CHAPTER 11

Operational Frustrations and Ethical Strain for Army Psychiatrists: "Crushing Burdens and Painful Memories"

. . . [As Vietnam veterans, it] was easy for us to get ourselves accepted as long as we maintained, for instance, that there was absolutely no excuse for American soldiers to be in any overseas theater, that military doctors were crude and inhuman, that poverty and misery in the U.S. was far more important and more horrible than such problems anywhere else in the world, that the Communists were not serious competitors of ours, and that the less we learned from Asia, Africa, and South America the better. For the home Americans seemed to "know" from the media that the Vietnam war was more immoral than the Civil War, the Spanish American War, or World War II. They explained how we soldiers should feel guilty for fighting such an immoral war.[1(p2)]

Colonel Matthew D Parrish, Medical Corps
3rd Neuropsychiatry Consultant to the Commanding General
US Army, Republic of Vietnam (1972)

Photograph of Army trained psychiatrist Major Richard D Cameron, Medical Corps, division psychiatrist with 1st Cavalry Division (March–October, 1970), providing general medical care for local civilian children during his free time under the MILPHAP (Military Public Health Action Program). These programs were designed to "win the hearts and minds" of the Vietnamese; however, they brought only qualified success. Photograph courtesy of Richard D Cameron, Major General, US Army (Retired).

Psychiatrists are specialized physicians who enter military service already committed to their profession's humanitarian ethical values, which emphasize care of the individual. However, like all soldiers, while serving in the military they also function in the ethical shadow of the institution's enormous and strict hierarchy, the central organizing principle of which is the subordination of individual values to those of the organization[2]—presumably for the benefit of society. It follows that, in time of war, Army psychiatrists incur an obligation to support the US Army Medical Department's mission of contributing to the accomplishment of the combat mission, which means the clinical priority centers on the recovery of the individual soldier's

combat function. In instances when humanitarian values (treatment of the sick and wounded) come into conflict with those of force conservation, elimination of otherwise tolerable symptoms among soldiers who are capable of returning to the battle becomes of secondary importance. As stated by Colbach and Parrish with respect to Vietnam, "[i]t is expected that soldiers in a combat zone will experience varying degrees of discomfort. This is a sacrifice that society expects them to make, and mental health personnel are guardians of this painful reality."[3(p341)]

Nonetheless, during and after the war in Vietnam, the ethical foundation for the Army's combat psychiatry forward treatment doctrine, a regimen in which basic physical and psychologically supportive treatments are utilized to encourage rapid resumption of combat duty function, was vigorously challenged by many in medicine and psychiatry, despite its historical validation as effective and ethical. These new critics opposed a treatment regimen designed to induce symptomatic soldiers to believe that facing further combat risks would be in their best interest or that of the nation. In particular they objected to the elements in the doctrine that would expect (the accusation was, coerce) psychologically traumatized soldiers to return to combat exposure if they were opposed or if they would be vulnerable in subsequent combat.[4] Furthermore, in that a much wider range of psychotropic medications was available to military psychiatrists and other physicians in Vietnam compared to earlier wars, these objections became even more pointed.

This chapter explores the ethical challenges surrounding military service as a psychiatrist during wartime and reviews the available literature to consider their effects (personally as well as professionally) on those who served in Vietnam. It also utilizes selected results from the Walter Reed Army Institute of Research (WRAIR) survey of Vietnam veteran psychiatrists to complete the picture.

BACKGROUND

The Historical Ethical Foundation for Military Psychiatrists

As indicated above, military psychiatrists who serve in a combat theater may have to contend with an exquisite and absolute contradiction of professional values.[4] Whereas their clinical decisions can have far-reaching consequences, they may face organizational expectations that they function in ways that may be perceived, at least by others, if not by themselves, as violating the basic ethical tenets of psychiatry serving the welfare of the individual. This may become even more of a problem for civilian-trained psychiatrists. Brigadier General William C Menninger, the Army Surgeon General's Chief of the Neuropsychiatry Branch during most of World War II, had this to say about what was required of civilian psychiatrists in uniform:

> As civilian doctors they had to understand and correct abnormal reactions to normal situations. As medical officers they had to help normal personalities maintain their integration under horribly abnormal conditions. The Army psychiatrists saw war as a pathological activity which tended to force the development of psychopathology in its participants.[5(p49)]

However, before the Vietnam era, conflict between military and civilian psychiatric value systems was rarely mentioned in the professional literature,[6] even if it was implied.[7–9] The potential conflict pertained especially to the application of the forward treatment doctrine's principle of "expectancy," which referred to the overarching treatment attitude recognized since World War I to be essential in helping combat-stressed soldiers recover and return to duty (discussed in Chapter 7). For example, Peterson and Chambers acknowledged the discomfort their colleagues experienced in satisfying military priorities during the Korean War:

> It is easy to evacuate a soldier from combat and difficult to do the reverse. It is easier to say, "this man should never have been drafted," than to help him adjust to his duties. It is easier to send a frightened young soldier, who reminds one of one's self or one's own son, to the rear than to return him to combat duty. . . . One's own feelings of guilt over returning another to combat duty, make it difficult for the psychiatrist to function effectively and without anxiety.[7(p253)]

The daunting moral weight associated with having to send soldiers back into battle from one's position of relative safety is surely no more burdensome for the military psychiatrist than it is for the military leader, but in being a professional soldier, the military leader may be far more prepared. In this regard, as was pointed out in

Chapter 5, in previous wars the psychiatrists who were new to the military and who had not been sufficiently "indoctrinated" in the modified goals and methods of military psychiatry failed to understand both sides of the soldier's struggle to overcome his fear. As a result, they overly empathized with his heightened self-protective tendencies and overdiagnosed psychiatric disturbance. Furthermore, such outcomes had negative implications for both overall combat readiness and increased morbidity among individual soldiers. Although by this description the ethical strain for military psychiatrists—balancing the needs of the individual and those of the organization—is specific to combat circumstances, in fact, many of the professional responsibilities of military psychiatrists carry this ethical contradiction, even if latent and in derivative form.

As will be described, it was only after the war in Vietnam became so bitterly controversial that a frank and impassioned debate arose within psychiatry concerning the proper role for psychiatrists, especially military psychiatrists, in time of war. To understand how this value clash arose it is necessary to appreciate how the military distinguished between psychiatric reactions to combat and similar civilian casualties during the Vietnam era. As discussed in Chapter 6 and Chapter 7, the combat stress reaction was regarded by military psychiatry as a "normal" and typically reversible reaction to an abnormal circumstance, at least in its acute stages. Although not necessarily the primary etiology, the combat stress reaction could express the soldier's "refusal to fight"[10(p11)] in instances when he had reached the point where his fear, and perhaps his own ethical conflict,[11,12] overshadowed his combat motivation.

In a wartime context it followed that, even if such a soldier was reluctant, he had a duty on recovering to return to function and risk further sacrifices, perhaps to the point of giving his life. The military psychiatrist treating such a patient would be in a similar position. Also a soldier, he would be expected to aid his patient in fulfilling this duty—even if the psychiatrist was reluctant. More specifically, because the military psychiatrist's foremost responsibility in a combat theater is that of stemming the flow of individuals who manifest a temporary psychological incapacity or reluctance to soldier, he may be obligated to deny a psychologically traumatized soldier's anticipation of relief from further exposure to combat (or from a court-martial) to conform to the military's need for him to return to the battle if he could function, even if he has some persisting (if not disabling) psychiatric symptoms or was opposed to returning.[13] The profound nature of this quandary was etched into America consciousness through Heller's 1961 best-selling farce about World War II, *Catch-22*.[14]

Dual Agency as a Problem for the Military Psychiatrist

A full appreciation of the military psychiatrist's potential for ethical strain requires acknowledgment of the dual or double agency nature of his position. This can be summed with the question: for whom does he work—the individual patient or the military organization? This dilemma may affect any physician when patient responsibilities contradict obligations to a third party and can affect treatment decisions (as well as those of allied mental health professionals).[15] As will be demonstrated, with regard to treatment of the combat soldier it can be seen as the choice between serving humanitarian values (treatment of the sick and wounded) versus a collective one centered on force conservation. There are at least two reasons why balancing loyalties can become more difficult for psychiatrists than for other types of military physicians. Not only are military psychiatrists more often required to make clinical decisions in which both advice (ie, patient-centered) and control (ie, organization-centered) functions are intertwined,[16] but there is a greater degree of professional disagreement about mental health norms.[17] Furthermore, the clinical decisions of military psychiatrists may also be affected by their personal ideology,[18,19] training, and experience,[20] as well as changing social contexts.[21]

The Importance of the Nation's Sanction and the Approval of One's Colleagues

The historical accounts of World War I, World War II, and the Korean War indicate that thousands of military psychiatrists—primarily mobilized civilians—performed their professional and military duties with a sustained allegiance to military objectives, and they accepted that their clinical goals and techniques would be altered by expediency associated with fighting those wars.[2,22] Although, as Albert J Glass noted, in contrast to World War I when America seemed eager to fight, in World War II there was greater reluctance within organized psychiatry to contribute to a war effort; nonetheless, once mobilization was a reality, commitment to supporting the military forces and their colleagues in uniform was evident within psychiatry.[9,23]

Psychiatrists perceived that these American wars were necessary and thus, like society, they expected soldiers to "do their part."[24(p242)] Any remaining doubt the psychiatrists in uniform may have had that the forward treatment doctrine was humanitarian was negated by convincing data indicating that in most cases of combat breakdown, the longer the soldier was hospitalized or the farther he was evacuated from his combat unit and comrades, the more intractable his symptoms became.[25(p731)] They apparently suffered little ethical conflict because they believed that they were simultaneously serving the best interests of their soldier-patients, the military, American society, and their profession.

The following is an especially elegant rationale for the forward treatment doctrine written during the Korean War by David McK Rioch, a distinguished neuropsychiatric researcher:

> [R]apid diagnosis, treatment, and return to duty of men with tolerable [stress] symptoms itself represents a significant communication to the group as a whole. In addition to demonstrating the serious consideration the Army has for the soldier's personal welfare, this policy establishes the importance of the individual to the group by the unequivocal implication that his presence and effort are more highly valued than comfort. That this policy represents a positive support and is not merely an inhibitory threat is indicated by the fact that reduction in the rate of evacuation for psychiatric causes has not been accompanied by a compensatory increase in other categories. The policy is "tough" in the sense that it assesses the personal worth and abilities of men at a higher level than many have been confident they could maintain. It is by no means "tough" in the sense of expressing personal disregard and contemptuous punishment for failure.[26]

VIETNAM

As indicated earlier in this volume, it was not new to observe in Vietnam that some soldiers with combat stress-generated psychiatric symptoms struggled with a conflict between self-protective motives and those representing feelings of obligation to their military comrades and mission (see Case 6-2, PFC Golf and Case 6-6, PFC Love in Chapter 6). In fact, this was anticipated in how medical and psychiatric care was structured in Vietnam, including the promulgation of the forward treatment doctrine. However, what was new during Vietnam were accusations that the doctrine, which was intended to limit the former (self-protective motives) and bolster the latter (feelings of obligation to military comrades and objectives), was harmful—challenges that became more pointed as the antiwar and antimilitary sentiment in America grew more strident.[15]

Operational Frustrations for Mental Health Personnel

As indicated in the individual reports by the psychiatrists and other mental health personnel reviewed in Chapter 3 and Chapter 4, the deployed mental health personnel in Vietnam often encountered substantial practical impediments and operational frustrations. Many of these overlap with ethical challenges if not conflicts per se; however, only a few examples will be mentioned in passing. For example, probably the most repetitive complaint was from the division psychiatrists who noted that not being issued a jeep severely hampered their clinical and command consultation capability. A more specific example was Franklin Del Jones' exasperation from when he accompanied the 25th Infantry Division (ID) to Vietnam and found he was not provided the essential equipment to do his job—"a jeep, a typewriter, a general-purpose medium tent and tent frame . . . to house [my] mental health clinic, a desk, and a locking file cabinet."[27(p1008)]

Much later in the war, Joel H Kaplan, with the 98th Psychiatric Detachment, objected to the fact that according to Army policy he was unable to ensure the confidentiality of soldier records for those in treatment for marijuana use—a deviation from civilian standards that he felt negatively affected their treatment.[28] And Nathan Cohen, with the 98th Psychiatric Detachment 2 years after Kaplan, expressed extreme frustration that the Army management and treatment program for heroin users in Vietnam, the amnesty program, was poorly conceived and implemented, and that this negatively impacted the treatment and recovery of many soldiers.

Ethical Strain Among Mental Health Personnel in the First Half of the War

In general, the information provided during or shortly after their tours in Vietnam by psychiatrists and other mental health personnel who served in the first half

of the war suggested that they did not *experience* ethical strain while there.

Psychiatrists Assigned to the Divisions

Because most of the reporting division psychiatrists served in the first half of the war, the period of the greatest combat intensity, ethical dilemmas could have potentially been greater among that group. However, it seems noteworthy how unfazed they appeared to be. For example, John A Bostrom, with the 1st Cavalry Division (1967), advocated a treatment model that supported the combat soldier's return to duty function through minimizing his regressive urges (by downplaying the protective/"maternal" message) and strengthening his duty-centered, progressive ones (ie, by emphasizing the aggressive/"paternal" message). In his report there was no evidence that he was doubtful that this approach was in the soldier's best interest.[29] But lack of evidence for ethical strain does not prove that ethical conflicts aren't influential. As was discussed in Chapter 3, when the reported experience of Army-trained Jones was compared with his counterpart, civilian-trained Byrdy, during the first year of the war, Byrdy greatly exceeded Jones in the percentage of referrals that he hospitalized and the percentage that he evacuated out of the division (see Table 3-5 in Chapter 3). This is consistent with observations from earlier wars that civilian-trained psychiatrists are likely to be more protective of the combat stress casualty. The later experience of civilian-trained Bey (also in Table 3-5), whose rates for hospitalization and evacuation also exceed those of Jones, appear to provide further substantiation. However, his rates are substantially lower than Byrdy's, which could be partially explained by his having had an offsetting year of pre-Vietnam military experience, which "reoriented" him to the clinical priorities of the wartime military.

Psychiatrists Assigned to the Hospitals and Psychiatry Specialty Detachments

In contrast, some of the psychiatrists assigned to the KO detachments in the first half of the war did indicate that they were affected by ethical strain. Because they controlled the two choke points for medical evacuations out of Vietnam, they may have been more burdened than the other psychiatrists in Vietnam who could at least know that the final decision for medically exempting a soldier from further exposure to seemingly unbearable stress was not theirs to make. For example, during the first year of the ground war, John A Bowman, an experienced, Army-trained psychiatrist (October 1965–October 1966), indicated that he and his colleagues at the 935th Psychiatric Detachment returned approximately 90% of all hospitalized soldiers back to duty; however, as illustrated by his moving description in Chapter 7, this could be an exquisitely difficult process. Here are some further recollections of the personal repercussions he and his psychiatrist colleagues sustained in holding that line:

> The staff did not allow evacuations from the combat zone or transfers within the combat zone unless it was medically indicated or militarily feasible. Due to our *rigidity* [emphasis added] on evacuation policy our colleagues in the BOQ [bachelor officer quarters] frequently referred to us as "tough guys" and whimsical but pointed remarks about "Catch 22 were aimed in our direction.[30(p5)]

Elsewhere Bowman commented further:

> Some of my own personal experiences in dealing with the [Psychiatric Detachment] were to convince the team that, even though the patient was technically a psychiatric casualty, he wasn't necessarily to be considered sick. My [colleagues], I think, tended initially to view them in a most classical way, as being sick, but ended up at the year more "hard-nosed" than I was. They used to refer to me as a tough guy, but I'm sure that [they] became tougher than I was, or we found ourselves changing roles somewhere around the middle of the tour.[31(p65)]

Bowman's counterpart with the 98th Psychiatric Detachment, Louis R Conte, a civilian-trained psychiatrist, and his team presented an interesting contrast. They reported that they returned only 40% of hospitalized cases to duty—apparently as a consequence of their efforts to provide "humanness, giving, and feeding."[32(p165)] Yet they indicated they were pressured by military priorities and unsure if they were striking the right balance between protection and expectancy for their soldier-patients:

> How much "feeding" in a combat zone is appropriate was never clearly established in the minds of those concerned. We could never fully decide how comfortable we wanted to make it for

> the patients . . . [for fear they would] cathect the patient role and then have separation problems when they were *asked* [emphasis added] to return to their duty unit.[32(p165)]

Bowman and Conte served early in the buildup years in Vietnam, and the higher attrition rate reported by civilian-trained Conte is consistent with the earlier observation regarding civilian-trained Byrdy, who served as a division psychiatrist. Otherwise there is no evidence that the clinical attitudes of Bowman or Conte were influenced by the beginning antiwar movement in the United States; however, this would soon change among the cohorts of replacement psychiatrists who followed (for example, see Chapter 5, Exhibit 5-2, "The Jones–Dr A Correspondence"). In the winter of 1967, the second USARV Psychiatry Consultant, Arnold W Johnson Jr, acknowledged the emerging criticism of the doctrine as applied in Vietnam and provided a vigorous defense using historical data from earlier wars. He also reiterated the preeminence of the military mission:

> It may be initially pointed out in answering these criticisms that, even if they were true, the action was justified since in combat whether an individual is ill, injured or psychiatrically disabled, the criterion for return to duty is not comfort or complete absence of symptoms but rather ability to perform.[33(p44)]

Defense of the doctrine was extended by Johnson in a follow-up article in 1969 when he suggested that the high morale and low psychiatric rate in Vietnam was partially based on patriotism ("doing one's part for one year as a good citizen in a common cause"[34(p336)]), and he reminded the reader that this was consistent with masculine virtues. ("There is the opportunity [for the soldier in Vietnam] to prove oneself a man and a chance to take part in helping those who need help."[34(p336)]) For those serving in medical roles, he acknowledged the added ethical weight brought about by the antiwar movement and offered a reassuring rationale: "[Medical personnel can] justify their presence in Vietnam on the basis of upholding the medical tradition of helping where needed, even if unsure about the war as a whole."[34(p337)]

Medical Field Service School Preparation

In July 1967, psychiatrists who received their basic Medical Corps orientation and training at the Army's Medical Field Service School (MFSS) were told, "The ultimate aim of any Army is to destroy the ability and will of the enemy to fight, [and] each soldier must have the capability of using the firepower of the modern army to destroy the enemy while preparing himself to defend himself from a similar attack."[35(p9)] They also were taught that military psychiatry's unique objective is to supplement the military mission through maintenance of the soldier's psychological effectiveness—to "conserve the fighting strength." However, the MFSS faculty felt it necessary to add the following:

> Junior psychiatrists . . . [i]n their first flush of humanitarian enthusiasm, crusading against incomprehension and intolerance [by the Army], may regard every patient with a grievance as a victim of an impersonal system. They identify themselves with the individual gallantly resisting dehumanizing and destructive pressures, and forget that they have an obligation equally as important—to serve the best interests of the organization.[36(pp3–4)]

And by way of a solution, they provided the following:

> . . . [Whereas the military psychiatrist] had to know the point of view of the men in the Army . . . he had to identify with the Army to the extent of believing in it, wanting to contribute constructively to it, and feeling a sense of pride in being part of it.[37(p4)]

Evidently, even at that early stage of the war, the Army had become concerned with growing opposition to the war and worried about its impact on military physicians, including psychiatrists. (Also see Chapter 5, Exhibit 5-1, "Potential Identity Problems Facing the Drafted, Civilian-Trained Psychiatrist.")

Widening Criticism of Military Psychiatry

As increasing numbers of Americans denounced the conflict in Southeast Asia, military psychiatry and its doctrine came under direct attack, indicating a shift in professional attitudes from the more sanguine early war period to the late war enmity.[38] Criticism came both from psychiatrists and other physicians who had served in Vietnam as well as from those who had not served there. With regard to those who had served in Vietnam, at least three former Army psychiatrists, including Dr A, provided their names and identified themselves as physicians in the war protest document, *Vietnam*

Veterans Against the War: Vietnam Veterans, Stand Up and Be Counted.[39] Robert J Lifton, a prominent psychiatrist with experience with military populations, veterans, and survivors of extreme military and civilian stress, is an example of a critical psychiatrist who had not served there. In his opinion, the military psychiatrists in Vietnam were "technicist" professionals who had colluded with an "absurd and evil organization."[40(p808)] In a subsequent publication he equated them with the German physicians who worked in Nazi death camps.[41]

> It turned out that many of these [Vietnam veterans I worked with] had experienced a mixture of revulsion and psychological conflict . . . and were taken to either a chaplain or a psychiatrist . . . [who] would attempt to help the [soldier] become strong enough to overcome his difficulties and remain in combat, which in Vietnam meant participating in or witnessing daily atrocities. . . . In that way, the chaplain or psychiatrist, quite inadvertently, undermined what the soldier would later come to view as his last remnant of decency in that situation.[41(p464)]

Lifton theorized that one reason psychiatrists became ethically corrupted was that they assumed that because they were practitioners of a healing profession, whatever they did served to heal. He also believed that "psychiatrists returning from Vietnam to their clinical and teaching situations had experienced psychological struggles no less severe than those of other Vietnam veterans."[41(p464)]

While not as starkly judgmental, Brass reviewed Peter G Bourne's *Men, Stress, and Vietnam* for the *Journal of the American Medial Association*, including Bourne's description of the practices of military psychiatrists in Vietnam, and inquired incredulously,

> If the soldier is seriously enough disturbed to require hospitalization or evacuation, is it good medicine to treat only his symptoms and then reexpose him to the cause of his breakdown? Just how well does a [soldier] on tranquilizers (a) fight, and (b) look after his own skin? One would like to know the comparative casualty figures of soldiers on tranquilizers against those not taking prescribed drugs.[42(p1473)]

Disputes Between Civilian and Military Psychiatrists Regarding the Ethical Treatment of Troops in Vietnam

Levin vs Arthur and Strange

Whereas the private disagreement between Jones and Talbott presented in Chapter 5 was centered on the morality of the war, there were public disputes that focused specifically on professional ethics. The debate between EC Levin, a civilian psychiatrist from Berkeley, California, and Robert E Strange and Ransom J Arthur, both Navy psychiatrists, illustrated the growing split between military psychiatrists and those in civilian positions. In 1967 Strange and Arthur published a report in America's leading psychiatric journal summarizing their experience with Marine and Navy personnel hospitalized aboard the USS *Repose* off the coast of South Vietnam between February and August 1966.[43] Levin reacted with a letter to the editor condemning the Navy's utilization of the forward treatment doctrine:

> Psychiatrists in general pride themselves on their ability to see their patients holistically and humanistically . . . [b]ut nowhere in their article do Cdrs. Strange and Arthur present any evidence for their having done anything more than see their patients as defective cogs in the military machine, to be repaired as quickly as possible so that they could be speedily returned "to combat and possible death or mutilation." I presume that the authors were too busy or too enamored with the task of secondary and tertiary prevention to ponder what primary prevention might have meant to the 13,000 Americans and the uncounted Vietnamese who have already died in the war.
>
> . . . Might not the greatest mark of personal and professional maturity lie in the willingness to work to lead men out of battle rather than into it?[44(pp1137–1138)]

The rebuttal by Arthur and Strange was equally sharp:

> Whether it is easier to evade war's realities in a hospital ship off Viet Nam or in a consultant's office in Berkeley, we leave to the readers of the *Journal* to judge. Based on our clinical experience and data from follow-up studies by the Navy [it

> is evident that] . . . premature discharge from the Armed Forces for psychiatric reasons may in itself exert a life-long deleterious effect on the individual; and that provided the patient is not too ill, every effort should be made to enable him to complete his obligation to his nation and his comrades. In our paper we pointed out the necessity for early therapy oriented toward helping the patient marshal enough ego resources to finish his task. A psychiatrist does not need even a single day's experience in military medicine to understand the importance of this approach, with its attendant preservation of self-esteem.[45(p1138)]

Maier vs Bloch

More specific to the Army is the dispute between psychiatrists H Spencer Bloch and T Maier, which was also in the *American Journal of Psychiatry*. In 1969 Bloch wrote an article describing the psychiatric goals and methods used in Vietnam at the 935th Psychiatric Detachment (1967–1968).[46] A civilian-trained psychiatrist in uniform, Bloch confidently explained how his team adapted the Army's traditional doctrine for the treatment of combat casualties to fit the unique features of the low-intensity, counterinsurgency combat theater there. He also highlighted the value of previously unavailable psychotropic medications, like Thorazine, in their treatment.

Maier, a psychiatrist who treated psychiatric casualties from Vietnam while serving in the Army in Japan (1965 to 1967), reacted in a letter to the editor that was intensely critical of the ethics and practices of military psychiatrists in Vietnam. Maier concluded,

> By acting to 'conserve the fighting strength' in this war of boundless immorality, [the military psychiatrist] partakes of the passive complicity that is the mark of guilt in our time. . . . Whatever else Army psychiatry may be, I see neither moral nor scientific justification for the dignity of its definition as clinical psychiatry.[47(p1039)]

Bloch rebutted that in his experience in Vietnam, soldiers who struggled with concerns regarding the morality of the conflict typically were driven by underlying, pre-Vietnam psychological conflicts. He also defended the goals and methods of military psychiatry in Vietnam:

> If reality is that America's youth are now fighting, then they deserve the best psychiatric care that can be afforded them. Such care neither oversimplifies issues nor encumbers and compromises the evaluation or treatment setting by intrusion of the psychiatrists' moral judgments and emotions.[48(p1040)]

War-Related Ethical Dilemmas Facing Other Psychiatrists

A number of Vietnam-era authors also explored the ethical dilemmas inherent for military psychiatrists that were indirectly linked to the combat theater.[18,19,49–53] For example, Daniels referred to the military psychiatrist as a "captive professional."[50(p255)] Friedman saw him (or her) as "the overseer of a system of social control which is distinctly nonmedical in its character."[51(p122)] Kirshner suggested that when evaluating and treating dissenting soldiers military psychiatrists were antitherapeutic because of obstacles based on the psychiatrists' unresolved identity issues.[54]

Locke, who provided a personal account of his stateside tour with the Army in 1969, contended that psychiatrists who served with the military systematically dehumanized the soldier, prosecuted the war, and betrayed their individualist values. As a consequence, the military psychiatrist was transformed into "a soft policeman, a pacifier, an institutional ombudsman, a mystifier, and the official stereotyper and narcotizer."[55(p20)] Locke's personal solution was his "third alternative," that is, active participation in the antimilitary soldiers' movement.[55]

Barr and Zunin proposed a different remedy. They suggested that military psychiatrists be redesignated "psychiatric military officers" (PMO) to warn drafted psychiatrists and soldiers of the subordination of their medical ethics to those of the institution. The authors argued that lack of confidentiality, emphasis on returning disordered patients to duty and conformity, and the unavoidable real role the psychiatrist has in the military organization of his patient serve to create medical, ethical, and moral dilemmas for the psychiatrist, distortions in the treatment relationship, and tendencies for patients to try to maximize their advantage through exaggeration of symptoms.[56] Similarly they were doubtful of the therapeutic effectiveness of military psychiatrists: "[Because] the PMO owes his primary allegiance to the military service . . . therapy is clearly secondary to returning a man successfully to duty."[57(p19)]

Concern for these potential ethical dilemmas was not confined to the role and activities of the psychiatrists serving in the military services. A number of civilian psychiatrists indicated that they were deeply troubled by conducting evaluations of young draft eligible men with symptoms that apparently arose in response to the threat of being drafted,[54,58–63] and several were overtly suspicious of allegiances of their colleagues in uniform. For example, Ollendorff and Adams defined the military-oriented "establishment" psychiatrist as one who is corrupt and who "declares as fit everybody who is not dead."[58(p89)]

Operational and Ethical Strain Among Mental Health Personnel in the Second Half of the War

Compared with the more confident accounts by psychiatrists who served in the first half of the war, several who went during the second half, such as Camp (as quoted in Ingraham and Manning,[64] also see Prologue), Char,[65] Joseph,[66] Ratner,[67] and Fisher (Navy/Marines),[68] expressed more frustration and cynicism (Figure 11-1). Collectively they gave the impression that conventional military psychiatric structures and doctrine were not adequate to address the avalanche of psychiatric and behavioral problems of the later years of the Vietnam conflict. Nonetheless, specific reference to ethical conflicts did not appear to be central in their reports—but perhaps it was implied. Two nonpsychiatrist individuals, one who served in the transition phase of the war and the other during the drawdown, warrant mention because they openly opposed the war and the Army's psychiatric treatment doctrine while they were in Vietnam.

Protest by Major Gordon S Livingston, Medical Corps

Livingston, a West Point graduate who volunteered to serve in Vietnam, was not a psychiatrist at the time he was assigned there as a medical officer in 1968; however, he did pursue psychiatric training after he left the Army. Livingston's postwar account[69,70] of the moral outrage he developed while serving as a regimental surgeon (a general physician who is also a staff officer) is noteworthy because of his specific reference to the combat psychiatry doctrine:

> I was confronted with several cases of "combat neurosis" who told me that they saw nothing in what they were doing that justified the risks they

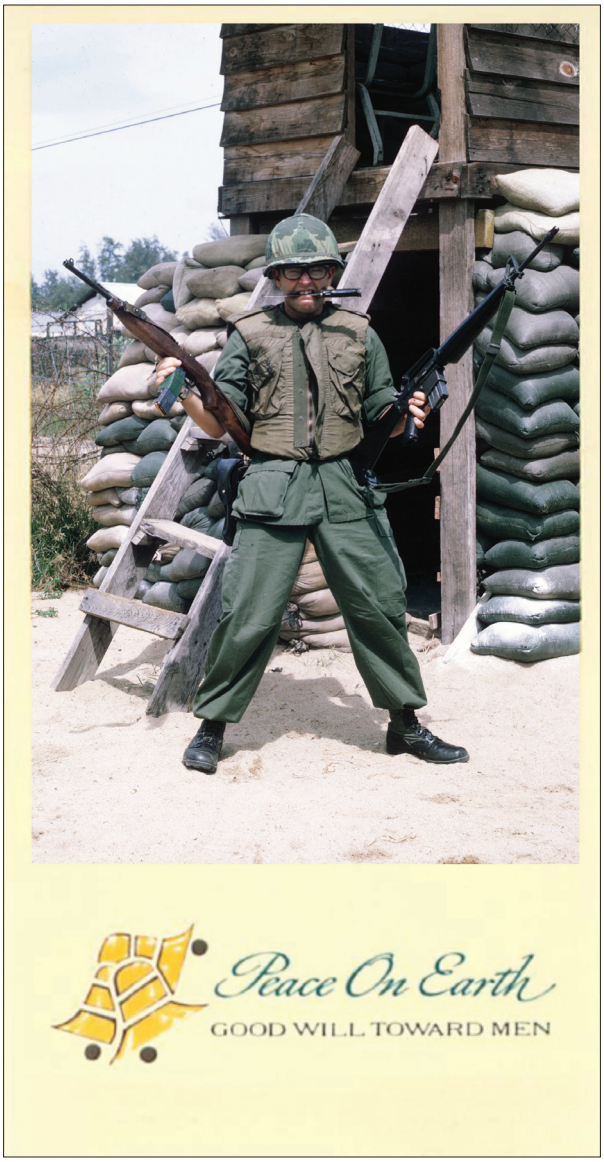


FIGURE 11-1. Captain Frank Finkelstein, Medical Corps, 98th Psychiatric Detachment (September 1969–September 1970). Finkelstein was a civilian-trained psychiatrist, and his holiday card's evident cynicism suggests that he endured role-related operational and ethical strain, especially that stemming from a clash between his physician's commitment to serve humanity and his wartime obligation to serve military expediency. Finkelstein was not unique in this regard, even if he was more demonstrative; this problem arose among many mental health providers assigned in Vietnam, particularly those who served in the latter half of the war and who had no prior military experience. Photograph courtesy of Frank Finkelstein.

> were being asked to take. In effect, they had seen enough of death to know that they preferred life. What was I to do with deviant behavior like that? They were given a brief respite and returned to their units; the fighting strength was conserved. How many were later killed I do not know, nor do I wish to.[69(pp268–269)]

Livingston made numerous allusions to his belief that the psychiatric doctrine as practiced in Vietnam was hypocritical, and he concluded that because "without medical support the prosecution of this war would not have been possible. . . . [Physicians therefore are being used] to sanction and perpetuate one of the most anti-life enterprises of our time."[69(p272)] To solve his ethical conflict Livingston "disqualified" himself from future military service by disseminating the following satirical prowar prayer to the press at the change of command ceremony for Colonel George S Patton III.

> God, our heavenly Father, hear our prayer. We acknowledge our shortcomings and ask thy help in being better soldiers for thee. Grant us, O Lord, those things we need to do thy work more effectively. Give us this day a gun that will fire 10,000 rounds a second, a napalm which will burn for a week. Help us to bring death and destruction wherever we go, for we do it in thy name and therefore it is meet and just. We thank thee for this war fully mindful that while it is not the best of all wars, it is better than no war at all. We remember that Christ said, "I came not to send peace, but a sword," and we pledge ourselves in all our works to be like Him. Forget not the least of thy children as they hide from us in the jungles; bring them under our merciful hand that we may end their suffering. In all things, O God, assist us, for we do our noble work in the knowledge that only with thy help can we avoid the catastrophe of peace which threatens us ever. All of which we ask in the name of thy son, George Patton. Amen.[70(p23)]

As a consequence he was relieved of his duties, evaluated psychiatrically, returned to the United States ("as an embarrassment to the command"[70(p23)]), and administratively discharged from the Army.

Protest by Captain Floyd (Shad) Meshad, Medical Service Corps

Meshad was assigned as an Army social work officer to the 98th Psychiatric Detachment during the drawdown phase. In his account he described the mounting soldier despair and dissent he encountered and its impact on him and his functioning as an Army mental health professional. According to Meshad, he sustained intolerable frustration while attempting to provide psychosocial assistance to soldiers and their leaders in a war he believed was wrong. As the narrative progressed, he increasingly identified with the confused, frightened, and often traumatized soldiers he met, which produced in him severe, role-linked guilt. ("It could have been me. I'd watch them and I'd have to ask myself, 'do I have the balls to do what they're doing?' Meanwhile, I'd be sitting there counseling them about their problems—the main problem being the same thoughts I was grappling with."[71(p98)])

In time he decided that the chief problem was that the soldiers, as well as himself, were victims of military authority. ("We were on a tight wire balanced between the chaos of war and the madness of military regulations . . . I began to think my biggest service to them was to help them manipulate the system."[71(p24)]) He became a maverick mental health officer who believed in passionate advocacy on behalf of soldiers and against military authority and the war. In the end he martyred himself by provoking the Army to court-martial him for the length of his mustache.[71]

The Reactions of Organized Psychiatry

Mental health organizations also reacted strongly to the war's increasing unpopularity. In March 1971, 67% of American Psychiatric Association (APA) members responding to a poll indicated that they wanted the US government to terminate all military activity in Vietnam.[72] This was followed by APA Board of Trustees' passing official resolutions that condemned the war and argued for an American withdrawal[73] and the APA eliminating the military psychiatry section of its annual convention as an expression of protest.[38]

In July 1972, the American Psychological Association joined seven other mental health associations in the following public statement, "We find it morally repugnant for any government to exact such heavy costs in human suffering for the sake of abstract conceptions of national pride or honor."[74(p1)] In raising questions about the morality of the US military intervention

in Vietnam, these organizations increased the ethical tension for psychiatrists, psychologists, and social workers in uniform, yet they neglected to acknowledge that there was a dilemma of these proportions facing their members or to provide guidelines for addressing it. Psychiatry in particular left its military colleagues in uniform to struggle alone amidst the insinuated collective disapproval and open collegial criticism and scorn.

Defending Military Psychiatry

There were a few publications in the latter half of the war and afterward that sought to justify the role, doctrine, and methods used by military psychiatrists in Vietnam. Generally, these were authored by career military psychiatrists such as Arthur[22] and Brown,[38] both Navy psychiatrists; Hays,[75] an Air Force psychiatrist; and Parrish,[1] Johnson,[34] and Gibbs,[76]Army psychiatrists—all of whom were more restrained than their critics.

One notable exception on both counts was the review by Bey and Chapman.[77] Bey, who served in Vietnam with 1st ID (April 1969–April 1970), and Chapman rebutted those who would criticize the methods of military psychiatrists as dehumanizing and unethical by pointing out that, "While war is indeed immoral,"[77(p344)] all citizens become responsible by association for its destructive consequences.[77] They were unapologetic in declaring that in support of wartime mobilization the military psychiatrist's first priority must be the predominance of collective goals and values over those of the individual, and they enumerated 15 critical differences between military and civilian psychiatry. These centered around differences in the populations served (because individuals serving in the military have been selected and screened, they are generally healthier than those typically seen by the civilian psychiatrist); altered clinical goals (in a combat situation the military psychiatrist's task is to help normal individuals adjust to an abnormal situation); and revised allegiances and priorities (as an employee and agent of the organization the priority for the military psychiatrist is to be a management consultant to command and allied medical personnel regarding matters of morale, organizational stress, and psychiatric disorders and behavior problems; his secondary role is providing direct clinical care).

According to Bey and Chapman, in the combat theater the provision of psychotherapy—as well as diagnoses—is contraindicated because it encourages secondary gain and thereby interferes with effective adaptation of the soldier. The authors were not opposed to the absence of privileged communication between the military psychiatrist and his patient. They also were accepting of the fact that whereas the military psychiatrist often makes recommendations to a commander regarding the disposition of a soldier with character and behavior disorder, the commander has the option of disregarding it.

Finally, there also were some authors who felt it was crucial that the individual psychiatrists who served in Vietnam be distinguished from the implementation of the military psychiatry doctrine there and the criticism it provoked because of the war's unpopularity. They argued that a more realistic consideration would acknowledge the impossible clash of military and professional obligations faced by military psychiatrists under those circumstances. For example, Boman said, "The role of the military psychiatrist in a conflict like Vietnam encompasses so many ambiguities and moral dilemmas that one would not be surprised at his lapsing into almost a state of frozen ambivalence."[78(p124)] London, an ethicist, went further by challenging the new "moralistic 'right think'" of those who would fault military psychiatrists for not actively opposing the military in Vietnam: "it is unseemly, if not immoral, to retrospectively condemn the doctors of last decade's war for doing what then looked like their duty."[79(p250)]

POST-VIETNAM

Lingering Postwar Criticism of the Military Psychiatry Doctrine

Following the cessation of hostilities in Southeast Asia, the large numbers of veterans reporting post-Vietnam psychiatric symptoms and adjustment difficulties led some critics to fault the use of the forward treatment doctrine in Vietnam through speculating that it had served to mistreat psychiatric casualties in favor of questionable military and political goals.[40,80–83] These criticisms fell into three overlapping areas: (1) the incomplete treatment of combat troops and their premature return to duty, (2) the undisciplined use of psychotropic medications, and (3) the mislabeling of psychiatrically affected troops as character and behavior disorders.

Accusations of Incomplete Treatment and Premature Return to Duty

Australian military psychiatrists Spragg[84] and Boman[78] were very critical of the US combat psychiatry doctrine based on their experiences with Australian troops in Vietnam. Boman thought that reading US Army psychiatry literature from Vietnam was "hair raising."[78(p111)] Kolb, a posttraumatic stress disorder (PTSD) investigator, was especially disturbed because military psychiatrists had exhibited satisfaction in quickly returning combat stress-affected soldiers back to duty. He argued that such practices were etiologically influential in causing delayed PTSD in Vietnam veterans.[83] Similarly, Abse commented:

> Such [PTSD] patients in my experience have not received early effective treatment with emphasis on cathartic psychotherapy. On the contrary, they received, while in Vietnam, treatment which emphasized massive psychotropic medication, followed by crowding out with sundry recreational activities any focus on their essentially traumatic and pathogenic experiences. Such temporary suppressive treatment invited the reinforcement of dissociation though it may have worked for the while, while the soldier was in active service overseas.[81(p20)]

Accusations of the Undisciplined Use of Psychotropic Medications

A related concern was voiced after the war regarding the ethics associated with prescribing psychotropic medications for combat troops in Vietnam. Grossman,[85] Holloway,[86] and Abse[81] wondered if the suppressive use of pharmacotherapy contributed to delayed PTSD in veterans, and Gabriel[87] worried that the military was skating on ethical thin ice by prescribing such drugs as a prophylactic measure against disabling fear in soldiers.

Accusations of Mislabeling Affected Troops as Behavior Disorders

Like Renner, a Navy psychiatrist who expressed concern for the "hidden casualties" in Vietnam,[88] Australian military psychiatrist Boman similarly argued that Army psychiatrists systematically, if inadvertently, mistreated combat-generated psychiatric casualties in Vietnam by labeling them character disorders—a practice that served to disguise soldiers' true pathology in favor of a more expedient administrative (and prejudicial) disposition.[78] Similarly, Radine, a professor of sociology, was critical of the principles and means utilized by Army psychiatrists in Vietnam based on the published record and opined that the Army induced mental health professionals to minimize treatment of true mental disorders in the service of "deviance control."[89] He noted that, "Even at the [psychiatric detachment] level, diagnosis and treatment seem to have been casual and brief."[89(p165)]

Questionable Evidence for Inadequate Treatment

In Chapter 2 it was noted that in the mid-1980s the government-sponsored National Vietnam Veterans Readjustment Study (NVVRS) found that large numbers of veterans (approximately 30% of male and 27% of female study participants) acknowledged PTSD symptoms at some point since serving in Vietnam, and that for many PTSD had become persistent and incapacitating (15% and 9% of study participants, respectively).[90] However, correlation between combat-associated psychiatric difficulties, psychotropic prescriptions, or character and behavior disorder diagnosis *while in Vietnam*, and postwar PTSD or other psychiatric or adjustment problems among veterans was apparently not systematically explored by these investigators.

On a more informal basis, (as noted in Chapter 2) Arthur S Blank Jr, former Army psychiatrist in Vietnam, and later the National Director for the Department of Veterans Affairs Readjustment Counseling Centers, noted that acute combat stress reactions did not typically meet the criteria for PTSD and did not generally evolve into diagnosable PTSD later.[91] And senior Army psychiatrist and Vietnam veteran Franklin Del Jones indicated that overly sympathetic attitudes toward Vietnam veterans have led some civilian psychiatrists to misunderstand the typically temporary and reversible nature of combat stress reactions and to fail to appreciate the increased risk for psychiatric morbidity (including PTSD) if treatments while in the field do not promote symptom suppression and rapid return to military function and comrades.[92]

On the other hand, Palinkas and Coben interpreted the results of their postwar study of all Marines who received psychiatric hospitalization in Vietnam, which was described in Chapter 7, as suggesting that strict implementation of the military treatment doctrine by Navy psychiatrists, including the use of modern psychotropic medications, may have

resulted in inadequate treatment and impaired combat performance.[93] Obviously much more study of these questions was warranted.

Lingering Postwar Conflict Among Mental Health Professionals Who Served in Vietnam

This chapter opened with Parrish's poignant account of the ordeal that faced Vietnam returnees. His observations and reactions depicted substantial guilt-producing societal pressure on veterans, including medical and mental health professionals. With this in mind, it is not surprising to find that military psychiatrists and allied professionals may have struggled with unmitigated self-recrimination over the years following their service there (or defensive blame of society, the government, or the military). For some, the associated self-doubts would especially surround the ethics of doing one's job.

Major Edward M Colbach, Medical Corps

Colbach was civilian-trained in psychiatry and had no experience as a military physician before being assigned in Vietnam in October 1968, shortly following the enemy's pivotal Tet '68 offensives. During most of his year he was assigned as a solo psychiatrist to the 67th Evacuation Hospital in Qui Nhon (sometimes assisted by Raymond R Crowe, an Air Force psychiatrist). Based on his tour, Colbach published a pair of articles regarding clinical challenges in treating drug abuse (see Chapter 9). Upon his return to the United States in October 1969, he served as Assistant Psychiatry Consultant to the Office of The Surgeon General, US Army, and while there published an article on Army criteria for compassionate reassignment.[94] Also, along with Parrish, the Psychiatry Consultant, he published an overview of US Army mental health activities in Vietnam through mid-1970. Among other factors their review credited the clinical attitude of "expectancy" and the use of psychoactive medications in promoting a commendably high return-to-duty rate. They also included justification for the combat psychiatry doctrine used there:

> Mental health personnel have been criticized for their involvement in Vietnam. It has been implied that to maintain the fighting strength in such a controversial war, by sending reluctant, nervous soldiers back to duty and possible harm, is both inhumane and unethical. As has been stated, the military mental health worker is first and foremost a guardian of reality. And the reality is that we are fighting in Vietnam, and someone has to carry a gun there, even though very few men actually choose to do so. If one soldier is relieved of this duty, another will have to replace him. And the soldier replaced by another will have to live a long time with the realization that he was so "sick," so weak, that someone else had to take over for him when the chips were really down.[3(p341)]

Fifteen years after his service in Vietnam, Colbach wrote a personally and professionally wrenching retrospection on his role and activities there—experiences that evidently haunted him long after his return. Throughout his narrative there were expressions of psychological conflict and regret. For example, he believed that his anger at being sent to Vietnam interfered with his empathy for his soldier-patients: "in many ways I was a failure in actually reaching out to those fellows and touching them and alleviating their suffering."[21(p265)] Similar to Bloch, Colbach was resigned to being the "guardian of reality"; however, this position seemed to give him little relief from his role-linked guilt. "I tried to help my patients learn that lesson [that all of life is a struggle], not to quit but to go on. Probably a few of them did learn that, *if they survived* [emphasis added]."[21(p265)] Ultimately, he found an ethical position he evidently hoped would bring him peace of mind:

> . . . Whether the Vietnam conflict fits these criteria [of a just war] or not is really beyond me to say. I did accept it as a just war when I agreed to serve in it.
>
> . . . I then had to accept that my obligation to my individual patient was far superseded by my obligation to the military and, eventually, to my country.[21(p265)]

Second Lieutenant Roger A Roffman, Medical Service Corps

A similar postwar lament came from Roffman. Early in 1967, he traveled by troop ship to Vietnam with the 9th ID as the division social work officer. He had received his commission in the Army several months after being awarded his master's degree in social work, and he completed 1 year of military service at Fort Riley, Kansas, before arriving in Vietnam. After serving with the 9th ID, Roffman was assigned to the 935th Psychiatric Detachment, where he conducted a pioneering survey of drug and alcohol use among

enlisted confinees of the USARV Installation Stockade ("Long Binh Jail") as well as a similar one (with Ely Sapol, an Army psychologist,) with soldiers departing Vietnam, which was described in Chapter 9. In his unpublished manuscript, *Tilting at Myths: A Marijuana Memoir*, which was written four decades after his service in Vietnam, he included the following:

> . . . I told [the new 9th ID psychiatrist] how ambivalent I felt when, following military psychiatry protocol, we sent traumatized soldiers back to their units after a few days of rest and reassurance that they'd get through this very normal reaction to a very tragic experience.
>
> I also ranted about contrasts that seemed incomprehensible in a war zone, maybe even obscene. American kids in their teens and twenties were losing limbs when stepping on land mines, being impaled on stakes in punji pits, and being decimated in ambushes. Yet, many of us had had dinners in superb riverfront French restaurants in Bien Hoa, spent hours at an officers' swimming pool, and enjoyed "happy hour" in the roof-top bar of a Saigon hotel.[95(p27)]

Second Lieutenant Raymond M Scurfield, Medical Service Corps

Another example is that of Scurfield, also a social work officer, who was assigned in Vietnam to the 98th Psychiatric Detachment in March 1968, on the heels of the Tet offensives. He spent his year in the outpatient clinic serving as clinician and the detachment's administrative officer. He received his commission in the Army shortly after being awarded his master's degree in social work, and he completed 10 months of military service at Fort Bliss, Texas, before being assigned in Vietnam. Thirty-five years later he published *A Vietnam Trilogy: Veterans and Post Traumatic Stress: 1968, 1989, 2000*,[96] which included references to the guilt he carried from serving in Vietnam.[96(p127)] The following quotation serves to exemplify his ethical strain associated with implementing the combat psychiatry treatment doctrine:

> Some soldiers, convinced that they were going to die or be maimed or go crazy if they stayed any longer in the war zone, would do and say anything to try to build a case that they were "crazy" and had to be evacuated out of Vietnam. It was our responsibility as psychiatric gate keepers to keep that gateway from blowing open.[96(p43)]

It should be noted that Scurfield's perspective was not only based on his experiences in Vietnam; it was also influenced by his many years of work with veterans while affiliated with the Veterans Administration and the Readjustment Counseling Service. Scurfield believed that the Army's system for dealing with emotionally troubled soldiers in Vietnam was neglectful and apparently resulted in large numbers of veterans developing chronic PTSD and other psychiatric conditions. In particular, he blamed commanding officers for being unsympathetic and punitive and not referring soldiers for psychiatric care. He also faulted them for discharging soldiers from the Army for nonmedical conditions, that is, character and behavior disorders, which denied them timely treatment. He held the psychiatrists responsible for enabling this process and for providing minimal psychiatric treatment and sending traumatized soldiers prematurely back to duty:

> The vast majority of soldiers who suffered extraordinary reactions to extraordinary events were not hospitalized psychiatrically, nor evacuated out of their duty stations. They received minimal or no psychiatric treatment, and were sent back to duty within several hours.[96(pp34–35)]. . . The overall mission in Vietnam was the same as the military medicine mission everywhere else—to conserve the fighting strength. This is extremely important in that our mission was not to do what was necessarily in the best interests of the longer-term mental health of the individual soldier.[96(p36)]

To prove his assertion that combat troops in Vietnam received inadequate psychiatric treatment, Scurfield alluded to seven cases (referring to examples provided by former Army psychiatrist, Arthur S Blank Jr); however, his assertion seems arguable because of the scant amount of information he included.[96(p35)] These consisted of either seemingly adequate treatment (one soldier was "subdued with injections of Thorazine,"[96(p35)] and another "slept for 22 hours and subsequently was completely clear and non-anxious"[96(p35)]), or were brief and dramatic descriptions of circumstances surrounding their admission without definitive information regarding treatment, clinical course, or disposition. Mostly,

however, he blamed the situation in which he found himself:

> The internal conflicts this policy [ie, the forward treatment doctrine] raised in the medical, psychiatric and social work personnel fed an anger, indeed a rage, that we suppressed: rage at the government, at the country, at being in a Catch-22 situation. Freudian-based psychiatric theory was at best being unwittingly used by well-intentioned military mental health officers and at worst was being perversely misused to justify a military policy that was far more concerned about "the mission" than about the men and women who carried out the mission.[96(p42)]

Apparently Scurfield ultimately bolstered his psychological defenses through his career activities in veteran mental health:

> Any guilt that may be mine from having been so naïve I channel into purpose and conviction and drive to attempt to make the system and society more responsive to the real needs of vets and the real psychiatric legacies of war.[96(p127)]

Major Douglas R Bey, Medical Corps

Also pained were postwar comments by Bey, despite his defense of military psychiatry outlined earlier. Bey served later in Vietnam as the division psychiatrist for the 1st ID (April 1969–April 1970). He trained in psychiatry in a civilian program and during the period before his arrival in Vietnam he was assigned to the Army Hospital at Fort Knox, Kentucky. Bey served with distinction in Vietnam and authored or coauthored numerous articles regarding his experiences there as well as wrote a memoir. The following comments, also charged with guilt and blame, are from his personal account, some of which was published 35 years after he left:

> While in Vietnam I saw considerable waste of American lives, equipment, and money. I had little understanding of the mission of the 1st Infantry Division. The Civic Action Program didn't seem to make much sense medically. I saw that the Vietnamese people were suffering greatly. Our presence contributed to the disruption of the family structures, we corrupted their daughters who sold themselves for money, their sons who sold stolen goods and pimped for their sisters. We damaged their crop lands with our bombs and military equipment and we treated them like lesser beings (running over them on the roads, barging into their fine restaurants in boots and fatigues, had them burn our shit and do menial labor).[97]
>
> My impression was that soldiers in World War II had the feeling they were morally in the right and were supported by the folks back home. Men who avoided service were shunned.[98(p260)]
>
> . . . After my return from 'Nam, I tried to forget the whole experience. I didn't wear anything green for several years. I carried my own load of guilt going into Vietnam. In addition, I felt a vague sense of guilt in response to the criticism by the antiwar groups—particularly those from my colleagues in psychiatry.[98(p265)]

Bey indicated that over the years he had made peace with his role in the Vietnam War. For part of this, he credited a renewed religious spirituality. He also considered helpful his near-death experience from a heart attack, his industrious professional life, including scholarship regarding psychiatry in Vietnam, and his relationship with his wife and children. He concluded his account with the following:

> From all the stories of drinking, throwing optometrists through doors [*sic*], and such, the reader may conclude that I have been flawed by my experience in Vietnam and that perhaps I'm one of the many supposed victims of PTSD. . . .
>
> We weren't greeted warmly when we returned, but I have no regrets and am proud that I served. I support my son's wish to enlist. I feel it is important to support our military and our government in these troubled times. I make a special effort to welcome and praise our returning veterans.[98(pp256–257)]

A Challenge to Reconcile the Ethical Dilemmas Associated With the Military Forward Treatment Doctrine

In 2011 the Army Surgeon General's Office published a comprehensive update of military psychiatry, *Combat and Operational Behavioral Health*.[99] However, despite including chapters describing the contemporary organizational structure for responding to combat and operational stress problems,[100] psychiatric medications in military operations,[101] ethical conflicts in military

mental health,[102] and the subject of stress on military health care providers,[103] there was no acknowledgment of the critical—and evidently latent—ethical dilemmas associated with the combat psychiatry forward treatment doctrine apart from a brief mention in this author's review chapter of the psychiatric experience in the Vietnam War.[104] Almost 20 years earlier this author had written the lead article in the *American Journal of Psychiatry* reviewing the doctrine's contradictory ethics and urging leaders in military and civilian psychiatry to reconcile the dilemmas that became so torturous for practitioners, both civilian and military, during the Vietnam War.[4] The following material is borrowed from that review to illustrate the value conflicts that surrounded the implementation of the doctrine in Vietnam.

A Case Example From Vietnam

Case 2-1, the case of SP4 Delta, presented in Chapter 2, will serve as an example of the management and treatment of a combat stress casualty in Vietnam. According to the hospital record, upon his admission to the 93rd Evacuation Hospital/935th Psychiatric Detachment in 1967, he was in a severely disorganized and dysfunctional combat stress-induced state. In the course of his treatment, he talked about the painful loss of his buddies and his revulsion toward the killing. He also declared he could not return to the field. Nonetheless, the treatment staff encouraged him to see his duty through, and he was quickly returned to his unit without recurrence of symptoms, at least as far as the 935th Psychiatric Detachment knew. Except for the substitution of the tranquilizer, Thorazine, for sedatives and hypnotics of an earlier era, he would have been managed similarly by military psychiatrists during the latter phases of World War I, in World War II, or in the Korean War, and probably with the same rapid return to duty.[46] As previously noted, in those wars there was consensus regarding the military doctrine's effectiveness in providing satisfactory treatment.[64] Thus, by Army standards, the treatment of SP4 Delta was a success because it was felt to serve both the needs of force conservation and those of this individual.[105,106]

However, just as legality is not a sure test of morality, neither is apparent treatment effectiveness a sure test of ethical treatment. Anti-Vietnam War sentiment and the new Vietnam-era humanitarian sensibilities would question whether this example of the implementation of the Army psychiatry doctrine there demonstrated its harmfulness. Should the psychiatric team at the 935th be faulted for crossing an ethical line in exhorting SP4 Delta to return to more combat duty despite his opposition? Once returned to his unit, did reactivated psychiatric symptoms reduce his combat effectiveness and contribute to his becoming killed or wounded? Because his treatment was abbreviated to return him quickly to fight again, did he later develop post-Vietnam psychiatric symptoms or adjustment difficulties?[107] The accusations that the forward treatment doctrine was unethical centered on two confounding claims:

1. It primarily served, as some believed, the prosecution of an immoral or unjust war; and
2. It served military expediency or political objectives at the expense of the soldier's interests or welfare.

The Question of Participating in an Unjust War

Regarding the first question, whether SP4 Delta's treatment and disposition according to the forward treatment doctrine was unethical because it primarily served, as some believed, the prosecution of an immoral or unjust war, it is logically straightforward. Any professional activity by military psychiatrists that contributes to an immoral or unjust war would be categorically immoral and unethical. Although many came to believe that America's intervention in Vietnam was unjust and immoral,[12,108] such a conclusion remains controversial.[109] Some felt it was justified based on the principles of international law established after World War II by the military tribunal at Nuremberg.[110] Certainly specific combat activities, such as atrocities, may be readily distinguishable as immoral. But a link between particular immoral combat activities and the specific clinical activities of military psychiatrists may be very difficult to establish.

The Challenge of Distinguishing Harm and Benefit

The second question is a more general one and highlights the psychiatrist's obligation to the soldier. It is also complicated and has implications for the use of the military treatment doctrine in any war. In short, because of the double agent position, the military psychiatrist faces a complex array of competing values and influences and is held responsible for the effects of his treatments in terms of the balance of harm and benefit.[111] These can be

examined along the following three lines: (1) the question of harm to the soldier, (2) the question of benefit to the soldier, and (3) the question of coercive treatment and the benefit to society.

The Question of Harm to the Soldier. Is it likely that SP4 Delta was harmed by the combat psychiatry treatment approach because it put him in unreasonable jeopardy in subsequent combat? If he was only partially treated, or if he was still under the sedating effect of Thorazine, or because of his already demonstrated susceptibility, his vulnerability in combat may have been greatly increased. As was mentioned previously, the question of the effects of the neuroleptic and anxiolytic drugs on the performance (or vulnerability) of combat soldiers who served in Vietnam was not studied. However, the aforementioned study by Palinkas and Coben[93] did suggest that, at least for some diagnostic groups, returning soldiers to combat exposure after psychiatric hospitalization, apparently including the administration of psychotropic medications, may have increased their risks.

The Question of Benefit to the Soldier. Is it likely that SP4 Delta benefited by being treated according to the combat psychiatry doctrine? As noted in Chapter 7 and this one, psychiatric morbidity in prior wars was greatly reduced among soldiers affected with combat stress reaction who were treated and managed according to the traditional doctrine[112] because it apparently (*a*) reinforced the soldiers psychological defenses against subsequent breakdown in combat and (*b*) opposed the fixation of his symptoms into a "self-protective disabling neurotic compromise."[8(p731)] It was the impression of the earlier military psychiatrists that through suppressive and repressive clinical means, they could strengthen the affected combat soldier's investment in his combat comrades, leaders, and objectives, as well as reinforce his confidence in his own capabilities, thereby reestablishing his primary psychological resistance against further combat-induced disorganization:

> [To adapt to combat the soldier must] fuse his personal identity with the new group identity, to form deep emotional relationships with his buddies and with his leader, in sharing boredom, hardship, sacrifice and danger with them, and whether by compromise or illusion, to become oriented with them toward the destructive goals which he understands to be necessary for the common good.[113(p365)]

Also, as noted in Chapter 7, deeper, longer, or more complicated treatments, and especially those occurring far from the soldier's original unit and in more comfortable surroundings, were found as far back as World War I to favor the development of chronic psychiatric disability.

The Question of Coercive Treatment and the Benefit to Society. Was SP4 Delta's treatment unethical because his combat reaction represented the combat refusal of a dissident or because it is normal not to want to return? By labeling him with the exclusively military diagnosis of combat exhaustion, disregarding his opposition to further combat, and imposing the military doctrine's treatment regimen, were his military psychiatrists "blaming the victim"?[50] Some writers have even referred to the soldier's new willingness to enter combat after such coercive treatment as an iatrogenic psychosis.[11,40]

The matter of informed consent or refusal is especially critical when psychiatrists are representing the interests of other parties in addition to those of their patients—the problem of dual agency.[114] In his presenting condition of near catatonia, he was not competent to understand an adequate consent process and there can be little doubt about the rightfulness of treating him as the military psychiatrists deemed necessary. However, on the following day, his regression and decompensation had largely resolved, and the situation became quite different. He was treated with more Thorazine and behavioral strategies, including exhortation of the duty side of his conflict, to sway him from his expressed (at least initially) opposition to killing, and he was rapidly returned to more combat duty.

No matter what efforts the treatment team might have expended to obtain SP4 Delta's consent, the existence of a powerful negative incentive, that is, the threat of a court-martial, eliminated the possibility of proper informed consent or refusal. Because these clinical techniques were imposed on an individual who was sufficiently competent and rational to cooperate with a consent process, SP4 Delta's treatment was technically coercive by definition and violated a "moral rule" (against causing pain and depriving freedom).[111]

There may, however, be overriding moral justification for coercive treatment when it is felt to serve the best interests of the patient (so-called paternalistic treatment[111]), but in civilian settings, the paternalism exception to the moral rule does not apply to rational, competent adults. However, because the rights of those

EXHIBIT 11-1. A Proposal to Reconcile the Ethical Dilemmas Surrounding the Army's Traditional Forward Treatment Doctrine

The following was included in an address ("The Vietnam War and the Ethics of Combat Psychiatry") by the author [NMC] made to the Department of Psychiatry, Walter Reed Army Medical Center, Washington, DC, 8 August 1993.

In lieu of further research addressing the short- and long-term consequences from implementation of the forward treatment doctrine and based on military psychiatrists' observations across three major wars and my own experience serving in Vietnam, I propose that the following principles should predominate in the treatment of combat stress casualties:

Once in military uniform, and especially once assigned in a combat theater, the military psychiatrist must entrust the military to define duty, his and the patient's—except in the most dire circumstances.

This is necessary because of the exceedingly strong tendency for various compromises to arise in the soldier's "will to fight," as well as in the clinician's "will to treat," under the extreme circumstances of war.

With regard to an ethical stance associated with the forward treatment doctrine:

- It is acknowledged that a behavior treatment milieu, such as the forward treatment doctrine, does violate the ethical principle of informed consent/refusal.
- Nonetheless, whereas compassion can be extended to affected soldier-patients, their expressed opposition to military performance requirements should be overridden if their basic mental functions are not impaired.
- Such rapid return to military function is justified by the preeminence of group/unit/national needs. It is incumbent on the military psychiatrist to function as if serving in a locum parentis-like capacity (ie, such as making parental decisions for an adolescent). Consequently the military psychiatrist would ordinarily direct soldier-patients toward completing their duty—even if additional combat hazards are predictable.

Among clinical populations:

- If the combat stress-generated condition is expressed in intractable and disabling psychiatric symptoms, it is necessary to provide protection and additional treatment.
- If it is expressed in treatable symptoms and accompanied by avoidance of resumption of duty, this may be briefly accommodated but with rapid return to duty as the explicit goal.
- If it is expressed in a situationally derived (eg, new) opposition to more combat exposure, no matter how logically constructed, this represents a self-serving rationalization. If it is taken at face value by treators, soldier regression and persisting "sick role" is encouraged, other soldiers often follow suit, and the "fighting force" may be degraded.

In other words, the military psychiatrist:

must take responsibility for expecting that the (competent) soldier resume his duty function—but ***cannot*** take responsibility for the outcome (risk).

in active military service have historically been abridged by law, these boundaries are less certain.[12] In fact, there are numerous military regulations and policies that shape the practice of psychiatry to represent the preeminence of institutional goals and values over those of the individual.[77,115] Besides the absence of a right to informed consent or refusal with regard to hospitalization or psychiatric treatment, there are also limitations in the service member's rights to privileged communication[116] and to psychiatric due process.[117]

There also may be overriding moral justification for coercive treatment when the treatment is deemed necessary for the welfare of others (so-called utilitarian value). Was there sufficient benefit to society to justify treating SP4 Delta according to the combat psychiatry doctrine? That is, in overriding his autonomous choice and quickly returning him to fight again in spite of some additional risk to him, was his treatment team serving a superseding value representing the welfare of

the American people? As a soldier, was he obligated to unconditionally sacrifice his self-interest for the common good? On the other hand, some would argue that a treatment approach that purports to sacrifice the interests of the individual soldier for the good of society might simply coincide with the military's value of teamwork and combat efficiency in some situations. The military's values can diverge from those of society, as many believe was the case in Vietnam.

Practical Realities in Treating Combat Stress Casualties

It seems reasonable to say that in practice it is unrealistic to believe that the individual combat psychiatrist can distinguish at any given time whether the military treatment doctrine serves essential public welfare or only conforms to military objectives, political goals, or a war's popularity. Furthermore, this uncertainty may compound the already difficult task of determining clinically whether a soldier who is opposed to returning to combat is suffering from a mental disorder or expressing a rational refusal.[17] Brill's comment from World War II illustrated the influence of the seeming utilitarian values on clinical judgment: "It was difficult to define exactly how much of such patients' ineffectiveness was due to illness and how much to lack of desire to do their part."[24(p242)] During the Vietnam era, Baker took a more disparaging attitude when he speculated that the soldier with a prolonged postcombat recovery had "consolidated his adaptation on a *parasitic* basis (emphasis added)."[112(p1835)] Since American troops were withdrawn from Vietnam, the ethical dilemmas surrounding the combat psychiatry forward treatment doctrine have remained unreconciled between civilian and military psychiatry. In an effort to help military mental health professionals avoid getting lost in these value crosscurrents, this author [NM Camp] proposed a set of ethical principles in an address in 1993 to the Department of Psychiatry of Walter Reed Army Medical Center (Exhibit 11-1); however, this had no measurable effect. Until official ethical guidelines can be established for the psychiatric management and treatment of combat casualties, it will regrettably remain incumbent on each individual psychiatrist who serves in the combat theater to bear a greater burden of conscience in performing his/her duties, just as was the case for those who served in Vietnam.

WALTER REED ARMY INSTITUTE OF RESEARCH PSYCHIATRIST SURVEY FINDINGS: OPERATIONAL FRUSTRATIONS AND ETHICAL DILEMMAS FOR MENTAL HEALTH PERSONNEL IN VIETNAM

The following extends the presentation of findings from the Walter Reed Army Institute of Research post-war survey (1982) of Army psychiatrists who served in Vietnam that was begun in Chapter 5. Under the heading of subjective reactions to service in Vietnam, the survey psychiatrists were asked to indicate on a scalar range of 1-to-5 the strength of their "disagreement" (1) or "agreement" (5) with 31 statements referring to their attitudes, dilemmas, and frustrations as a result of assignment and functioning in Vietnam. The section also included open-ended questions and a general invitation to make marginal notations that would further explain their personal reactions. Notably, the number of psychiatrist participants who responded to these questions ranged from 78 to 85, the highest response rate among all sections of the questionnaire.

Qualitative Responses

Participant responses to open-ended questions are arranged below according to dominant patterns. Overall a large proportion of the study psychiatrists emphasized that they felt quite strongly—typically negatively—about the war and their participation in it. This was especially true for those who had civilian training in psychiatry and those who served after the midpoint in the war in general. Whereas it has been noted throughout this work that the psychiatrists who served in the second half of the war published relatively little describing their experiences in Vietnam, when prompted by the survey they were vigorously outspoken, often bitter, and also defensive. As will become evident, the psychiatrists of this latter period were also more likely to complain of inequities and to be critical of their preparation and utilization by the Army.

Reactions to the Walter Reed Army Institute of Research Survey

Participants' reactions to the questionnaire and to the research more generally were quite variable and often passionate. The majority of comments about the research questionnaire were positive; however, there were also a number of comments that in one way or another could be considered negative. Quite a few participants

expressed gratitude that the research had provided them with an opportunity for remembering and catharsis. One respondent also sent his inpatient log and copies of clinical summaries he had collected from his tour in the event that such data might support other research. (Only three participants gave an affirmative response to the question of whether they brought back clinical records.)

Many participants remarked on the extent of time that had passed between when they completed their year in Vietnam and when they were contacted for the study (ranging from 10 to 17 years). A small number expressed regret that some questions asked for more detail than their memory could provide, and others volunteered that they had been aware of trying to forget their Vietnam experiences. Several were more specific in stating that they had not spoken of their Vietnam tour since they returned—in spite of an appreciation that it was one of the most important experiences of their life. One participant provided the following explanation for his "clinical amnesia." He wrote, "A curious thing about my Vietnam experience is that I recall my personal—as opposed to clinical—experience more vividly. . . . I suspect the personal trauma of isolation from home and family made the actual work secondary in importance."

A number of other participants emphasized a bitterness that it had taken so long for someone to ask for their impressions, which led to a cynicism that any positive changes would come from the study. For example, one participant wrote, "this study is about 15 years too late. . . . My social work officer and I did attempt to collect [clinical] data at the time we served, but I got only static from the Army when I attempted to find out what happened to the [patients] I had seen."

Another psychiatrist declined to participate in the study, referring to the project as "pseudo-recollective science at its worst." He felt so strongly that he wrote the editors of several psychiatric journals to warn them about the study. Another example was that of a psychiatrist who faulted the study design as a poor epidemiological approach because of the lengthy interval for recollection. He suggested that a better approach would be to get the case records from those who were there. He acknowledged that he retained such records and expressed a willingness to analyze them if the Army would pay him. Ultimately he completed the questionnaire, indicating that he had carefully consulted his records. He remarked, "[seeking] the truth about our experiences in Vietnam is now the most valuable professional goal in the service of our country."

One psychiatrist returned an unmarked questionnaire with the following unsigned statement, "Many of us who served as medical officers in Vietnam were as deeply affected and carry as lasting reactions as any of the other men who served there. I have yet to find the peace of mind that would allow [me] to watch any of the Vietnam War movies, or talk about the war without threat of loss of control."

A final example is the participant who offered a general, but obviously also personal, justification for the psychiatrist's participation in the war in Vietnam. After acknowledging his efforts at forgetting the associated painful memories, he revealed his residual bitterness and cynicism. He wrote,

> [My memories] are now quite dim and probably repressed. . . . I believe our government made a political error in going to Vietnam, but once the Army is sent somewhere, it does what it is supposed to do . . . and support people—like psychiatrists—do what they do . . . [therefore this study] strikes me as rather unimportant, something like focusing attention on a skin blemish and ignoring a cancer.

Reactions to Being Assigned to Vietnam

Participant reactions to questions regarding attitudes about being assigned to Vietnam, preparation for serving, and perceptions of one's counterparts patterned especially around the distinction between pre-Vietnam military and civilian psychiatric training.

Attitude About Being Sent to Vietnam

Civilian-Trained Psychiatrists. The civilian-trained participants included little about how they happened to go to Vietnam despite their often profuse and usually emotional expressions of regret and resentment for having served there. Only one civilian-trained psychiatrist spontaneously indicated that he was truly a volunteer. Perhaps this contributed to his apparent conflicts about the war and his role in it. He wrote, "I was there early in the war when there was no stigma. I volunteered to be assigned . . . and wanted to go because I was curious. I came away more cynical about life and institutions [like the Army], but that's a good effect." Perhaps another participant spoke more clearly for the civilian-trained group when he simply said, "Most of us were drafted."

Somewhat related were the several comments by civilian-trained psychiatrists reflecting feelings of dismay

about a perceived inequity in the relative proportion of military-trained psychiatrists required to serve in Vietnam. As one wrote, "I noted that few career Army psychiatrists went to Vietnam. They got out of it in various ways—threatening to leave the Army, etc." A similar complaint by another civilian-trained participant emphasized his feelings of relative inexperience. He stated, "Note that so many career military psychiatrists avoided Vietnam [thereby] leaving it to neophytes like me." Another spoke about how he was reassigned to Vietnam from his stateside post, only to be replaced there by an Army-trained psychiatrist "who was single."

Evidently, he, too, believed that the Army-trained psychiatrist had a greater obligation, but this feeling was compounded with a similar one about those with fewer family obligations.

Military-Trained Psychiatrists. Generally there was somewhat less regret and resentment expressed by the group of military-trained psychiatrists. Perhaps it can be presumed that having been trained by the military generated some sense of commitment to support the military mission. Still, negative reactions to having been sent to Vietnam predominated. A small minority of military-trained psychiatrists spontaneously commented on how they became assigned to Vietnam. A few of these indicated that they had some eagerness to professionally support the war effort. For example, one psychiatrist wrote, "Having chosen to 'identify with the enemy' by joining the Army in my senior year of medical school, I took my internship and residency with the full expectation that I would be assigned in some capacity in Vietnam if the war was still going on—as it was."

More common, however, were military-trained participants who recalled a frank regret at having been made to go. This feeling was commonly linked to a resentment of Army colleagues who succeeded in avoiding a Vietnam assignment. Others seemed to have experienced a combination of eagerness and reticence. An example of such apparent mixed motivations can be seen in this comment by one military-trained participant, "I volunteered because we were told that 80% of [graduating Army residents] were going anyway, and that volunteers would get [special] consideration for a next assignment. I was also a patriot, and a Europe assignment seemed as boring as Ft. [Knox]. Basically, I was curious." This individual went on to highlight his feeling of being cheated because he was the only one of his graduating class to be sent.

Another military-trained psychiatrist voiced a similar concern for fairness, only in this instance he included an explanation for the perceived inequity. He stated, "It did not help my morale nor that of most other MDs [medical doctors] to know that [late in the war] only the 'losers' were sent to Vietnam. I felt that I was sent there as punishment for having antagonized my superiors during the [Army] residency."

Apparently it was not only late in the war that such feelings of being punitively assigned to Vietnam affected the military-trained psychiatrist. One who served early commented, "I was assigned to Vietnam [because] I turned down several attractive offers for continuance with the Army [and] indicated I was going to resign my commission. Needless to say, this did cause some bitterness on my part."

Another military-trained psychiatrist spoke with some resentment about the fact that of his graduating class of eight, two of the three psychiatrists without children were assigned to Vietnam, with the third being assigned to Korea. In his estimation, the intent to evade Vietnam by his colleagues was transparent in that in several cases their wives became pregnant for the first time as the class began its last year of training.

Lastly were the remarks of a very experienced Army psychiatrist who also expressed dismay about inequity. Yet in his instance, the comparison was with the Army psychiatrists who also had extensive military backgrounds. He wrote, "My disappointment was solely due to what I thought was discrimination. I had already served two hardship tours, one in heavy combat and one in a combat zone, while over half of my peers had [not]."

Professional Preparation for Vietnam

Civilian-Trained Psychiatrists. Study participants were asked several questions about the specifics of their professional preparations for service in Vietnam, such as unique training environments or personal study. Most of the civilian-trained subjects either left this question blank or indicated they had none. However, a number did comment on training experiences that they felt overlapped with the clinical challenges in Vietnam, as in crisis intervention, community psychiatry, industrial psychiatry, and psychoanalytic anthropology.

Several of the civilian-trained psychiatrists felt they were well prepared because a particularly influential faculty member in their residency program had served in a prior war and had shaped the program in the direction of a social psychiatry model. An example was

the following comment: "I probably adapted easier than most to the needs of the service and the philosophy (early return to duty) because that is how I was trained in my residency by a very senior and experienced retired Army psychiatrist." One individual highlighted that his civilian training was in a Veterans Administration center where he learned about combat stress. Lastly, quite a few commented, much more so than those trained in the military, that they had prepared for their tour by reading books and articles about the Vietnamese people and culture or other works exploring the history and geopolitics surrounding the war.

Military-Trained Psychiatrists. Among those trained in military settings, many acknowledged that their training was to some extent a specialized preparation, and they generally highlighted their exposure to the classical writings in combat psychiatry. A few, however, expressed dismay that their training was in fact not distinguishable from civilian training. One participant acknowledged that while there were aspects of his military residency that emphasized combat theater psychiatry, his training was nonetheless "anecdotal, minimal, adjunctive, and self-taught." Another similarly affected psychiatrist commented, "Being lucky, I was assigned [in Vietnam] to a hospital and not [to do] field psychiatry so I did not feel the effects of my lack of training . . . a marked deficit."

Only one among the military-trained group commented that he felt more prepared because he had been exposed specifically to soldiers who had been evacuated from Vietnam. Especially notable was a comment by a psychiatrist who had trained both in civilian and military programs (only two participants had this hybrid training). To the question asking if his training was in part directed to special considerations of the combat theater, he emphasized, "No, not even in [my Army training] program."

Retrospective Conclusions About Preparation

At the end of the questionnaire participants were asked, "Knowing now what you know, what would you have done better to prepare for Vietnam service?" Of all the questions, this one evoked the greatest collection of remarks expressing strong personal sentiments about having served in Vietnam. They ranged from highly emotional to quite rational and included suggestions for professional preparation as well as comments relating to Army policies and methods. These did not split so strongly between civilian and military training background, suggesting that those who trained in a military setting did not automatically incur a functional familiarity with the Army culture and its ways and means.

In analyzing the responses it was sometimes difficult to distinguish the often bitter and resentful feelings from practical suggestions about preparation. Many participants, especially the civilian-trained ones who served later in the war, dismissed the question with pithy sarcastic answers such as, "Not go!"; "Go to jail, or Canada"; "Joined the Navy!"; "Switched to surgery!"; and "Get a good lawyer!" The comment of another—"I'm not sure anything would have helped!"—was echoed by several colleagues. One psychiatrist combined both personal and practical reflections in his response, "[I would] vote against LBJ (President Johnson)—I was adequately prepared for a bad situation." Similarly, another said, "I don't think there was much I could have done to prepare for Vietnam. It was a stressful and harrowing experience." Yet a third chose to speak more explicitly about his personal side when he suggested his "preparation" would be "to not get married or certainly not have children."

With respect to professional preparation specifically, the predominant refrain was that of having needed beforehand the distilled experience and wisdom of those psychiatrists who preceded them. The implications in this, and in a few cases explicitly stated, were (*a*) that the orientation and training at the MFSS for the psychiatrists deploying to Vietnam was not adequate, and (*b*) that the psychiatrists in central roles in the Army failed to serve a critical function by not systematically "debriefing" each returning psychiatrist so as to extract practical information for use in preparing subsequent cohorts of replacements. As one participant stated, "MFSS did a decent job of preparing one for medical unit duty, but not for combat unit duties." Another said, "MFSS is not the answer. Some sort of training with previous field (not [psychiatric detachment]) psychiatrists would have been helpful." The perceived need to have been briefed before arrival in Vietnam was often intertwined with frustrations at never having been debriefed following their own tour.

Other comments made under the heading of preparations included the wish to have had specific training and practical experience with the types of clinical problems that were the most challenging for the psychiatrist during his tour. Not surprisingly, several spoke of having needed more information on the

treatment of combat stress reactions. Others spoke of needing more expertise with such problems as toxic psychoses, sociopathy, drug abuse, and addiction, as well as with treatment modalities such as narcotherapy and hypnotherapy. One participant spoke of needing "clearer training in psychiatric treatment options [in the combat setting] and when to use them."

Even some of the civilian-trained psychiatrists who had pre-Vietnam military assignments noted how they might have enhanced their preparation by tailoring their activities toward the Vietnam assignment. One such participant wrote, "[I would have] practiced more unit consultation at Ft. [Knox]." Another wrote, "I should have spent the year at Ft. [Riley] entirely with the division so that I could have known the middle level command people better."

Several participants highlighted their initial unfamiliarity with Army policies and methods. Although one psychiatrist spoke of his great appreciation for how quickly his enlisted staff helped to orient him, another spoke instead of a negative experience. He commented, "I needed more experience being in the military before going directly to a war zone. Being so dependent on a [sergeant] for basic military knowledge made me feel inadequate. The way it really operates is not in the books." Some also alluded to the need for a more functional familiarity with the "line" Army [nonmedical units] so as to have facilitated primary prevention interventions, that is, command consultation. Lastly, and in some contrast to the specific recommendations above, were a number of comments emphasizing how necessary it was to actually become a part of the combat theater environment before mastering it. One subject put it this way, "No [further preparation would have helped]! The actuality of the Vietnam experience was in no way comparable to the stateside view of it. Furthermore, the unpredictable nature of [Vietnam] negates the possibility of greater preparation." Another commented, "I really don't know [how to have better prepared]. What I did not know, I learned very quickly."

Stateside Military Experience as Preparation for Vietnam

Civilian-Trained Psychiatrists. Several civilian-trained psychiatrists indicated that their pre-Vietnam Army assignment had served several important preparatory functions. It provided a general process of enculturation, taught them critical differences in the perspectives and goals of civilian versus military psychiatry, and provided a context for the goals of military psychiatry within the institution of the Army. Several civilian-trained psychiatrists also mentioned the benefit of their having grown up with a father who had been in the military. They remarked on their comfort and familiarity in the military culture as well as an appreciation for the objectives of the military.

Military-Trained Psychiatrists. The military-trained participants who served in military assignments before service in Vietnam said very little about how those experiences affected their preparation for the tour in Vietnam. However, one commented, "I felt my skill was adequate. Part of my comfort lay in knowing personally some of the important medical commanders [before arriving in Vietnam], and in having served in the Far East before having to participate in actual combat."

Finally, a psychiatrist who served as the USARV Psychiatry Consultant late in the war provided the following observation pertaining to psychiatrist preparation, "The Surgeon General's Office seemed to be more busy filling slots rather than seeing to it that the assignees were provided with the literature, training, overlap, and especially time to get ready for the job." One could assume that this allegation would have its greatest impact on the civilian-trained psychiatrist with no prior military assignment.

Perceptions of One's Counterparts

Civilian-Trained Psychiatrists. More than one civilian-trained psychiatrist commented on his perception that the career Army psychiatrists were questionably competent. One participant emphatically declared: "None were adequately militarily trained!" Another commented, "Too many of the Army doctors above the rank of Major with whom I had contact both in Vietnam and [in the United States] were incompetent both as doctors and as administrators, and they seemed to have chosen to stay in the military because they could not make it in the real world."

Contrasting that perspective were the remarks of a civilian-trained psychiatrist who referred to himself as "a right-wing nut." He wrote, "Not only was I completely persuaded to patriotic virtue and the extraordinary ability of career military [psychiatric] people. I was also highly impressed with [their] professional competence."

Military-Trained Psychiatrists. One experienced military psychiatrist wrote,

> We did not adequately prepare [the civilian-trained] psychiatrists for Vietnam, nor were they given adequate senior role models . . . [consequently] they never did fully identify themselves as part of the Army. A lot of their emotional energy was expended in expressing their frustration with the "system" and this attitude was frequently communicated to patients and was not constructive.

Overall Reactions to Having Served in Vietnam

Participant responses to questions regarding reactions to having served in Vietnam, including recollections of ethical conflicts, strongly patterned around which half of the war the psychiatrist served. These comments are presented below without commentary to allow the reader to fully appreciate their individual poignancy.

Early-War Psychiatrists

- "[I regret not receiving] any recognition for patriotically having done [my] duty at great personal expense."

Late-War Psychiatrists

- "[I wish] I would have been 10 years older and post psychoanalysis."
- "[I wish] I would have been psychoanalyzed."
- "Overall I have felt then and now that it has been one of the most interesting and best experiences of my professional life . . . a very gratifying experience."
- "I would never choose to go to . . . Vietnam. However, the experience was valuable from a psychiatric viewpoint because of the intensity and myriad of feelings generated by all in such an environment but best understood and recognized by a psychiatrist. One recognizes more so one's own mortality and accepts the proximity to death, rationalizes away fear in order to survive and not be paralyzed by it."
- "I was afraid of dying."
- "Would I go again? I don't know. Hopefully I will never have to make that decision. The whole Vietnam debacle had its ravages on us all."

Ethical Conflicts

Early-War Psychiatrists

- "I did have personal emotional trauma to the extent that I identified with individual needs when they conflicted with the needs of the service."

Late-War Psychiatrists

- "Psychiatrists need to accept the age old notion that 'war is hell' . . . all the preparation and best on the spot treatment we can give will increase the efficiency of the military's function, at best, [but] will not in my opinion significantly reduce the psychiatric casualties—sorry."
- "I'm proud to have served. I wish I had done more for the troops. I'm left with the feeling of having contributed very little. The war was close and yet I seemed safe enough. I almost wish I'd been exposed to more danger. I carry a legacy of painful memories and a crushing burden of the image of carnage, yet I perceive that others experienced far worse than I."
- "Didn't the practice of returning individuals with combat related disorders to duty as expeditiously as possible prove deleterious in the long run?"

Adaptations

Early-War Psychiatrists

- "What I did was get clear in my mind that my job was to meet the needs of the system as the first priority."
- "I had to decide that this was my job, but I didn't like it."
- "As my year in Vietnam passed my ethical dilemma increased some, but I was hired by the Army, not the specific patient. The second fact was that I knew if I wanted to try to do something for a specific person, someone else would have to come to Vietnam to take his place."

Late-War Psychiatrists

- "I was only partly trained—but that was the Army's choice, not mine."
- "I accepted my assignment as an obligation despite my conviction as early as 1964 that our involvement was stupid, would fail, would be a disastrous waste of wealth, power, and lives, and was unjustified politically, historically, and morally. I did not feel strong ethical conflict over my role in the Army in RVN [Republic of Vietnam] . . . the therapeutic technique of psychiatry is inimical to the military cast of mind and would probably undermine morale and exacerbate disciplinary problems with many soldiers."
- "I did not feel it was my business to greatly dwell on moral or ethical issues of our involvement in Vietnam. Rather I felt like an orthopedic surgeon at the bottom of a ski slope—there was a great deal

of clinical necessity for my presence and to this I put my attention. Wars occur, people are injured, doctors take care of the sick [therefore] I should be there."
- "I soon adapted by realizing I could only be of use by cooperating with the military in most ways. To have tried to be another Ghandi [sic] would have been pointless and would have deprived those few I could help with my expertise."
- "My attitude was apolitical and patriotic."
- "I had no [ethical] dilemma but I sure as hell wasn't neutral and didn't perceive what I did as neutral. I believe what I did was a positive contribution to the war. I'm proud I did it and I'd do it again tomorrow."
- "I wasn't neutral, I treated patients and rooted for us to win."
- "My values are clear to me—I wasn't a 'double agent' [in Vietnam], I didn't return [my patient-soldiers] to combat. I medevac'd them to Japan."

Recriminations

Early-War Psychiatrists

- "I think it is significant that the whole experience did personally affect me for many years. I was active in the [antiwar movement], practically from the moment I received my discharge. Even though my combat experience in Vietnam was minimal, I am, like many Vietnam veterans, still horrified by the stupidity of that particular war; and I have generalized that experience to war in general. I am sure that my years in the antiwar movement could be termed a posttraumatic stress syndrome."
- "The injuries and deaths which I felt resulted from the [individualized 1-year assignments] far outweighed the low psychiatric casualty rate. My efforts to convey this impression to people in Saigon and later in the US [United States] met with the result I expected—nothing. This was because, my guess, this was a politically expedient decision."
- "[To have prepared for the assignment I would] have learned some Vietnamese history, and then probably not have gone. You hint at but don't get at the constant double talk that went on from the Ia Drang battle on . . . phony body counts, phony optimism . . . double accounting . . . war crimes . . . military cover-ups. . . . It was a deception [beginning with] the Gulf of Tonkin."

Late-War Psychiatrists

- "A war has to be fought with full support, including folks back home. We all felt so alone and isolated."
- "There was absolutely no leadership, either from the medical commanders or the Consultant, or myself."
- "If ever I am called again, I will not accept an assignment that entails great discrepancy between responsibility (great) and authority (little)."
- "Where in the hell were all the other Army shrinks when I was over there?"
- "Hell, none of us should have been there."
- "I'd have been more motivated to go, to function as a shrink, if the US [United States] had been more positive about winning!"
- "My [Army] residency did little or no formal teaching about combat psychiatry. I received good psychiatric training, but miserable military training. My preparation for Vietnam consisted of being handed a little booklet called 'This is Vietnam' when I boarded the plane at Travis AFB [Air Force Base]. [I had asked not to be assigned away from my family because of serious marital problems, yet] I was told I was the only member of my class that they could trust to send out from residency directly to a responsible assignment in the field. Two of my classmates had avoided [Vietnam] by applying for child fellowships. [Once in Vietnam] I learned how little I really knew about the Army and how poorly my training had prepared me for a role as a military psychiatrist."
- "Vietnam was an experience for which I was poorly prepared personally or professionally. I have never been more depressed, [and] I did not understand why for months after my service obligation was over. To some extent I am still bitter. I felt poorly prepared by the Army for what I was to do. I did not understand the dilemma of being treated like the 'enemy' by my side. I felt I was given propaganda and not information. I felt poorly valued by the military and that the majority of psychiatric problems could have been handled by a social-worker."

Quantitative Responses

Operational Frustrations and Ethical Dilemmas

The WRAIR survey participants were provided 31 forced-choice statements intended to address a range of potential operational frustrations and ethical dilemmas

associated with assignment and professional functioning in Vietnam and asked to indicate the extent of their agreement while they were there. Table 11-1 presents the summaries of the statements, which are arranged according to the means of participant responses for each item (right-hand column).

Responses to these items were further submitted to factor analysis, which yielded the following observations:

- The factor analysis of the responses to the set of 31 items generated four factors (W, X, Y, and Z) composed of 23 items. The four factors were interpreted and named as Factor W: "Patient Allegiance and Ethical Conflict" (30% of the variance); Factor X: "Civilian Professional Allegiance and Psychiatrist Burnout" (27% of the variance); Factor Y: "Opposition to the War and Compassion Fatigue" (23% of the variance); and Factor Z: "Opposition to Military Medical Structure and Policies" (20% of the variance). These are indicated in the column on the left side of Table 11-1.
- The clustering of participant responses into these four factors indicated that many psychiatrists experienced the set of items comprising each of the factors similarly and distinct from the items comprising the other factors; and
- Only one of the factors, Factor W, explicitly centered on ethical conflict.

Two of the eight items not included in the four factors warrant additional emphasis: survey participants agreed that more career military psychiatrists should have served in Vietnam (3.24), and they disagreed that Vietnam was a constructive experience for them (1.93). The others are self-explanatory. Further analysis of the responses to the item regarding the value of the guidance from the senior Army psychiatrist in Vietnam, that is, the US Army Republic of Vietnam (USARV) Psychiatry Consultant, will follow.

Multiple regression analysis was also performed using each of the four factors as the dependent variable while the three psychiatrist dichotomous variables, that is, key distinctions between psychiatrists, served as the independent variables: (1) phase of the war served (early vs late), (2) type of assignment in Vietnam (with *any* combat unit vs *only* with hospitals), and (3) site of psychiatry residency training (military vs civilian). The regression model included the "main effects" of these three predictors as well as all interactions of the three variables. The relationship between each factor and each of these predictors is visually depicted in Figures 11-2, 3, 4, and 5. Considering the small sample size and the exploratory nature of the analysis, the main and interaction effects presented below include those that reached the level of significance of $p < .10$ and below [note that in these figures, the dependent variable has been scaled such that "0" corresponds to the "average" or "typical" psychiatrist's score].

Factor W: Patient Allegiance and Ethical Conflict. A high score means the psychiatrist *did not* primarily serve in Vietnam out of patriotism and felt conflict over implementing the military forward treatment doctrine there. Among the reasons for this conflict were because a patient's need for refuge from combat or deployment stress could clash with the collective need to "conserve the fighting strength," restoring patients to military function could force dissenting soldiers to conform and vulnerable ones to return to more trauma, and commanders could exercise military authority to manipulate clinical decisions. With regard to the multiple regression analysis, Figure 11-2 depicts a statistically significant interaction only when all three of the psychiatrist dichotomous variables, that is, key distinctions between psychiatrists, and their two and three-way interactions, were included.

During the second half of the war, when moral and ethical ambiguities were increasing, all psychiatrists reported some heightened patient allegiance and ethical conflict, especially the military-trained psychiatrists who worked in the hospitals. This latter finding could represent the combination of (*a*) the higher prevalence for demoralization among noncombat troops (the majority of the troops treated by the hospital psychiatrists) during the second half of the war because of drawdown stress, and (*b*) a greater susceptibility for ethical conflict among the military-trained psychiatrists because they possessed a greater loyalty to military goals, structure, and discipline.

More difficult to explain are the findings for the first half of the war, that is, those military-trained psychiatrists assigned to the combat units and the civilian-trained psychiatrists who worked in the hospitals reported greater ethical conflict. In that the stress during the first half of the war was borne more by combat troops because of the overall higher levels of combat activity at that phase of the war, the military-trained psychiatrists who were assigned to the combat units

TABLE 11-1. Recollections of Operational Frustrations and Ethical Dilemmas in Vietnam

Factor Loadings	Subjective Reactions of Army Psychiatrists in Vietnam	Mean Value
	5 = STRONGLY AGREE	
-0.58 (W)	I accepted assignment in Vietnam out of a sense of duty and obligation	4.08
	4 = AGREE	
0.63 (W)	Psychiatric care for troops is not always neutral and humanitarian	3.64
0.55 (Z)	I reacted negatively to notification of my assignment to Vietnam	3.53
0.64 (X)	Officers or senior NCOs needing care rarely sought it nor were referred	3.45
	More military-trained psychiatrists should have served in Vietnam	3.24
	3 = INTERMEDIATE	
0.51 (Y)	Soldiers and unit leaders expected magic from mental health team	2.98
0.68 (W)	It was difficult to reconcile Army requirements (group needs) vs soldier expectations (who wished to avoid their military situation)	2.94
0.80 (Y)	Before serving in Vietnam I felt American involvement there was counterproductive and destructive	2.89
-0.77 (Y)	Before serving in Vietnam I felt American involvement there was justified	2.84
0.49 (X)	The military in Vietnam paid insufficient attention to human factors	2.81
0.73 (W)	A psychiatric diagnosis may help in Vietnam but cause harm as a veteran	2.76
	Guidance from the senior Army psychiatrist (USARV Consultant) was timely and beneficial	2.71*
0.57 (X)	I may have misled soldiers as a "double agent," ie, by also representing military priorities	2.68
0.55 (Z)	Military psychiatrists cannot guarantee confidentiality for soldiers	2.68
0.51 (W)	Restoring a patient to duty status may mean returning him to more trauma	2.62
	I reacted to notification of my assignment in Vietnam with ambivalence	2.61
0.73 (Z)	A character disorder diagnosis left the commander responsible for the disposition	2.56
0.66 (W)	Following the military psychiatry doctrine (PIES) meant some soldiers were inadequately treated and vulnerable when returned to combat	2.48
0.66 (X)	Psychiatric clinical need exceeded clinical capability in Vietnam	2.48
0.67 (W)	Commanders pressured me to act contrary to my clinical judgment	2.42
0.53 (Z)	I had a real position, ie, as an officer, in the social system of patients and thus may not have been trusted	2.42
0.61 (W)	I felt obligated to clinically coerce some patients into military conformity	2.29
0.65 (Z)	My decisions may be reversed by physicians up the evacuation chain	2.23
0.83 (X)	I felt troubled in Vietnam by social condemnation of those serving there	2.18
0.78 (Y)	Before serving in Vietnam I perceived US involvement there to be immoral	2.17
	I reacted to notification of my assignment in Vietnam with eagerness	2.03
	2 = DISAGREE	
	Vietnam was a constructive experience for me	1.93
	General medical officers had too much authority in psychiatric decisions	1.90
	Enlisted social work/psychology techs had too much clinical authority	1.85
0.76 (X)	I felt troubled by professional condemnation of military psychiatrists	1.85
	Ethical doubts stemmed from treating patients who insinuated atrocities	1.79
	1 = STRONGLY DISAGREE	

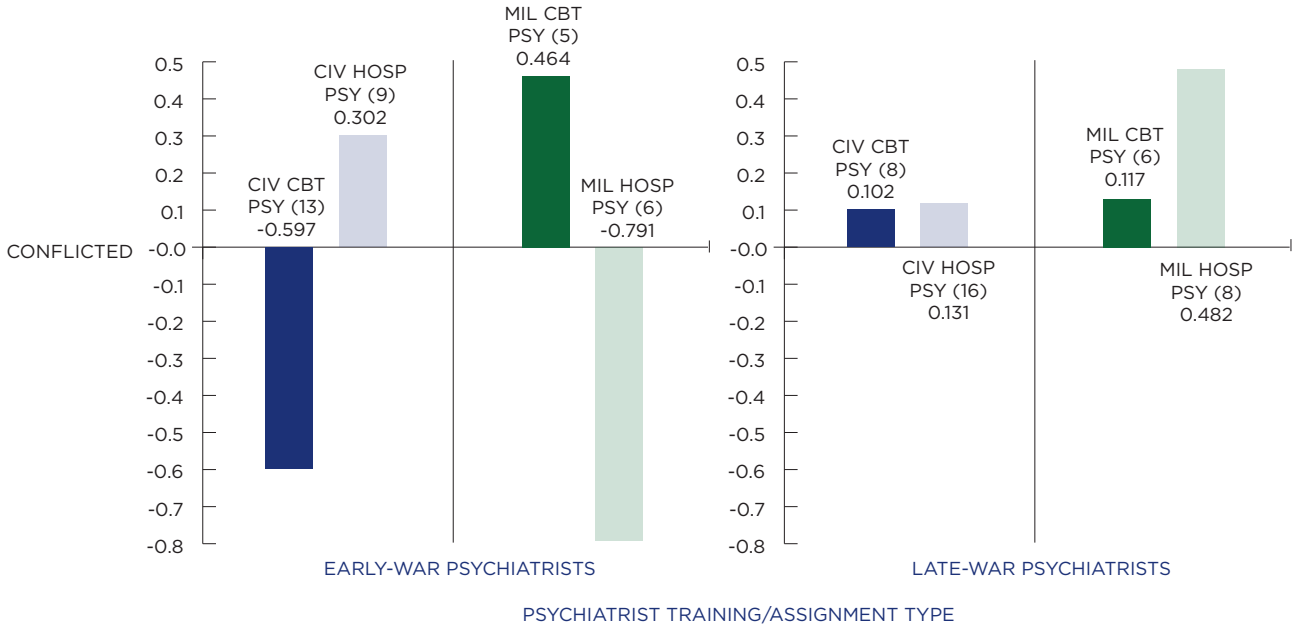
These 31 items were ranked by means of survey participants' agreement using a 1-to-5 scale where 1 = "strongly disagree" and 5 = "strongly agree." (N = 78 to 85). In the left column are the four factors (W, X, Y, and Z) from the factor analysis of responses (23 items) along with the factor loading for the items included in each factor.

Factor W: Patient Allegiance and Ethical Conflict
Factor X: Civilian Professional Allegiance and Psychiatrist Burnout
Factor Y: Opposition to the War and Compassion Fatigue
Factor Z: Opposition to Military Medical Structure and Policies

PIES: proximity, immediacy, expectancy, simplicity
USARV: US Army Republic of Vietnam

*Further analysis is provided in text.

FIGURE 11-2. Multiple regression results for Factor W: Patient Allegiance and Ethical Conflict, by three-way interaction of war phase, type of psychiatry training, and type of assignment in Vietnam (p <.01).



EARLY-WAR PSY: psychiatrist arrived in Vietnam before mid-1968
LATE-WAR PSY: psychiatrist arrived in Vietnam after mid-1968
CIV CBT PSY: psychiatry training was in a civilian program and psychiatrist served with at least one combat unit in Vietnam
CIV HOSP PSY: psychiatry training was in a civilian program and psychiatrist served only with a hospital or psychiatric detachment in Vietnam
MIL CBT PSY: psychiatry training was in a military program and psychiatrist served with at least one combat unit in Vietnam
MIL HOSP PSY: psychiatry training was in a military program and psychiatrist served only with a hospital or psychiatric detachment in Vietnam

may have been more sensitive to the ethical dilemmas than their civilian-trained counterparts. However, that the civilian-trained psychiatrists who served in hospitals would report more ethical conflict than their civilian-trained counterparts assigned to the combat units seems counterintuitive. It may indicate that the civilian-trained psychiatrists assigned to the combat units were buffered by combat unit membership. Recall from Chapter 5 that 21% of psychiatrists (18) in the WRAIR survey indicated that they served only with their original combat division and declined a mid-tour rotation to a safer and more comfortable hospital facility. These psychiatrists were almost exclusively civilian-trained and served during the first half of the war. Many indicated they eschewed reassignment because of their strong allegiance to their combat unit and comrades. It also may be the result of an unstable estimation due to the small sample size.

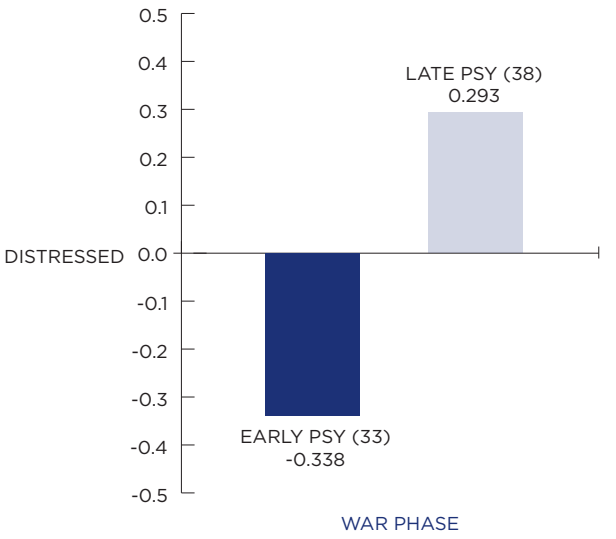
Factor X: Civilian Professional Allegiance and Psychiatrist Burnout. For this factor, a high score means the psychiatrist felt distress from social and professional opprobrium for serving in the war, being a "double agent" with patients due to his (the psychiatrist's) military rank and authority, the military's paying insufficient attention to human (risk) factors in Vietnam and providing inadequate psychiatric care, and the unwillingness of military leaders to access psychiatric care for themselves. This factor's inclusion of the item "Psychiatric clinical need exceeded clinical capability in Vietnam" suggests that psychiatrist "burnout," that is, exhaustion from an overwhelming workload,[103] was important in this factor. With regard to the multiple regression analysis, Figure 11-3 depicts the statistically significant main effect of phase of the war in which the psychiatrist served, with distress secondary to this factor increasing among Army psychiatrists serving in Vietnam

after the war passed the midpoint and American resolve to achieve victory was replaced with an urgency to pull out. Neither the setting of one's psychiatry training nor assignment with a combat unit in Vietnam apparently buffered these late-war feelings.

Factor Y: Opposition to the War and Compassion Fatigue. For this factor, a high score means the psychiatrist felt the war was not justified, was immoral and destructive, and that the expectations of the mental health personnel in Vietnam by both soldiers and their leaders were grossly exaggerated. This factor's inclusion of the item "Soldiers and unit leaders expected magic from mental health team" suggests that "compassion fatigue" (emotional distress among those caring for traumatized individuals consequent to secondary traumatization[103]) was important in this factor. With regard to the multiple regression analysis, Figure 11-4 depicts a statistical trend regarding the interaction between the phase of the war in which the psychiatrist served and the type of assignment he had in Vietnam. This suggests that among those who served during the first half, neither the combat nor the hospital psychiatrists expressed a high score for this factor (ie, exceeding 0.0), but on a relative basis the combat psychiatrists indicated more opposition to the war and compassion fatigue than the hospital psychiatrists. However, this relationship strongly reversed among the psychiatrists who served during the second half, that is, the hospital psychiatrists expressed strong opposition to the war and compassion fatigue compared to the combat psychiatrists who did not. Whereas it is expectable to find a higher overall opposition to the war among psychiatrists who served in the second half of the war, the low score for the psychiatrists assigned to the combat units is noteworthy. Perhaps this finding is explained by the lowered combat activity in the second half of the war and a morale-buffering effect from psychiatrist membership in a line, that is a nonmedical, unit. Inversely, the high scores for the hospital psychiatrists are consistent with the late-war shift in psychiatric challenge to the support units and the hospitals who served them.

Factor Z: Opposition to Military Medical Structure and Policies. For this factor, a high score means the psychiatrist was averse to assignment in Vietnam and felt frustrated in the practice of psychiatry because enlisted patients mistrusted those with rank, evacuation decisions could be reversed by unsympathetic military physicians

FIGURE 11-3. Multiple regression results for Factor X: Civilian Profession Allegiance and Psychiatrist Burnout, by war phase ($p < .007$).



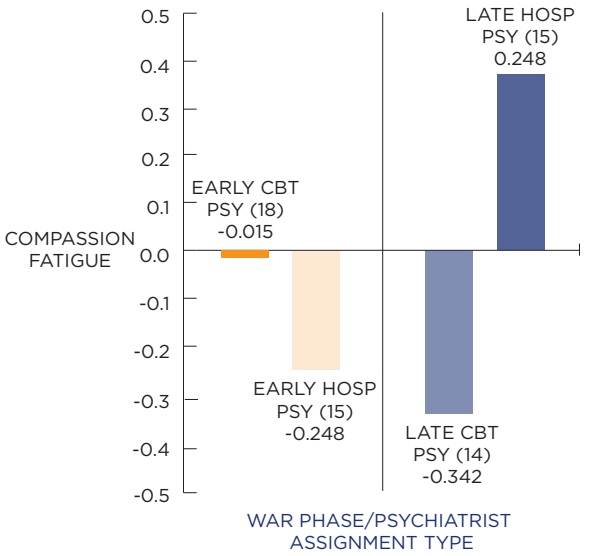
EARLY PSY: psychiatrist arrived in Vietnam before mid-1968
LATE PSY: psychiatrist arrived in Vietnam after mid-1968

(insinuating military-loyal psychiatrists) further up the evacuation chain, and line commanders decided the final disposition of soldiers diagnosed with character disorder. With regard to the multiple regression analysis, Figure 11-5 depicts the statistically significant main effect of type of the psychiatrist's pre-Vietnam psychiatric training. Compared to their Army-trained counterparts, civilian-trained psychiatrists were frustrated throughout the war by the unique policies pertaining to patient care that represented the preeminence of military expediency.

In conclusion, analysis of the Army psychiatrists' responses to statements pertaining to subjective reactions to service in Vietnam produced a number of interesting and provocative findings. The following impressions seem notable; however, because of small sample size and the delay between service in Vietnam and participation in the survey, the results are only suggestive.

- The results coincide with the strong negative reactions to service in Vietnam that were expressed by many of the survey participants in their answers to the open-ended questions and their voluntary comments, especially the psychiatrists who served in the second half of the war.

FIGURE 11-4. Multiple regression results for Factor Y: Opposition to the War and Compassion Fatigue, by two-way interaction of war phase and type of assignment in Vietnam ($p < .08$).

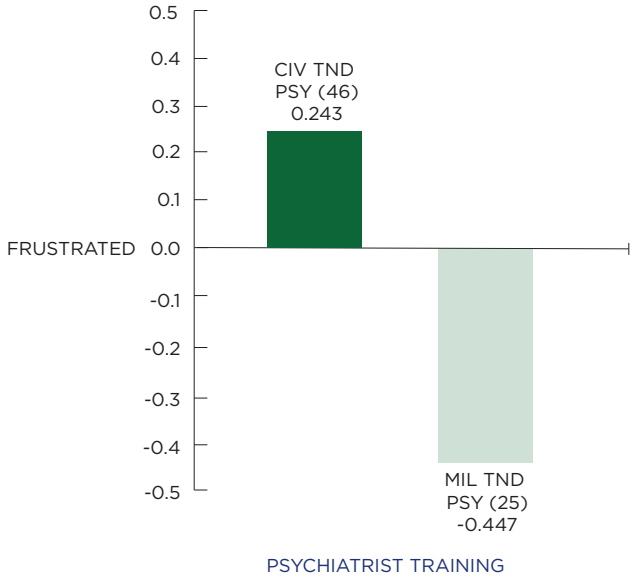


EARLY CBT PSY: psychiatrist arrived before mid-1968 and served with at least one combat unit in Vietnam
EARLY HOSP PSY: psychiatrist arrived before mid-1968 and served only with a hospital or psychiatric detachment in Vietnam
LATE CBT PSY: psychiatrist arrived after mid-1968 and served with at least one combat unit in Vietnam
LATE HOSP PSY: psychiatrist arrived after mid-1968 and served only with a hospital or psychiatric detachment in Vietnam

- Only one of the four factors produced by the factor analysis clearly defined ethical dilemmas (Factor W: Patient Allegiance and Ethical Conflict). The other three factors acknowledged stress in the performance of psychiatric duties in Vietnam but were apparently experienced by the survey psychiatrists as discrete from ethical conflict. This suggests that, whereas there may be conceptual agreement that an ethical dilemma is present in a given clinical event based on its particular circumstances, the experience of the individual clinician involved may be affected by additional variables, some of which can be measured separately, that may exacerbate, mitigate, or have no effect, on their experience of it as an ethical dilemma. Some of this variability was found to be associated with principal distinctions between the deployed Army psychiatrists (ie, Army vs civilian psychiatry training, era of the war served, and assignment with a combat unit in Vietnam). In other words, an Army psychiatrist who served in Vietnam could be opposed to the war, feel at odds with civilian colleagues about clinical priorities, feel overwhelmed by the psychiatric challenges or by compassion fatigue, or object to Army medical policies that served military expediency, and yet not feel ethically conflicted while implementing the military forward treatment doctrine. Of course, as one respondent indicated, it is also possible that some may have experienced little ethical strain because they opposed and subverted the doctrine.
- Having received one's psychiatric training in an Army program did not necessarily protect psychiatrists from experiencing ethical strain; in fact, it may have exacerbated it. Figure 11-2 suggests that the military-trained group was more strained when serving in combat divisions during the first half of the war and when serving in the hospitals in the second half. This seems notable because the clinical challenges were heightened in both of those settings depending on the phase of the war.

Finally, although it has been demonstrated that clinician values can affect clinical decision making,[18,19] there were no studies of the effects of such values on clinical outcomes either in Vietnam or among Vietnam veterans. Still, the divergence of perspectives between subgroups of psychiatrists represented here is striking. Were clinical decisions of some late-war psychiatrists affected by doubt and demoralization? As the nation turned progressively against the war, did they, perhaps especially those with civilian training, lean more in the direction of a protective, sympathetic overdiagnosis (at least from the military's point of view) and overevacuation of soldiers as suggested by Jones,[118] even though in past wars such a clinical attitude threatened force conservation and contributed to sustained disability among soldier-patients? Future research should systematically explore clinical outcome as it relates to the organizational, personal, and interpersonal dimensions that affect orientation to service in military psychiatrists (and allied mental health personnel).

FIGURE 11-5. Multiple regression results for Factor Z: Opposition to Military Medical Structure and Policies, by type of psychiatry training (p <.005).



CIV TND PSY: psychiatry training was in a civilian program
MIL TND PSY: psychiatry training was in a military program

Perceived Caliber of Leadership From the US Army Republic of Vietnam Psychiatry Consultant

The questionnaire asked respondents to rate (on a 5-point scale) the extent of their agreement or disagreement with the statement "I found the guidance from and input to the Vietnam theater Psychiatric Consultant timely and beneficial" (ie, the senior Army psychiatrist in Vietnam). The mean for 79 participants (excluding the Consultants) was 2.75 (SD = 1.41), suggesting an absence of strong feelings about this question.

However, to look closer at this question from the perspective of military chronology, the study participants were divided by three phases of the war: the buildup phase (n = 31), the transition phase (n = 25), or the drawdown phase (n = 23). Means for the psychiatrists of the early (3.13), middle (2.88), and late (2.09) stages of the war suggest decreasing confidence in the leadership of the theater Psychiatry Consultant. This was substantiated in an analysis of variance (ANOVA) conducted on the three means ($F = 4.07$, $df = 2,76$, $p < .052$). Further confirming this impression, the most conservative post-hoc multiple range test of differences among these groups (Scheffe's) revealed significant differences ($p < .05$) between the late and early groups and between the late and middle groups.

This finding—that as the war proceeded, the deployed psychiatrists felt less allied with, and supported by, their theater Psychiatry Consultant—appears to be important. As Menninger pointed out regarding World War II, one of the most valuable functions of the command consultant was to improve the morale of his colleagues in the field:

> The consultant brought status and prestige to the clinician who often felt neglected and forgotten. . . . A renewed sense of a professional identity was gained in addition to the military model to which most [of the psychiatrists] were overwhelmingly and scrupulously loyal, even though discouraged about their own activities.[119(p82)]

Of course, the progressive decline in confidence in their consultants among the Vietnam psychiatry respondents must be considered as affected by all the other declining features in the second half of the war: the rise in clinical demand, the eroding public and professional support for the war, the declining morale among Army personnel in Vietnam, and the role uncertainties in psychiatrists. That is, one can speculate that their waning confidence in the Psychiatry Consultant was in part a reflection of waning confidence in themselves. But these differences could also be explained by the declining levels of pre-Vietnam military psychiatry experience among successive Psychiatry Consultants (see Chapter 4). One senior Army psychiatrist wrote, "There was a tendency [in the last years] to assign less than the best we had as [USARV Psychiatric] Consultant—it was more a game of 'who can we get/force to take the position,' [rather] than 'who is our most qualified.'" It does seem logical in retrospect that, under such deteriorating circumstances, consultants with more practical experience should have been provided, perhaps even in greater strength, or with an augmented staff. The evidence indicating a seriously declining confidence in the clinical and administrative leadership of the theater Psychiatry Consultant is even more noteworthy when recalling that the psychiatrists who served in the latter half of the war were themselves less experienced.

Post-Vietnam Psychiatrist Retention

Sixty-five percent (52 of 80) of the WRAIR survey participants indicated that they left the Army within the year following their service in Vietnam, and an additional eight left after their third year (reaching a total of 75% out of uniform within 3 years of completing their tour in Vietnam). The interpretation of this finding is uncertain as these individuals represented various career paths (starting with military vs civilian psychiatric training) and obligations with the Army (such as the Berry Plan deferment) that influenced post-Vietnam retention. However, the subjective data reviewed earlier indicating considerable bitterness toward the Army among the psychiatrists who served in Vietnam would explain an overall disinclination for further service beyond one's irreducible obligation. Such a drain on Army psychiatry's most experienced individuals would have been detrimental for subsequent needs of the Army, especially for training and preparation of future mental health providers and leaders.

SUMMARY AND CONCLUSIONS

This chapter began with a review of the rationale for military psychiatry's traditional forward treatment doctrine and its associated ethical quandaries. It also explored the subjective experience of the Army psychiatrists who served in Vietnam with an emphasis on the military policies and circumstances that affected their professional activities and shaped the ethical frame within which they functioned. The following summary of this chapter's observations and findings includes a reiteration of selected historical features. All references to hospital psychiatrists are intended to also include those who were assigned to the psychiatric specialty detachments.

Historical Context

- **The rationale for the traditional military forward treatment doctrine brought to Vietnam was pragmatically derived from the preceding main force wars.** Although the doctrine is illustrated in this chapter using the example of the management and treatment of the soldier with a combat stress reaction, many other clinical activities of military psychiatrists in the combat theater are variations of the model.
  - The typical combat exhaustion casualty manifests a stress-induced condition that appears to be reversible, at least in its acute stages. Because it arises under the unique circumstances of warfare, it is considered to be distinct from similar stress reactions seen among civilians (acute stress reaction). In its inception, it is not a PTSD.
  - Although there are other pathogenic contributions, overall it is presumed to represent a final common pathway in which the overwhelmed soldier's self-protective motivation has eclipsed his commitment to his combat buddies and his unit.
  - Nonetheless, it is the soldier's duty to recover as quickly as possible and return to duty status—even if he is hesitant, expresses a moral opposition to killing, or faces additional physical and psychological risks.
  - The military forward treatment doctrine serves that objective by providing the affected soldier simple but abbreviated physical and psychosocial support near his unit and the fighting—including exhortation that he resume his duty function.
  - The military forward treatment doctrine is justified as a wartime necessity, that is, supporting force conservation and national defense.
  - In a paternalistic sense, it also is justified based on past observations that such a treatment approach reduces chronicity (morbidity) among combat-affected soldiers.

- **There are potential ethical conflicts that surround the military psychiatrist in the implementation of the doctrine.**
  - The psychiatrist is also a soldier and subject to the authority and hierarchical values of the military.
  - He is obligated to aid his patient in fulfilling his duty *if he can function*—even if the psychiatrist is reluctant.
  - Symptom elimination is *not* the clinical priority as would be the case in civilian medical practice.
  - "Tender" individualist values, that is, ideals of humanitarian care of the sick and wounded, can be at crossed purposes with "tough" collectivist

values, that is, those favored by the military in the service of combat objectives.

- **This ethical conflict is theoretical until war begins. Under wartime circumstances military psychiatrists can feel placed in an ethically difficult position because of a clash of values.**
  - Accomplishment of military objectives is crucial to victory.
  - Severe losses are predicted and critical manpower shortages are anticipated.
  - Overall combat effectiveness may be eroded by excessive numbers of unrecoverable psychiatric casualties.
  - Some traumatized soldier-patients may incur further harm if they are incompletely treated and face more combat exposure, that is, if not protected.
  - Some soldier-patients may incur increased psychiatric morbidity if treatment is prolonged, that is, if they are overprotected.
  - The Army expects military psychiatrists to distinguish between these two possibilities and to implement the forward treatment doctrine when appropriate.
  - The profession of psychiatry may or may not endorse use of the doctrine.

- **In the more popular wars before Vietnam, the Army's forward treatment doctrine rested on a foundation of mutually reinforcing ethical positions that seemed sufficiently humanitarian.**
  - Military psychiatrists felt they were conforming to the expectations and values of the military.
  - There was congruence between what was perceived to be best for the soldier and best for America. The doctrine appeared to not only contribute to national defense but also represent the most effective, scientifically based regimen for protecting soldiers from further combat traumatization and from chronic psychiatric disability.
  - Military psychiatrists were apparently also conforming to the expectations and ethical values of the profession of psychiatry.
  - The psychiatrist who failed to understand both sides of the soldier's struggle to overcome his fear or moral doubt could overly empathize with his self-protective tendencies, "overdiagnose" and "overevacuate," thereby increasing his psychiatric morbidity and jeopardizing the military mission.

Vietnam Observations and Impressions

- **Army psychiatrists assigned to Vietnam late in the war experienced demoralization in sympathy with the troops.** Many psychiatrists (and allied mental health personnel) who served in the second half of the war appear to have been greatly affected by the psychosocial deterioration there. As indicated in earlier chapters, these later cohorts of replacement psychiatrists faced an accelerating array of more complex, and in many ways unique and unanticipated, problems in Vietnam. Furthermore, many apparently shared the demoralization and antiwar passions of the dissenting soldiers that they served, personally if not publicly objecting to US objectives in Vietnam, and became uncertain of their own goals and procedures, including the forward treatment doctrine. More specifically they questioned the treatment regimen that would induce soldiers to believe that further exposure to combat, or even the hardships associated with service in the theater, was in their best interests; and they evidently worried they might "expect" soldiers to risk their lives or their mental stability without moral justification.

- **Military psychiatry and military psychiatrists were openly challenged by civilian psychiatrists regarding the ethical justification for the forward treatment doctrine.** The alignment of justifying moral principles for combat psychiatry's doctrine that had held throughout the earlier wars was precariously balanced. During Vietnam, opponents of military psychiatry argued that the doctrine's treatment goals and methods violated psychiatry's humanitarian principles by neglecting the needs of the soldier in order to wage an unjust war. They alleged that psychiatrists in uniform corrupted the principles of humanitarian care (violated the principle of primum non nocere), opposed the vital interests of American society, and principally served political interests and military expediency while coercing symptomatic soldier-patients to face further risks.

- **The proportion of civilian-trained psychiatrists assigned in Vietnam increased in the latter half of the war, and overall they were less convinced of the preeminence of military values and policies.** They had come directly from a fractious American society and were surrounded by a professional climate hostile to military psychiatry.

- **Although the psychiatrists assigned in Vietnam were influenced by powerful, potentially competing value systems, they could not realistically assess some of the most important factors affecting the balance of harms and benefits associated with their treatment decisions.** Army psychiatrists serving in Vietnam functioned in the dark. Although they knew of the successful implementation of the military treatment doctrine in past wars, they had no reliable information about whether their patients might face unacceptable risks because of its use in Vietnam. Nor could they comprehend whether the doctrine truly served public welfare. Even if the conflict met objective standards for a just war,[12] its morality for the psychiatrist in Vietnam, just as for the soldier or citizen, may have been far more subjectively determined.

- **The ethical burden for Vietnam's military psychiatrists was magnified because they struggled with these issues alone.** Civilian psychiatry failed to recognize their dilemma; monitor the institutional regulations, policies, and treatment doctrine that affected the practice of military psychiatry; or provide them with ethical guidelines. Furthermore, the tendency for critics to equate the questions about the institutional abuse of psychiatry with those regarding the conduct of the individual psychiatrist greatly added to the burden associated with the military psychiatrist's role.

Walter Reed Army Institute of Research Survey Results

The robust responses to the survey, both qualitative and quantitative, indicated that despite the 10 to 17 years since their service there, most of the psychiatrist participants had strong feelings—typically negative—regarding their tour of duty in Vietnam. The general impression was that many still sustained substantial personal and professional anguish as a result.

Qualitative Responses

- **Many of the study psychiatrists indicated they still felt bitter about the war and their role in it.**

- **Psychiatrists with civilian training in psychiatry generally, and psychiatrists who served in the second half of the war regardless of training background, appeared to have the most role-linked psychological conflict.** Data reviewed in earlier chapters suggest more specifically that as the war prolonged, they increasingly felt overwhelmed by the challenges associated with the raging drug epidemic, racial tensions and incidents, and outbreaks of violence; betrayed by the Army because of their poor preparation and support in the theater; and blamed by their stateside colleagues and countrymen for doing the job it was their duty to do.

- **The responses also suggest wide variability in adapting to these pressures.** Some acknowledged the ethical and personal strain, some said they felt none, while others indicated that their solution was to intentionally shield patients.

Quantitative Responses

The factor analysis of participants' responses to a set of statements pertaining to professional frustrations and ethical dilemmas in Vietnam yielded four statistically distinct clusters (factors). This suggested that the deployed psychiatrists could have been stressed in their professional roles from compound sources, and interpretation of the stress could have differed considerably among them. However, multiple regression analysis yielded significant differences among psychiatrists for each of the four factors based on the three key dichotomous distinctions between psychiatrists: (1) in which half of the war they served, (2) whether their residency training in psychiatry was in a civilian or military setting, and (3) whether they served in a combat unit at some point or exclusively in a hospital. Findings included:

- **Psychiatrists were stressed by ethical conflict (Factor W):**
  - **Second half of the war: Regardless of site of residency training or assignment type in Vietnam, psychiatrists overall indicated some measure of frank ethical conflict in their role**

of "conserving the fighting strength." This was especially true for the psychiatrists with military training who were assigned to the hospitals. The increasing ethical conflict is predictable as opposition to the war increased. The rising clinical challenge among the support troops and the psychiatrists working in the hospitals who served them in the second half of the war may be predictable also. The military-trained psychiatrists who worked in the hospitals may have experienced more ethical strain because of greater loyalty to military values, structure, and discipline adopted during their Army residency training.

- **First half of the war: Greater ethical conflict was also reported by those who served in the first half of the war who had military training and were assigned to the combat units, and by those who had civilian training and were assigned to the hospitals.** Greater combat-generated clinical challenge could be found in the combat units in the first half of the war because of higher combat intensity and stress, which could explain greater ethical conflict for psychiatrists assigned to combat units. But the greater ethical strain among the psychiatrists with military training may again be due to greater loyalty to military values, structure, and discipline. Hospitals were not exempt from having increased combat-generated clinical challenges as they were required to treat the more intractable cases from the combat units. However, it seems plausible to explain the increased ethical strain among the civilian-trained psychiatrists assigned with the hospitals based on their not being afforded the morale-buffering effect that the combat psychiatrists seemed to derive from their membership in a line, that is, a nonmedical unit.

- **Psychiatrists were stressed by the criticism of civilian colleagues and professional exhaustion (Factor X): In general, psychiatrists who served in the second half of the war indicated they felt greater criticism from civilian peers for doing their job and depleted by the challenges they faced compared to those who served in the first half of the war.** This is true regardless of whether their residency training in psychiatry was in a civilian or military institution and whether they served in a combat unit or in a hospital.

- **Psychiatrists were stressed from feeling opposition to the war and from feeling overwhelmed by the suffering they encountered (Factor Y):**
  - **Second half of the war: Psychiatrists assigned to hospitals expressed more opposition to the war and compassion fatigue than their counterparts with combat units as well as all early-war psychiatrists.** This is consistent with the increasing antiwar spirit among Americans and troops in Vietnam as the war lengthened. It also is consistent with the dramatic rise in psychiatric and behavior problems among noncombat troops, the majority of whom would be treated by hospital-based psychiatrists.
  - **First half of the war: Psychiatrists with combat units expressed relatively more opposition to the war and compassion fatigue than early war hospital psychiatrists.** This is consistent with apparently greater levels of psychiatric and behavior problems within combat units because of the higher combat intensity in the first half of the war.

- **Psychiatrists were stressed by having to conform to military medical and psychiatric policies (Factor Z): Throughout the war, compared to military-trained psychiatrists, civilian-trained psychiatrists were bothered more by the organizational modifications of the structure of medical and psychiatric care that favored military expediency.**

- **Survey respondents indicated that over the course of the war there was a significant decline in confidence in leadership provided by the successive USARV Psychiatry Consultants, the senior Army psychiatrists in Vietnam.**

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