CHAPTER 2

Overview of the Army's Accelerating Psychiatric and Behavioral Challenges: From Halcyon to Heroin

. . . Public, congressional, and even media support of an earlier day . . . dropped off precipitously once it was clear that the United States had opted out of the war. Societal problems of drug abuse, racial disharmony, and dissent, . . . reached epidemic proportions in the United States and, inevitably, spilled over to the forces in the field. Cumulatively, these differences constituted one of the most difficult challenges to leadership in the military history of the United States, and eventually their effects were felt throughout the forces in every theater.[1(p347)]

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Dust-off helicopter retrieving a casualty in the field. Despite Vietnam's challenging physical environment, sick and wounded soldiers were provided rapid access to sophisticated medical support, especially through the utilization of the new helicopter ambulance capability. This proved to be one of the chief stress-buffering influences on troops throughout the war. Photograph courtesy of Richard D Cameron, Major General, US Army (Retired).

Whereas Army planners anticipated that once US forces were fully committed in Vietnam the war would be short and America and its allies would prevail, they also presumed, based on experience in the main force wars that preceded Vietnam—World War I, World War II, and Korea—there would be large numbers of soldiers disabled by combat exhaustion. As a consequence they incorporated in Vietnam the structure and doctrine of military and combat psychiatry that had been pragmatically established in the course of fighting those earlier wars to prevent and treat these types of casualties. In particular this meant that the allocation and the preparation of psychiatric assets throughout all 8 years of the war was weighted in favor of combat-committed soldiers[2,3] (the US Army Medical Department mission is "conserve the fighting strength"[4])—despite the fact that such troops would

only represent roughly a quarter[5] to a third[6] of the Army personnel deployed in South Vietnam. This arrangement, nonetheless, seemed satisfactory for the first few years of the war as evidence indicated overall rates for psychiatric attrition and misconduct were exceptionally low for a combat theater.

However, as was described in Chapter 1, the ultimate reality in Vietnam proved to be far different than anticipated. The enemy reverted to mostly counterinsurgency/guerrilla tactics and was far more resilient and committed than expected. (Guerrilla warfare can be defined as irregular warfare in which a small group of combatants use mobile military tactics in the form of ambushes and raids to defeat a larger and less mobile formal army.) This led to a prolongation of the fighting along with rising costs and losses, which provoked the American public into increasingly passionate opposition to the war. In turn, as the war lengthened, the morale of the deployed force declined dramatically and troops—noncombat as well as combat—demonstrated in a wide variety of ways their reluctance to soldier and their antagonism to military authority, including accelerating rates for psychiatric conditions and behavioral problems.

In fact, among the wars in the 20th century, Vietnam became historically unique in having rising psychiatric hospitalization rates as the fighting waned and combat-generated physical casualties declined. Matters became substantially worse in 1970, when a heroin epidemic quickly spread among the lower-ranking soldiers—an unprecedented problem that seriously undermined soldier health, morale, and military preparedness. Military leaders as well as law enforcement, administrative, and medical/psychiatric elements were all severely tested before the last US military forces were withdrawn in March 1973.

This chapter provides an overview of the dominant patterns of psychiatric conditions and behavioral problems that arose within the Army in Vietnam and the consequent challenges faced by Army leaders and allied mental health personnel. Its approach is one of linking rising rates for traditional (psychiatric), as well as nontraditional, measures of soldier dysfunction, including misconduct, with the kaleidoscope of social, political, and military features that changed over time. In so doing it becomes evident that, although it prepared itself well for large numbers of combat stress reactions, the Army was not prepared for eventual morale inversion and the associated upsurge in what might be referred to as "(combat theater) deployment stress reaction." (It is acknowledged that this distinction—ie, between combat stress-generated reactions [psychiatric and behavioral] and deployment stress reactions contradicts current trends in Army psychiatry. As codified in the 2009 US Army Field Manual 6-22.5, *Combat and Operational Stress Control Manual for Leaders and Soldiers*, acute dysfunctional combat stress reactions are lumped in with other stress-generated psychiatric and behavior problems under "Combat and Operational Stress Reaction" [COSR], a concept that includes noncombat personnel and does not even require that the affected individual is in a combat theater.[7] Adding further confusion, current doctrine also utilizes the term "COSR/combat misconduct stress behaviors" for soldiers who commit "serious" disciplinary infractions, whether the behavior is combat-related or not.[8])

Furthermore, with respect to providing humanitarian care, if not strictly that of serving force conservation, the data indicate that many who returned home from Vietnam subsequently experienced serious and sustained readjustment problems, including frank posttraumatic stress disorder (see Chapter 6, Exhibit 6-3, "The Post-Vietnam Era and Posttraumatic Stress Disorder"). Following their return to stateside life, many Vietnam veterans complained of emerging irritability and difficulty concentrating, recurrent nightmares of disturbing combat experiences, overreaction to environmental stimuli that reminded them of Vietnam, estrangement from others and serious relationship difficulties, and emotional numbing and disabling feelings of guilt and depression, which they often sought to tame with alcohol and drugs.[9–12] Although, as mentioned in the Preface, a comprehensive review of postdeployment adjustment and psychiatric morbidity is outside the scope of this work, it should be noted that some investigators have suggested that the prevalence of debilitating psychological and social problems among Vietnam veterans greatly exceeded that for earlier US wars; and that when postdeployment adjustment difficulties are included with psychological problems that arose in the theater, the psychosocial cost for the Vietnam War was unprecedented. This chapter will close with additional discussion of the postdeployment difficulties found among many Vietnam veterans.

US ARMY PSYCHIATRY IN VIETNAM: AN EXAMPLE OF "PREPARING TO FIGHT THE LAST WAR"?

Combat Stress Reactions and Conservation of the Fighting Force

Acute, disabling psychological symptoms among soldiers subjected to the extreme circumstances of combat have been variously labeled *shell-shock* (World War I), *combat neurosis* and *combat fatigue* (World War II), and *combat exhaustion* (Korean War and Vietnam War),[13,14] as well as newer names: *combat stress reaction* and *battle shock* (both of which Jones labeled "transient anxiety states"[15]). In the 20th century, these sorts of "bloodless casualties" were described beginning with the Russo-Japanese War of 1904–1905, but at that time they did not arise in numbers sufficient to constitute a military-medical problem.[2,3,16,17]

The introduction of weapons with greater lethal potential in World War I ushered in the era of the modern battlefield, and combat-generated psychiatric casualties were seen in much larger numbers[14]—numbers that could determine the outcome of a battle or a war. Furthermore, from the observations made through these later wars it became evident that not only could these reactions to combat present in a wide variety of psychological and behavioral forms, but they could also spread among soldiers by suggestion.[18] Although the term *combat exhaustion* was used in Vietnam—defined by the Army's Medical Field Service School in 1967 as "a transient emotional disease caused by the stress of combat [and by] fear [and] prolonged mental and physical exhaustion"[18(p10)]—this work will also use interchangeably the terms *combat reaction*, *combat stress reaction* (CSR), and *combat breakdown*.

The importance of combat stress reactions for military planners can be seen in these three examples:

1. In World War II, because of the mistaken belief that thorough induction screening could eliminate susceptible men and therefore prevent combat breakdown, 970,000 men (5.4%) of the almost 18 million men examined at induction stations were rejected for mental or emotional reasons.[3(p72)] Studies of a group of rejectees who were subsequently allowed to serve revealed that 79% served successfully.[14]
2. Also in World War II, psychiatric casualties were admitted to military hospitals at twice the rate in World War I, and psychiatric disabilities accounted for more World War II disability discharges (486,000) than any other medical reason—nearly three times the rate in World War I.[2]
3. To focus on just one campaign in World War II, but one that included an especially notable example of how psychiatric casualties can seriously undermine an army at war, forward deployment of psychiatrists in the early phases of the fighting in North Africa was not begun until late in the campaign and psychiatric casualties were therefore evacuated far from the fighting. Not only was the neuropsychiatric casualty rate unusually high (25%–35% of all nonfatal casualties), only 3% ever returned to combat duty.[19] At one point the rate of psychiatric evacuation from the area of fighting exceeded the rate of theater replacements.[20]

Psychiatric experiences during these wars also indicated that, sooner or later, the psychological stamina and resiliency of any soldier could be exceeded by the rigors, dangers, losses, or horrors (ie, the trauma) of the combat situation, and that such a "breakdown" was not primarily a measure of weakness of character or cowardice. For example, a study of 1,000 infantrymen fighting in the Mediterranean theater in World War II reported that the breaking point of the average rifleman was 88 days of company combat.[21] Furthermore, through projection it was estimated that, considering psychiatric attrition alone, a unit could become 90% depleted by combat day 210.[21]

These wars also taught military psychiatry that a vigorous, crisis-oriented, but conservative, forward treatment aimed at quickly restoring affected soldiers to duty function was mostly effective in reversing these combat reactions. By way of example, in August 1950 during the Korean War, before the forward placement of mental health personnel was instituted, the annualized rate for psychiatric admissions was 250 per 1,000 troops.[22(p25)] In 1951, following the implementation of the three-echelon system of psychiatric care, the rate dropped to 70 per 1,000 troops. In 1952, during the 6 months preceding the armistice, the rate fell to 21 per 1,000 troops.[22]

Finally, it also was made evident from past experience that if these combat stress casualties received premature evacuation, or even overly sympathetic treatment, not only was there needless elimination of capable soldiers from the fighting force, but levels of morbidity among these soldiers (ie, chronicity) greatly increased as well.[20]

Combat Stress Reaction and the Individual Soldier: Adapting the Combat Psychiatry Forward Treatment Doctrine in Vietnam

The following clinical material will illustrate the presentation and management of a soldier with acute combat exhaustion (or combat stress reaction) in Vietnam:

CASE 2-1: "Classic" Combat Exhaustion

Identifying information: Specialist 4th Class (SP4) Delta was a 20-year-old, single, white infantryman who had been assigned to one of the infantry divisions in Vietnam for 5 months and was transported from the field by helicopter to the 93rd Evacuation Hospital near Saigon along with other combat casualties.

History of present illness: (See clinical course)

Past history: Negative for psychopathology

Examination: Upon his arrival SP4 Delta was observed by the psychiatrists of the 935th Psychiatric Detachment, which was attached to the 93rd Evacuation Hospital, to be strapped to a litter, grunting incomprehensibly, and posturing. He was quite disorganized and could not communicate with his examiners. He was easily startled by noises and walked with a slow, shuffling gait, needing support and guidance. When he sat in a chair, he rocked with his eyes closed and occasionally mumbled "Mama." He spoke only if urged, and then in immature sentences. SP4 Delta reported unemotionally that many of his men had been killed while moving up a hill; no other information was obtainable. His physical examination was otherwise normal.

Clinical course: On the psychiatric unit, the patient was given a shower and reassurance and was "put to sleep" with Thorazine (dose not available). When he awoke 18 hours later he appeared alert, coherent, and rational. He was issued a fresh uniform and received instructions about the quasi-military ward routine. The staff told him that he was recovering from overexposure to combat, and that he could expect to be returned to his military unit soon. In the group therapy meeting, SP4 Delta emotionally described how he had been serving as a fire team leader when six of his friends were killed and mutilated by enemy fire, and that he had become agitated and began screaming while loading their bodies into a helicopter. He talked despondently of his revulsion at the killing and his regret that he had "gone to pieces" such that another squad leader had to take charge of his men. He said he felt torn because he always sought to be "good" and wanted to be a good soldier, but it just wasn't his "makeup" to kill. SP4 Delta said that he could not return to the field. The record noted that the psychiatric staff responded to his feelings "with reality-testing and ego support of his duty and mission." That night he was informed that he would be returning to his unit the following day, and he was again given Thorazine.

Discharge diagnosis: Combat exhaustion.

Disposition: SP4 Delta was returned to his unit and combat duty with a recommendation that he receive follow-up care at his battalion aid station.

Source: Adapted with permission from Camp NM. The Vietnam War and the ethics of combat psychiatry. *Am J Psychiatry.* 1993;150(7):1005.

Because SP4 Delta rapidly improved while in treatment and because he had no past psychiatric history, he was discharged back to his unit with a diagnosis of combat exhaustion—implying a temporary, stress-induced, nondisabling condition. Apart from prescribing chlorpromazine (Thorazine), a neuroleptic tranquilizer, rather than barbiturates and other sedatives of an earlier era, a patient like this one would have been managed similarly by military psychiatrists and allied medical personnel in late World War I, World War II, and the Korean War. This refers to a treatment regimen for psychologically overwhelmed combat soldiers that was pragmatically developed during those earlier conflicts and adapted by the 935th Psychiatric Detachment psychiatrists to the unique circumstances in Vietnam.[23]

Historically, this treatment regimen—referred to throughout this work as the combat psychiatric forward treatment doctrine, or the "doctrine"—included brief, simple, mostly restorative measures such as: safety; rest and physical replenishment; peer support; sedation, if necessary; and opportunities for emotional catharsis of the soldier's traumatic events. Such conservative

treatment elements were to be applied as close to his unit as practical and accompanied by the expectation that he would quickly recover, rejoin his comrades, and resume his military duties.[24,25] Leading up to and throughout the Vietnam War, the Army confidently advocated this approach believing that it would serve both the needs of force conservation and those of the individual soldier.[26,27] (Pathogenesis, diagnosis, and treatment of combat stress disorders in Vietnam will be explored in Chapters 6 and 7.)

Available records from the 935th Psychiatric Detachment indicated that SP4 Delta was not rehospitalized at the 93rd Evacuation Hospital during the remaining 7 months of his assignment in Vietnam. However, because of the fluid nature of the military situation in Vietnam and frequent variations in the pattern of medical evacuations, it cannot be said with certainty that he was not subsequently treated somewhere else in the theater for a recurrence of his psychiatric symptoms. It is also not known if SP4 Delta was later killed or wounded, or suffered with delayed, postdeployment readjustment problems or psychiatric symptoms, including those that were later incorporated in the entity that was codified in 1980—posttraumatic stress disorder (PTSD).[28] However, in the absence of such information, by the standards passed down from earlier wars, his apparent recovery and return to duty after treatment at the 935th Psychiatric Detachment would have been a favorable outcome.

Army Psychiatry in Vietnam Was Organized to Treat Large Numbers of Combat Stress Casualties

Army medical and psychiatric planners anticipated sizeable numbers of combat exhaustion cases in Vietnam and therefore replicated the system of care that was pragmatically established in World War I by Major Thomas Salmon, chief psychiatrist of the American Expeditionary Forces, and validated in subsequent wars.[17] It was furthermore intended to conform to the Army's doctrinal three-tier (echelon) medical treatment system in Vietnam.[14,29] According to this system of psychiatric care (codified in US Army, Republic of Vietnam [USARV] Regulation 40-34, *Mental Health and Neuropsychiatry*[30]), soldiers with psychiatric symptoms who failed to respond to unit-based first aid, which consisted of efforts at increasing morale and confidence through counseling, reassurance, exhortation, and leadership, were to be provided graduated levels of psychiatric care as follows:

1st echelon psychiatric care: The soldier with more than temporary psychiatric symptoms and disability, including those with combat exhaustion, would enter the medical system through the battalion aid station (1st echelon treatment facility), where basic physical and emotional treatment would be provided by field medics working under the direct supervision of a general medical officer (battalion surgeon). In some instances the battalion aid station personnel would be augmented by an attached social work/psychology technician/specialist (91G military occupational specialty [MOS]), an enlisted corpsman with additional education and training who was under the technical, if not direct, supervision of the division psychiatrist. If these symptoms extended beyond 24 to 48 hours, the soldier would typically be evacuated further from the fighting to the division's medical clearing company for more specialized care.

2nd echelon psychiatric care: Throughout the war, combat divisions maintained a small clearing company treatment facility at a brigade's, or the division's, base camp. Here a broader range of support and treatment could be provided to combat stress casualties by the division psychiatrist, the division social work officer, and the enlisted social work/psychology technicians. If the soldier's symptoms failed to respond to treatment here within 3 to 5 days, he would be evacuated out of the operational area of the division to one of the Army-level hospitals in Vietnam.

3rd echelon psychiatric care: This refers to the more extensive psychiatric care provided at either of the two psychiatric specialty detachments in Vietnam. Each psychiatric treatment and rehabilitation center was attached to an evacuation hospital and was fully staffed with psychiatrists and other mental health professionals as well as enlisted personnel with specialized training. It was expected to provide up to 30 days inpatient treatment for soldiers from divisional as well as nondivisional units. (Apparently their high staffing allocations were primarily based on predictions that they would be required to treat up to 100 combat fatigue cases/24-hour period.[31]) The second priority for psychiatric specialty detachments was to provide outpatient treatment and mental health consultation services

(MHCS) for the nondivision, mostly noncombat, units in their coverage area.[29]

There were other evacuation hospitals (10 at most) and field hospitals (three at most) in Vietnam, each of which had an authorized psychiatrist position; however, these positions were often not filled because of lack of available personnel, they were generally not staffed with allied mental health personnel, and they did not have dedicated psychiatric wards. In instances when they did have a psychiatrist assigned, the inpatient treatment was limited to about 10 days and took place on a general medical ward. (Additional distinctions between the structure, staffing, and treatment capabilities of these echelons of psychiatric care will be provided in Chapter 7.)

As it turned out, the psychiatric assets deployed in Vietnam were not distributed in proportion to the professional challenges that arose. If 1969 is used as an example, on the surface numerical balance appears to be in effect. On April 30, Army strength peaked in Vietnam at 363,300,[32] with the seven full combat divisions accounting for approximately 126,000 of those (a figure derived from multiplying the number of divisions times an estimated 18,000 troops per division), that is, the full divisions accounted for one-third of the Army personnel in Vietnam. Furthermore, one-third (seven) of the 22 Army (clinical) psychiatrists in Vietnam were assigned as division psychiatrists (as indicated by the Walter Reed Army Institute of Research psychiatrist survey [to be discussed in Chapter 5]) with the remainder assigned to the two psychiatric specialty detachments or as solo psychiatrists at selected evacuation or field hospitals. However, four factors suggest that this allocation of psychiatric capability was out of balance:

1. Although the organizational structure dictated the prioritization of psychiatric attention in favor of staffing the combat divisions in anticipation of large numbers of combat stress casualties, they never materialized.
2. About half of the evacuation and field hospitals (excepting the two with psychiatric specialty detachments) did not have assigned psychiatrists, yet it was the job of these hospitals to support the approximately 237,000 nondivisional support and service support troops. Arranging for their psychiatric care would prove more awkward and unpredictable.[33] (Appendix 8, a summary of a presentation by Johnson to a 1967 expert panel discussion of Army psychiatry in Vietnam, addresses these difficulties.)
3. The Army's heavy reliance on heliborne medical evacuation meant that the overall echelon-based system of medical care in Vietnam was often not followed. Casualties of all types (including psychiatric patients from the field) frequently bypassed the 1st, and even 2nd, treatment echelon to be taken directly to field and evacuation hospitals (so-called overflying).[24]
4. Support troops, who constituted most of the nondivisional units, generally had greater rates of psychiatric disorders and behavior problems except during periods of high-combat activity.[15]

Furthermore, as the war progressed, this arrangement became increasingly out of balance. This is partly because as the war passed the midpoint there was a dramatic shift in the character of psychiatric and related problems. After 1969, when combat activities were being scaled back, troop demoralization, dissent, and drug use—disabling psychiatric and behavioral conditions in and of themselves—accelerated, apparently especially within the ranks of the nondivisional units—the noncombat, combat support and service support units (ie, the "rear").[5(p55)] However, no structural changes were made in the organization of mental health assets in Vietnam or modifications in the selection, preparation, or deployment of mental health personnel in order to offset this growing psychiatric challenge.

Army Psychiatrists Deploying to Vietnam Were Primarily Prepared to Treat Large Numbers of Combat Stress Casualties

Equally problematic, the training and indoctrination of physicians who would be assigned in Vietnam, including psychiatrists, mostly emphasized the psychological limits of soldiers in combat, the causes of breakdown (social, physical, and emotional) under sustained fire, and the prevention or management of large numbers of combat-generated psychiatric casualties. Other psychiatric or behavior problems associated with low morale and indiscipline—unrelated, or only indirectly related to combat exposure—were evidently presumed to be less pressing. This was the case in the Army's two psychiatric residency-training programs (Walter Reed General Hospital, Washington, DC, and Letterman General Hospital, San Francisco, California), where the principles of prevention and

TABLE 2-1. Expected Neuropsychiatric Casualties Among Troops as a Function of Combat Intensity and Cumulative Time in Combat*

Cumulative Combat Days	Wounded in Action (WIA) Per Thousand Troops Per Day (Combat Intensity)							
	0 WIA	5 WIA	10 WIA	20 WIA	30 WIA	40 WIA	50 WIA	60 WIA
1–5 days	0.3	1.0	1.6	2.9	4.2	5.5	6.8	8.1
6–10 days	1.7	2.4	3.0	4.3	5.6	6.9	8.2	9.5
11–20 days	3.9	4.6	5.2	6.5	7.8	9.1	10.4	11.7
21–40 days	6.4	7.1	7.7	9.0	10.3	11.6	12.9	14.2
41–80 days	8.6	9.3	9.9	11.2	12.5	13.8	15.1	16.4

*In means of estimates for infantry, armored, and airborne troop neuropsychiatric casualties.

Adapted from: Medical Field Service School. *Expected Neuropsychiatric Casualties Among Infantry, Armored, and Airborne Troops as a Function of Combat Intensity and Cumulative Time in Combat*. Fort Sam Houston, Tex: Department of Neuropsychiatry, Medical Field Service School; distributed July 1967. Training Document GR 51-400-104-105.

treatment of combat breakdown were central elements in the curricula (see Prologue).

Similarly, at Fort Sam Houston in San Antonio, Texas, newly commissioned, civilian-trained psychiatrists, including those who would be assigned in Vietnam, received their orientation to Army psychiatry at the Army's Medical Field Service School along with other new Medical Corps officers (physicians), and they were provided only a few hours of instruction in military psychiatry, most of which centered on combat-stress generated casualties. In July 1967, this training included the following three presentations:

1. A lecture with handout on the organization of psychiatric services in the combat division—especially the division psychiatrist's critical role in supporting the recovery and redeployment of the scores of men who were predicted to become overwhelmed with the stress of sustained combat operations in Vietnam:

   > The organization of the psychiatric services of a division is based upon the requirements generated by expected combat experiences. The design and structure of these services are based largely upon the necessity of preventing, detecting, treating, and disposing of cases of combat exhaustion. Whether [the psychiatric services] deal with problems of mental illness or other problems of mental health in the [division] are of secondary importance.[34(p1)]

2. A lecture with handout addressing the etiology and presentation of combat exhaustion: It made reference to four severity levels and acknowledged the wide range of possible disabling symptoms. Theories as to pathogenesis centered on fear and exhaustion as primary and combat avoidance as secondary.[18]
3. Repeated warnings as to the likelihood of a flood of combat exhaustion psychiatric casualties in Vietnam ("Projecting psychiatric casualty rates an additional 4–6 months . . . most of the divisions in World War II would have been completely ineffective from the number of combat exhaustion cases alone"[18(p11)]). Table 2-1 is a combat stress casualty prediction schedule that was distributed to the Medical Field Service School participants illustrating the covariance of combat breakdown with combat intensity/duration derived from earlier military experience. The shaded box (6.5) has been selected here to serve as a conservative hypothetical example: If a combat division has 12,000 combat-committed soldiers engaged in a fight of moderate intensity (ie, 20 wounded-in-action/1,000 troops/day) over a moderate period of time (11–20 days), this schedule indicates that the division psychiatrist would be responsible for the care of *78 new combat exhaustion casualties per day* [emphasis added] (eg, 12 x 6.5). For simplicity's sake the physician participants were also given these rules of thumb: "One combat exhaustion case for every four wounded"[18(p11)] and "For every

> four soldiers wounded in combat, there is a soldier that requires medical attention because of combat exhaustion."[34(p1)]

The Low Incidence of Classic Combat Stress Reaction Casualties in Vietnam

Over the course of the war senior military psychiatrists observed that the large number of combat exhaustion cases that were anticipated and planned for never materialized, at least not in their classical form.[17] Anecdotally the psychiatrists assigned to the Army combat divisions during the first few of years of the war reported a range from no combat exhaustion cases[35] to four to 12 per month,[36] with the higher numbers being associated with episodes of increased combat activity.[37,38]

Further substantiation of a low incidence for combat exhaustion appears to come from the observation that, although all hospitals were required to provide combat exhaustion casualty statistics to USARV medical command, the official summary of US Army medical experience in Vietnam (1965 through May 1970, two-thirds through the war) made no mention of combat exhaustion as a military medical problem.[27] Also, the official overview of the psychiatric problems in the Vietnam War, which was published after the war by Jones and Johnson when Johnson served as the Chief, Psychiatry and Neurology Consultant Branch, Office of The Surgeon General, US Army, did not report theater-wide incidence statistics for combat exhaustion; but the authors did attest to the fact that the incidence throughout the war was extremely low.[39]

An alternative means of measuring the clinical challenge represented by combat exhaustion cases in Vietnam was their percentage of all hospitalized psychiatric conditions. In the process of comparing US Army psychiatric hospitalization rates in Vietnam with those of the Army of the Republic of Vietnam during the first 6 months of 1966, early in the buildup phase, Peter G Bourne, Chief, Division of Neuropsychiatry, Walter Reed Army Institute of Research Medical Research Team in Vietnam (1965–1966) found only 6% of US Army psychiatric admissions were diagnosed as combat exhaustion.[40] Later, in a preliminary overview of US Army mental health activities in Vietnam, Matthew D Parrish, who was Chief, Psychiatry and Neurology Consultant Branch, Office of The Surgeon General, and Edward M Colbach, who was Assistant Psychiatric Consultant, reported only 7% of all psychiatric admissions through the first two-thirds of the war were diagnosed as combat stress reaction.[41]

All this is not to say that the specialized treatment of combat stress reactions was not an important challenge in Vietnam; rather, that these casualties apparently never achieved the incidence rates that had been anticipated—or perhaps not in the more incapacitating forms anticipated. Still, it is regrettable that true combat reaction incidence figures are missing—data that could contribute to further understanding the various efforts of the US Army Medical Department to adapt the traditional psychiatric doctrine of forward treatment to Vietnam. This appears to be especially important considering: (*a*) the irregular, counterinsurgency/guerrilla warfare that was waged, and (*b*) the widespread use of newly developed psychopharmacologic medications for the treatment of combat stress reaction cases. (These themes will be developed further in Chapters 6 and 7.) In any event, in time psychiatric concerns for soldiers affected by combat stress in Vietnam became greatly overshadowed by the increases in other, unanticipated psychiatric conditions and behavior problems—essentially psychosocial disorders—that ultimately dismayed Army leaders and swamped mental health capabilities. As previously noted, the incidence of these problems was evidently greater among noncombat troops, thus the center of effort for mental health personnel shifted progressively to the understaffed nondivisional medical treatment facilities (the field and evacuation hospitals and the psychiatric specialty detachments).

A SYNOPSIS OF ARMY PSYCHIATRY'S TWO, SEQUENTIAL VIETNAM WARS

In presenting an overview of the clinical (and personal) challenges faced by Army psychiatrists assigned in Vietnam, this chapter draws upon selected references from the literature that provide markers bearing on the Army psychiatric experience there with respect to the ground war. These have been divided roughly along lines of the principle military deployment phases, that is, buildup (1965–1967), a transition phase (1968–1969), and drawdown (1970–1973), and placed against the war's shifting backdrops and contexts noted in Chapter 1.

The Buildup Phase (1965–1967)

By the end of 1965, the first year the US Army deployed in Vietnam, there were 116,800 Army troops; by the end of 1966 there were 239,400; and by the end of 1967 there were 319,500.[32] As noted in Chapter 1, during these years, opposition to the war was gradually building at home while draft call-ups quickly gathered momentum to meet the huge manpower needs in Southeast Asia. Because Reserve units and the National Guard were, for all practical purposes, exempted from deployment throughout the war, the ground forces were composed of a mix of career soldiers, draftees, and volunteers. The latter included many draft-motivated volunteers—soldiers who anticipated being drafted and who enlisted with a promise of a more advantageous training or assignment with regard to risk or privation. Thus, whereas officially only 39% of the Army's enlisted personnel in Vietnam were technically draftees,[42] regarding the matter of low morale and associated difficulties, the many "draft-motivated" volunteers should also be considered as conscripts.

Combat could be very intense during these initial years, and the cities and countryside were not secure; however, troops maintained high morale and a sense of purpose. According to General William C Westmoreland, the overall commander of US forces in Vietnam (Commander, US Military Assistance Command, Vietnam [MACV]), the troops operating in Vietnam during the buildup years were "the toughest, best trained, most dedicated American servicemen in history."[43(p34)] More specific to the Army in Vietnam, retired Brigadier General SLA Marshall, combat veteran of World War I and front-line observer in World War II and Korea, commented after his visit to Vietnam in 1966:

> My overall estimate was that the morale of the troops and the level of discipline of the Army were higher than I had ever known them in any of our wars. There was no lack of will to fight and the average soldier withstood the stress of engagement better than ever before.[43(p34)]

Nonetheless, the stress on the typical serviceman assigned in Vietnam was considerable. Navy Lieutenant Stephen Howard, who served as a Marine battalion surgeon, provided the following portrayal of the initial shock experienced by all newly arrived troops. According to Howard, alienation and depersonalization begin upon arrival in Vietnam.

> He is torn from everything that is familiar and comforting to him: his family and friends, his country, even the familiar routine of stateside barracks life; his normal hopes and troubles and ways of relating. He finds himself in a strange Asian country, knowing nothing of its language, history, or meanings, surrounded by desolation and threatened with death; *he is the alien* [emphasis added]. . . . He is a non person . . . a thing expected to function, while everything around him is strange and lacking in meaning. . . . And the excruciating boredom which he frequently must endure in the hiatus between military operations, along with the deprivation of privacy, only reinforces his experience of himself as a thing which is [expected to perform] in a prescribed way. . . .[44(p123)]

There are at least several additional stressors that should be added to Howard's synopsis. The first would be simply the presumed stress borne by the high numbers of very young, first-term, draftees and enlistees who entered Vietnam as their first assignment. Equally potent and linked would be the new replacement's difficulty in having to manage his shock alone as a consequence of the military's individual rotation policy. Of course, members of the receiving unit likewise incurred a stress in having to accommodate green troops who arrived singularly to replace seasoned troops.[45]

More specific to the fact of being assigned in an active theater of combat operations, innumerable accounts attest to how the type of warfare in Vietnam (ie, a counterinsurgency/guerrilla war) meant that no setting could be assumed safe from enemy-directed violence (eg, rocket and mortar attacks, ambush, terrorist activities, sniper fire). This meant that all troops were at least diffusely subjected to some degree of combat stress.[46–48] Of course the risk varied considerably by locale and role (especially, combat vs noncombat), and, as expected, great tensions arose between troops with higher combat exposure, as well as hardship in general, and those considered "rear echelon" (the despised "REMF"—"rear echelon mother f--ker"), although this was a relative measure.[5] For example, Major Douglas R Bey, a division psychiatrist with the 1st Infantry Division, underscored how deeply the combat troops resented the REMF who had it relatively safe and comfortable. "Grunts (infantry or ground soldiers) in the field often claimed that they had more in common with Charlie (the VC [Viet Cong] enemy)

than they did with the REMFs."[49(p80)] Cincinnatus, a military historian, remarked that predictable resentment of the noncombat troops and those in the rear by those facing combat was a far greater irritant in Vietnam overall because of the "circular" nature of the tactics—soldiers perpetually returned to their secure base camp after going out to seek contact with the enemy, and there would encounter others who remained clean, comfortable, and, most of all, safe.[50] "Swarming base camps were filled with officers functioning in staff jobs or service support activities who were never in danger of being sent into combat despite the fact that they were serving in a 'war zone.'"[50(p149)] According to Cincinnatus, resentment of opportunism among those with rank or status advantage was corrosive to morale from early on:

> The war was torture for those who fought it, yet they saw others using that conflict for personal gain. They saw American contractors enriching themselves through multimillion-dollar building projects. Everyone seemed hell-bent . . . to manipulate currency, to deal in whiskey trades, to hoard a little gold or a few diamonds. They were often forced to live in flimsy tents and ramshackle quarters while their more fortunate noncombat brethren were housed in concrete-block, air-conditioned buildings. They swatted mosquitoes and despised the leeches they pulled from their crotches while others picked up fresh laundry from government-provided base facilities.[50(p151)]

Nonetheless, despite the rigors of the counter-insurgency warfare and the extremely inhospitable setting, morale and combat motivation remained high during the buildup years. The observations and interpretations by Moskos, a military sociologist, from his time in Vietnam as a war correspondent between 1965 and 1967 provided some explanation, at least for combat troops. He believed this arose from a linkage between the soldiers' individual self-concern (heightened because of the 1-year, individual rotation system) and devotion to the other soldiers in the immediate combat group (eg, instrumental interdependencies motivated by the functional goal of survival).[51] Moskos also noted their shared belief in an exaggerated masculine ethic as well as a latent ideology of devotion to US ideals that stemmed from their conviction regarding the supremacy of the US way of life. Furthermore, the soldiers he studied were notably apolitical and antagonistic toward peace demonstrators ("privileged anarchists") at home.[51]

Comments by Bourne from his year in Vietnam are also illuminating. He reported that soldiers in these early years maintained a positive motivation in part through what he labeled "combat provincialism."

> They are not only unconcerned about the political and strategic aspects of the war; they are also disinterested in the outcome of any battle that is not in their own immediate vicinity . . . [The soldier] retains certain deep allegiances and beliefs in an . . . amorphous positive entity, 'Americanism,' which allow him to justify his being sent to Vietnam.[52(p44)]

Bourne especially credited the fixed, 1-year tour for soldiers for the high morale, but he also expressed concern for its consequent disturbance to the "solidarity of the small unit"—the traditional stress-protection system for combat soldiers.[53]

Buildup Phase Psychiatric Overview

Correlating with the observations of high esprit and commitment, troop attrition due to psychiatric or behavioral dysfunction was exceptionally low during those first few years. The Army psychiatric evacuation rates from Vietnam through mid-1968 averaged 1.97 per 1,000 troops per year (compared with a rate of 2.6 in the Korean War and 13.8 in Europe during World War II).[54(p59)] Similarly, the proportion of medical evacuations out of Vietnam for psychiatric diagnoses early in the war (3%–4%)[39] compared quite favorably with that for the Korean War (6%) and for World War II (23%).[14] Reporting from the Vietnam theater in January 1967, Johnson, the senior Army psychiatrist (the USARV Neuropsychiatry Consultant), observed:

> A cross section of psychiatric patients seen in Vietnam would include patients having symptoms of psychosis, psychoneurosis and character disorder in approximately the same proportion as a similar body of troops in the continental United States but with a relatively small increment of patients with more directly combat-induced symptoms.[55(p305)]

On a more granular basis, over the first 6 months of 1967 it was reported that among all medical causes, psychiatric cases accounted for only 6.7% of Army evacuees from Vietnam to Travis Air Force Base,

California (a rate that was almost one-third of that for the Navy/Marines or the Air Force). Furthermore, soldiers with character and behavior disorder diagnosis only accounted for 11.5% of Army psychiatric evacuees (US Navy/Marines = 53.5%; and US Air Force = 17.6%).[56(Figure 2)]

Rates for misconduct in the theater were also low (eg, the annual stockade confinement rate for 1966–1967 was 1.15/1,000 soldiers/year as compared to the expected overseas rate of 2.2).[57] According to Major General George S Prugh, former Staff Judge Advocate at the US Military Assistance Command in Vietnam,

> Criminal offenses in the Army were not a serious problem in the early years of U.S. involvement in Vietnam. At the beginning of 1965 the monthly Army court-martial rate in Vietnam was 1.17 per 1,000; at the end of 1965 it was 2.03 per 1,000. Yet the Army-wide court-martial rate for 1965 was even more; 3.55 per 1,000.[58(p98)]

Some senior Army psychiatrists attributed these favorable metrics to an array of operational and preventive factors that appeared to protect the soldiers from psychiatric and behavioral difficulties: (*a*) technological superiority; (*b*) the professionalism of the troops; (*c*) fixed, 1-year assignments; (*d*) high-quality leadership; and (*e*) adequate supplies, equipment, and support—especially medical support.[13,24,39] Others also credited the application of the aforementioned doctrine of combat psychiatry.[59,60]

Evidently also quite important in reducing the psychiatric attrition rate was the type of warfare waged in Vietnam. According to Colonel William J Tiffany, then Chief, Psychiatry and Neurology Consultant to The Surgeon General, US Army, and Lieutenant Colonel William S Allerton, his Assistant Chief:

> The fighting in Vietnam is in brief, intensive, and sporadic episodes, with periods of relative calm and safety interspersed. Troops are not pinned down by enemy fire for prolonged periods of days or weeks. The fact that no large artillery barrages exist may also be significant.[24(p813)]

However, quite presciently, these senior psychiatrists warned that the low psychiatric rates may be somewhat based on the deployment of "seasoned and motivated troops"; and that the greener or less motivated troops who follow may produce "a change," that is, deterioration.[24]

Alcohol use and abuse was predictably a common stress outlet for the soldiers of the buildup phase,[39] but military leaders and the psychiatric contingent expressed more concern for the use of illegal drugs by troops,[58,61,62] especially the locally grown marijuana that was readily available and highly potent. In their survey of drug use patterns of lower-ranking enlisted soldiers departing Vietnam in 1967, Roffman and Sapol reported that of the 32% who acknowledged ever smoking marijuana, 61% began in Vietnam and one-quarter were considered heavy users (greater than 20 times during their 1-year tour in Vietnam).[63] The authors also noted that the extent of marijuana use by soldiers in Vietnam was very similar to their civilian peers.[63] Furthermore, Bourne observed that marijuana use created almost no psychiatric problems in the theater.[52] Use of opiates was also mentioned, but it was not as pure as that which was sold after 1970 and was not used by soldiers in sufficient numbers to constitute a serious problem for command.[64] The senior psychiatric leaders in Vietnam were also not very concerned about effects of antiwar sentiment in the United States.[33]

One psychological phenomenon that did attract a fair amount of attention from military psychiatrists was the phasic nature of stressors, moods, and attitudes affecting soldiers as a consequence of the individual, 12-month tour of duty.[39,47,48] To paraphrase the observations by Army psychiatrists Gary L Tischler and Jerome J Dowling, (*a*) there is a period of initial emersion shock, fearfulness, and highest levels of psychiatric symptomatology; (*b*) followed by one of mastery and reduced preoccupation with home, but with some depression, resignation, and flight into a "hedonistic pseudocommunity" (peer-group sanctioned hypomanic pursuit of pleasure and materialism); (*c*) followed by growing combat apprehension and perhaps expressions of a "short-timer's syndrome." The latter refers to a low-grade form of disability often exhibited in soldiers within 4 to 6 weeks of their date of their expected return from overseas. Symptoms consisted of reduced combat tolerance and efficiency; preoccupation with fears about being killed; and sullen, irritable, or withdrawn behavior. This had also been noted among troops serving in the Korean War after individualized tour limitations were introduced there in mid-1951.[65(p73)]

The following is an account provided by Captain Harold SR Byrdy, who served during the first year of

the war as division psychiatrist with the 1st Cavalry Division (August 1965–June 1966). It is especially illustrative of the cumulative stress experienced by many of the division's combat troops over time and their efforts to adapt.

> During the course of the year there were vast changes in people and changes in the kinds of patients I saw. When the Cavalry troops first took over the safety of the perimeter of the base camp from the 1st Infantry Division in mid-September of 1965 they fired thousands of rounds throughout the first night. That was the main body getting used to being in Vietnam. I had the impression that we often saw a new trooper in his 2nd week in Vietnam. I speculated that it must take a while before the novelty of the place wore off, before he finally became familiar with the routine of his unit and learned its expectations of him and before compulsive mechanisms of adjustment were strained by the realization of a year of sad separation from home, tedious days of work and anxious nights.
>
> The troops would make adjustments to being in the field. They would make some sort of adjustment to the mobility wherein they would sleep perhaps 3 or 4 hours a night and eat 1 or 2 meals a day. I don't think it was an exact plan of any sort, but they would attempt to develop this pattern. When they'd return to the base camp they would have to perhaps make a rapid adjustment from being in the field back to being in garrison where 'spit-shine' boots and polished brass then became the obsession. Often after the return to camp there would be some sort of explosion in the trooper who had done well out in the field. We believed that with time troops were less successful in protecting themselves against repeated loss. I think that during the Ia Drang campaign people tended to spring back to their usual selves with resiliency, but during the Bong Son campaign they wouldn't make it all the way back. Ambivalence would be more prominent. About that time I began seeing more depressed sergeants. A guilt for leading the troops was building up. Also we had several cases in which new sergeants without combat experience came to take over troops who were obviously battle seasoned. These men felt quite inadequate in a leadership role and realistically, they were.
>
> The troops would steel themselves against repeated life-threatening situations and repeated loss of buddies. One fellow was a self-referral through his commanding officer; that is, he referred himself, then the CO [commanding officer] agreed. His complaint was simply that he just didn't feel right. With time due to loss of men through malaria, battle casualties and rotation he had seniority in his company. Having even lost friends among the newly rotated, he had no inclination to make friends and indeed had none. Denial to my mind was the most important mechanism for survival in the area, at all levels.[66(pp51–52)]

However, by the standards of military leaders, the short-timer's syndrome was not the only problem in Vietnam associated with the personnel turbulence brought about by the individualized, 1-year tours; apparently unit cohesion and combat effectiveness were also becoming seriously compromised.[5] (Short-timer's syndrome will be explored further in Chapters 3 and 8.)

Buildup Phase Psychiatrist Reports

The morale and confidence of the deployed Army psychiatrists during these early years also appears to have been high. This is suggested both in the large numbers who were motivated to publish professional accounts (Exhibit 2-1) and in the role satisfaction that these reports reveal. Taken together, these psychiatrists reflect optimism and they tout the effectiveness of the traditional doctrine of forward treatment in Vietnam, the extension of principles of social psychiatry to military leaders (command consultation), and the utilization of newly developed pharmacologic agents (neuroleptics, anxiolytics, and antidepressants) for the treatment of symptoms related to combat stress and other conditions. However, regarding the use of these medications, whereas a limited survey in 1967 confirmed a high level of this type of prescribing by Army physicians, including psychiatrists,[67] no associated clinical or research studies were undertaken to address risks and benefits under the unique circumstances of a combat zone. Buildup phase psychiatrist reports will be reviewed in more detail in subsequent chapters; however, simply scanning the titles provides an impression as to the predominant psychiatric challenges faced through these early years in the war.

With regard to the growing antiwar sentiment in the United States, Captain Arthur S Blank Jr and Captain H Spencer Bloch, two Army psychiatrists who served in the buildup phase and who published

accounts, indicated that they did not believe the growing opposition to the war was significantly affecting their patients. Blank, who served during the first year of the war, was very specific: "Do the ambiguities of the war seem to be a problem for the soldiers? The answer is very simply, 'No.' I did not see a single patient in whom I felt that any kind of conflict about the war on any level was primary in precipitating his visits to me."[68(p58)]

Bloch served as the Chief of the Psychiatry and Neurology Inpatient Service of the 935th Psychiatric Detachment, a unit in which Blank had served approximately 2 years earlier. Even then, nothing in Bloch's review suggested either low morale among the troops they encountered or among the psychiatric staff of the 935th. He asserted that in his experience soldiers who struggled with concerns regarding the morality of the conflict typically were driven by pre-Vietnam psychological conflicts. In fact, he spoke favorably about the 935th Psychiatric Detachment's adaptation of the military's psychiatric treatment doctrine, including use of the new psychoactive medications, to the conditions of the irregular counterinsurgency/guerrilla warfare in Vietnam. He also made evident his team's alignment with military priorities in response to persisting conflicts that might arise within the soldier-patient.[23]

Nevertheless, the morale and attitude of deployed ground troops may have already started to slip by that point. Shortly after he returned to the United States from Vietnam, Lieutenant Colonel Jack R Anderson, who was the commanding officer of the 935th Psychiatric Detachment (September 1967–September 1968) when Bloch served, not only expressed concern for a rising incidence of soldiers with drug-induced psychoses and other forms of misconduct, he was also struck by the emergence of the "dedicated soldier turned 'dropper-outer.'"[54(pIII-56)] This refers to the drafted soldier with a stable background and a history of academic and military achievement who would "suddenly and steadfastly refuse to fight any more, and then steadfastly maintain this refusal, even after repeated courts-martial and stockade sentences."[54(pIII-56)]

Perhaps the morale of some of the deployed Army psychiatrists was starting to ebb as well. Captain John A Talbott, a drafted civilian-trained psychiatrist who reported that, pre-Vietnam service, he disagreed with the government and with the war,[69(pG-1)] nonetheless served in Vietnam during the same period as Bloch and Anderson. In an interview following his year there, he said: "[Unique for Vietnam] is the degree of complaining and dislike for this particular war. . . . Almost without question, all nonpsychotic individuals who appeared at the mental health clinics complained of being in Vietnam and wanted to get out immediately."[70(pIII-58)] Talbott believed that although these were labeled psychiatric problems, they were primarily expressive of a "widespread negative sociologic phenomenon."[70(pIII-58)]

Buildup Phase Impressions

Measures of psychiatric and behavior difficulties among the deployed Army troops in Vietnam during these years was no greater than comparable stateside units. In addition, most military and psychiatric leaders were satisfied that adequate psychiatric resources had been deployed from the start in contrast to previous wars.[14,29,33]

However, as will be demonstrated in this volume, as the years passed, the positive morale in Vietnam did not hold, nor did the low psychiatric attrition rate. In fact, the contentious and protracted counterinsurgency war was already starting to have its corrosive effects on successive cohorts of replacement troops. Quoting a former infantryman:

> [Soldiers] did not know the feeling of taking a place and keeping it. . . . No sense of order and momentum. No front, no rear, no trenches laid out in neat parallels, no Patton rushing for the Rhine, no beachheads to storm and win and hold for the duration. They did not have targets, they did not have a cause. . . . On a given day they did not know where they were in Quang Ngai or how being there might influence larger outcomes.[71(p270)]

The Transition From Buildup to Drawdown (1968–1969)

There were 354,300 US Army troops in Vietnam by the end of 1968. Army troop strength peaked at 363,300 by April 1969, and from there it gradually declined. At the end of 1969 there were still 331,100 Army troops in Vietnam.[32] However, as the war lengthened, the Army had been forced to rely increasingly on relatively inexperienced officers and noncommissioned officers, young draftees, and volunteers as more experienced troops rotated back after their year-long tours. According to Spector, a Marine field historian in Vietnam in 1968 and 1969, the negative consequences of not calling up the (experienced) reserves and the constant turnover of troops produced a very ineffective "Vietnam-only Army."[5] Years later, Sorley, a military historian, came

EXHIBIT 2-1. Selected Publications by Buildup Phase Army Psychiatrists (including research reports)

Years in Vietnam	No. Who Published Articles/ Total No. Deployed Army Psychiatrists (as a percentage)*	Publications
1965	1/7 (14.2%)	Huffman RE. Which soldiers break down: a survey of 610 psychiatric patients in Vietnam. *Bull Menninger Clin*. 1970;34:343–351. Bourne PG. Urinary 17-OHCS levels in two combat situations. In: Bourne PG, ed. *The Psychology and Physiology of Stress: With Reference to Special Studies of the Viet Nam War*. New York, NY: Academic Press; 1969: 95–116. Research report.
1966	6/16 (37.5%)	Conte LR. A neuropsychiatric team in Vietnam 1966–1967: an overview. In: Parker RS, ed. *The Emotional Stress of War, Violence, and Peace*. Pittsburgh, Penn: Stanwix House; 1972: 163–168. Johnson AW. Psychiatric treatment in the combat situation. *US Army Vietnam Med Bull*. 1967;January/February:38–45. Jones FD. Experiences of a division psychiatrist in Vietnam. *Mil Med*. 1967;132:1003–1008. Dowling JJ. Psychological aspects of the year in Vietnam. *US Army Vietnam Med Bull*. 1967;May/June:45–48. Tischler GL. Patterns of psychiatric attrition and of behavior in a combat zone. In: Bourne PG, ed. *The Psychology and Physiology of Stress: With Reference to Special Studies of the Viet Nam War*. New York: Academic Press; 1969: 19–44. Kenny WF. Psychiatric disorders among support personnel. *US Army Vietnam Med Bull*. 1967;January/February:34–37.
1967	12/22 (54.6%)	Roffman RA, Sapol E. Marijuana in Vietnam: a survey of use among Army enlisted men in two southern corps. *Int J Addict*. 1970;5:1–42. Research report. Anderson JR. Psychiatric support of the 3rd and 4th Corps tactical zone. *US Army Vietnam Med Bull*. 1968;January/February:37–39. Baker WL. Division psychiatry in the 9th Infantry Division. *US Army Vietnam Med Bull*. 1967;November/December:5–9. Bloch HS. Brief sleep treatment with chlorpromazine. *Comp Psychiatry*. 1970;11:346–355. Bostrom JA. Management of combat reactions. *US Army Vietnam Med Bull*. 1967;July/August:6–8. Casper E, Janacek J, Martinelli H. Marijuana in Vietnam. *US Army Vietnam Med Bull*. 1968;September/October:60–72. Evans ON. Army aviation psychiatry in Vietnam. *US Army Vietnam Med Bull*. 1968;May/June:54–58. Fidaleo RA Marijuana: social and clinical observations. *US Army Vietnam Med Bull*. 1968;March/April:58–59. Gordon EL. Division psychiatry: documents of a tour. *US Army Vietnam Med Bull*. 1968;November/December:62–69. Motis G. Psychiatry at the battle of Dak To. *US Army Vietnam Med Bull*. 1968;March/April:57. Pettera RL, Johnson BM, Zimmer R. Psychiatric management of combat reactions with emphasis on a reaction unique to Vietnam. *Mil Med*. 1969;134:673–678. Talbott JA. The Saigon warriors during Tet. *US Army Vietnam Med Bull*. 1968;March/April:60–61.

*These numbers do not count research reports, although they are listed in the Publications column.

to the same conclusion following his review of the American experience in Vietnam.[1]

Fatefully, in early 1968 the enemy's intensification of combat activities (the surprise, countrywide Tet offensives; the 77-day siege of the US Marine base at Khe Sanh; and the extended battle for Hue) following almost 3 years of bloody fighting convinced the American public that the costs incurred in Vietnam overshadowed the war's ostensible objectives.[1(p12),72(p546),73(pp68–69)] The resultant spike in public protest led President Johnson to announce the administration's intention to pursue peace with North Vietnam. Yet the fighting and dying continued during the tortuous peace negotiations, as did the assignment of replacement troops (albeit in decreasing numbers), and the progressively confrontational antiwar/antimilitary faction in the United States grew louder. The war took on characteristics of a tedious, agonizing stalemate, and the lack of tangible measures of progress contributed to the widespread feelings of futility and frustration about the war.

According to Spector:

> [A]s the war ground on through its third and fourth year, the prestige of performing a mission well proved increasingly inadequate to men who more and more could see no larger purpose in that mission, and no end to the incessant patrols, sweeps, and ambushes which appeared to result only in more danger, discomfort, and casualties.[5(p61–62)]

Kirk, a journalist, reported from the field in 1969 that the attitudes of troops did not turn seriously negative until fall of 1968, when President Johnson stopped the bombing of North Vietnam and agreed to enter into peace talks.

> The change in attitudes was so sudden . . . the overwhelming sentiment was that the war was a waste, that 'We aren't fighting it like we should. . . . We should go home and let the dinks fight their own war' . . . [soldiers] by and large applauded the [antiwar] demonstrators . . . the senselessness of the struggle.[74(pp61–62)]

Sterba, a correspondent, provided observations on the shifting demographics and particularly the attitudes of the soldiers who went to fight in Vietnam in 1969. (On 8 June 1969, President Nixon, in concert with South Vietnam's President Thieu, had announced his intention to withdraw the first US troops [25,000] from South Vietnam during July and August.[1(p128),72(p684)]) Sterba demonstrated how the rapidly unfolding political events in the United States caused the romance and idealism of the early war to be replaced by a "hated, dreary struggle"[75(p447)] in which the soldier's overriding preoccupation was that of self-protection:

> These were the grunts of the class of 1968—they had come out of that America some of their commanders had seen only from the windows of the Pentagon. They were the graduates of an American nightmare in 1968 that stemmed mostly from the war they had now come to fight—the year of riots and dissention, of assassinations and Chicago, the year America's ulcer burst.[75(p447)]

Transition Phase Psychiatric Overview

The pivotal year, 1968, started off well enough. A few of the psychiatrists in the field in Vietnam indicated that US forces had held up well despite the enemy's countrywide Tet surprise attacks.[76,77] Furthermore, Frank W Hays, a US Air Force psychiatrist who monitored medical evacuations from the theater to Travis Air Force Base in the United States, reported that the proportion of evacuation out of Vietnam for psychiatric conditions dropped to a low 2.7% of all medical evacuations during and immediately following the Tet fighting. "[T]his seems to indicate that the Army has set a new record in the management of psychiatric patients within a combat zone as well as in support areas."[60(p506)] Counterpoint came from Colonel Matthew D Parrish, the USARV Neuropsychiatric Consultant (1967–1968), whose summary of the medical problems and solutions associated with the enemy's Tet offensive observed that under these extreme conditions, by necessity psychiatric patients were evacuated instead of being sent to lower-echelon psychiatric care facilities; in fact, they were evacuated out of Vietnam at three times the usual rate. Parrish worried that, in having their treatment applied offshore and remote from the soldier's primary unit and comrades, these psychiatric conditions would become more intractable.[78]

But concern for soldier reactions to combat stress would soon fade in importance in Vietnam as the war started to have a more generally corrosive effect on the attitude and performance of successive cohorts

TABLE 2-2. Army Incidence Rate for Psychiatric Hospitalizations in Vietnam [and in Europe] in Cases/1,000 Troops/Year

	Total Psychiatric Conditions	Psychosis	Psychoneurosis	Character and Behavior Disorder	Other Psychiatric Conditions
1965	*10.8 [7.7]	1.6 [0.7]	2.3 [1.0]	3.1 [2.2]	3.8 [3.8]
1966	11.6 [7.3]	1.4 [0.8]	2.5 [1.0]	2.8 [2.2]	4.9 [3.3]
1967	9.8 [8.2]	1.7 [0.9]	1.3 [1.0]	2.9 [2.2]	3.9 [4.1]
1968	12.7 [7.9]	1.8 [0.9]	2.2 [1.2]	3.7 [1.8]	5.0 [4.0]
1969	15.1 [7.8]	3.4 [1.6]	1.9 [1.5]	4.2 [1.6]	5.6 [3.1]
1970 (Jan–Sep)	24.0 US [9.7]	3.8 [2.4]	3.3 [1.8]	8.4 [1.9]	8.5 [3.6]

Data source: Neel SH. *Medical Support of the US Army in Vietnam*, 1965–1970. Washington, DC: GPO; 1973; Table 5.
*Neel's rate for 1965 is discrepant with the 6.98 reported by Datel (Datel WE. *A Summary of Source Data in Military Psychiatric Epidemiology*. Alexandria, Va: Defense Technical Information Center; 1976. Document No. AD A021265).

of replacements. Budding demoralization and dissent during these pivotal years began to reveal itself especially in racial incidents and widening drug use (particularly marijuana, but also commercially marketed stimulants and barbiturates) by soldiers. Law enforcement figures demonstrated an increase of over 260% in the number of soldiers involved with possession or use of marijuana during 1968 as compared to the previous year.[5] Also, excessive combat aggression (atrocities) seemed to become more prevalent.[79–82] The official Army overview of medical support for the war showed that overall psychiatric attrition rates (soldiers hospitalized or confined to quarters for at least 24 hours) among all types rose steadily after 1968 through the third quarter of 1970 (from 13.3/1,000 for 1968, to 25.1/1,000),[27(Table 3,p36)] and overall psychiatric hospitalization rates doubled similarly during that period (Table 2-2). Although psychiatric hospitalization rates among Army troops stationed in Europe also increased during the same time frame, the increase was far more pronounced in the Vietnam theater.[27(Table 5,p46)]

As noted earlier, the official summary of Army medical activities in Vietnam (mid-1965 through mid-1970), authored by Major General Spurgeon Neel, made no mention of combat stress reactions as such. However, it did express concern that the overall psychiatric hospitalization rate was rising despite the falling wounded in action (WIA) rate—a contradiction of the covariance that was found in previous, high-intensity wars.[27(p47)] Neel attributed this increase to dissenting soldier subgroups who were motivated by racial, political, or drug culture priorities and to the widening use of illegal drugs by soldiers in Vietnam. (This work was regrettably not published until 1973, after troops were withdrawn from Vietnam.)

Published more contemporarily (in 1970), Parrish and Colbach, both of whom had served in Vietnam, indicated that morale had been generally good in Vietnam; and they acknowledged their satisfaction that "The average soldier . . . has not seemed overly concerned with the justification for the war."[41(pp339–340)] Nonetheless, they did express "real concern"[41(p340)] for the doubling of the psychiatric casualty rate between 1968 and mid-1970 and speculated that this was fueled by increased racial tensions and a decrement in perception of military purpose within the soldier. They also correctly predicted that the intent to disengage from Vietnam would likely produce accelerating psychiatric problems among those newly assigned there.[41]

Regarding spreading drug use in Vietnam, M Duncan Stanton's survey of drug use patterns among soldiers entering or departing Vietnam in late 1969 revealed sizable increases in the use of most drugs compared to the 1967 survey by Roger A Roffman and Ely Sapol.[64] Stanton speculated, however, that marijuana and some other drugs might actually allow certain types of individuals to function under the stresses of a combat environment and separation from home.[64]

Problems for the US Marines fighting in Vietnam paralleled those of the Army. Lieutenant Commander John A Renner Jr, a Navy psychiatrist who served in the Vietnam theater in 1969, noted a similar rise in disciplinary problems, including racial disturbances, attacks on superiors, combat atrocities, drug abuse, and

EXHIBIT 2-2. Selected Publications by Transition Phase Army Psychiatrists (Including Research Reports)

Years in Vietnam	No. Who Published Articles/ Total No. Deployed Army Psychiatrists (as a percentage)*	Publications
1968	3/22 (13.6%)	Colbach EM, Crowe RR. Marijuana associated psychosis in Vietnam. *Mil Med*. 1970;135:571–573. Colbach EM, Willson SM. The binoctal craze. *US Army Vietnam Med Bull*. 1969;March/April:40–44. Forest DV, Bey DR, Bourne PG. The American soldier and Vietnamese women. *Sex Behav*. 1972;2:8–15. Postel WB. Marijuana use in Vietnam: a preliminary report. *US Army Vietnam Med Bull*. 1968;September/October:56–59.
1969	2/22 (9.1%)	Bey DR. Change in command in combat: a locus of stress. *Am J Psychiatry*. 1972;129:698–702. Bey DR, Smith WE. Organizational consultant in a combat unit. *Am J Psychiatry*. 1970;128:401–406. Bey DR, Zecchinelli VA. Marijuana as a coping device in Vietnam. *Mil Med*. 1971;136:448–450. Master FD. Some clinical observations of drug abuse among GIs in Vietnam. *J Kentucky Med Assn*. 1971;69:193–195. Stanton MD. Drug use in Vietnam. *Arch Gen Psychiatry*. 1972;26:279–286. Research report.

*These numbers do not count research reports, although they are listed in the Publications column.

the number of men diagnosed with character disorders (all of which he lumped under "hidden casualties").[83] He expressed concern that military psychiatrists were premature in touting the low rate for psychiatric difficulties in the war. Still, although he agreed there was a growing "morale problem," he believed that "the average soldier, despite complaints about his duties and possible reservations about involvement in Vietnam, seems to adapt to the situation."[83(p171)] (His work was not published until 1973, after the Marines left Vietnam.)

Transition Phase Psychiatrist Reports

Army psychiatrists serving in these years were mostly not motivated to publish accounts of their professional experience in Vietnam compared to those who served in the buildup phase (Exhibit 2-2). The titles of the articles that were published suggest increasing attention to challenges surrounding drug use and other morale issues and away from combat-related problems. Still, dissent within the ranks appears not to be a subject of major concern among these psychiatrists.

Especially notable were the postdeployment observations of Captain John Imahara, an Army psychiatrist. His tour (September 1968–September 1969) was unique in that, although assigned to the 935th Psychiatric Detachment, he volunteered to provide specialized services for the confinees of the USARV Installation Stockade ("Long Binh Jail") following the August 1968 riot (". . . the 'worst prison riot in the modern history of the US Army'"[84(pIII-57)]). Imahara recalled the innumerable soldiers who were in the stockade who might have otherwise warranted psychiatric attention. Singled out among this group of disruptive, deviant, and sometimes violent soldiers were the "restive 'soul brothers' whose . . . certain gestures, ornaments, and modes of behavior were known to intimidate white soldiers."[84(pIII-57)] According to Imahara, their intense hostility expressed a belief that the military was an oppressive institution, and that whites were the oppressors. Imahara also acknowledged the widening drug use in Vietnam and its potential to fuel violent incidents.

> [E]xplosive situations arising from the combination of drugs, available weapons, and stress, necessitated confinement of the passive resistive marihuana

> smoker, the paranoid methamphetamine injector, the hyperactive amphetamine user, the AWOL [absent without leave] emaciated opium injector, and the moody individual who takes barbiturates.[84(pIII-57)]

A contrasting picture came from Bey. He spent his year in Vietnam (1969–1970) as division psychiatrist with the 1st Infantry Division and authored or coauthored 11 timely articles reporting on his experiences in the war along with associated matters such as psychiatric problems within other cultures in Vietnam, adjustment issues for returning veterans, and problems facing waiting wives. Bey's efforts constituted a rich and optimistic exposition of the means and achievements of a division psychiatrist and his staff. He especially commended his enlisted mental health technicians for their work with the widely dispersed commanders, physicians, and soldier-patients of the division.[85] Regarding his sustained confidence, it appears that Bey was unique among the Army psychiatrists assigned in Vietnam during this phase. Despite having received his psychiatric training in a civilian setting, evidently his additional background in organizational consultation, his family heritage of military service, and a predeployment military assignment equipped him for the challenges he faced in Vietnam and allied him with the military organization. Bey's more positive take on his year in Vietnam,[86] despite serving there a year after Imahara, may also reflect that morale and associated psychiatric and behavior problems were less prevalent among combat units than in noncombat units.

Transition Phase Impressions

America's war in Vietnam had become prolonged, stalemated, and costly during this transition phase. Waging war during the highly contentious, off-and-on peace negotiations with the enemy and the ever-widening antiwar sentiment at home was wearing away the initial sense of national purpose and resolve among those who were nonetheless sent to fight as replacements. In retrospect, the gradually rising rates for psychiatric conditions and behavior problems during these pivotal years, including drug abuse and racial conflicts, signaled brewing discontent and dissent among the deployed troops. Still, falling morale and its psychological and behavioral repercussions do not generally appear to be of major concern among the Army psychiatrists in Vietnam through these years.

The Drawdown Phase (1970–1973)

There were 249,600 US Army troops in Vietnam by the end of 1970 and 119,700 by the end of 1971.[32] Six months later, in July 1972, Army strength had dropped to 31,800 support troops.[32] During these final years, although more troops were leaving than were being sent as replacements, hostilities and dangers continued, even if attenuated. Unrelenting public opposition to the war may have accelerated the American pullout, but the process severely demoralized those who were sent there during the drawdown years. Many soldiers interpreted antiwar sentiment as criticism of them personally—not the war more generally. In addition to accelerating rates for psychiatric conditions and behavior problems, two new and very alarming behavior problems emerged in 1970, primarily among lower-ranking enlisted troops: (1) widespread heroin use and (2) soldier assaults on military leaders with explosives ("fragging")—symptoms unmistakably indicating that the US Army in Vietnam was becoming seriously compromised. Despite the reduction in combat activity, Army leaders and the medical/psychiatric contingent in Vietnam became increasingly consumed with problems associated with the wholesale alienation and dysfunction of soldiers.[87] Furthermore, by now the deployed psychiatrists were surrounded by a professional literature that was mostly critical of the military psychiatric structures and priorities there.[88]

Shelby Stanton, distinguished military historian and the author of *Vietnam Order of Battle,* provided this description of the problems in maintaining military order and discipline among US military units as the end of the war approached:

> Lowered troop morale and discipline were manifested in increased crime, racial clashes, mutinous disregard of orders, anti-war protests, and monetary corruption in black market currency exchanges, as well as drug use. The Army had become extremely permissive as it tried to cope with changing societal attitudes, and standards of soldiering eroded proportionally. In Vietnam serious disciplinary problems resulted in disintegrating unit cohesion and operational slippage. In the field, friendly fire accidents became more prevalent as more short rounds and misplaced fire were caused by carelessness. There was an excessive number of "accidental" shootings and promiscuous throwing of grenades, some of which were deliberate

FIGURE 2-1. M42 Duster self-propelled antiaircraft gun "Sly and the Family Stone" This particular M42 Duster was given the name of a popular rock band by its crew. This choice likely alludes to the group's iconic hit song from the 1969 counterculture Woodstock festival, "I Want to Take You Higher," which is also suggestive of the growing popularity of the drug culture. More-broadly it connotes the counterculture attitude shared by young adults of that time, which was captured in the phrase popularized by hippie guru, Timothy Leary, "Turn on, tune in, drop out". This name is in striking contrast to those commonly applied to planes and tanks in earlier wars that were intended to be ferocious and intimidating; and it seems to reflect a generation of troops fightingin Vietnam—resonant with their civilian counterparts—who were ambivalent regarding the military mission and values. Photograph courtesy of Richard D Cameron, Major General, US Army (Retired).

> fraggings aimed at unpopular officers, sergeants, and fellow enlisted men. Redeploying units gave vent to years of frustration as their speeding [A]rmy vehicles tore down the frequently ambushed highways, shooting and hurling rocks, cans and insults at the Vietnamese alongside the roads.
>
> Widespread breakdowns in troop discipline forced the military police into a front-line role serving as assault troops against other soldiers. These actions were typified by two instances. Composite military police Whisky Mountain Task Force was engaged in a rather spectacular standoff on 25 September 1971. Fourteen soldiers of the 35th Engineer Group had barricaded themselves in a bunker and were holding out with automatic weapons and machine guns. A homemade explosive device was exploded in the rear of the bunker, and all 14 surrendered and were treated for wounds. Chinook helicopters had them in Long Binh Stockade the next day. A month later, on 27 October 1971, another military police strike force air-assaulted the Praline Mountain signal site near Dalat. Two fragmentation grenades had been used in an attempt to kill the company commander two nights in a row. Initial escorts had proved insufficient protection, and military police had to garrison the mountaintop for a week until order was restored.[87(pp357–358)]

Validation for these observations came from an exceptionally comprehensive historical series by The Boston Publishing Company. It provided vivid accounts of the various expressions of contempt for the war and the South Vietnamese shared by US military forces in the war's last years. In particular, they noted that, "The daily round of random death and incapacitation from

EXHIBIT 2-3. A Specimen of Leadership in Late Vietnam

The 1st Battalion, 5th Cavalry, 1st Cavalry Division (Airmobile), and its commander in early 1971, Lt. Col. Richard Kattar, was one example of a unit that remained effective and disciplined.

When Kattar took command . . . his men received a jolt. "He energized the battalion," said Captain Eugene J. White, Jr., Company A commander. "He pulled me out of the field and brought me back to the base and said, 'My name's Kattar. Here's what you can expect from me, and here's what I expect from you.' That's the first time a battalion commander had talked to me like that." . . . Company B commander Captain Hugh Foster at first was skeptical. Kattar came on too strong for Foster. "But he was supportive and he gave his people credit for common sense," said Foster. Many of the troops at the time grumbled about going into the field. But Kattar told operations officer Lieutenant John D. Stube, "We cannot have that attitude. People will be sloppy, make mistakes, and get killed."

Kattar immediately improved firebase security. He ordered more patrolling and required his men to change the positions of the 105MM howitzers after dark. He had them loaded with fléchette rounds (an antipersonnel round containing short, nail-like projectiles) for direct fire against any attackers. Units returning from patrol were given additional tasks to keep them busy on the base; the prior habit of "flopping out" had raised the level of boredom.

In his second tour after serving as an advisor in 1963–1964, Kattar believed that the soldiers "deserved to be inspired to believe in a cause," and their own survival was an excellent cause. Kattar visited each company separately and gave the men a version of the following speech:

> No one in his right mind wants to be shot at, indeed killed. Unless you're a crackpot, and I'm certainly not a crackpot. But I am a professional soldier. I've been here before, I've been shot at before, and I have lived as you live, on the trail with my whole life on my back. I am not here to demonstrate courage under fire. Because I'm scared to death every time somebody shoots at me. The only thing I'm delighted with is that the army took the time to train me well enough so I react properly under fire. Because that's all it is—a reaction. No one really thinks about what the hell they're doing.
>
> Now I have a beautiful wife, three lovely children and a great life ahead of me. I want to get this done and get back to that. The things I can guarantee you are that I will die for you, if it's necessary, and that I will never experiment with you, and that if you listen to what I tell you and do as I say and am prepared to do with you, then your opportunity to fight and win will be the greatest, will be maximized. Because it makes no sense to me at all for someone to draw the conclusion that they're giving themselves an opportunity to get back home by walking around the jungle in a stupor, either because of dope or preoccupation of mind. . . . When you walk through that jungle, you'll walk through there sharp and intent upon insuring that if that sonofabitch raises his goddam ugly head to blow you away, you're going to blow him away first. And then we're going home.

mines and booby traps, combined with short-timer's fever and skepticism about the worth of 'search and clear' missions steadily lowered American morale."[89(p97)] The pervasive demoralization in the theater and the brittle nature of race relations, especially within noncombat units, became associated with a weakening of the military legal system. According to these authors, combat refusals, drug problems, and racial strife often proved impossible to resolve in the last years in Vietnam. Although punishments tended to be increasingly lenient, commanders openly acknowledged that, rather than hunt the enemy or carry out a tactical mission, they considered their primary responsibility to be to return their men safely home. "It sometimes seemed to be little more than a ragtag band of men wearing bandannas, peace symbols, and floppy bush hats, with little or no fight left in it"[43(p16)] (Figure 2-1).

Similarly Balkind's historical review of the severe breakdown in morale and effectiveness of the US military in Southeast Asia during the drawdown phase of the war provided thoroughly referenced data indicating an unprecedented increase in rates of combat refusals, combat atrocities, heroin use, assassinations (or threats) of military leaders, racial conflicts, AWOL, and desertion, and the emergence of the soldier antiwar movement.[65] Balkind also underscored the corrosive effects on morale and cohesion consequent to emergent careerism among military leaders ("ticket punching"), a criticism similarly brought to bear by Gabriel and Savage[90] and by Cincinnatus.[50]

Firsthand observations came from Kirk, a journalist:

EXHIBIT 2-3. A Specimen of Leadership in Late Vietnam, continued

Kattar forbade the wearing of bandannas and required his men to wear steel helmets. He also put a stop to one of the characteristic "grunt" symbols of the war—the wearing of "Pancho Villa" bandoliers of M60 ammunition crossed over the shoulders [because dirt got in the ammo links]. . . . Kattar required company commanders to attach [the heavy] "secure" scrambler devices to the standard PCR-77 radio for communications security. . . .

Under the prevailing circumstances of 1971, Kattar's insistence on tight discipline and "by-the-book" procedures might have made him a candidate for "fragging" by disgruntled troops. But most of the men responded to his leadership. "He took care of the soldiers," said Captain Foster. Operating from Firebases Apache and Mace, the 1st Battalion's mission was to pursue the 33d NVA Regiment. "Kattar always came out into the field," Foster said. "He talked with the soldiers. He went out on sweeps with the company. He showed that he shared the risks."

The 1st Battalion also had had its share of the problems of the times—combat refusals, drug problems, racial strife—which the weakened "system" proved incapable of resolving. Punishments for offenses that once were considered to be serious had become lenient. A squad leader who had refused Foster's order to stake out an ambush was court-martialed and found guilty, fined only $100, and was not demoted. Another soldier, a machine gunner, threatened to kill a squad leader if he forced his men to advance down a certain trail. Sent to the rear for prosecution, the man returned shortly without having been court-martialed. The legal authorities said that since he had not fired his weapon, he had committed no offense. . . .

As the battalion came off the helicopter pad at Bien Hoa to stand down prior to leaving Vietnam, the troops were enthusiastic, shouting "All the way!" and "Airborne!" as they left the war behind them. . . . A writer from the division historical office . . . asked operations officer Lt. Stube how the battalion commander had managed to get these troops to act as they did. "He is the finest leader I have ever known," Stube answered. "He motivated soldiers and officers to do the right thing."

Reproduced with permission from Fulghum D, Maitland T, & the editors of Boston Publishing Co. *The Vietnam Experience: South Vietnam on Trial*. Boston, Mass: Boston Publishing Co; 1984: 22–24.

> [I]t is, in reality, a desultory kind of struggle, punctuated by occasional explosions and tragedy, for the last Americans in combat in Vietnam. It is a limbo between victory and defeat, a period of lull before the North Vietnamese again seriously challenge allied control over the coastal plain, as they did for the last time in the Tet, May and September offensives of 1968. For the average "grunt," or infantryman, the war is not so much a test of strength under pressure, as it often was a few years ago, as a daily hassle to avoid patrols, avoid the enemy, avoid contact—to keep out of trouble and not be the last American killed in Vietnam.[74(p65)]

More ominous was the investigative report by Linden, another journalist, from his visit in 1971. Linden covered much of the same ground as those mentioned above, but in addition he provided case examples and other observations. These included corroboration from Captain Robert Landeen, an Army psychiatrist assigned to the 101st Airborne Division. Linden dynamically depicted the circumstances and meanings that combined to produce a "class war" between leaders and subordinates in Vietnam—often with fragging as its final result. He described the mounting tensions that commonly arose when bitter, dispirited enlisted soldiers, black activism, and heroin combined within small, isolated units, especially noncombat units; and how common it was for fraggings and threats of violence to be used as means of controlling officers and noncommissioned officers (NCOs). "[Fragging in Vietnam became] prevalent, passionless, and apparently unprovoked, representing the grisly game of psychological warfare that [soldiers] use."[91(p12)]

Not surprisingly, the Army's pernicious morale and discipline problems were mirrored on a comparable scale among the Marines fighting in Vietnam. The official review of US Marine activities late in the war acknowledged rampant combat atrocities, "friendly fire" accidents, combat refusals, racial strife, drug abuse, "fraggings," and dissent.[92] William Corson, a retired Marine lieutenant colonel (and an expert on revolution and counterinsurgency warfare and veteran of World War II, Korea, and Vietnam), blamed the military's problems in late Vietnam on both America's failure in Vietnam and an "erosion of moral principle within the

military."[93(p100)] He referred to the rise in "fragging" incidents as a new service-wide form of psychological warfare and an aspect of institutionalized mutinous behaviors (along with sabotage, evasion of leadership responsibilities, and internecine conflict). According to Corson, "[a]s with fragging, the potential for a mutinous refusal to carry out an order is so widespread [in Vietnam] that routine actions are being avoided by those in charge."[93(p99)]

The subject of the role and effectiveness of military leaders, including in Vietnam, is beyond the scope of this work, but history has amply illustrated the inexorable tie between high caliber of leadership (eg, intelligence, skills, tact, knowledge, personality, maturity, ethics, and devotion to the mission and to the welfare of the troops) and high morale within military units. Observers and commentators have acknowledged a critical downturn in Army leadership as the war in Vietnam lengthened, American opposition to the war grew more forceful, and troop morale slumped ever lower. Many officers and senior enlisted personnel also lost their commitment to the war and thus had little with which to inspire their troops. (See Appendix 6, "Administrative Elimination Under Provisions of AR 635-212.")

However, even though the yearly rotation of these senior grades in and out of Vietnam was especially responsible for deficiencies in leadership, there were other policies that also contributed to the problem.[1,5] For instance, within Vietnam officers commonly served only 6 months as commanders, while being utilized in the remaining 6 months of their tour in a staff position. For the enlisted soldier this meant that, at any given point, his unit officers had either been in a command less than 3 months and, in many respects, were still learning their jobs and the personnel, or they had less than 3 months before rotating out and were perhaps experiencing their own short-timer's syndrome of emotional withdrawal.

One postwar critic utilized the term "institutional inexperience" to refer to the tentative, clumsy, and indecisive style of American operations in Vietnam consequent to the short command tours for officers.[5] Illustrating the problem, John Paul Vann, who served as an Army officer in Vietnam and later became the II Corps senior advisor, provided the oft-quoted and cynical line, "The United States has not been in Vietnam for ten years . . . but for one year ten times."[43(p47)] Others noted the emergent careerism that had replaced commitment to military objectives in Vietnam (so-called "ticket punching," ie, an officer's belief that service in Vietnam would advance his career through collecting experiences and awards that would push him ahead of his contemporaries).[90] Exhibit 2-3, "A Specimen of Leadership in Late Vietnam," presents the description of one exceptional battalion commander who opposed this trend and remained disciplined and effective during the drawdown phase in Vietnam, evidently with salutary consequences.[43]

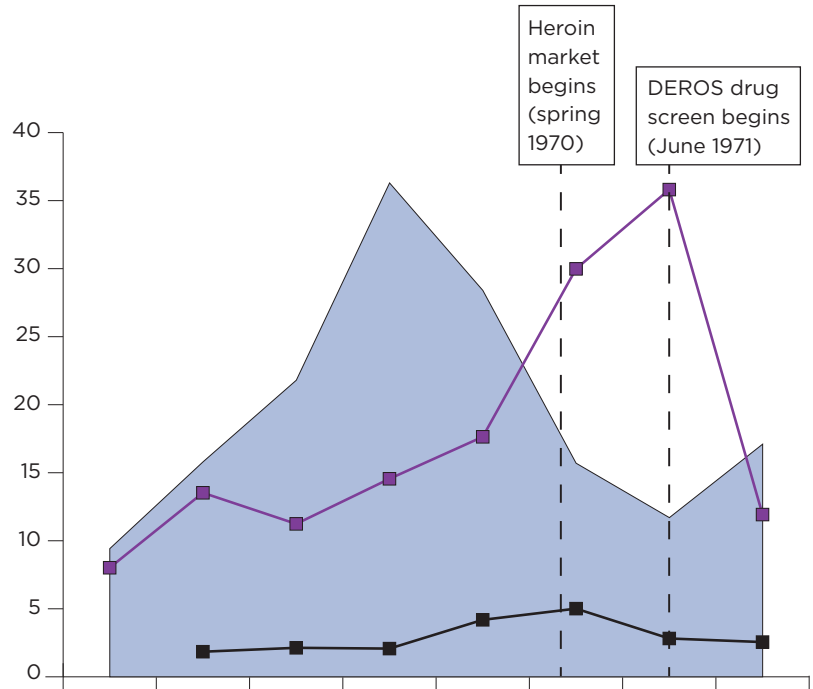
It seems remarkable in retrospect that the enemy did not find ways to exploit these serious fault lines in the morale and discipline of the American forces late in the war. However, according to Sorley, the military historian, "Perhaps, even in the midst of the undeniably widespread problems of drugs, race, and indiscipline, there were enough good soldiers left to do what had to be done."[1(p295)] He posited that the Army's problems in Vietnam, although substantial, had been exaggerated by those who were opposed to the war. Still, it was a precarious situation as exemplified by the incident on 28 March 1971, when elements of the 196th Light Infantry Brigade at Fire Support Base Mary Ann suffered severe casualties (33 American soldiers killed and 78 wounded) when they were infiltrated by enemy sappers.[87] By Sorley's report, this arose because the unit was "riddled with drugs and incompetence."[1(p295)]

Drawdown Phase Psychiatric Overview

The drawdown years saw a dramatic increase in the traditional indices of psychiatric attrition. As noted in the Preface to this book, through the early years of the war, the Army psychiatric hospitalization rate had hovered between 12 and 16.5 per 1,000 soldiers per year,[14,39,94] which was very favorable compared to rates for the preceding wars. However, the rate in Vietnam started to rise in 1968, doubled by April 1970, and doubled again by July 1971 (reaching an annualized rate of 40/1,000/year).[39] From there it rapidly dropped until the remaining combat troops were pulled out in mid-1972. New policies that permitted troops detected as narcotic-positive by urine testing to be medically evacuated out of Vietnam were largely responsible for this reversal (marijuana use was not detectable at that time).[95] Figure 2-2 illustrates the independence of the accelerating psychiatric hospitalization rate from the variable of combat intensity in Vietnam (as measured by the Army battle death rate) after 1968.

The rising out-of-country psychiatric evacuation rate is especially striking. This remained at the favorable rate of below four to five per 1,000 troops per year through 1970. By July 1971 it had risen to 42.3, and by the following year, July 1972, the rate had climbed to

FIGURE 2-2. US and Army Vietnam rates per 1,000 troops for battle deaths,[1] psychiatric hospitalization,[2] and psychosis[3]



	1965	1966	1967	1968	1969	1970	1971	1972
Army battle death rate	9.42	15.6	21.6	36.3	28.4	15.7	11.7	17.1
Army psychiatric hospitalization rate	6.98	11.8	9.8	12.7	15.4	25.2	31.3	10.4
Army psychosis rate		1.58	1.83	1.78	3.63	4.35	2.43	2.2

[1] US Army Adjutant General, Casualty Services Division (DAAG-PEC). Active duty Army personnel battle casualties and nonbattle deaths Vietnam, 1961–1979, Office of the Adjutant General counts. February 3, 1981.

[2] Datel WE. *A Summary of Source Data in Military Psychiatric Epidemiology*. Alexandria, Va: Defense Documentation Center, 1976. Document ADA 021-265.

[3] Jones FD, Johnson AW Jr. Medical and psychiatric treatment policy and practice in Vietnam. *J Social Issues*; 1975;31(4):49-65.

DEROS: date of expected return overseas

129.8.[39(Figure 2)] In other words, at that point in the war, *one out of every eight soldiers* was medically evacuated from Vietnam for psychiatric reasons (primarily for drug dependency, especially heroin).

A corollary measure of the rapidly deteriorating mental health of soldiers assigned in Vietnam was the skyrocketing percentage of neuropsychiatric cases among medical evacuations for all causes from Vietnam. It had remained below 5% through the first two-thirds of the war but rose to 30% in late 1971 (at which point more soldiers were being evacuated from Vietnam for drug use than for war wounds[96]). By late 1972, the percentage of neuropsychiatric evacuations was at 61% of evacuations,[39] a rate almost triple that during World War II (23%[29]). However, taken alone this metric could overstate the case for spiraling neuropsychiatric rates because the WIA rate was simultaneously declining.

It is of special note that the doubling rate for psychosis in 1969 and 1970 in Vietnam (see Figure 2-1) from its historically predictable 2 per 1,000 troops per year presented a paradox for Army psychiatry. Because it coincided with an Army-wide rise in the psychosis rate, it was initially explained by Jones and Johnson as secondary to the influence of illegal drugs in confusing the diagnosis.[39] Jones subsequently noted that in 1971 the psychosis rate reverted back to its historical levels but only in the Vietnam theater after the Army allowed drug-dependent soldiers to utilize medical evacuation

TABLE 2-3. Rates for Fragging Incidents and Narcotic Overdose Deaths in Vietnam (All Branches/1,000 US Troops/Year)

	1969	1970	1971	1972
Fragging rates[1]	0.5	1.12	2.4	2.3
Narcotic overdose death[2] rates†	0	0.34*	0.3	No data

*The 1970 narcotic overdose death rate is annualized from the 49 deaths confirmed between August and December. Ninety-five percent pure heroin only became widely marketed in South Vietnam in spring of 1970, and the first heroin overdose death proven by autopsy was in August 1970.[3]
†These figures are discrepant from those provided by Baker, a senior Army psychiatrist, who suggested an even higher rate in 1970 (75 confirmed or suspected incidents between August 1 and October 18, which provides an annualized rate of 1.05). Baker also said there were 11 confirmed by autopsy in 1969, and 14 in 1970 before August[4]; however, these must involve other drugs such as barbiturates because heroin was not yet available.

Data sources: (1) Gabriel RA, Savage PL. *Crisis in Command: Mismanagement in the Army*. New York, NY: Hill and Wang; 1978; (2) US Department of Defense. *Drug Abuse in the Military—A Status Report (Part II)*. Washington, DC: Office of Information for the Armed Forces; August 1972. DoD Information Guidance Series No 5A-18: 1-3; (3) Colonel Clotilde Bowen, USARV Psychiatric Consultant. End of Tour Report, 8 June 1971; (4) Baker SL Jr. Drug abuse in the United States Army. *Bull N Y Acad Med*. 1971;47(6):541–549.

channels.[21] He speculated that the rising rates may have also reflected the tendency for Army psychiatrists and other physicians in Vietnam to mislabel soldiers "who did not belong overseas" as psychotic (eg, insinuating the physicians' intent to manipulate the system).[21]

In themselves, these traditional measures of psychiatric attrition are startling. However, they must be viewed in conjunction with the equally alarming rise in behavioral problems during the drawdown years in Vietnam: (*a*) judicial and nonjudicial (Article 15) disciplinary actions,[58] (*b*) noncombat fatalities,[97] (*c*) combat refusals,[89] (*d*) corruption and profiteering,[5,65] (*e*) racial incidents,[5,65] (*f*) convictions for the specific crime of "fragging,"[98,99] (*g*) suicides,[100] and, especially, (*h*) use of illegal drugs. Table 2-3 presents grim, "tip-of-the-iceberg" statistics for the most dramatic of these: fragging incidents and narcotic overdose deaths. Army mental health personnel were often called upon to intervene with these types of problems and sought to apply traditional means and models but with uncertain results.

Drawdown Phase Psychiatrist Reports

As it turned out, as soldier morale, psychological fitness, and military readiness were declining in Vietnam, greater numbers of Army psychiatrists with little or no military experience were sent as replacements. Similarly, those serving in Vietnam as the senior Army psychiatrist (the USARV Neuropsychiatry Consultant) had progressively less Army psychiatry experience as the war extended.[101] The psychiatrists deployed during the drawdown phase of the war were generally not motivated to publish accounts of their experience. Perhaps somewhat contributory was the fact that publication of the *USARV Medical Bulletin* was discontinued in 1970. The few who published wrote exclusively about the heroin epidemic and implied a relative failure of traditional psychiatric approaches to solve this problem and ones stemming from soldier demoralization and dissent (Exhibit 2-4).

Two publications from this period warrant special attention. In a lay publication, Major Richard Ratner, an Army psychiatrist, described his service with the 935th Psychiatric Medical Detachment ("Drugs and Despair in Vietnam") 2 years after Bloch left Vietnam. Ratner's recollections centered on the challenge of the drug epidemic, and he summarized the patterns of use, clinical presentations, and treatment results (poor) for over 1,000 drug-dependent soldiers who were voluntary residents in the Army Amnesty Center on Long Binh Post near Saigon between January 1971 and July 1971. In the process he conveyed a dark picture of military life in Vietnam at that time. He considered that his caseload was only a fraction of the estimated 30% of the young, lower-ranking soldiers who use heroin regularly, and that they in turn only partially reflected the pervasive demoralization within the larger military force in Vietnam. Although alluding to likely predeployment factors in the drug-dependent soldiers he saw, Ratner credited more their universal despair, which he believed was due to a combination of societal factors (eg, America's motivation for waging war in Southeast Asia represented a displacement of its "racial hostilities") and an "inhumane" Army. Ratner acknowledged the sense

EXHIBIT 2-4. Selected Publications by Drawdown-Phase Army Psychiatrists (Including Research Reports)

Years in Vietnam	No. Who Published Articles/ Total No. Deployed Army Psychiatrists (as a percentage)*	Publications
1970	2/20 (10%)	Char J. Drug abuse in Vietnam. *Am J Psychiatry*. 1972;129:463–465. Ratner RA. Drugs and despair in Vietnam. *U Chicago Magazine*. 1972;64:15–23.
1971	1/13 (7.7%)	Joseph BS. Lessons on heroin abuse from treating users in Vietnam. *Hosp Community Psychiatry*. 1974;25:742–744. Holloway HC. Epidemiology of heroin dependency among soldiers in Vietnam. *Mil Med*. 1974;139:108–113. Research report.
1972	0/1 (0.0%)	Holloway HC, Sodetz FJ, Elsmore TF, and the members of Work Unit 102. Heroin dependence and withdrawal in the military heroin user in the US Army, Vietnam. In: *Annual Progress Report, 1973*. Washington, DC: Walter Reed Army Institute of Research; 1973: 1244–1246. Research report.

*These numbers do not count research reports, although they are listed in the Publications column.

of clinical impotence he and his colleagues experienced ("there seems to be no place for a psychiatrist to begin"); he also seemed to share the cynicism of his soldier-patients.[102]

Equally troubling is the account by Lieutenant Commander Howard W Fisher, a Navy psychiatrist who served with the 1st Marine Division during the same year as Ratner only further north near Da Nang ("Vietnam Psychiatry: Portrait of Anarchy"[103]). According to Fisher, of 1,000 consecutive Marine referrals, 960 warranted personality disorder diagnoses ("usually antisocial"), with 590 of these presumed to be involved with illegal drugs. Although he differed from Ratner in attributing more of their dysfunction to predeployment defects of character, Fisher also faulted the officers and NCOs who encouraged their misconduct and rebellion. He felt this occurred because of vacillations in enforcing regulations, and he argued that these problems were exacerbated by expectations that psychiatry would either provide these Marines medical evacuation out of Vietnam or recommend administrative separation from the service in lieu of punishment.

Finally, the 1982 Walter Reed Army Institute of Research survey (mentioned in the Prologue) of Army psychiatrists who were veterans of the Vietnam War confirmed that, in large part, those who served in the second half of the war felt overwhelmed when trying to treat soldiers affected by a raging drug epidemic, incendiary racial animosities, and outbreaks of violence. Compared to their counterparts in the first half of the war, these late war psychiatrists tended to be more vocal, more divided according to training differences (military vs civilian), and, in some cases, quite defensive. They also were more likely to be critical of their preparation and utilization by the Army.[101,104]

Drawdown Phase Impressions

During these final 3 years, as the US military was carefully reducing its presence in South Vietnam and turning the fighting over to the Army of the Republic of Vietnam (ARVN), deployed troops increasingly expressed their opposition to serving through anti-military behaviors and psychosocial disability. Collectively this represented a rampant social/military breakdown within the deployed force—an "inverted" morale. Replacement Army psychiatrists and allied mental health personnel in Vietnam found themselves in a radically different war—with a radically different Army—than was faced by those who served in previous wars or even those who preceded them in Vietnam. The record from this phase suggested that the psychiatric contingent, like the military leaders, failed to anticipate these emergent psychiatric and conduct disorders. Furthermore, psychiatrists with appreciably less military experience, including those in leadership

positions, were sent to the theater as the problems there were multiplying. Ultimately the morale of the later Army psychiatrists paralleled the flagging morale of the deployed soldiers.

A Case Example of "Deployment Stress Reaction"

The following case material (disguised) was extracted from the report of an Army Sanity Board hearing for Private (PVT) Echo, which was held at the 98th Psychiatric Detachment in Da Nang, Republic of South Vietnam, in early 1971. In many important respects PVT Echo personified the avalanche of soldiers seen by the psychiatric component during the final third of the war, especially including the fact that he had a good pre-Vietnam service history and little or no active exposure to combat risk at the time of the incident. Perhaps he should be labeled a "(combat theater) deployment stress reaction" as defined earlier.

CASE 2-2: Sanity Evaluation of a Private Who Threatened His Platoon Leader and First Sergeant

Identifying information: PVT Echo was a 19-year-old, single, black E-2 with 17 months of Army service and 4 months duty in Vietnam. He was facing a general court-martial after he had pointed a gun at Lieutenant (LT) K, threatened to kill him and the First Sergeant (1st SGT), and demanded the LT's shirt, which he put on.

History of present illness: Although rated as a light weapons infantryman, at the time of the incident PVT Echo was permanently assigned as a jeep driver for Headquarters Company of one of the battalions of his division—an assignment with little, if any, direct exposure to hostile enemy forces. On the day prior to the incident PVT Echo had received an upsetting letter from his mother in which she admonished him for getting into trouble with military authorities (some months earlier he had been convicted in a court-martial for threatening a superior officer and demoted). Also on that day, PVT Echo injured his leg and had been excused from duty. On the morning of the incident, he had become very distressed when he learned that another soldier had been assigned to drive his jeep, and he believed he would be financially responsible if something were to happen to it. After smoldering with anger throughout most of the day, PVT Echo got his M16A1 rifle and went to his platoon leader, LT K, with the intention of demanding he get his vehicle back. PVT Echo could not explain to the Sanity Board why he had threatened LT K and the 1st SGT; only that he "lost control" and wasn't himself. He argued that there should not be an attempted murder charge against him because he was certain that he could have killed them had he wanted to. His explanation as to why he put on LT K's shirt was that he had been "pushed around enough" as a private; and that Army rank and regulations "Don't mean nothing."

Past history: PVT Echo was raised in the rural South as the fourth of five children. His family's standard of living was near the poverty level. His father worked at various semiskilled jobs and was described as "mean" during the week and docile on the weekend when he would be drinking. PVT Echo's parents often fought, and he was closer to his mother than to his father. His description of his psychosocial development was not notably abnormal. He was a popular youth and a valued member of various athletic teams. He did not have a history of violent behavior. He completed high school by receiving special help because of his status as an athlete. Following his graduation he enlisted in the Army to gain some measure of independence from home. He admitted to recreational drug use in the United States after entering the Army and acknowledged he smoked marijuana and heroin "with the brothers" on occasion in Vietnam, but he denied using drugs or alcohol on the day of the incident in question. He had no civilian history of arrests or convictions, and the character of his military service before being sent to Vietnam was excellent. He had received numerous awards while in the Army including several for marksmanship.

Examination: The report of examination indicated that PVT Echo was a large, muscular, black male with a neat, military appearance. He was alert, pleasant, and cooperative. His mood was lowered and consistent with his circumstance. His thinking was completely rational and centered on the sequence of events that landed him in the stockade and caused him to worry about his fate. He expressed dismay that he would be punished when he had not, in fact, hurt anyone. His cognitive capacities appeared intact and his intellect appeared to be in the range "dull normal." This

impression was confirmed with formal psychological testing.

Clinical course: Not applicable.

Diagnosis: The board arrived at an impression of acute situational maladjustment, without current impairment for further military duty.

Disposition: Regarding the court-martial allegations, the board judged him to have been capable of distinguishing right from wrong (as evidenced by a statement by one witness who reported PVT Echo saying he was "going to make the [news]papers and go out in a big splash and take some people with him"), but to have diminution in his ability "to adhere to the right secondary to his distress over his mother's letter, his leg injury the day before, and his misunderstanding that he would be held accountable for damages to his vehicle if he was ordered to let someone else drive it" [plus the combination of a socioeconomic background that made it difficult to solve problems by use of intellect and reasoning or to delay impulse gratification, and the limitations imposed by a dull-normal intellect]. The board also recommended clemency.

Source: Medical Board report prepared by the Mental Hygiene Consultation Clinic, 98th Psychiatric Detachment.

The medical board concluded that PVT Echo had an episode of serious, even dangerous, breakdown of mental functions, but their diagnosis—acute situational maladjustment—indicated they believed that this was temporary and uncharacteristic for him. They also did not believe he suffered with a more sustained psychiatric condition or that this incident was caused principally by compromised brain function secondary to substance abuse or mental deficiency. Still, there are two, potentially etiologic, features of the case that warrant amplification:

1. *Mental impairment secondary to drug and alcohol use*. Considering PVT Echo's drug use history, his denial of use on the day of the incident may be questionable (the Sanity Board had no medical information to rule in or out the presence of intoxicating substances during the incident). In a study of men convicted and sentenced for using explosives in attacks on superiors in Vietnam, investigators found that 87.5% acknowledged being intoxicated at the time of the incident.[105]
2. *Mental impairment secondary to low intellect*. Early in the war, the Department of Defense lowered its educational and physical requirements for induction for selected individuals to increase the eligible pool of potential recruits ("Project 100,000," which came to be known as "McNamara's 100,000").[42,106] In one study in Vietnam, soldiers who had entered the Army through this program were represented among mental health referrals at ten times the rate as those who were not.[107] Because the program ultimately mandated that Project participants could not be identified, PVT Echo's military record would not have contained information as to whether he was a Project 100,000 participant or not; however, his low IQ (intelligence quotient) scores, which were ascertained during the Sanity Board proceedings, suggested that he was.

In limiting the scope of their opinion to PVT Echo's individual mental and physical state regarding the charges, the Sanity Board psychiatrists acted true to the Army's charge to them. However, should there also have been some recognition of the social pathology associated with PVT Echo's incident, that is, that he also represented a "deployment stress reaction"? His presentation strongly mirrored the extraordinarily demoralizing influences apparently borne by all young, first-term, enlisted soldiers to some degree late in the war: racial tensions, class tensions, tensions with military authority, a sense of purposelessness, and, especially, a sense of persecution by those in the United States at that time consequent to the repudiation of the war and those serving in Vietnam. Even the factors of drug/alcohol use and limited intelligence—both of which would represent PVT Echo's features as an individual—don't diminish the prospect that he was also expressive of a larger social pathology, or more specifically, of disintegrating morale and military order, that is, a breakdown of commitment and cohesion. Such a perspective would be consistent with the tenants of social/community psychiatry as adapted to military populations. However, despite concerted efforts on the part of several prominent Army psychiatrists,[20,24] the social/community psychiatry perspective among Army psychiatrists in Vietnam at that time was mostly recessive.

VIETNAM VETERANS AND READJUSTMENT PROBLEMS

Estimates as to the prevalence of sustained postwar adjustment and psychiatric problems among Vietnam veterans seem to vary as widely as the political reactions to the war itself.[3,108–113] Furthermore, comparisons of the psychosocial effect of combat service in Vietnam with earlier US wars is especially challenging because measures are inconsistent.[114] Somewhat reassuring, a 1980 Harris Poll of Vietnam veterans commissioned by the then-Veterans' Administration found 91% reporting they were glad they had served their country, 74% said they enjoyed their time in the service, and nearly two-thirds said they would go to Vietnam again, even knowing how the war would end.[1]

Nonetheless, there was rising professional concern for the psychological injury of veterans secondary to service in Vietnam, and in the decade that followed the war, the *International Classification of Disease,* 9th edition, *Clinical Modification* (ICD-9-CM),[115] and the *Diagnostic and Statistical Manual of Mental Disorders,* 3rd edition (DSM-III),[28] both contained the new category "Post-Traumatic Stress Disorder or PTSD," which had been originally called "post-Vietnam syndrome."[14] The inclusion of PTSD in DSM-III reflected the political efforts of the Vietnam veterans who were seeking greater recognition, as well as Americans with residual antiwar sentiment and psychiatrists who believed that DSM-II had neglected the ordeal of combat veterans.[116] However, many took this new diagnosis to mean that the *acute* effects of overwhelming combat stress were indistinguishable from those associated with civilian catastrophes—an arguable equivalency. Others confused PTSD with the reversible, if temporarily disabling, combat stress reactions. For example, the glossary to DSM-III (published separately) commented that combat fatigue is "an obsolete term for posttraumatic stress disorder." Another example can be found in Kentsmith's review of principles of battlefield psychiatry.[117] This misunderstanding can also be found in mainstream psychiatric textbooks published decades later. For example, the 2001 edition of the American Psychiatric Association's *Introductory Textbook of Psychiatry* (3rd edition) included the comment, "[Before the term posttraumatic stress disorder was introduced], the disorder was recognized as shell shock or war neurosis because it was seen most commonly in wartime situations."[118(p236)]

The most commonly referenced findings regarding PTSD prevalence and incidence following the Vietnam War come from the government-sponsored National Vietnam Veterans Readjustment Study (NVVRS). At the time of the study (mid-1980s), approximately 30% of male and 27% of female study participants had evidenced PTSD at some point since serving in Vietnam, and for many PTSD had become persistent and incapacitating (15% and 9% of study participants, respectively).[119] However, some challenge to the validity of the PTSD diagnostic construct has arisen from the observation that among the over 30% of Vietnam veterans complaining of these symptoms, only 15% had been assigned to combat units in Vietnam, and the incidence of reported PTSD is higher among those who served later in the war despite the fact that the combat intensity, as measured by killed-in-action and wounded-in-action rates, was falling.[120] Others, like Nadelson, the former Chief of Psychiatry at the Boston Veterans Administration Hospital, feel that the character of some postwar psychiatric conditions cannot be approached with a checklist of symptoms as does the DSM for posttraumatic stress disorder ("Labeling [a veteran's preoccupation] with visions of exploding bodies, of carnage, and of devastation. . . , 'posttraumatic stress disorder,' virtually trivializes a consuming experience."[121(p103)]

Noticeably, over the years there has been a gradual divergence from the original PTSD model's emphasis that the "trauma" is singularly explanatory, and disputes have arisen as to the relative weight to give various etiologic influences (eg, predisposition and personality, traumatic extent of combat theater circumstance, and, particularly, social dynamics[111,122–128])—differences in perspective that have complicated the diagnosis and treatment of PTSD and related adjustment difficulties. Regarding the latter, a more recent review of the myriad studies of the postwar adjustment of Vietnam veterans by Wessely and Jones, British investigators, concluded that the origins of posttraumatic stress disorder appear to be less often from the purportedly traumatic Vietnam combat experiences, and more from opposition to the war.[129,130] The logical extension is that, at least among some veterans, continuing adjustment difficulties and chronic psychiatric conditions in part serve to (unwittingly) obtain, through the "sick role,"[131] an honorable adaptation to impossibly contradictory public (moral) pressures that surrounded the war (eg, "Foolish for going, wrong for participating, and inadequate for

losing"[132]). According to Blank, a psychiatrist who served with the Army in Vietnam and subsequently served for many years as National Director for the Department of Veterans Affairs (DVA) Readjustment Counseling Centers,

> [S]ince 1973 I have treated, evaluated, supervised the treatment of, or discussed the cases of approximately 1,400 veterans of Viet Nam with PTSD and have yet to hear a single case where the veteran's symptoms were not accompanied by either: (1) significant doubts or conflicts about the worthiness of the war, or (2) considerable anger about perceived lack of support for the war by the government or the nation. Furthermore, *although researchers have been barred from exploring the relationship between the occurrence of PTSD and the overwhelmingly conflicted nature of the war* [emphasis added], it is the observation of almost all clinicians who have treated substantial numbers of Viet Nam veterans with PTSD that the clinical condition is almost always accompanied by a deeply flawed sense of purpose concerning what happened in Viet Nam.[133]

Following the cessation of hostilities in Southeast Asia, the ethical challenges to military psychiatry voiced during the war[88] shifted to speculations on the harmful long-term consequences of field psychiatric practices in Vietnam (the aforementioned doctrine). The criticism was that these forward treatment methods may have expeditiously served the military priority of force conservation, but in the process they ignored the needs of the soldier and unnecessarily fostered the development of PTSD.[122,134–136] Offsetting opinion came from Blank, who noted that acute combat stress reactions usually do not meet the criteria for PTSD and do not generally evolve into diagnosable PTSD later.[137] It also came from Franklin Del Jones, a senior Army psychiatrist who also served in Vietnam and who argued vigorously that postwar sympathies for maligned Vietnam veterans may have led psychiatrists without military experience to misunderstand the unique aspects of a soldier's state when his psychological defenses become overwhelmed in combat. As a consequence, they failed to appreciate the fluid and reversible nature of the resultant acute stress disorder and the increased risk for psychiatric morbidity (including PTSD) if treatments do not promote symptom suppression and rapid return to military function and comrades.[138]

SUMMARY AND CONCLUSIONS

This chapter provided an overview of the emergent patterns for psychiatric conditions and behavior problems that challenged Army medical and psychiatric resources over the 8 years that ground troops fought in Vietnam. It also correlated them with the military, social, and political events that increasingly roiled America throughout the period. Salient observations include:

- **Army psychiatrists in Vietnam apparently did not encounter the large numbers of combat exhaustion cases that were predicted, at least not in the forms seen in earlier wars.** The organization of Army psychiatric services in Vietnam was weighted in favor of the combat divisions in anticipation of large numbers of combat exhaustion cases (combat stress reactions). Preparation included the promulgation of the combat psychiatry doctrine that was developed in World War I and World War II and validated in Korea (ie, a vigorous, crisis-oriented, forward treatment aimed at quickly restoring the soldier's duty function). Unfortunately, incidence rates for combat stress reaction cases for Vietnam were never released by the Army. The preliminary official overview of US Army mental health activities in Vietnam (through years 1–5 of 8) did indicate that only 7% of all psychiatric admissions were diagnosed as combat exhaustion, and anecdotal reports from some of the psychiatrists who served during the buildup phase of the war appeared to corroborate a very low CSR rate.

- **The overall low levels for psychiatric conditions and behavioral problems were limited to the buildup years.** In that during the first half of the war psychiatric attrition rates for all types of conditions, including behavior problems, remained uncharacteristically low for a combat theater, the allocation of mental health resources that favored the combat divisions in Vietnam did not present a problem. Unfortunately the situation reversed itself in the second half of the war but without modifications in the selection, preparation, or deployment of mental health personnel.

- **Anecdotal and published reports indicate that the newly developed psychotropic medications were commonly prescribed in Vietnam, but their use and effects were not systematically documented or studied.** Neuroleptic (antipsychotic), anxiolytic (antianxiety), and tricyclic (antidepressant) medications were available for the first time during the Vietnam War, and anecdotal reports, at least from the first half of the war, indicate they were commonly prescribed by military physicians throughout the theater for a full range of combat and noncombat stress-related symptoms. A limited survey in 1967 confirmed a high prescribing level of these medications and enthusiasm for their salutary effects, but there were no associated clinical or research studies.

- **Over time medical/psychiatric capabilities became overwhelmed by the numbers of soldiers with psychiatric conditions and behavior problems—expressions of "(combat theater) deployment stress reaction."** Rates for psychiatric hospitalization and evacuations, as well as those for behavior problems, began to increase throughout the theater beginning in 1968 following the enemy Tet offensives and associated political turbulence at home, and they rapidly accelerated once the American troop withdrawals had begun in 1969. By then Americans had become intolerant of the war and impatient for peace. Prolongation of the fighting over the next 3 years aggravated the smoldering societal crisis at home, which was expressed in increasingly radical, sometimes violent, American politics and an expanding drug culture. These attitudes quickly spread among the US forces in Vietnam through the 1-year rotation schedule and rapid troop transport. The growing collection of psychiatric disorders and behavior problems seen by the mental health personnel in Vietnam had little or no apparent connection to combat risk or the falling combat casualty rates, and ultimately they reached unsustainable proportions and likely threatened military preparedness. Because most of the affected soldiers had demonstrated an adequate predeployment military service record, in failing to adapt to the changing circumstance in Vietnam and becoming symptomatic they warranted a generic descriptor such as "(combat theater) deployment stress reaction" in addition to their primary psychiatric diagnosis.

- **Command was equally burdened by the effects of widespread dissent and indiscipline—expressions of "inverted morale."** From 1970 through 1972, when the last Army combat units in Vietnam finally redeployed, an unprecedented proportion of troops—especially lower-ranking, enlisted replacement troops—exhibited wholesale demoralization, a reluctance to soldier, antagonism to military authority, and a propensity to disable (or demobilize) themselves through racial conflicts, drug use, and other forms of misconduct. Like Army psychiatry, Army leaders in Vietnam faced an avalanche of dysfunctional soldiers and a degradation of military order and discipline—a situation that thankfully went unchallenged by the enemy—for which the traditional models of military leadership proved marginally effective. From the standpoint of these soldiers collectively, this mostly passive-obstructionistic movement was expressive of antimilitary authority and warranted the descriptor "inverted morale."

- **Heroin use eclipsed other medical and psychiatric problems in the late war.** The popular and casual use of heroin by soldiers in the last few years of the war represented a new form of soldier dissent as well as disability. Enabled by an extremely accommodating indigenous heroin market, this became an especially disruptive problem for the Army and one for which military psychiatry had no answers. By late 1971 more soldiers were being evacuated from Vietnam for drug use than for war wounds; in the month of July 1972, one out of every eight soldiers in Vietnam was medically evacuated back to the United States for psychiatric reasons, primarily for drug dependency, especially heroin.

- **Attacks on military leaders also accelerated in the last years of the war.** Associated with the rapid rise in dissent and misconduct in the last few years of the war were vicious assaults on military leaders, especially attacks using explosives ("fragging"). Whereas assassination of unpopular officers and noncommissioned officers had been seen in earlier wars to a limited degree while in combat, the

Vietnam theater is distinct in that not only was the prevalence of such incidents exceptionally high, but the attacks apparently occurred more often in rear areas and among support troops. More broadly, threats of enlisted member attacks were utilized to intimidate and control military leaders, that is, they were expressions of class warfare.

- **Army psychiatry expertise and morale in the theater declined as problems accelerated.** The record of psychiatric effort through the course of the war in Vietnam is unquestionably laudatory. Still, as the problems mounted, the collective expertise among replacement Army psychiatrists declined substantially; the evidence suggests that the mental health component ultimately became overwhelmed, depleted, and demoralized. Furthermore, a large proportion of the psychiatrists who served during the drawdown phase and who responded to the Walter Reed Army Institute of Research survey complained, often bitterly, of inadequate predeployment preparation and poor professional support in the theater.

- **The evidence of large numbers of Vietnam returnees with sustained adjustment difficulties, including psychiatric conditions, provoked postwar questions regarding the adequacy and appropriateness of in-theater military mental healthcare as well as that provided by the government for veterans.**

The chapters that follow will amplify these themes and explore more fully the Army's mental health problems in Vietnam and the professional (and personal) challenges faced by successive cohorts of Army psychiatrists assigned there over 8 years of war.

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