CHAPTER 12

Lessons Learned: Linking the Long, Controversial War to Unsustainable Psychiatric and Behavioral Losses

. . . [I]t is important that the psychiatric experience of Vietnam and its aftermath be subjected to continuous re-evaluation utilizing new source material, operational concepts and conceptual procedures so that the important lessons in military psychiatry hidden within the heart of human tragedies like Vietnam be perceived and applied to the mitigation of human suffering in the practice of psychiatry and in future conflicts.[1(p19)]

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This is a photograph of Sergeant First Class Keith Abrahams, a senior enlisted social work/psychology specialist, in an encounter with a Vietnamese man at a Cham temple near Nha Trang in 1969. Their apparent interpersonal remoteness is emblematic of a widespread problem. Because friend and enemy alike were both indigenous (within Vietnam) and exotic (to Americans), US government and military leaders, as well as the troops, did not comprehend their historical and cultural set, the complexity of their motives, and their capabilities. Photograph courtesy of Richard D Cameron, Major General, US Army (Retired).

Material presented in the preceding chapters provides the basis to characterize the Army's psychiatric experience in Vietnam, propose lessons learned, indicate lingering questions (of which there are many), and offer recommendations in retrospect. Despite four decades having passed since the end of hostilities in Vietnam, this information may prove especially worthwhile considering:

- **America fought a new type of war in Vietnam—a counterinsurgency/guerrilla war.** Vietnam was a protracted, divisive, bloody, irregular, counterinsurgency/guerrilla war in which US forces utilized superior weaponry, communication, medical care, and transportation, especially heliborne. This was in striking contrast to the preceding high-intensity wars, which were of shorter duration and accompanied by full mobilization and censored public knowledge. Thus in certain important respects Vietnam appears

to have presaged the type of American wars that have arisen so far in the 21st century and that may become more common in the future.

- **The US military went to war in Vietnam armed with new psychopharmacologic capabilities.** Vietnam provided military medicine with its first set of physicians—especially psychiatrists—routinely trained in the use of neuroleptic and anxiolytic tranquilizing medications and the tricyclic antidepressants. These compounds had revolutionized the practice of psychiatry generally, including military psychiatry. More specific to the combat environment, in contrast to the sedatives used sparingly in earlier wars, these new medications were widely utilized in Vietnam as therapeutic agents because they were far less likely to produce sustained central nervous depression and interfere with military performance.
- **Vietnam ultimately became a lost cause.** Despite great effort and sacrifice, the United States failed to achieve its political and military objectives in Vietnam. Withdrawal was ultimately forced by opposition at home, not military defeat, and became a lengthy and tentative process that produced thousands of additional casualties, widespread soldier demoralization and dissent, and unprecedented numbers of psychiatric and behavioral problems.

This work is a composite of published and unpublished reports by psychiatrists and other medical and mental health personnel describing their activities, observations, or studies while there, as well as documents pertaining to soldier morale and mental health in the theater. This approach was taken because the Army Medical Department failed to develop in a timely fashion a historical summary of psychiatry in Vietnam or systematically study the related problems that arose there for "lessons learned." Furthermore, in contrast to World War I, World War II, and the Korean War, the lack of archival material from Vietnam prohibited database analyses. Potential primary source material was evidently lost, abandoned, or destroyed at the conclusion of hostilities (see Appendix 13, Parrish's postwar commentary on why this happened). Some of the deficits in this alternative approach were offset by findings from the 1982 Walter Reed Army Institute of Research (WRAIR) survey of veteran Army psychiatrists (N = 115 of the estimated 135 Army psychiatrists who were assigned in Vietnam). Although there are limitations to this study that have been previously noted in each chapter, patterns have emerged that appear to be especially instructive.

THE UNEVEN PSYCHIATRIC LEGACY FROM VIETNAM

The existing psychiatric literature that came out of Vietnam is fragmented and misleading. This is primarily because it mostly rests on individual psychiatrists' motivations to publish their accounts, and these are heavily skewed toward the first and more optimistic half of the war. Overall the only consensus is that there was a relatively low incidence of acute combat exhaustion (also known as combat stress reaction [CSR]) casualties in Vietnam (estimated to be 6–7 cases/1,000 troops/year). Otherwise rival claims as to the predominant clinical conditions and their causes and treatment have come from psychiatrists whose vantage points may have been affected by time and role differences and, in some instances, political perspective. The following are illustrative examples:

- *Disorders of frustration and loneliness.* Jones, in his overview (with Johnson) of the Army psychiatric experience in Vietnam, emphasized that "disorders of loneliness"—alcohol, venereal disease, and drug problems—predominated in Vietnam over combat stress-related disorders.[2] In his opinion, neither combat stress nor soldier dissent was of overriding importance. Instead, low combat intensity led to lowered unit cohesion, which produced "nostalgia" casualties (disabling homesickness), especially among noncombat troops, which led to various forms of military ineffectiveness and misconduct. ("[T]he disenchantment toward the end . . . may not have been as important a factor in generating nostalgic casualties as the loss of unit cohesion."[3(p67)]) But Jones was likely affected by having served as a division psychiatrist in the first year of the war where he reported he treated no combat fatigue cases nor encountered soldier dissent.[4]
- *Character and behavior disorders.* During roughly the same time frame as Jones, Bourne, a WRAIR research psychiatrist operating in the theater, noted that the predominant cause for psychiatric

attrition in Vietnam was the character and behavior disorder; however, he determined that many of these soldiers, at least those who were hospitalized, were exaggerating their symptoms to secure a socially acceptable path to avoid hardships and combat risks.[5]

- ***Psychological reactions from antiwar attitudes.*** Two years later, Talbott served in Vietnam as a hospital psychiatrist and subsequently declared that all of his (nonpsychotic) cases were primarily affected by opposition to serving in Vietnam ("a widespread negative sociologic phenomenon"[6]). Notably, Talbott had been strongly against the war before he was assigned in Vietnam and became a prominent antiwar activist following his return.
- ***Psychological reactions from fighting guerrilla warfare.*** Serving 2 years after Talbott (1969), Renner, a Navy psychiatrist, saw many of the same symptomatic behaviors among Marine psychiatric casualties as the others, but he was convinced that they were primarily affected by the pernicious nature of the counterinsurgency/guerrilla warfare.[7] He also proposed that their pathodynamics were further influenced by the growing antiwar movement in the United States. ("Our troops in Vietnam have not been able to rely on socially reinforced rationalizations [that existed in earlier wars] to help them justify their . . . doubts about the morality of their actions."[7(p172)])
- ***Drug problems and dissent.*** This author's observation (presented in the Prologue)—that the Army in Vietnam was disabled by a social disorder and the collapse of military discipline—was certainly affected by serving the following year (1970–1971), when the new heroin epidemic took center stage along with myriad antimilitary behaviors, including soldiers threatening to assassinate their leaders.
- ***Minimal use of psychotropic medication.*** As reviewed in Chapter 7, the available literature amply documented that Vietnam represented the first effective use of modern psychotropic medications under combat circumstances (ie, the anxiolytics, neuroleptics, and tricyclics—drugs without a high sedating potential); yet a recent review of the military use of psychotropics written under Army auspices failed to acknowledge that the use of these medications in Vietnam was historically unique.[8] By way of contrast, Stewart L Baker Jr, senior Army psychiatrist and Neuropsychiatry Consultant to the Army Surgeon General during the latter years of the war, summarized the vital role served by those medications in the theater as follows: "[In Vietnam] *most combat syndromes* [emphasis added]—including acute agitation, hysterical episodes, and even psychosomatic problems—responded encouragingly within 48 hours to heavy doses of Thorazine coupled with nighttime sodium amobarbital sedation. Thereafter, medication could be rapidly reduced, and psychotherapy could profitably be undertaken."[9(p1836)]
- ***Posttraumatic stress disorder.*** In one sense this is really a postwar feature in that posttraumatic stress disorder (PTSD) did not exist as a defined diagnostic entity during the war but was later devised to account for the high prevalence of psychiatric and behavior symptoms among Vietnam veterans. Many psychiatric observers came to believe that PTSD was a unique readjustment problem borne by Vietnam veterans—despite the evidence for large numbers of similarly affected veterans from earlier wars.[10] However, this led to conflation of the clinical concept of PTSD with that of combat exhaustion (or combat stress reaction), which many took to mean that PTSD was the preeminent condition arising *in the theater*.

In fact, psychiatric problems in Vietnam cannot be easily characterized by a single salient feature. As the following synopsis illustrates, the war consisted of two halves, each the inverse of the other: a "good" war—in which the US military was effectively fighting the enemy, followed by a "bad" war—in which the US military was fighting itself. Each occurred under distinctly different military and sociopolitical circumstances and with a totally different set of personnel. Also in each, psychiatric resources were dominated by different professional challenges.

SYNOPSIS OF CRITICAL PSYCHIATRIC AND BEHAVIORAL FINDINGS FROM VIETNAM: FROM CONFIDENCE TO CRISIS

During the first half of the Vietnam ground war (mid-1965 through mid-1968) the deployed Army psychiatrists and allied medical and mental health

personnel effectively treated an array of problems, and according to their individual reports the overall morale in the theater stayed positive, the numbers of referrals were manageable, and prevention and treatment of combat stress-related disorders (granted in modest numbers) remained the priority. Then, as described in Chapter 1 and Chapter 2, the military and political events that occurred in 1968 not only ended America's resolve to win in Vietnam, but also led to radical changes in strategy, tactics, and troop attitudes—as well as overall social dynamics. During the second half (mid-1968 to mid-1972) the military drawdown saw a dramatic drop in Army morale along with unprecedented levels of dissent, misconduct, drug use, and psychiatric referrals. Despite reduced combat activity, a huge proportion of previously functional soldiers (replacements) became psychiatric and behavioral casualties. In time military order and discipline became marginal while military leaders, law enforcement, and mental health services were all severely challenged. The following is a more detailed list of prominent findings:

- ***Psychosocial disorders progressively outweighed combat-generated ones.*** In contrast to prior American wars in the 20th century, acute psychiatric casualties generated by the stress of combat (ie, shock trauma) were not the predominant clinical conditions requiring professional attention. They also did not become a force conservation problem during the war. On the other hand, noncombat-related psychiatric and behavior problems accelerated despite declining combat intensity.
- ***Insidious stressors were associated with fighting counterinsurgency/guerrilla warfare.*** Evidence suggests that the enemy's guerrilla strategy and tactics and the bloody, ambiguous, protracted, and often discouraging nature of fighting provoked large numbers of troops to develop diffuse behavioral, psychological, and psychosomatic reactions that remained mostly unrecognized for what they were—partial trauma and strain trauma (ie, emotionally taxing events—singular or recurring—that were not of sufficient intensity at the time to make them disabling, but that were nonetheless psychologically damaging). It is further speculated that these more subtle factors affected the health and adjustment of many veterans as well.
- ***Psychotropic medications were commonly prescribed and highly valued.*** Among troops who suffered with various psychiatric symptoms in Vietnam, including combat-related ones, new psychotropic medications assumed a primary role in facilitating their treatment, restoring them rapidly to function, and minimizing disability. However, prescribing physicians had no systematic way to measure short-term and long-term risks associated with their use.
- ***Morale, conduct, and mental health problems started to climb between mid-1968 and mid-1970.*** The two years following the enemy's Tet offensives, which occurred in the winter and spring of 1968, saw a rise in numbers of troops, including those with no combat exposure, referred for disciplinary problems, racial disturbances, challenges to military authority, drug abuse, and character and behavior disorder diagnoses.
- ***Low morale and associated conduct problems became disabling from mid-1970 through mid-1972.*** During the last 2 years of the drawdown, various forms of misconduct increased dramatically, especially heroin use (although most users were not addicted) and assassination attempts (or threats) on superiors. These appeared to express both the individual, "(combat theater) deployment stress reaction," and the group, "inverted morale" (eg, when the requisite military culture of commitment and cohesion retrogresses into a pathological, antimilitary one with features suggesting a class war between lower ranks and their superiors). This was somewhat more common among support and service support units. The resultant fulminating antimilitary spirit among the younger troops and the heroin epidemic failed to yield either to efforts to strengthen military leadership, commitment, and cohesion or conventional psychiatric approaches. In time administrative and law enforcement measures had to be intensified until the remaining troops were withdrawn.
- ***Coordination between Army leaders and psychiatrists in Vietnam was uncommon.*** As the war progressed, matters bearing on military morale and soldier mental health became quite entangled, and yet those primarily responsible for the former, that is, military commanders, and those responsible for the latter, that is, mental health personnel, did not typically maintain a running dialogue, especially

in instances of divergent command structures. This was verified from the WRAIR survey findings indicating that with few exceptions, the psychiatrists operating in the field had only limited success with efforts at primary prevention, that is, program consultation with line commanders, in an effort to prevent psychiatric casualties and behavior problems. Furthermore, it is especially regrettable that no documentation survives as to the efforts of those individuals assigned as Psychiatry Consultant to the Commanding General/US Army Republic of Vietnam (USARV) to influence senior Army leaders.

Thus, despite a promising beginning, the Army ultimately underwent an alarming psychosocial and institutional decline in Vietnam that was only indirectly related to fighting the enemy (but most certainly had to do with Vietnam being a theater of combat operations) and mostly did not produce the expectable types of psychiatric disorders. Regrettably following the war there was little apparent interest in studying what went wrong there, certainly by Army psychiatry. However, even at this late date it would seem foolish to assume that the political/social/environmental circumstances that led to the morale, discipline, and mental health failure in Vietnam were so historically unique, that the US military's experience there can be discounted as unlikely to repeat.

EPIDEMIOLOGIC CONSIDERATIONS: TROUBLING QUESTIONS WITH FEW ANSWERS

In the spirit of prevention, could more have been done by medical/psychiatric leaders to maintain esprit, bolster military order and discipline, preserve the mental health, and, by extension, help maintain combat readiness in Vietnam? During the drawdown did the medical leadership in Vietnam overlook early signs of mounting problems and fail to adjust psychiatric perspectives or modify the selection, preparation and training, and distribution/organization of mental health personnel to meet these challenges?[11,12]

Linked to these questions about the specific activities of military medicine and psychiatry in the theater (micro) are equally important questions about where they fit in the bigger picture (macro). The unprecedented high levels for psychiatric disorders and behavior problems during the last 2 years in Vietnam should prompt epidemiologic considerations that acknowledge a pathogenic pathway reaching back to decisions by the US government and military leaders regarding whether, and how, to fight in Vietnam, as well as to the administration's management of public relations during the war—decisions that indirectly but powerfully affected the mental health risks for the troops who fought there.

Indirect Influences on Troops Fighting in Vietnam (Macro)

Questions Regarding the Effects of Decisions Originating in Washington

- Was the initial decision to commit American ground forces in Vietnam, which was justified as necessary to oppose the worldwide spread of communism, a mistake?[13(p177)] (Or, put another way, should the commitment to go to war have had a higher threshold, that is, be limited to circumstances when the threat to the nation is more imminent?[14])
- Was it a mistake to rely on a strategy of winning via enemy attrition, that is, measured by body counts and kill ratios? (Should the United States and its allies instead have opted to fight for territorial pacification and control?[15,16])
- Were the force management policies implemented, which included the extensive reliance on conscription, 1-year tour limitations, and individual rotation schedules (vs full mobilization of US forces, including Reserves and National Guard, unit-based deployments, and individual tours, if not "for the duration" as in earlier wars,[11(p177)] at least by a rotation system based on hardship and risk)?

According to Bourne, apart from the means by which the administration sold the war to the American people, specific policy decisions were made, including those regarding the selection and deployment of forces, for the sole purpose of minimizing public opposition and dissent. These would include gradualism in the force deployment, minimization of perception of national sacrifice, avoidance of media censorship, exempting Reserves and National Guard units, 1-year tours, etc. The government's objective was to have the public feel that in most important regards in the United States, it was business as usual. These proved to be colossal miscalculations—mistakes that had equally enormous

consequences for the attitudes of the American public toward the war and, ultimately, for each soldier whose fate it was to serve there.[17]

Questions Regarding the Effects of Failed Public Relations

An equally important question was whether America's adversaries in Vietnam were more adept at psychological warfare than the US government and military. (Psychological warfare includes ways in which the soldier's perception of the reality of his situation is altered to varying degrees by the enemy's disinformation, and, in the case of the US military in Vietnam, by that coming from home and the antiwar movement—which also may have been manipulated by the enemy.) Particularly crucial in this respect, what should be assumed as to the public relations effect on the American people, as well as the troops, following the 1968 surprise Tet offensives in which the enemy, despite the Johnson administration's assurances of imminent defeat, launched coordinated attacks on cities and towns throughout South Vietnam? Although militarily unsuccessful, these attacks, along with the simultaneous siege of the Marine base at Khe Sanh and the extended battle for Hue, encouraged the American media to effectively make the case that the war could not be won at any reasonable cost.[18] The resultant reversal of public and political support for the war demoralized both those at home and those sent there to fight, which in turn powerfully affected the war's outcome.

In addition to these critical decisions that indirectly influenced soldier morale and mental health, the following are some of the more predominant stress-inducing and stress-reducing features in the theater that directly affected the morale, performance, and mental health of Army troops.

Direct Influences on Troops Fighting in Vietnam (Micro)

Stress-Inducing Features in the Buildup Years

- Vietnam was a very long way from home.
- Troops had to master formidable environmental and cross-cultural challenges.
- They had to tolerate the hardships associated with serving in a theater of combat operations.
- Because of the enemy's perseverance and elusiveness, no location was completely safe.
- Combat troops had to contend with a complex combat ecology that was dictated by the enemy's guerrilla strategy and tactics. Apparently for some troops this provoked excessive combat aggression.

Stress-Reducing Features in the Buildup Years

- Most troops (65%–75%) had noncombat assignments.
- The fighting was typically intermittent.
- US troops utilized helicopter mobility and other technological advantages including superior communications, individual weapons, and ordnance systems.
- Combat forays were of limited scope and staged from secure enclaves that were relatively comfortable and easily resupplied.
- Psychiatric observers praised the professionalism of the troops and the high caliber of leadership.
- There was an abundance of supplies, equipment, and support, especially medical support.
- Alcohol (legal) and marijuana (not legal) were available and used frequently. Although they obviously differ in important respects, evidently for most users these served as a safe means of stress-reduction and bonding (but for some they were disabling).
- The Army replacement policy of fixed, 1-year tours apparently had mostly a stress-reducing effect in the early years by allowing soldiers to anticipate the end of their tour.

Additional Stress-Inducing Factors in the Drawdown Years

- Prolongation of the war, the perception of military setbacks, and the growing numbers of casualties were ultimately extremely morale depleting.
- Also demoralizing were divisive US politics and corresponding shifting, sometimes contradictory, government and military policies for prosecuting the war and pursuing the peace.
- The young men who fought in Vietnam were affected by increasingly confrontational antiwar and antimilitary passions in America, which resulted in a reversal of national will regarding the war and a redefinition of patriotism—with honor becoming associated with opposing induction into, or cooperation with, the US military.
- They also were strongly influenced by incendiary social tensions in the United States, especially

the radicalized, liberal, "counterculture" youth movement (the "generation gap"); racial polarization; and widespread antagonism toward American institutions, especially the US military.
- Before deployment, replacement troops were surrounded by the rapidly expanding youth drug culture, which included more dangerous drugs.
- In 1970 indigenous South Vietnamese established an efficient heroin trafficking system throughout the country that greatly expanded heroin accessibility to soldiers in the field.
- The thousands of miles separating Vietnam from the United States were easily bridged by jet-speed transmission of discordant stateside attitudes as media representatives shuttled back and forth and the full complement of troops was replaced annually.
- The Army replacement policy of fixed, 1-year tours had more of a stress-inducing effect as the war wore on because it compromised unit cohesion and commitment as well as depleted the leadership pool of experienced officers and noncommissioned officers.
- Public scorn for those serving in the military, including returning veterans, became open and commonplace.

No data are available that would help answer questions as to whether military psychiatrists, or social scientists for that matter, had any influence on either the decisions made by the US military in Washington or regarding the administration's management of public relations. Also no evidence exists that the assigned military psychiatrists were able to influence any of these stress-inducing features in Vietnam. Still, in the spirit of "lessons learned," if it is not possible to agree that these two levels of phenomena are epidemiologically linked—macro-decisions regarding the "whether" and "how" a war is fought, and micro-influences pertaining to the experience of the individual soldier—then future military psychiatrists (and later those associated with the Veterans Administration [VA]) will, as was the case with Vietnam, mostly serve at the sump end of a long, complex, and sorry ordeal, relegated to providing sympathy and psychological/medicinal balms. (As one of the WRAIR survey psychiatrists commented, "waiting at the bottom of a ski slope").

NOVEL MENTAL HEALTH RISK FACTORS IN VIETNAM

Among these lists of principal psychiatric and behavioral findings and epidemiologic influences, six areas of mental health risk deserve elaboration as novel for US troops serving in Vietnam: (1) conventional troops fighting counterinsurgency/guerrilla warfare; (2) troops fighting for a divided America; (3) fixed, individual, 1-year assignments; (4) deterioration of military morale and discipline near the tipping point, with troops opposing military authority and the military mission (inverted morale); (5) soldier-patients treated by military psychiatrists with limited military experience and allegiance; and (6) Vietnam veterans returning to a rejecting society.

Conventional Troops Fighting Counterinsurgency/Guerrilla Warfare

As discussed in Chapter 6, the mental health effects for conventional ground troops fighting a mostly irregular type of warfare were not systematically addressed by military psychiatry in Vietnam. Overall combat intensity remained relatively low (measured by the wounded-in-action rate), and this correlated with the low rate for acute, disorganizing combat exhaustion cases (roughly estimated at less than 25% of rates seen in earlier, high-intensity wars). Furthermore, the record indicated that by military standards, combat exhaustion cases were effectively treated using a modified version of the traditional forward treatment doctrine, which included liberal use of pharmacotherapy. However, additional evidence suggested that the psychological toll for combat troops was greater than that measured by the combat exhaustion casualty rate. Renner, the Navy psychiatrist mentioned earlier, was the first to suggest that among the growing numbers of psychosomatic disorders, cases of misconduct, drug and alcohol problems, soldiers diagnosed as character and behavior disorders, and veterans with postdeployment PTSD, many were in fact "hidden casualties" of fighting counterinsurgency/guerrilla warfare (ie, they sustained partial trauma or strain trauma).

Anecdotally, some of the Army psychiatrists, as well as some individual case records, appear to corroborate this proposition. US combat units employed aggressive search-and-destroy tactics and other means to isolate the enemy in Vietnam; however, the enemy proved to be patient and elusive and utilized a variety of ruses

to dictate the tempo of the fighting. Over time, the gradual attrition of American troops resulting from the enemy's hit-and-run tactics (ambushes, sniping, mortar and rocket fire, and nighttime infiltration by sappers) and indirect means of attack (mines, punji sticks, and booby traps), as well as their terrorism toward civilians, apparently psychologically traumatized and demoralized uncounted numbers of US troops—like the "death by 1,000 cuts." Also, the principle US strategy of enemy attrition, that is, body counts and kill ratios, employed through the first half of the war appeared to be uniquely stressful for troops as well.

Troops Fighting for a Divided America

Chapter 1 described how the growing American opposition to the war rapidly accelerated following the events in early 1968 to become highly charged and confrontational. To fully appreciate the effects of this shift on the soldier fighting in Vietnam, one has to also take into account that this was the first televised war, and the Johnson administration chose not to suppress news coverage. After the war, Baker addressed the epidemiologic effects on the soldiers in Vietnam generated from the home front from his vantage point as the Neuropsychiatry Consultant to the Army Surgeon General during the latter years of the war. According to Baker,

> Simply, war cannot be waged successfully by the military alone. War can be waged successfully only by a united nation. During the Vietnam War, the painful absence of such unity was emphasized by the news media and was reflected to the units in the combat zone as diminished support and discredited performances.[9(p1837)]

Baker spoke of "the shock theater of combat,"[9(p1837)] referring to the public's experience with immediacy of "battlefield color television,"[9(p1837)] which provoked them to have a sense of their own, that is, vicarious, participation in the war, particularly identification with the destructive behavior by the US forces in the field. He felt that this generated guilt in the public psyche, which in turn evoked an urgency to withdraw from Vietnam. ("The public mind becomes . . . defensive [, tending] to abrogate any corresponding personal discipline or geopolitical responsibility."[9(p1837)]) Also, because they corresponded with military personnel in Vietnam ("strongly negative feedback"[9(p1837)]), such reactions, particularly those coming from friends and loved ones, contributed to some troops developing "incapacitating emotional disorders."[9(p1837)] According to Baker, the overall effect on the troops serving in Vietnam was, "chronic anxiety . . . often associated with a progressive feeling of alienation, isolation, decreased self-esteem, and inexpressible anger at the institutional aspects of combat—the structure of the military service, its standard policies, the political meaning proposed for the war effort, and so on."[9(p1837)]

Fixed, Individual, 1-Year Assignments

The military planners for Vietnam evidently assumed that fixed, individual, 1-year assignments would be the most efficient and effective method of force management and would also bolster morale and reduce attrition from psychiatric disorders and behavior problems, that is, it would be stress-mitigating in spreading the risk and hardship. Early in the war the merits of this policy were even defended by Matthew D Parrish (July 1967–July 1968), the third USARV Psychiatry Consultant.[19] According to Parrish, maximum effectiveness for a specific combat ecology was achieved when a soldier became symbiotic with his work group or infantry unit and its technology ("man-team-environment"[19(p9)]), which created, "the ultimate weapon for work or war."[19(p9)] He argued that the individualized replacement system in Vietnam was the least disruptive to the team's task adaptation (ie, it assimilated new members with the least disequilibrium to the group's effectiveness).

However, the record from Vietnam indicated that the rotation policy was increasingly problematic as the war prolonged, both from the standpoint of impairing the stress-reducing potential derived from soldiers bonding with fellow soldiers and unit leaders (cohesion) and the broader dimension of commitment to the unit's history and its mission. Baker concluded after the war that morale in Vietnam had been seriously degraded by the combination of the individualized, 1-year tour and the relative ease of communicating with home. This was problematic in that "[the soldier's] adjustment was often marked by an intense *personalized* (emphasis added) struggle to survive . . . [such that] he developed no great concern about the outcome of the war and, in the main, felt only personal relief when he left Vietnam."[9(p1836)]

Deterioration of Military Morale Near the Tipping Point

The reduction in combat activities and the perception of demobilization surely explains some of the rise in psychiatric conditions and behavioral problems after 1968. In this regard, the skyrocketing medical evacuation rate in Vietnam for soldiers whose urine tested positive for heroin breakdown products in 1971–72 may reasonably be considered a collective form of the "evacuation syndrome" (ie, they were motivated to manipulate the system to get relief from foreign deployment and, perhaps, combat risks).[20] However, beyond these sorts of reactions to demobilization familiar from earlier wars, the troops in the latter part of the Vietnam War were unique in that they bonded around their intense opposition to military authority and the mission—an attitude that coincided with the virulent antiwar, antimilitary feelings of those at home. The unprecedented rates for psychiatric conditions and behavioral problems evidently expressed soldier resentment of being asked to make sacrifices to salvage America's lost cause there while surrounded by the moral outrage and blame of the US public. It has been suggested that these soldier behaviors collectively represented a "macromutiny."[21] Considering that many of the antimilitary authority behaviors were passive or covert, for example, "search and avoid" combat missions[16(p97)] and "shamming" (the pretense of activity but without productivity), and considering that young soldiers commonly referred to the Army as "the green machine,"[16,22] perhaps sabotage is a preferable term to mutiny.

Regardless of the terminology, the disturbing truth is that by the end of the war many soldiers had more or less disabled (or demobilized) themselves through mental disorders, drug use, and other symptoms and forms of misconduct. Although clearly some soldiers brought preservice personality susceptibility to the theater that facilitated their acting out their frustrations in these ways, the exceptionally high incidence of these problems among previously functional soldiers ("epidemic") and the very reduced levels of combat activity at the time suggest more. In this author's opinion, a full pathodynamic explanation must include a recognition that a social disorder—a crisis of the collective—was a principle contributor to the disturbed functioning of these soldiers (eg, that a social–psychiatric "disorder" emerged, such as in Goffman's pathogenic "total institution,"[23] Fleming's "sociosis,"[24] or Rose's "macromutiny"[21]), as opposed to one primarily centered on individual psychology. In other words, these were symptoms of a failure of adaptation at the level of the group. They arose from a complex interaction of personal circumstance and powerful biological (often including drug-induced), psychological, and social stressors (in Vietnam as well as from home) —stressors that became progressively onerous for sequential cohorts of replacement soldiers as the war wound to its bitter conclusion.

Fortunately, American military readiness in the last few years of the Vietnam War was not seriously tested by the enemy, leaving moot the question of the degree and consequences of force erosion stemming from public doubt, low troop morale, opposition to the military mission, and widespread "evacuation syndromes." In retrospect it seems plausible that the enemy didn't challenge the remaining US forces for one compelling reason: the US military was at war with itself. However, the potential for disaster seems indisputable.[25]

Soldier-Patients Treated by Military Psychiatrists With Limited Military Experience and Allegiance

Among the psychiatrists who served during the second half of the war, the few who wrote about it reflected increasing frustration in applying traditional military psychiatry models and structures in response to the changing nature and scope of the behavioral and psychiatric challenges. Even if in many respects these problems were insoluble, at least on any terms pertaining to clinical psychiatry, possibly contributory were:

- Theater psychiatric statistics collected by USARV utilized a taxonomy that was too limited.
- In the latter half of the war when other data emerged that reflected deteriorating troop morale, discipline, and performance, timely modifications in the selection, preparation, deployment, and organization of psychiatric assets were not devised to address these challenges.
- The morale of many of the psychiatrists who served in the latter half of the war suffered a serious decrement that paralleled that of the typical soldier. It also appeared that they lost confidence in their objectives, structure, methods, and results.
- As theater problems deteriorated and opposition to the war increased, the Army deployed fewer

psychiatrists with postresidency military experience and familiarity with military priorities and structures. Also, replacement psychiatric leaders (USARV Psychiatry Consultants) had less military psychiatry experience than those who had preceded them. Furthermore, many of the civilian-trained psychiatrists were inclined to be more alienated from the mission.

- After the war many of the veteran psychiatrists were troubled by their role in Vietnam and expressed feeling inadequate and betrayed because they were ill prepared and unsupported by the Army in Vietnam. This occurred despite the fact that, overall, the Army psychiatrists assigned in Vietnam had an unprecedented degree of formal psychiatric training.
- Whereas the remarkable prevalence of problems that arose suggests the effects of a social disorder, especially the intense, adversarial relationship between soldiers and leaders, the psychiatric training of the times—somewhat so in Army residency programs but more so in civilian ones—did not emphasize social pathology and interventions nor provide sufficient practical training.

Apart from these features, it also seems safe to say that as the war lengthened, the deployed Army psychiatrists were affected by the public disapproval of the war and the increasing criticism of military psychiatry's priorities by psychiatrists in the civilian professional community. What is less certain is how much these influences may have affected the clinical decisions of the deployed psychiatrists. Ethical and moral reactions to a war and its politics have been shown to shape military psychiatrists' diagnosis and disposition of cases (eg, encourage what the military would describe as sympathetic "overdiagnosis" and "overevacuation"—clinical decisions believed in past wars to contribute to chronicity in combat-affected soldiers as well as jeopardize force conservation).

Did psychiatrists who believed the war was unjust perceive that participation was a primary etiologic factor in the pathogenesis of their soldier-patients? Were clinical perception and judgment affected by alignment between the soldier-patient's desire to be removed from combat duty, or the theater, and the psychiatrist's doubt about military necessity? Were psychiatrists with limited pre-Vietnam military psychiatry experience more prone to identify with their symptomatic soldier-patient's antimilitary sentiments in Vietnam? By extension, could the rising hospitalization rate in the second half of the war have also expressed identification of some psychiatrists with symptomatic soldiers? At least some of the WRAIR survey participants acknowledged that they sought to protect soldiers by exaggerating the diagnosis in order to get them evacuated from the theater. In the same vein, following the war some civilian psychiatrists raised concerns that the military may have harmed soldiers because of incomplete treatment and premature return to duty in Vietnam.

Vietnam Veterans Returning to a Rejecting Society

As noted earlier, a comprehensive review of postdeployment difficulties among Vietnam veterans is beyond the scope of this work. However, it is worth considering that a deployed soldier invariably worries about how he will be treated when he reenters stateside life, and this strongly influences his adjustment within the theater. Once back stateside it then becomes necessary for him to master and assimilate "his" war (his ordeal, reactions, and losses, and their meaning to him). If he succeeds, he is likely strengthened.[26] If not, he may make costly psychological compromises and remain more or less permanently affected or even disabled (Figure 12-1). For all who served in the theater, but surely more so for the veterans of the combat itself, his cherished premilitary self-image may have become damaged if circumstances contributed to his concluding that he had faced his personal ordeal as a coward, or as a savage.

Recovering his mental equilibrium as a veteran in large part depends on positive relationships, that is, social supports. His effort to reconcile his own moral dilemma about killing (or being an accessory to the killing[27]) and the war's destructiveness is a process that is especially affected by the manner in which he is treated by his family and the nation. Is there affirmation, redemption, as if he is a hero? Or is there disregard (or worse), as if he's a pariah? Reconciling his experience becomes more difficult for the citizen-soldier who, following his enlistment, leaves the military and its generally supportive culture.[28] It seems safe to say that when it is all over no one is the same as before it began. With regard to Vietnam, the clash of values over the war not only encouraged widespread problems among veterans, but it can additionally be said that sooner

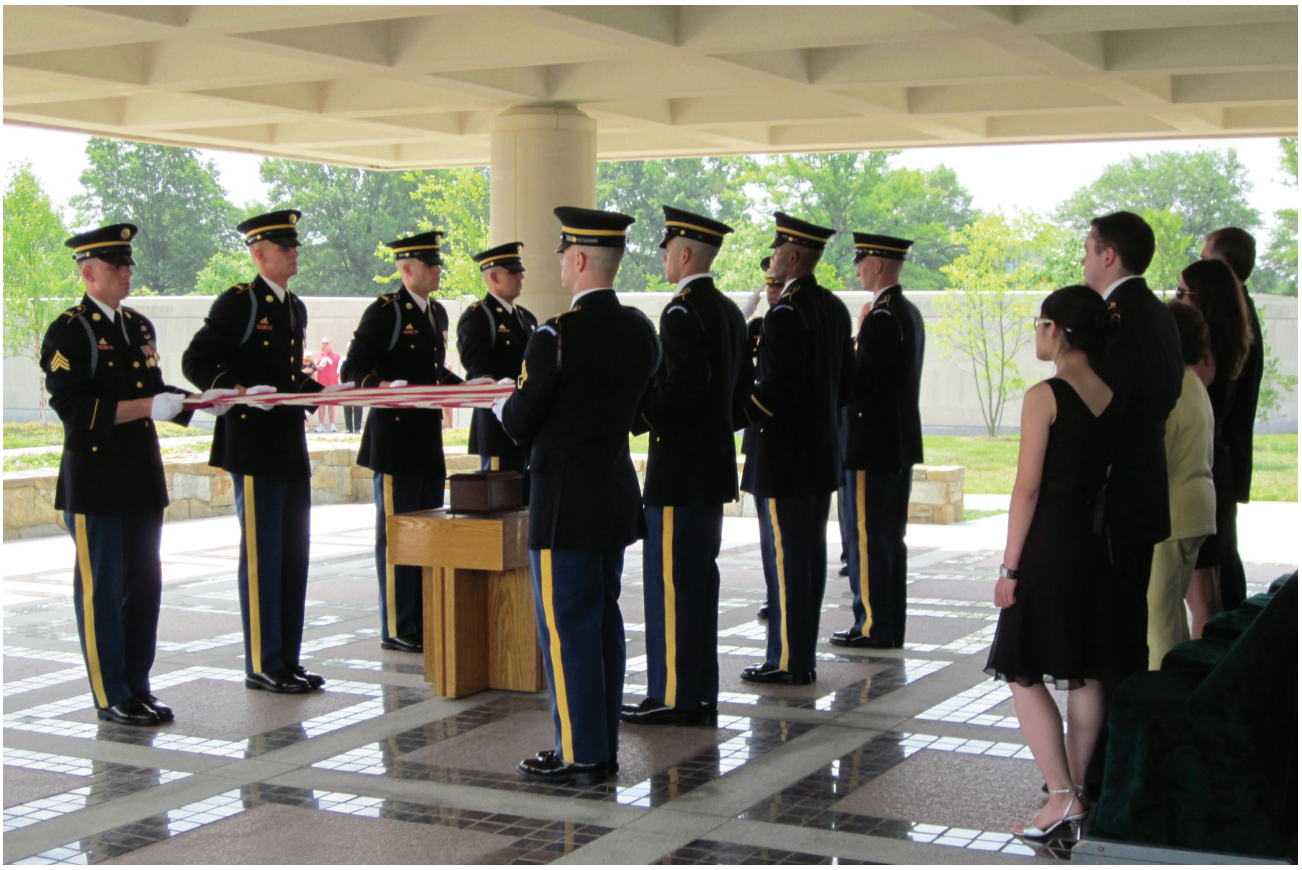

FIGURE 12-1. Military funeral at Arlington National Cemetery for Vietnam veteran Chris McGinley Schneider (2010). Although a female veteran, she is emblematic of thousands of soldiers, combat and noncombat, who became hidden casualties of the war—individuals who left Vietnam apparently unscathed but whose wounds, physical and psychological, emerged months to years later. Schneider volunteered to go to Vietnam as a nurse and served selflessly and with distinction at the 95th Evacuation Hospital in 1970–71. Soon after returning to civilian life she developed chronic posttraumatic stress disorder that was so severe she abandoned nursing as a career. In 2009 she was diagnosed with leukemia, which was suspected to be the consequence of her exposure in Vietnam to the herbicide Agent Orange and other environmental biohazards.

or later every soldier who served there had to contend with the added psychological burden of knowing he participated in, and sacrificed for, a lost and socially repudiated cause.

Some perspective regarding the unique psychosocial burdens affecting Vietnam veterans came from Richard P Fox, a Navy psychiatrist, who reported on his study of Vietnam returnee clinical referrals who had severe reentry symptoms and behavioral problems. Fox argued that, as a group, the troops returning from Vietnam were demonized by American society. In earlier wars, wounds to the soldier's self-esteem, which were the predictable consequence of participating in combat, were buffered by the "adulation" of those at home. Under those circumstances only soldiers with predisposing personality deficits would suffer sustained postwar disability. In contrast, for the soldiers who fought in Vietnam, the public opposition to the war meant that the adulation was instead directed to those who resisted the draft or in other ways avoided Vietnam. Families were pleased to see their sons and husbands return, but there were few heroes' welcomes. "The reluctance of family and friends to listen to the war stories the returnee had to tell not only added to his sense of isolation but also deprived him of [the adulation required for him to repair his self-esteem, which was traditionally] accorded the returning warrior."[29(pp810–811)]

In this respect, Dave Grossman, a retired Army Ranger and former West Point professor of psychology, offered a compelling model for

understanding the studies pointing to higher than expected PTSD levels among some Vietnam veterans whose exposure to combat may have been limited. According to Grossman's perspective, the process and experience of veterans reintegrating to stateside life is etiologically equivalent to, and interacts with, the ordeal he sustained in the combat zone because it either mitigates it or aggravates the psychological sequelae of his war experience. Grossman proposed the following complemental series for returnees from any war: that there is a sliding functional relationship between experiences in the combat zone ("combat trauma") and those upon returning to the United States ("social support") that shapes their postwar adjustment. For instance, soldiers with a high degree of combat exposure in World War II received a strong societal embrace and affirmation for what they saw and did because of the popularity of that cause, and may, consequently, have lower PTSD levels. In contrast, those who had a much lower degree of combat exposure in Vietnam nonetheless felt scorned and blamed for serving in the war upon their return because of that war's great unpopularity and, as a consequence, sustained higher PTSD levels.

Grossman's explanation for this included the proposition that if society turns on the war effort and reacts to it as morally unjustified, then in simply having been "in the midst" of the killing in the combat theater, the soldier is made into an accessory to murder. Quoting one veteran, "society didn't make any distinction who they spat on."[27] This is a model espoused by Bourne as well.[30] (This author [NM Camp] would further add that there is no such thing as "lack of support" for the veteran, or "nonsupport," suggesting a neutral or indifferent response. To the veteran, any ambiguity or nonsupport is experienced contextually as blame and condemnation, provoking a deeply troubling sense of being a social outcast.)

The perspective offered by Theodore Nadelson, Chief of Psychiatry at the Boston VA Medical Center, seems especially poignant:

> In Vietnam, where the usual guides to behavior disappeared and women and children killed also, some young combatants lost their moral center. They were forced to discover their competence in situations of mortal risk where loyalty to friends was most valued. It was, for most of them, in very young adulthood, a time of greatest sensitivity to such a strong force. In killing some of them celebrated their combined youthful strength, their survival and dominance and that of their nation. On return home they discovered only anomie, devaluation of their wartime experience, and rejection of their skill and loyalties.[31(p135)]
>
> . . . (Furthermore) these returned veterans have an awareness that something happened to them as a result of exposure to intense and addicting experiences dissonant with expectations "back home," in the "real world," in "so-called civilization." They experience further difficulty because of a sense of betrayal regarding their sacrifice and risk, the deaths of their buddies, and a failure on the part of the nation to reciprocally reinforce the ancient mutual loyalty to its warriors by appropriate "expiatory rituals" for killing.[31(p139)] (See also Exhibit 12-1: Post-Vietnam Challenges to the Military Psychiatry Forward Treatment Doctrine.)

RETROSPECTIVE CRITIQUE

The preceding review of stress-inducing and stress-mitigating phenomena affecting American troops in Vietnam compels a belated effort to consider remedies. The following list of recommendations pertains to the mental health activities of the Army Medical Department in Vietnam, especially its mental health specialists. The items are roughly arrayed in three categories: (1) prevention; (2) adaptation; and (3) documentation. However, as remedies they are limited as they would require corresponding efforts by USARV and the Department of the Army. Clearly, for lessons learned in military psychiatry to have any broad impact, they must be linked to lessons learned on the leadership side; but to this author's knowledge, there has been no official review from that vantage point.

Prevention

- **A preventive medicine-like system to monitor the various (changing) indices indicating the rising incidence of psychiatric and related medical disability, unit demoralization, and flagging soldier performance in Vietnam should have been employed by the Army.** The taxonomy used by USARV to collect psychiatric information from the medical treatment facilities was too limited to

account for the growing complexity in the theater. Also, evidently there was insufficient integration of the gleaned psychiatric information with data from major commands and other medical, administrative, and law enforcement sources pertaining to related problems. What was needed was a dedicated epidemiologic field team to collect, analyze, and disseminate information regarding a wide array of often initially innocuous indices of psychiatric and behavior dysfunction as well as flagging morale and group performance. This information would have permitted the early detection of deteriorating psychosocial and psychiatric circumstances and provided clinicians and commanders a timely map of the psychosocial "terrain" regarding stressors and their effects. In turn this could have triggered development of preventative and intervention measures. It also would have satisfied historical, planning, training, research, and treatment goals. (An example is the model program provided by Douglas R Bey and Walter E Smith with the 1st Infantry Division [1969–1970]. The list of unit parameters they monitored to identify troubled units was especially useful.[32]) At the very least the USARV Psychiatry Consultants should have teamed up with preventive medicine personnel to target specific dysfunctional units or problem areas for special attention by major unit commanders and their mental health assets.

- **During the buildup phase, Army medicine/psychiatry should have detected the rising incidence of covert psychiatric symptoms and behavior disturbances among combat troops and sought to modify systems of prevention at the unit level as well as treatment approaches by medical and mental health personnel.** From the standpoint of soldier stress, the Army was unprepared for the type of combat encountered in Vietnam, where many soldiers apparently sustained widespread but more subtle psychological and psychosocial effects, (ie, partial trauma and strain trauma) than that found in earlier wars. This was a consequence of fighting an irregular, drawn-out, bloody guerrilla/counterinsurgency war—a war fought on the far side of the world against a determined and resourceful enemy while using mostly citizen-soldiers and having to contend with intense controversy about the war at home. Recognition of these differences should have prompted a search for new strategies for prevention, early detection, and treatment of these types of casualties.
- **During the drawdown phase, Army medicine/psychiatry, as well as Army leadership, should have applied a social psychiatry model to aid in the early detection, prevention, and treatment of the growing numbers of psychiatric and behavioral casualties.** The Army, like the psychiatric component, failed to anticipate the unprecedented psychosocial strain associated with disengagement after years of stalemated and controversial war in Vietnam. What was needed was an overarching multivariate model of combat "theater" breakdown (as opposed to one limited to combat stress reaction [CSR]). Such a model would have encompassed both symptomatic soldiers (ie, those with "deployment stress reaction") as well as dysfunctional groups of soldiers (eg, units with inverted morale), and prompted a search for new strategies for prevention, early detection, treatment, or countermeasures.

Adaptation

- **Adjustments should have been made in the distribution of mental health assets as the situation deteriorated in Vietnam.** The mounting and changing psychiatric demands in Vietnam went unchallenged by adaptive strategies for the organization of psychiatric care. The Army initially deployed a pair of fully staffed psychiatric treatment centers (ie, the KO team/psychiatric specialty detachments). The establishment of these freestanding, but in many instances geographically isolated, centers, which provided mostly conventional, hospital-based, in- and outpatient services, was predicated on the Army's pre-Vietnam war experience; however, questions can be raised as to the wisdom of retaining this structure over the course of the war. The flood of combat-generated stress responses that was anticipated never materialized. Over time, the breakdown of morale and discipline became the greater hazard to combat readiness—especially through noncombat-related psychiatric disorders and behavior problems, and especially among noncombat units. As a result the initial distribution of mental health assets that favored the combat divisions became problematic because the center of effort shifted to nondivision support and service-support units, which went underserved.

EXHIBIT 12-1. Post-Vietnam Challenges to the Military Psychiatry Forward Treatment Doctrine

The historical narrative of military psychiatry leading up to Vietnam repeatedly observed that the lessons learned in previous wars had been forgotten between wars, and that in the next war there was a costly delay before mental health specialists were placed in forward positions and the combat psychiatry forward treatment doctrine was reinstituted in order to limit evacuations among otherwise recoverable combat stress casualties.[1–3] Unfortunately, this may be happening again.[4] In particular, at this point in time (late 2013), and even in the wake of two recent military engagements with similarities to Vietnam but on a smaller scale—Iraq and Afghanistan—civilian/humanitarian sensibilities, that is, consistent with Department of Veterans Affairs–oriented protective ones, have served to challenge the traditional forward treatment doctrine because the latter is based on the primacy of force conservation for the sake of mission accomplishment. This shift has arisen because of the convergence of four trends:

1. There was never a serious shortage of fighting personnel in Vietnam because of the draft. Even though the adaptation of the doctrine in Vietnam appears validated by this work, this carries only so much weight because force conservation was never a critical dimension during the war.
2. America's social and cultural wounds consequent to losing the war in Vietnam were expressed through sympathies for its physical and mental casualties, especially through the establishment of the new psychiatric diagnosis, posttraumatic stress disorder (PTSD). Although the PTSD concept drew much needed medical attention to the treatment needs of Vietnam veterans, it simultaneously served to discredit veteran complaints of contributory mistreatment by society, the government, and the military. Furthermore, as discussed in Chapter 2, a number of investigators and clinicians with experience with military veterans came to question the validity of the PTSD diagnosis. Also, clinical confusion often arose when distinguishing combat-generated acute stress reactions from PTSD. Nonetheless public opinion has been strongly shaped by suggestions that the America's military activities in Vietnam and since have produced unacceptable levels of PTSD.
3. The revolutionary change in the American taxonomy of psychiatric disorders in 1980, the 3rd edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), served by extension to cast doubt on earlier, empirically derived theories of causation for combat stress casualties—theories that encompassed predisposition, psychosocial disturbances, and psychic conflict. The resultant vacuum led some to favor neurophysiologic theories as alternatives. For example, William P Nash, a Navy psychiatrist, recently challenged the traditional military forward treatment doctrine—what he referred to as the "demedicalized" or "normalization" model—because it expected combat-exposed service members to withstand their strains and traumas predicated on an assumption that combat aversion and stress reactions were natural accompaniments to combat deployment.[5,6] According to Nash, the doctrine meant that there were frequent instances of combat stress-generated neurologic "injury" at the molecular and cellular level, especially from glutamate neurotoxicity, that were overlooked (he is not referring to soldiers with blast-generated traumatic brain injuries). He further argued that the traditional forward treatment doctrine caused combat-exposed troops with mental difficulties to be unnecessarily subjected to a military culture of stigma and shame and to consequently fail to seek timely care. Nash admitted that if combat stress casualties were instead treated according to his injury model, "Military leaders and public policy makers may fear [an increase in] the risk for epidemics of stress-injured [soldiers] seeking evacuation from war zones or disability compensation from the Dept. of Veterans Affairs"[6(p794)]; however, he provided no solution for this disturbing possibility. Thus in effect, Nash appears to have reverted to the abandoned World War I model of shell shock with its disastrous potential for unsustainable psychiatric attrition, unnecessary and high soldier morbidity, and the risk of military defeat.
4. Military psychiatry has increasingly turned toward an occupational medicine model as opposed to one centered on the (psychiatric) risk/benefit ratio required in accomplishing the combat mission. During the four decades since Vietnam, the US military has been fortunate in being able to sustain itself using an all-volunteer force. Through augmentation of active units with Reserve units and National Guard units, and by redeploying military personnel, fighting military America's major engagements, for example, the Persian Gulf War, and Iraq and Afghanistan, has not required full mobilization and conscription. The result, however, is that deployment stress, as well as combat stress, have come to be viewed simply and dispassionately as "hazardous exposures in the workplace," with the associated mental health objective being to "define levels of acceptable exposure to those hazards."[7] This paradigm shift has been led by Charles Hoge (an Army-trained psychiatrist and epidemiologist) and his colleagues at the WRAIR Department of Psychiatry and Behavioral Sciences. In the publication "Priorities for Psychiatric Research in the US Military: An Epidemiologic Approach," they repeatedly used the adjective "occupational" to allude to the soldier's adaptational

EXHIBIT 12-1. Post-Vietnam Challenges to the Military Psychiatry Forward Treatment Doctrine (continued)

challenge (as in "occupational . . . functioning," ". . . dysfunction," ". . . attrition"; "the highly structured occupational environment in the military"; and "the occupational burden of mental disorders"). On the other hand, the unique psychological requirements associated with combat, such as duty, valor, commitment to a unit's mission and fellow soldiers, or sacrifice, are omitted.[8] Equally illustrative of this new mindset are publications by Hoge et al of results of their surveys of military personnel before and after deployment in Iraq and Afghanistan exploring soldier mental health and behavioral complaints and self-reported extent of contact with the enemy.[9] Although their approach is laudatory as a preliminary study of the psychological and psychosomatic consequences of combat theater deployment, it is also misleading both because it is more consistent with the treatment objectives of the Department of Veterans Affairs than that of an army at war, and because it fails to account for the true nature of war with its complex physical and psychosocial challenges. In effect, by relying on participant self-reports without corroboration from the field (objective measures and clinical findings), the authors studied these troops as if they were simply individuals who had been exposed to high occupational risk that was now in the past (as one might do with disaster workers), and as if those who reported psychological wounds were primarily victims, that is, tantamount to civilians who sustained unforeseen trauma. They seem not to comprehend that every soldier struggles to manage the conflict between his self-protective instincts and his desire to honorably and selflessly perform his military duty (eg, through loyalty to comrades, unit, and country); that increased psychological symptoms under those circumstances are the predictable consequence of that strain; that for many it is how their psychological perturbations are managed at the time and later (referring especially to the quantity and quality of available social supports, both in-country and at home) that makes the difference in psychological sequelae; and that, for the sake of the mission, commanders invariably worry that too much attention can be paid to mild to moderate symptoms among troops that stem from the heightened dangers, hardships, uncertainty, and homesickness that arise in a combat environment.

In conclusion, this volume's study of Army psychiatry in Vietnam strongly suggests that the country owes it to the troops to keep in mind the history of military psychiatry and *(a)* employ a complex model of combat stress, breakdown, and recovery—one that is fully bio\psycho\social in nature, and *(b)* retain the military psychiatry doctrine that was validated through America's earlier wars in the modern era. Although the traditional doctrine carries with it a sometimes regrettable requirement that in extreme circumstances the protection of individual soldiers must be subordinate to military necessity, the failure to envision a future, large-scale war requiring full mobilization and reinstitution of the draft—a war that may again become unpopular and bring with it widespread combat aversion and evasion and require psychosocial treatments supporting force conservation—may put American military forces, and thus the nation, at more risk than the nation is willing to accept.

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- **Greater attention should have been given to training and mentoring psychiatrists in command consultation.** Participants' responses to the WRAIR survey (corroborated with anecdotal data) indicated that program-centered command consultation, that is, true primary prevention, was not routinely provided. When psychiatrists did engage in program-centered command consultation, they reported greater success if they had some military experience before being sent to Vietnam (either a military residency or a pre-Vietnam assignment) or had been assigned at some point in Vietnam to a combat unit. This is an important finding regarding the saliency of a military background and familiarity in teaching the psychiatrist the value of a socioenvironmental preventive approach for reducing both incidence and morbidity of psychiatric problems among soldiers. Psychiatrists without this background should have been systematically taught these critical skills in Vietnam by those who had the requisite experience.
- **As implementation of the military psychiatry forward treatment doctrine in Vietnam became more ethically burdensome the assigned psychiatrists should have received specific support in managing the strain.** The major goal of this work was to illuminate a history of the Army's effort to fight and win in Vietnam through the lens of military psychiatry's twin and sometimes clashing values: "conserve the fighting strength" and "care of the sick and wounded" (humanitarian values). In this regard it is necessary to remind the reader that although it is desirable that humanitarian values be served, military medicine was born of the necessity for the prevention and restoration of battle casualties. The priority for military psychiatrists has historically been to promote maximal psychological endurance among soldiers committed to combat through preventive advice to their commanders and the effective treatment and rehabilitation of those whose personal resources have been exceeded by the circumstances.[33] Yet the psychiatric literature and the WRAIR survey participants indicated that when it came to fighting in Vietnam, maintaining this values hierarchy was more difficult than in earlier wars.

  Whereas Army psychiatrists serving during the first half of the war did not appear to struggle with operational or ethical strain, those who served in the second half, and despite falling combat activity, indicated the opposite. More specifically, to varying degrees they were affected by stresses of: *(a)* being overworked (burnout), *(b)* provider fatigue (or compassion fatigue), *(c)* opposition to Army medical policies that favored military expediency over patient rights, and *(d)* true ethical strain (having protective impulses toward soldier-patients, ie, civilian values, in opposition to military ones that would urge soldiers to quickly return to duty).
- **Policies and procedures for selection, preparation, and deployment of psychiatrists and other mental health professionals and paraprofessionals for Vietnam should have been revised and strengthened by Army psychiatry leaders.** The unmitigated increase in psychosocial casualties among the US Army troops in Vietnam raises questions about decisions and policies made at the level of the Psychiatry Consultant, Army Surgeon General, pertaining to: (*a*) the selection and preparation of psychiatrists, especially in the second half of the war, and (*b*) the assimilation of, and accommodation to, information from the theater. The Army's two residency training programs were able to provide for a substantial proportion of the deployed psychiatrists (roughly one-third); however, the median amount of postresidency experience among the respondents was only 4 to 6 months, and there were repeated expressions by the WRAIR survey respondents of feeling ill-prepared, especially among those with civilian training and those who served in the later half.

  The responses from the psychiatrist participants in the WRAIR survey do not suggest there was an official Army policy as to what constituted sufficient specific preparation or training for service as a psychiatrist in Vietnam. Nor for that matter was it apparent what were the requisite background factors for the selection of the USARV Psychiatry Consultants. It is clearly notable that greater numbers of psychiatrists with less military experience, especially those just graduated from civilian residencies, would be sent as replacements amidst the perceptibly deteriorating morale, psychological fitness, and military readiness in the second half of the war. It also seems puzzling that the USARV Psychiatry Consultants assigned in the drawdown phase would also have had appreciably less experience serving as military psychiatrists than their predecessors.

Compounding the matter, a critical deficiency was that there was no systematic debriefing of returning psychiatrists. Considering that the Army psychiatrists in Vietnam and the USARV Psychiatry Consultants were replaced annually, an aggressive program of debriefing the returning psychiatrists should have been implemented so as to impart to the replacement psychiatrists the gleaned wisdom and to guide modifications of the structures and policies in the theater. In fact WRAIR survey respondents repeatedly complained about wanting to have been informed about the actual conditions they would face in Vietnam before they deployed. In particular such a process could have prompted replacement psychiatrists to redirect some of their attention from a combat stress model toward a social stress model of psychiatric dysfunction.

Other structural adaptations as the war in Vietnam lengthened might have included: (*a*) development and distribution of operationalized diagnostic criteria and treatment guidelines for common psychiatric disorders, especially uniquely military conditions such as combat exhaustion; (*b*) extending the tours of each of the USARV Psychiatry Consultants beyond the standard year (as well as tours of other psychiatrists in leadership positions) to provide needed continuity; (*c*) increasing the level of seniority of the replacement military psychiatrists as the pool of experienced civilian psychiatrists unavoidably decreased; (*d*) linking numbers of deployed psychiatrists to epidemiologically documented need, rather than to overall troop strength or an outdated structure; (*e*) modifying the curricula of the Army psychiatric residency programs to reflect the changing nature of the challenge in Vietnam; (*f*) requiring that each recently graduated psychiatrist, regardless of the type of his/her original training, serve some time with a stateside military unit before departing for Vietnam (presuming such an arrangement otherwise did not interfere with overall mobilization requirements); and (*g*) providing for a 1- to 2-week overlap between the arriving and departing psychiatrists in Vietnam.

Documentation

- **Psychiatric research projects should have been devised and conducted in Vietnam throughout the war.** Considering the aforementioned list of unique risk elements comprising the combat or theater ecology, it seems logical that the Army Medical Research and Development Command should have conducted formal studies in Vietnam throughout the war on matters pertaining to stress, morale, and mental health. Among other possibilities, these could have addressed the impact on regular troops consequent to fighting an unconventional/guerrilla war and the short- and long-term effects of psychotropic medications.
- **The Army should have committed to maintaining a historical record of psychiatric matters in Vietnam.** A prominent and surprising finding of this review is that evidently throughout the war there was no centralized psychiatric information collected except for the theater-wide statistics mentioned earlier. This situation stands in stark contrast to published historical accounts of World War II. Bernucci and Glass described how they, in anticipation of writing a history and while hostilities were still under way, collected the relevant materials and documents. ("Key personnel and many of the consultants were periodically brought into the [Surgeon General's Office] to record their experiences before they were deployed elsewhere or released from the Army."[34(pxv)]) Equally important was the Army's ultimate decision to establish a formal dedicated position as editor for its historical account. As they described, initially the project failed under the assumption that it could be written with part-time leadership. Regarding any war, certainly Vietnam, it seems logical that there must be a before-the-fact commitment to a historical record—in the form of policies and structures for data gathering and storage, and an after-the-fact commitment of resources to analyze and present the salient facts.

  As the record from Vietnam shows, assuming that the participating psychiatrists will, in time, publish their observations risks leaving a very incomplete or skewed record of what may turn out to be critical information. Responsibility for this failure with respect to Vietnam certainly lies with Army psychiatry and more generally with USARV. Disturbingly, some have speculated that it could have reflected the intentions of some politicians who sought to prevent such research.[35]

FINAL THOUGHTS

It has been arguably estimated that the Vietnam War was the most psychologically damaging of all of America's wars in the 20th century. This may, in fact, be the case if it includes not only psychiatric conditions and behavior disorders, especially among veterans, but also America's decades-long postwar malaise. Furthermore, wars with features similar to those that arose in Vietnam may become increasingly common in the future—protracted, low-intensity wars with limited goals that are surrounded by intense media scrutiny and political controversy. It was with this in mind that this review sought to reconstruct the experience of US Army psychiatrists who served in Vietnam and the record of care they provided there. Regrettably, it is a disheartening account. Following a commendable first few years, the enemy proved to be more formidable than expected and the war dragged on the American public withdrew its approval, and troop morale and mental health declined and ultimately dissidence and misconduct rose to near mutinous proportions. And throughout all this, the Army psychiatrists and their mental health colleagues in Vietnam were increasingly challenged, were too often stymied, and in many instances left Vietnam indelibly embittered.

However, Army psychiatry's story in Vietnam is only reflective of the larger story of the war. Although President Reagan later referred to it as a "noble cause,"[36] realistically there is no way to avoid acknowledging that the American war in Vietnam was a tragic failure. Whether history decides that this was because it was ill-conceived, was mismanaged, or became despised and repudiated—or all the above—a central truth is that this outcome also came about because of human sensibilities and limitations, not a lack of military might. Despite Secretary of Defense Robert McNamara's highly touted managerial strategy,[37] and despite the sustained and courageous effort by US military forces, America was ultimately forced to withdraw from Vietnam because of critical miscalculations regarding the American public's willingness to tolerate continued fighting, losses, and international criticism, and the military's incapacity to maintain discipline and a sense of purpose under those circumstances. In fact, perhaps the greatest lesson from Vietnam was the discovery that there were irreducible limitations in the forbearance of the American people, as well as those fighting in Vietnam, for the specific conditions of war faced there—a variable that needs to be seriously considered in planning for future wars.

What happened in Vietnam was only indirectly related to the role and task for the Army psychiatrists assigned in Vietnam, but it is tempting to wonder if some of this could have been averted if senior military psychiatrists and other behavioral and social scientists had been included in the original planning for the war. And what about the direct role of Army psychiatry in Vietnam—particularly with regard to the swelling number of referrals during the second half of the war? It is evident from this review that as the country lost its will to make sacrifices for the sake of fighting the war, soldiers became progressively demoralized and dysfunctional, and the psychiatrists sent to support them struggled as well. But could the psychiatrists and allied mental health personnel have played more of a role in reducing the psychological toll? Military psychiatry is unique among the other military medical specialties because of its interest in the mind of the soldier-patient and the influence of his social environment (past and present). These influences became critical in Vietnam because soldiers were not only operating under combat conditions in a remote and extreme setting, but they also had to contend with the harsh criticism from home.

The sobering truth is that over time the mental health system became swamped with troops referred for various expressions of disobedience, defiance, and dissent; performance failure; violent, antimilitary behaviors; racial incidents; drug abuse and addiction; etc., most of which were unrelated to combat stress. Furthermore, the demoralization and antagonism toward the military mission and authority that was at the heart of this misconduct epidemic was fundamentally untreatable (apart from detoxification). The few soldiers who might have been treatable through conventional approaches—those with symptoms stemming from endogenous forms of psychiatric disorders such as psychosis, depression, anxiety, or psychosomatic conditions—were perhaps still not rehabilitable in the theater. And because the US Army in Vietnam was a completely closed system (eg, soldiers could not simply walk away or easily quit) and yet those at home were urging them to oppose participation, the principal and thankless task borne by the later psychiatrists was that of sorting and labeling antagonistic, command-referred soldiers, and they had little else to offer (again, "waiting at the bottom of a ski slope"). Adding to the strain, commanders were equally overwhelmed and ardently

hoped psychiatry would take the most unmanageable troops off their hands. In particular they wanted the mental health component to become the custodians for these troops and to label them character and behavior disorders so they could be expeditiously removed from Vietnam and eliminated from the Army—though this diagnosis was not usually warranted. In every respect the system was broken.

What about efforts at prevention by Army psychiatrists, that is, command (program) consultation? Evidently there was little commitment by the psychiatrists or military leaders to command consultation in Vietnam. This is despite the fact that during the Vietnam era senior Army psychiatrists had become quite taken with the idea that every military psychiatrist should utilize the new theories of social psychiatry in advising unit commanders to reduce the incidence of psychiatric conditions and performance failures. This does not mean that these principles had little potential utility in Vietnam, just that the psychiatrists assigned in the later years of the war had minimal training in this approach, limited practical familiarity with the Army, and little receptivity by line commanders.

It seems fair to say that the promise of military psychiatry was oversold with respect to the problems that arose in Vietnam. However, more truthfully, Vietnam proved that military psychiatry has limitations as a remedy for failed military and political leadership. Fitzgerald, a Vietnam War historian, put it poignantly:

> [T]he civilians may neglect or try to ignore it, but those who have seen combat must find a reason for that killing; they must put it in some relation to their normal experience and to their role as citizens. The usual agent for this reintegration is not the psychiatrist, but the politician. In this case [of Vietnam], however, the politicians could give no satisfactory answer. . . . [38(pp423–424)]

Although Fitzgerald limited his observation to postwar anomie, veterans, combat troops, and politicians, his point also applied to all troops in the theater, including noncombat troops, and to the overall military leadership.

In closing, it is important to acknowledge that by its nature, the medical specialty of psychiatry—and thus military psychiatry—generally concentrates on deficits while not fully addressing strengths and capabilities. With respect to military personnel the latter would include such positive attributes as patriotism, bravery, loyalty, sacrifice, and devotion to the mission, among many. This work has in no way intended to overlook these qualities as they were demonstrated by the troops who served in Vietnam; in fact the majority of those assigned in Vietnam fulfilled their duty faithfully with courage and commitment. Despite the outcome of the war, America surely owed every one of them a heartfelt demonstration of gratitude for their effort and sacrifices. This certainly also applies to the Army psychiatrists and their professional and paraprofessional colleagues. Although this work has highlighted the many problems that arose in the theater, not enough can be said about their sustained devotion to providing the best care for the troops that they could, their willingness to overcome hardships in the service of that end, and their record of capable and commendable service.

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