levels, the Army assigned psychiatrists as the USARV Psychiatry Consultants who had demonstrably less experience as military psychiatrists than had been the case earlier in the war.
 - **The accumulated evidence strongly suggests that no matter how meritorious the combined principles of community psychiatry and military psychiatry are, their implementation in Vietnam was spotty at best and primarily dependent on individual initiative and advantageous background experience of the assigned psychiatrists as opposed to being institutionalized.**

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