

CHAPTER 3

Organization of Army Psychiatry, I: Psychiatric Services in the Combat Divisions

The peak incidence of our combat exhaustion cases occurred during [the battle of the Ia Drang Valley]. . . . [K]nowing what was going on [from the commanding general's briefing] was vital so that one could realistically perceive the difficulties that the troopers were confronting and give the individual trooper some feeling that his story was falling on knowledgeable ears. Perhaps this was just to alleviate my own anxiety, but I think this is a real thing, that as the troopers pass back [through the evacuation chain] nobody sits down and listens; and one of the major needs of distressed people of this sort is for someone to sit and listen. Often this was one of the prime functions of the corpsmen in dealing with the combat exhaustion patient.^{1(p48)}

Captain Harold SR Byrde, Medical Corps, US Army
Division psychiatrist with the 1st Cavalry Division (Airmobile)
August 1965 to June 1966

The 326th Medical Battalion, 101st Airborne Division, Phu Bai, 1971. The building beyond the orange water tank housed the division's mental hygiene clinic, medical dispensary, and small inpatient unit for medical and psychiatric conditions. On the right are the officers' quarters, while on the left is a "club" where personnel could get beer and soft drinks. Photo courtesy of Phillip W. Cushman.



US Army psychiatrists were deployed in Vietnam to provide specialized clinical services and leadership for allied medical and mental health personnel to aid in the conservation of the force in support of the military mission and to provide humanitarian care for the sick and wounded. The first Army psychiatrist in South Vietnam was Major Estes Copen. He was assigned to the 8th Field Hospital in Nha Trang for 5 months in 1962 to provide specialized care for the approximately 8,000 assigned US personnel.^{2,3} In the decade that followed, an estimated 135 to 140 psychiatrists served with the US Army in South Vietnam, typically for 1-year assignments. The last Army psychiatrist in Vietnam, Major Dennis Grant, left Vietnam in March 1973.

One hundred forty psychiatrists is considerably fewer than the more than 2,400 who served with the Army in World War II, and, more generally, the scope of America's war effort in World War II dwarfs that of the Vietnam War. Still, the war in Vietnam brought new, and in many regards unanswered, challenges for Army psychiatry as it undertook to support the US military's efforts to defeat an enemy that employed a guerrilla/counterinsurgency strategy and capitalized on roiling social and political events at home.

This chapter begins a more detailed account of US Army psychiatry in the war with a description of the organization of Army psychiatric services in Vietnam. It also draws upon published and otherwise available written accounts by the division psychiatrists and allied mental health personnel to construct a composite picture of the psychiatric care that was provided within the combat units. Reports from the psychiatrists and allied mental health professionals assigned to the hospitals and psychiatric specialty detachments will be presented in Chapter 4, as will information regarding the professional activities of the nine psychiatrists who served as the senior Army psychiatrist in the theater (the Neuropsychiatry Consultant to the Commanding General, US Army Republic of Vietnam [CG/USARV] Surgeon).

THE ORGANIZATION OF ARMY PSYCHIATRY IN VIETNAM

Medical Command Authority and the US Army Republic of Vietnam Surgeon

Throughout the ground war years—1965 to 1973—the US Army Republic of Vietnam (USARV) Surgeon was responsible for command and control of Army-level medical resources in Vietnam (Figure 3-1): Army hospitals and all other medical units that were not components (ie, “organic”) of combat divisions or independent brigades. The USARV Surgeon was also responsible for advising the USARV commander on matters pertaining to the health of the command; providing technical supervision for all medical activities in the theater, including those that were organic to combat units; and assuring the availability of adequate medical support, that is, personnel, supply, and maintenance.⁴

The Mission, Structure, and Deployment of Army Psychiatry in Vietnam

The Army Regulation (AR) governing the provision of psychiatric care when America entered the Vietnam

War, AR 40-216, *Medical Service: Neuropsychiatry* (dated 18 June 1959), directed neuropsychiatry to “aid command to conserve the manpower of the Army and maintain it at the highest possible peak of efficiency through the application of sound psychiatric principles.”⁵(§1,¶2,p1) This mission statement directed Army psychiatrists and allied mental health personnel to prioritize military and combat objectives, an emphasis that coincided with the overall mission of the Army Medical Department. The regulation stipulated that the responsibilities of psychiatrists should include “professional services in the prevention, diagnosis, and treatment of emotional and personality disorders, mental illness, and neurological diseases and in the evaluation and disposition of such involved military personnel.”⁵(§1,¶3,pp1-2) Further specifications directed Army psychiatrists to provide state-of-the-art, specialized psychiatric care for soldier-patients; clinical/psychiatric authority and leadership for other deployed military health professionals and paraprofessionals (enlisted specialists); and consultation to commanders regarding factors affecting the morale and mental health of their troops.⁵

In March 1966, Headquarters (HQ)/USARV published Regulation No. 40-34, *Medical Services: Mental Health and Neuropsychiatry*,^{6,7} which provided more specifics pertaining to the Vietnam theater (USARV Regulation 40-34 is reproduced in Appendix 2). This regulation tasked both commanders and the deployed medical/mental health elements for “the maintenance of high standards of mental health and for the management of psychiatric and neurologic problems in this command.”⁶(§1,¶1,p1) The regulation was clear that: (a) prevention is as critical as treatment; (b) outpatient management is emphasized over inpatient; (c) hospitalization is to be avoided when possible, especially in the case of soldiers who primarily need “custodial care” (ie, supervision while awaiting administrative or judicial processing); and (d) Army psychiatrists should serve as consultants to unit commanders.

From the outset of hostilities in Vietnam, US Army planners committed ample mental health assets to avoid a problematic shortage situation similar to that which had arisen in the startup phases of previous campaigns.⁸(pp819-821) In fact, during the first year of the buildup period, the ratio of deployed Army psychiatrists to troops was higher than in any previous engagement.⁹ The mental health component in Vietnam consisted of psychiatrists, allied mental health professionals (social workers, psychologists, psychiatric nurses),

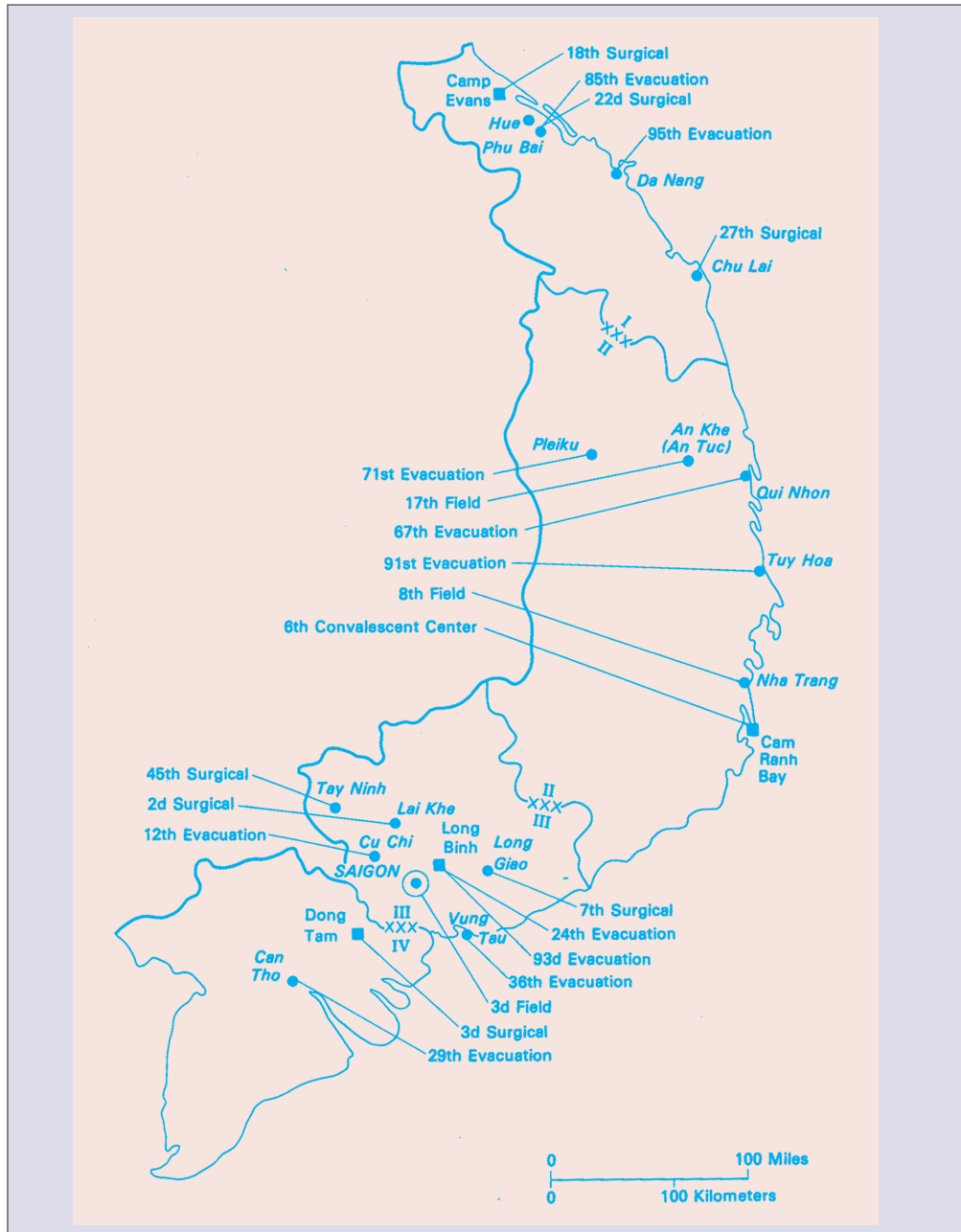


FIGURE 3-1. A map of South Vietnam dated 31 December 1968 shows the locations of US Army hospitals. Source: Ognibene AJ. Full-scale operations. In: Ognibene AJ, Barrett O'N Jr, eds. *General Medicine and Infectious Diseases*. Vol 2. In: Medical Department, United States Army. *Internal Medicine in Vietnam*. Washington, DC: Department of the Army, Office of The Surgeon General, and Center of Military History; 1982: 51.

and paraprofessionals (enlisted specialists, which included many who had college or even graduate-level degrees) who were provided behavioral science training by the Army.¹⁰ They were referred to variously as “neuropsychiatric specialists,” “social work/psychology specialists,” and “psychology technicians,” but most often they were simply referred to as “psych techs.” As will be described, the complement of mental health assets was deployed in the theater congruent with the Army’s three-echelon doctrine for the system of medical care mentioned in Chapter 2.

Army psychiatrists assigned in Vietnam served either close to the combat troops and the fighting when assigned as division psychiatrists, or in rear echelons when assigned to an evacuation or field hospital or to one of the two neuropsychiatry specialty detachments, so-called KO teams, the 98th and the 935th.^{3,7,11,12} (The initial “K” indicated that these were medical specialty detachments, which were typically attached to selected evacuation hospitals; the choice of the second letter was arbitrary.) In addition, in each year of the war a psychiatrist served as staff officer for the Army

TABLE 3-1. US Army Psychiatry Assignment Types in Vietnam

Organization Level	Psychiatrist Position
Division level medical resources	1) As division psychiatrist
Army level medical resources in Vietnam	2) As solo psychiatrist with an evacuation or field hospital 3) As staff with a psychiatric specialty detachment (935th or 98th)
Headquarters, United States Army, Republic of Vietnam (USARV)	4) As Neuropsychiatry Consultant to the CG/USARV Surgeon

CG/USARV: Commanding General, US Army, Republic of Vietnam

TABLE 3-2. Full US Army Divisions Deployed in Vietnam

Initially Deployed (main body) ¹	Combat Division	Withdrawal (main body) ²	Approximate number of years in Vietnam*
September 1965	1st Cavalry Division (Airmobile)	April 1971	5.5
October 1965	1st Infantry Division	April 1970	4.5
March 1966	25th Infantry Division	December 1970	4.75
October 1966	4th Infantry Division	December 1970	4.25
December 1966	9th Infantry Division	August 1969	2.75
September 1967	23d Infantry Division (Americal) <i>Formed in Vietnam</i>	November 1971	4.25
November 1967	101st Airborne Division (Airmobile)	January 1972	4.25
	TOTAL "DIVISION YEARS"		30.25

* Represents the time span between when the main body of the division arrived and when it withdrew, rounded to nearest quarter year.

Data sources: (1) Maitland T, McInerney P, and the editors of Boston Publishing Co. *The Vietnam Experience: A Contagion of War*. Boston, Mass: Boston Publishing Co; 1983: 10–11. (2) Fulghum D, Maitland T, and the editors of Boston Publishing Co. *The Vietnam Experience: South Vietnam on Trial: Mid-1970 to 1972*. Boston, Mass: Boston Publishing Co; 1984: 23.

commanding general and his staff as “Neuropsychiatry Consultant” to the CG/USARV Surgeon (Table 3-1).

The numbers of Army psychiatrists who served in clinical psychiatry positions in the Vietnam theater (ie, the division psychiatrists combined with hospital and psychiatric detachment psychiatrists) can be estimated to be six in 1965, 15 in 1966, 22 in each of the years 1967 to 1969, 20 in 1970, 14 in 1971, and two in 1972 and 1973. These numbers are extrapolations from Tiffany and Allerton,^{9(p813)} Allerton,^{3(p9)} and information collected in 1982 from participants in the Walter Reed Army Institute of Research (WRAIR) Vietnam psychiatrists survey mentioned in the Preface and the Prologue. It should be noted that there were more established positions than there were psychiatrists to fill them. The USARV Psychiatric Consultant was responsible for deciding which positions got filled depending on anticipated need and psychiatrist availability. In some years, psychiatrists were also assigned as division, brigade, or battalion surgeon,

commander of a medical battalion, or as a flight surgeon, and in these assignments they often were called upon to provide some psychiatric care in addition to their primary duties.

COMBAT UNIT PSYCHIATRIC SERVICES IN VIETNAM: THE DIVISION MEDICAL BATTALION AND THE DIVISION PSYCHIATRIST

Organization of Psychiatric Care in the Combat Units

At the conclusion of the buildup of ground troops in Vietnam there were seven full Army divisions and two Marine divisions operating in the theater. Table 3-2 lists Army divisions arranged in the order of arrival of the main body of each division. Also provided are their withdrawal dates and the approximate number of years they were in Vietnam.

EXHIBIT 3-1. Ratio of Combat Troops to Noncombat/Support Troops in Vietnam

There has been controversy regarding the so-called tooth-to-tail ratio during the war in Vietnam, with accusations that it was unreasonably lopsided in the direction of noncombat troops. For example, military psychiatry historian Franklin Del Jones indicated that each combat soldier in Vietnam was supported by about eight noncombat troops.¹ This was refuted in a more recent review by military historian JJ McGrath. He calculated a far lower ratio in Vietnam (one combat to two noncombat), one that was very similar to that in the Korean War.² According to McGrath, whereas since the World War I era the US Army's functional tooth-to-tail ratio has risen in favor of noncombat elements, this primarily occurred during the period between the two world wars because of improvements in mass motorization and mechanization. Since the onset of World War II, combat elements have averaged 32.5%. They have ranged between 40% and 25%, with recent trends hovering toward the lower end.

In Vietnam the typical Army combat division was a "light" infantry division consisting of about 17,000 soldiers. In the light configuration, much of the heavy equipment was deleted in favor of additional infantry companies and battalions. Based on the Table of Organization and Equipment for these divisions, the combat components comprised roughly 58% of troops, logistics were 11%, and headquarters/administration were 31%.^{2(Figure 21)} Among the latter were the so-called life support functions or MWR (morale, welfare, and recreation) and base camp support.

McGrath also notes that if April 1968 is used as a measuring point, when Army troop strength was at its peak, although the seven deployed combat divisions represented only 22% of the deployed force, the numbers of soldiers comprising the other, nondivisional combat troops raised the level of combat troops to 35%.^{2(Figure 22)} In other words, by these calculations, the ratio of combat troops to noncombat troops was 1:2. (See also Chapter 1 for estimates by Spector.)

1. Jones FD. Psychiatric lessons of war. In: Jones FD, Sparacino LR, Wilcox VL, Rothberg JM, Stokes JW, eds. *War Psychiatry*. In: Zajchuk R, Bellamy RF, eds. *Textbooks of Military Medicine*. Washington, DC: Department of the Army, Office of The Surgeon General, Borden Institute; 1995: 1–33.
2. McGrath JJ. *The Other End of the Spear: The Tooth-to-Tail Ratio (T3R) in Modern Military Operations*. Fort Leavenworth, Kan: Combat Studies Institute Press; 2007.

For the full combat divisions, 1st and 2nd echelon medical support came from medical assets within their organizational structure, that is, division level resources. A typical combat division in Vietnam was composed of 15,000 to 18,000 soldiers (and by one estimate roughly 60% of those served in combat assignments while the remainder filled noncombat positions¹³). (See Exhibit 3-1.)

The division's schedule of organization called for a medical battalion of four companies, each with three platoons. The three-echelon medical care system implemented at the outset of the war meant that 1st echelon care would consist of treatments provided by unit medics and battalion aid station medical personnel under the direction of the battalion surgeon, and more extensive 2nd echelon medical care, which provided fixed beds, would be administered by medical personnel at the brigade or division headquarters/division clearing station (Figure 3-2). Soldiers who failed to respond within 3 to 5 days would ordinarily be sent to Army-level hospitals beyond the division (but within Vietnam) for more prolonged, that is, 3rd echelon care. Requirements for additional care beyond the 3rd

echelon meant evacuation out of the Vietnam theater.

Beginning in World War I, combat-generated psychiatric problems proved capable of reaching a magnitude that could significantly undermine the integrity and capability of the force and affect the outcome of the battle. As a consequence, in World War I and again in the later stages of World War II and in Korea, the US Army came to recognize the importance of military/combat psychiatry and assigned a psychiatrist to each combat division to provide specialized care for troops and guidance regarding troop morale and mental health.¹⁴ During the war in Vietnam, each combat division had included in its organizational structure (its Table of Organization and Equipment—the TO&E) a position for a division psychiatrist who was assigned to the division's Headquarters and Headquarters Company.

The division psychiatrist was assisted by the division social work officer and six to 10 enlisted social work/psychology technicians (the "psych techs").³ Whereas 1st echelon, nonspecialized, mental healthcare was to be provided by battalion surgeons and field medics, the division psychiatrist and his staff were



FIGURE 3-2. Headquarters and Headquarters Company, 15th Medical Battalion, 1st Cavalry Division, Phouc Vinh in 1970. The Army medical care doctrine at the outset in Vietnam called for a three tier, or echelon, system of treatment. Within the divisions, 1st echelon care was to consist of treatment provided by a unit's medics and battalion aid station medical personnel under the direction of the battalion surgeon; more extensive, 2nd echelon medical care, including that requiring fixed beds, was to be administered by medical personnel at the brigade or division headquarters/division clearing station level, such as at the 15th Medical Battalion. Only soldiers who failed to recover within roughly 3 to 5 days were to be evacuated out of the division to Army-level hospitals within Vietnam for more prolonged, that is, 3rd echelon care. However, because of the widening use of helicopters in Vietnam for medical evacuation, the lower echelons of medical care were often bypassed (so-called overflying). Photograph courtesy of Richard D Cameron, Major General, US Army (Retired).

expected to operate a small treatment facility and provide more extensive and specialized 2nd echelon mental healthcare. This took place in conjunction with the clearing company medical facility (clearing station), which was located with the division's medical battalion at a brigade, or the division's, base camp (Figure 3-3). Also, because a key objective in providing psychiatric care for a combat division is to place mental health assets as far forward as possible, it was common for one or two enlisted social work/psychology technicians to be attached to the division's forward operating brigades

to provide timely, specialized support of the battalion surgeons and other 1st echelon medical personnel.⁷

By policy, authority to evacuate psychiatric patients out of the division to the Army-level hospitals in Vietnam (ie, 3rd echelon care facilities) was restricted to the division psychiatrists who were to distinguish which casualties required additional specialized care. Finally, being assigned with a line unit (ie, in a nonmedical unit versus in a hospital or psychiatric specialty detachment) meant that division psychiatrists had a broader scope of duties than those assigned to the hospitals or psychiatric



FIGURE 3-3. The central psychiatric treatment facility of the 1st Cavalry Division base camp at Phuoc Vinh in 1970. During the war each of the seven full combat divisions in Vietnam included a position for a division psychiatrist who was assigned to the division's Headquarters and Headquarters Company. He was assisted by the division social work officer and six to 10 enlisted social work/psychology technicians. They operated a small treatment facility such as this one where they offered more extensive, specialized mental health-care for troops than was available in the field. Some of the enlisted technicians were also attached to forward units to provide acute treatment of psychiatric casualties and consultation to unit cadre and other medical personnel. Photograph courtesy of Richard D Cameron, Major General, US Army (Retired).

detachments. In addition to their clinical responsibilities, they also were expected to be readily accessible to provide professional consultation to unit commanders and the division surgeon.¹⁵ (See Chapter 7 for more specifics regarding the management and treatment capabilities for combat divisions.)

In Vietnam, because of the great distances that typically separated elements of the divisions, these duty requirements were often quite challenging because of transportation and communication impediments. This was partially remedied by having the enlisted psychiatric

technicians attached to forward operating brigades as noted. Still, the scattered nature of the brigades often complicated the division psychiatrist's supervision of these techs as well as consultations with the various battalion surgeons and unit commanders. Furthermore, the fluid nature of the tactical situation and new heliborne medical ambulance capability often led to deviations from the triple echelon care and evacuation plan, and this invariably affected the system of treatment of psychiatric casualties as well.⁹

In fact, because of the common practice of helicopters evacuating casualties directly to division clearing stations,¹⁶ as well as to surgical, field, and evacuation hospitals (so-called overflying), after he left the theater in 1969, Major General Spurgeon Neel, former Military Assistance Command, Vietnam (MACV) Surgeon, recommended that the battalion surgeon positions no longer be filled.⁴ (The 1st Infantry Division's Regulation 40-13, *Medical Service: Division Mental Hygiene Program*, dated 25 October 1967, which explained the policies, procedures, and functions of the division's Mental Hygiene Program, can be found in Gordon.¹⁷)

Four independent brigades were also deployed in Vietnam: (1) 11th Armored Cavalry Regiment; (2) 1st Brigade, 5th Infantry Division (Mechanized); (3) 199th Infantry Brigade (Light); and (4) 173rd Airborne Brigade. Each was about one-third the size of a division and was composed of approximately 30 company-size units (about 5,000 soldiers). They did not typically have a dedicated psychiatrist position. In some situations these brigades were attached to a combat division and utilized the division psychiatrist's staff; otherwise they arranged for specialized mental healthcare to be provided by the nearest evacuation or field hospital or one of the two psychiatric detachments.

Even the full divisions in Vietnam may not have had a psychiatrist assigned for periods of time because of personnel shortages. In these instances, specialized psychiatric care and consultation also had to be obtained from a hospital-based psychiatrist, but there were predictable disadvantages to such an arrangement.

Accounts by Division Psychiatrists and Allied Mental Health Personnel

Establishing a reasonably accurate history of the medical care and support provided combat units during a war should be a priority. However, as has been stated, this did not happen in the aftermath of Vietnam regarding the psychiatric components of the combat units and the care they provided. Whereas psychiatrists were directed by HQ/USARV Regulation 40-34, *Mental Health and Neuropsychiatry*,⁶ to be responsible for "keeping accurate records of all outpatients and inpatients, and for coordinating with registrars so that accurate morbidity figures are obtained and forwarded [to higher command]"⁶ (see Appendix IV in Appendix 2, Army Regulation 40-34), evidently there was no sustained effort at a central level to analyze and retain this data from the combat (division) psychiatrists

distinct from medical data from other sources. As a consequence, overall epidemiologic documentation for the combat units is missing.

Notably, Major General Neel's official summary of Army medical care in Vietnam through the first two-thirds of the war did not specifically mention combat stress reaction casualties. He also did not break out the yearly psychiatric rates among the major diagnostic subgroupings for combat units (refer back to Chapter 2, Table 2-2, Army Incidence Rate for Psychiatric Hospitalizations in Vietnam and [in Europe] in Cases/1,000 Troops/Year).⁴ Colbach and Parrish's overview of the first two-thirds of the war did indicate that combat stress reaction cases accounted for 7% of psychiatric hospitalizations,¹² but the fuller review of psychiatric care in Vietnam by Jones and Johnson did not include measures for combat stress reaction cases. Whereas they differentiated the psychosis rate from other causes for hospitalization, and generally distinguished inpatient rates and outpatient rates, there are no breakouts for the combat units.⁷

In search of an alternative means for understanding the fuller story, the available accounts of individual division psychiatrists and their mental health colleagues are reviewed below. These are arranged in a rough chronological order to provide some impression of the changing nature of the war and associated psychiatric challenges. (All quotation marks identify the terms used by the reporting individual.) Selected aspects will be presented in more detail in subsequent chapters. Additionally, a few psychiatrists assigned with the divisions reported on circumscribed problems, and these will be noted in subsequent chapters as well. Finally, as will be made evident, attempting to reconstruct the history of psychiatry in the combat divisions by this means is incomplete because the majority of the deployed mental health professionals did not produce records, or, if they did, most served in the first half of the war.

25th Infantry Division

Background. At the opening of the Vietnam War, the 25th Infantry Division was the only trained counter guerrilla unit in the US Army. The division's 3rd Brigade deployed to the central highlands at Pleiku, 28 December 1965. The rest of the division completed its deployment by March 1966. The soldiers of the 25th Infantry Division fought in some of the toughest battles of the war. During the Tet offensives in 1968 and 1969, they were instrumental in defending the besieged city of Saigon. In 1970 the division became heavily involved



FIGURE 3-4. Major Franklin Del Jones, Medical Corps, Division Psychiatrist with 25th Infantry Division. Jones, an Army-trained psychiatrist, accompanied the division when it deployed to Vietnam in February 1966. In September he was transferred to the 3rd Field Hospital in Saigon where he completed his yearlong assignment in Vietnam. Jones is credited with publishing the first overview of the psychiatric problems arising in a combat division in Vietnam. Also, the postwar summary of the Army's psychiatric problems in the Vietnam War he published (with Johnson) provided the only theater-wide statistics released by the Army that spanned all 8 years of the war. Photograph courtesy of June Jones.

in the “Vietnamization” program and participated in Allied thrusts deep into enemy sanctuaries in Cambodia. By the end of that year, elements of the 25th Infantry Division began redeployment back to the United States. Overall, between battle deaths and deaths from other causes, the division lost 4,540 men in Vietnam.¹⁸

Major Franklin Del Jones, Medical Corps. An Army-trained psychiatrist, Jones (Figure 3-4) was the first division psychiatrist to serve with the 25th Infantry Division in Vietnam (March 1966–September 1966) and the only one to publish an account. Jones traveled with the division when it deployed to Vietnam in early 1966.¹⁹ According to his published account, the division set up its base camp near Cu Chi, about 20 miles northwest of Saigon and 10 miles from the Cambodian

border, among abandoned peanut fields, rice paddies, and graveyards. This initially required heavy contact with the Viet Cong guerrillas. Dense vegetation, orchards, and rubber plantations were within the enemy's rifle range, but sniping and mortaring on the base camp ceased after the establishment of an effective perimeter of concertina wire, mines, and bunkers.

The heat and the dust in the dry months, and the heat, humidity, and mud in the rainy months, were debilitating. Establishment of reliable generators allowed for an array of electrical conveniences and diversions (fans, refrigerators, televisions and radios, and movies—but not air conditioning). Jones recalled that there was remarkable logistical support in that “almost no material deprivation was suffered by the men,”^{19(p1004)}

and he felt this contributed to the maintenance of high morale within the division. On the other hand, he complained about his dependency on the goodwill of medical battalion for staff and equipment. Whereas he was authorized a .45 caliber pistol, a compass, and psychological testing equipment, what he really needed were “a jeep, a typewriter, a . . . tent to house [my mental health clinic], a desk, and a locking file cabinet.”^{19(p1008)}

According to Jones, “Casualties of all kinds were relatively few, and psychiatric casualties were quite infrequent.”^{19(p1005)} He ultimately averaged 75 referrals per month; of those, approximately four per month (5.3%) required hospitalization. Most of the referrals were from support units and presented problems similar to those seen among garrisoned troops, for example, regarding disciplinary action or for alcohol-related incidents. Approximately two-thirds of referrals were diagnosed as character and behavior disorders (ie, personality disorders²⁰). The other third were for psychiatric “clearance” in conjunction with legal or administrative difficulties and generally received a diagnosis of “no disease found.” The few individuals who became psychotic were quickly evacuated out of the division.

Alcohol abuse incidents became a special problem category. Jones reported that beer was easier to obtain than soft drinks, and that incidents of soldiers going “berserk” became enough of a problem that command developed a coordinated response plan to disarm drunken soldiers who were brandishing weapons and threatening others. He also noted that there was no available treatment for chronic alcoholism, and that these individuals typically received administrative processing out of the Army.

The other major group of soldiers that required attention from Jones and his staff were variations of “combat avoidance” (including “helmet headaches” in soldiers seeking to avoid patrol duty, or sleepwalking in those who did not want to be quartered near the perimeter). Jones indicated that he never saw a case of combat fatigue, but he did see a few combat-generated “fright reactions [which were] occasioned by imminent danger or witnessing the death of a friend.”^{19(p1005)} He diagnosed these as situational reactions but nonetheless lumped them with the character and behavior disorders. In particular, there were no related psychiatric cases in the aftermath of a mortar attack on the base in July that left two dead and 100 wounded.

Jones speculated that the lack of psychiatric sequelae was the consequence of the command/psychiatric policy of opposing “environmental change.” This refers to a policy against reassigning away from danger soldiers who had some potential for becoming anxious after such an attack.

Jones mentioned the emergence of “short timer’s” syndrome (“mild anxiety and some phobic feelings”) seen among combat soldiers approaching their date of expected return from overseas (DEROS). He noted that commanders who routinely reduced combat exposure of such troops as a prophylactic measure found these symptoms arose even sooner among the other troops (Jones opposed commanders allowing the soldier’s 11th month to be his last in the field).

Finally, Jones reflected on the overall low psychiatric attrition rate he and other psychiatrists encountered at that early stage of the war. Although he credited the same features noted by other psychiatric observers detailed in Chapter 2, he also favored “the fact that we began to win the war in an observable fashion in 1966.”^{19(p1007)}

1st Cavalry Division (Airmobile)

Background. The 1st Cavalry Division was the first full combat division to be deployed in Vietnam. In August 1965, its initial elements arrived in An Khe, which was located between Qui Nhon on the coast and Pleiku in the central highlands. The division was fully deployed by September 1965. Among its more prominent combat operations were participation in the Battle of Ia Drang Valley in 1965; the battle to recapture Quang Tri and Hue; relief of the Marine units besieged at Khe Sanh; clearing operations in the A Shau Valley in 1968; and participation in the Cambodian incursion in 1970. The bulk of the division was withdrawn in April 1971, but its 3rd Brigade was one of the final two major US ground combat units in Vietnam, departing in June 1972. Overall, between battle deaths and deaths from other causes, the 1st Cavalry Division lost 5,439 men in Vietnam.¹⁸

Captain Harold SR Byrdy, Medical Corps. Byrdy had been draft-deferred under the Army’s “Berry Plan” (permitting the completion of civilian medical specialty training) and was commissioned as an Army Medical Corps officer shortly before being deployed to Vietnam as the 1st Cavalry Division’s first division psychiatrist in Vietnam. (In the previous segment, Jones was identified as an Army-trained psychiatrist; Byrdy is

TABLE 3-3. Diagnostic Distribution of Referrals to the 1st Cavalry Division Mental Health Service, August 1965–June 1966 (N = 503)

Diagnosis	% of cases
Psychotic reactions	2.4%
Psychoneurosis	13.9%
Personality disorders	40.4%
Psychophysiologic reactions	4.8%
Combat exhaustion	4.4%
Acute (alcoholic) brain syndrome	4.4%
Adult situational reaction	3.6%
Miscellaneous	26.2%
	100%

Data source: extracted from Byrdy HRS. Division Psychiatry in Vietnam. [Appendix 8 to this volume]. Table 2.

identified as a civilian-trained psychiatrist. The salience of this pre-Vietnam training distinction is considered in this chapter and the next. It is described more fully in Chapter 5, and it is utilized throughout the remaining chapters as a key background variable that may explain differences in the deployed psychiatrists' appraisal of the challenges they faced in Vietnam and their professional decisions.) Byrdy arrived in the summer of 1965 with the division's advance party immediately after attending the 5-week Medical Field Service School training at Fort Sam Houston, Texas. During his 10 months with the 1st Cavalry (also referred to as the 1st Cav), Byrdy was assisted by the division social work officer, but they were short five of their allotted eight enlisted social work/psychology technicians.

Descriptive aspects of Byrdy's experience in the 1st Cavalry are found in his unpublished manuscript²¹ (see Appendix 8, "Division Psychiatry in Vietnam") and his participation in a 1967 panel discussion.¹ According to Byrdy, despite the trying conditions associated with conducting military operations while establishing the division in Vietnam, the troops maintained high morale by drawing upon the 1st Cav's airmobile status as a new, albeit experimental, means of conducting warfare. However, transportation and communication obstacles faced by Byrdy and his team were substantial.

The division psychiatrist must try to compromise between his potential skills and his ability to be realistically effective. Telephone calls . . . would often take up to 45 minutes for a completion through the switches. I could borrow a vehicle at times from the surgeon or from the medical battalion. At other times I hitch-hiked. It is at this grass-roots level that the

best preventive measures are probably carried out for units in the division area. For units in the field outside of the base camp, travel, when indicated, was a major operation of scheduling. The net result was that we responded to crises rather than "heading them off at the pass."^{1(p50)}

Byrdy also referred to interpersonal impediments in providing primary prevention/command consultation to the various units of the 1st Cavalry.

I did not feel in the least that it was professionally desirable that we sell ourselves to the division. By that I mean that, though I did go and talk with unit commanders, I felt it an awful thing to sort of ferret out problems as though we were drumming up business. I thought this was a rather uncomfortable role for me. . . . Indeed, there were elements in the division that strongly felt that, because of the nature of the combat (we were in the Airmobile Division and moved around quite rapidly), there would be no psychiatric casualties . . . I was assured at the very beginning by some people that really I was just unnecessary baggage because I would have no work.^{1(p47)}

During the division's initial 9½ months in Vietnam, he and his staff had 503 referrals, or 53 per month. These were seen in 1,065 outpatient visits, which averaged two visits per patient and three patient visits per day. Table 3-3 presents the distribution of referrals by diagnostic groupings.

According to Byrdy, the combat troops bore the greatest stress, and most of the referrals were from the enlisted ranks, E-2 through E-6. The majority of soldiers who were diagnosed as personality disorders were passive-aggressive. Byrdy hospitalized 116 referrals (23%), averaging one admission every 3 days (maximum bed capacity was six, and maximum stay was about 3 days). Of these, 30 (26%) were evacuated out of the division for additional treatment (representing 6% of referrals and an estimated evacuation rate for the 1st Cavalry Division of 2.2/1,000 troops/year). This number included all 12 soldiers diagnosed as psychotic. Byrdy indicated that he often prescribed Thorazine and Librium; but, apart from the latter, he opposed the use of psychoactive medications for outpatient maintenance because of their potential for impairing reactions in combat.

Thirty-two soldiers (6.4% of referrals) received an initial diagnosis of combat exhaustion, that is, soldiers presenting disorganizing anxiety related to an active combat situation.¹ Most of these arose in conjunction with the division's two sustained combat operations: the Battle at the Ia Drang Valley near Pleiku (October 1965–November 1965) and the Bong Son campaign (February 1966–March 1966). However, 10 of the 32 failed to respond to brief, simple treatments—the Army's combat psychiatry forward treatment doctrine, which was augmented with “tranquilization”—and consequently received various amended diagnoses (including two as “alcohol agitations”[*sic*]). The incidence rate for the remaining 22, which by implication Byrde considered to be the true combat exhaustion cases, was 1.6 per 1,000 troops per year (vs his rate for all psychiatric referrals, 22/1,000 troops/year).²¹

Finally, Byrde provided this account of an attempt to forestall the development of the short-timer's syndrome by one unit,

[An] outgoing commander had instituted a program in which the “short-timers” in the unit would have a terminal, non-combatant status. I don't remember what the time duration was—perhaps 15, perhaps 30, days prior to rotation. The result was chaos in the unit with bitterness and breakdown in morale among the whole unit so that he had to rescind this time concession. I also feel that it was significant that the commander was getting to be a “short-timer.”^{1(p52)}

Captain John A Bostrom, Medical Corps. Some appreciation for psychiatric activities in the 1st Cavalry Division later in the buildup phase can be derived from two publications by Bostrom, the division psychiatrist (February 1967–February 1968). He also was trained in psychiatry in a civilian program and joined the 1st Cavalry Division in February 1967, some 9 months following Byrde's departure. Bostrom's publications were limited in scope compared to those by Byrde and Jones. In his first, he proposed a taxonomy of the combat stress-generated cases derived from his experiences with cases who were referred to the mental hygiene clinic over a 3-month span:

Type I–Normal Combat Syndrome (two cases): included soldiers who were frightened or experiencing “realistic anxiety,” but not to the extent that combat effectiveness was impaired.

Bostrom noted that most cases of this type were not referred to the mental hygiene clinic because they were effectively treated in the battalion aid stations.

Type II–Pre-Combat Syndrome (11 cases): included soldiers who were experiencing significant anxiety, psychosomatic complaints, and sleeplessness, and which degraded combat performance.

Type III–Combat Exhaustion (four cases): included soldiers who were experiencing a state of psychosis or near-psychosis, and resulting in a complete loss of combat effectiveness.^{22(pp6–8)}

With regard to treatment of combat exhaustion cases, Bostrom, like Byrde, utilized a blend of rest, physical replenishment, and empathy combined with emphatic expectation of return to combat duty. Some also received psychotropic medication. In the more severe cases he prescribed sufficient Thorazine to induce arousable sleep for about 24 hours—so-called *dauerschlaf*.²² This refers to a sleep therapy regimen that was also used by Bloch at the 935th Psychiatric Detachment, and later by Major Douglas R Bey with the 1st Infantry Division. (*Dauerschlaf* will be described in Chapter 4 and Chapter 7.) Bostrom's other publication provided case examples of two hypothetical referrals—one a soldier with psychosomatic back pain and the other a “troublemaker”—to demonstrate the unit consultation approach utilized by his enlisted social work/psychology technicians with good effect.²³

Additional information regarding the psychiatric challenges in the 1st Cavalry Division was provided by two Army psychiatrists: (1) Jerome J Dowling (June 1966–March 1967) described commonly seen soldier stress and adjustment patterns through the course of the 1-year tour early in the war (see Chapter 8) and (2) Frank Ramos (October 1970–May 1971) described the division's heroin detoxification/rehabilitation program late in the war (see Chapter 9).

9th Infantry Division

Background. The 9th Infantry Division was reactivated on 1 February 1966 and arrived in Vietnam in December 1966. Upon deployment the division was assigned to the III Corps Tactical Zone of Vietnam where it commenced operations in the Dinh Tuong and Long An provinces in Operation Palm Beach. Division headquarters, which initially housed the division's 3rd

Brigade, was at Camp Bearcat some 20 miles northeast of Saigon. The permanent base, Camp Dong Tam, was established in the Viet Cong-infested Mekong Delta near My Tho in January 1967.

In March the 2nd Brigade moved into Camp Dong Tam, and the 3rd Brigade relocated northward to Tan An. To improve division mobility in the inundated Mekong Delta, in June two battalions from the 2nd Brigade joined a US Navy Task Force afloat to establish the Mobile Riverine Force (with South Vietnamese Marines and units of the ARVN [Army of the Republic of Vietnam] 7th Division). In February 1968, the division's armor reconnaissance squadron relocated to the far north to Wunder Beach in I Corps Tactical Zone, 15 miles south of the demilitarized zone. This reassignment distinguished the 9th Infantry Division as the most widespread division in Vietnam. The 1st and 2nd Brigades, along with division headquarters, departed Vietnam in July and August 1969, leaving the 3rd Brigade at Tan An to operate as an autonomous combat unit. The 3rd Brigade withdrew a year later, September 1970. Overall, between battle deaths and deaths from other causes, the 9th Infantry Division lost 2,625 men in Vietnam.¹⁸

Captain William L Baker, Medical Corps. Baker was trained in psychiatry in a civilian program and was assigned as the division psychiatrist to the 9th Infantry Division between January 1967 and September 1967. He joined the division 1 month after the division arrived in Vietnam and in the midst of some of the heaviest fighting in the war. He published information regarding his tour with the 9th Infantry Division in the *US Army Vietnam Medical Bulletin*.²⁴ Baker's initial cases were not primarily combat-generated but were a heterogenic group of other psychological disorders such as situational, reactive, or chronic characterological problems.

After the fifth month and as combat activities became more regular, a few cases of combat stress reaction began to appear, which he labeled classic combat fatigue. Baker reported that most of these were managed at the 1st echelon care level by the battalion surgeons using rest and sedation (no details as to medications prescribed). Over time, the incidence of combat soldiers undergoing more severe regression ("brief periods of psychotic symptoms") went from rare to four to 12 per month. These received 2nd echelon care by Baker and his staff at the division base camp. Ultimately more challenging were "modified combat stress reactions," which became more frequent as the

division passed its 10th month in Vietnam. These were soldiers with good performance records, including in combat, who variously developed disabling anxiety, functional gastrointestinal disturbances, recurrent traumatic dreams, or "short-timer's syndrome."

Baker's impression was that the rapid rise in all these reactions represented a time-stress continuum in response to combat exposure. However, soldier stress was apparently compounded by the loss of unit bonding from: (a) combat losses, and (b) a command decision to transfer large numbers of soldiers to different units to reduce the impact of impending rotations back to the United States. Most of the combat stress reaction cases Baker saw responded to supportive psychotherapy, 2 to 3 days of rest, recreation, and pharmacologic support (Combid Spansules, Compazine, Probanthine, and Donnatal for the gastrointestinal symptoms; and nighttime Seconal for sedation). Baker also thought the treatment results were better when these soldiers were not hospitalized but were instead kept at the base camp and followed by his staff as outpatients. Still, some had persisting symptoms and required reassignment to noncombat duties (so they would not be a "liability in the field"). "True psychosis" (ie, schizophrenia or manic-depression) accounted for about 1% of Baker's caseload, and with these he saw no correlation with external stressors.²⁴

Lieutenant Colonel Robert L Pettera, Medical Corps. Two publications by Pettera, a military-trained psychiatrist who succeeded Baker, provided some further appreciation for psychiatric challenges that faced the 9th Infantry Division as the war intensified. In one, Pettera (with Basil M Johnson and Richard Zimmer, his colleagues) distinguished three varieties of combat stress-generated casualties seen:

1. A "nebulous, ill-defined transient anxiety reaction with little or no specific etiology"—which responded easily to supportive therapy;
2. Acute incapacitating "combat fatigue"—of which there were few, apparently because of the lack of sustained (ie, fatiguing) combat activities; and
3. "Vietnam combat reaction"—a disabling psychophysiological condition with anorexia, nausea, and vomiting; severe anxiety with tremulousness; insomnia and traumatic nightmares; and survivor guilt with incomplete grieving (this condition was commonly found among seasoned combat soldiers who were approaching the end of their tour).^{25(pp673–674)}

Incidence rates were not provided, but as with Baker, overall, combat stress reactions were treated in a fashion consistent with the Army psychiatry forward treatment doctrine, which was augmented with pharmacological intervention (Librium, Thorazine, and nighttime sedation with Seconal). Most symptoms resolved within 3 days; however, 30% of cases remained somewhat affected. Nonetheless, half were returned to duty and “were actually quite effective in combat.” Regarding the others, Pettera indicated that he initially interceded through the Adjutant General’s Office to oppose their being returned to their original units, and these soldiers had greater disability. In fact, he was explicit in describing how these observations shifted his clinical attitude to a mission-centered one once he discovered the secondary gain quotient derived by these soldiers by being symptomatic, that is, relief from combat duty. Pettera wrote, “our direct intercessions only served to crystallize the neurotic symptoms in these soldiers, and, in actuality, they continued to remain relatively ineffective.”^{25(p673)}

In his other publication, Pettera described the methods he used to provide consultation-liaison services for the division’s commanders and battalion surgeons. To demonstrate the success of the field consultation and intervention program implemented by Pettera and his cohorts, he indicated that in the month of January his team treated 55 patients (117 interviews) forward of the division base and another 50 patients (113 interviews) in the rear at the clearing station, and that as a result of their field visits, the referrals to the clearing station “office” were probably reduced by a factor of 3 to 5.²⁶ Pettera noted various resistances exhibited by some of the consultee commanders and battalion surgeons, and he recommended strategies to achieve credibility and reduce these obstacles. He also provided suggestions as to how to induce the battalion surgeons to trust the advice of the enlisted mental health technicians in lieu of the psychiatrist.²⁶ Finally, Pettera argued that a psychiatrist is maximally useful when assigned directly within a division as opposed to being borrowed from one of the hospitals.²⁶

9th Infantry Division, the Mobile Riverine Force, and Specialist 5th Class David B Stern

A postscript regarding the 9th Infantry Division came in the form of a publication by Stern, an enlisted social work/psychology technician, who served with the 9th Infantry Division in 1968, the year following

Pettera’s tour. Stern described the technician-level psychiatric support he provided to two of the division’s combat battalions that were part of the Mobile Riverine Force, a joint Army-Navy task force. These units conducted operations from an inland floating base in the Mekong River delta that was isolated and far from the division base camp and psychiatric supervision. Stern was attached to the Mobile Riverine Force over a 6-week period and saw a total of 10 psychiatric patients, fewer than he anticipated. However, he felt the low numbers of referrals allowed him to mix with the troops and practice informal preventive mental hygiene. Stern was especially concerned with a predicament surrounding the care of one psychotic soldier. According to Stern:

Managing a psychotic soldier can take most of my time and energy, even if the patient is snowed under on Thorazine, and even if I am lucky enough to get one of the corpsmen to help. [I am only allowed to] evacuate a patient to the division psychiatrist at the division base camp. But the [medical evacuation helicopters] only fly to an evac[uation] hospital. The only recourse is to send the patient knocked out with Thorazine and sandwiched between two litters to the surgical hospital next to the brigade clearing station at the Mekong Delta base camp. It is then up to [the psych tech] there to try to get the patient to the division psychiatrist (or wait for the division psychiatrist to travel there).^{27(p73)}

4th Infantry Division

Background. The 4th Infantry Division deployed to the Pleiku area in Vietnam in October 1966. Two brigades operated in the Central Highlands/II Corps Zone, but the 3rd Brigade, including the division’s armor battalion, was sent to Tay Ninh Province northwest of Saigon to take part in Operation Attleboro and, in 1967, Operation Junction City. Throughout its service in Vietnam the 4th Infantry Division conducted combat operations in the western central highlands along the border between Cambodia and Vietnam. The division experienced intense combat against North Vietnam Army (NVA) regular forces in the mountains surrounding Kontum in the autumn of 1967. The division’s 3rd Brigade was withdrawn from Vietnam in April 1970. In May the remainder of the division participated in the Cambodian incursion. With the exception of one battalion that remained in Vietnam as a separate organization (until January 1972), the rest of

the division redeployed to the United States in December 1970. Overall, between battle deaths and deaths from other causes, the 4th Infantry Division lost 2,524 men in Vietnam.¹⁸

Captain Gerald Motis, Medical Corps. Motis, a civilian-trained psychiatrist, was assigned to the 4th Infantry Division between June 1967 and April 1968, which was contemporaneous with Pettera at the 9th Infantry Division and during the period of peak combat intensity in Vietnam. A rich picture of the psychiatric support for the division's soldiers can be gleaned from his publications.^{16,28,29} According to Motis, his mental hygiene service operated out of the division base camp in the Pleiku area and served two of the division's brigades and part of a third, which was located at Duc Pho. They also were responsible for mental health support of the 173rd Airborne Brigade, elements of the 1st Cavalry Division (Airmobile) when they were located in the Kontum area, and numerous nondivisional support units in the Pleiku area. As with the other divisions in Vietnam, the 4th Infantry Division's units were scattered across a wide area, and in many instances contact with patients or consultation with commanders and with other medical personnel required helicopter transport—an often unpredictable arrangement. Also, as with the other divisions, Motis attached some of his enlisted social work/psychology technicians to forward medical clearing stations and medical companies to screen and treat psychiatric problems as close to their units as possible and to serve as consultants to the battalion surgeons.

This arrangement was seriously tested in November 1967, when elements of the 4th Infantry Division and the 173rd Airborne Brigade had repeated contacts with North Vietnamese Army regulars in the central highlands surrounding Dak To. Motis described the use and effectiveness of the Army's "time-honored" treatment methods for the tenfold rise in acute psychiatric battle casualties, which included classic combat reaction cases. In particular he praised the treatment applied by his forward-deployed enlisted technicians who functioned in concert with the battalion surgeons. According to Motis, this approach, which he supported through his regular visits, proved invaluable in limiting the attrition of combat personnel due to treatable psychiatric conditions. Typical counseling techniques used by the technicians were ventilation, encouragement, and exhortation to return to their units and duty function. The use of parenteral Thorazine to aid in rest and restraint also

proved invaluable.

The majority of these soldiers were eager to rejoin their units within 24 hours, and 78% (18 of 23) were returned to duty within 1 to 3 days after treatment in the forward clearing station. Ultimately only 13% required transfer to noncombat assignments, and none were evacuated beyond the division. Interestingly, Motis had the impression that being seen personally by the psychiatrist near the front contributed to the soldier's reluctance to return to the field and interfered with his recovery. Motis also noticed a drop in psychiatric referral rates and sick-call rates for troops in the rear during this period and credited the great increase in morale brought about by the division's concerted effort to win the battle.

Further reference to the psychiatric challenges in the 4th Infantry Division is made in Chapter 9 in a review of the results of a marijuana-use survey among hospital patients by Wilfred B Postel, the division psychiatrist (1968). Chapter 9 also describes how the 4th Infantry Division's drug "amnesty/rehabilitation program," established in 1968, ultimately became the model for the Army's worldwide Drug Abuse Prevention and Control program (Department of the Army Regulation 600-32, published in December 1970).⁴

1st Infantry Division

Background. The first elements of the 1st Infantry Division ("The Big Red One") arrived in Vietnam in July 1965, and began combat operations within 2 weeks. The division was fully deployed by October 1965. By the end of 1965 the division had participated in three major operations. In 1966 it participated in Operation Attleboro and in 1967 Operation Junction City and Operation Cedar Falls. On 17 October the division suffered heavy casualties at the battle of Ong Thanh. In 1968, the division was involved in the counterreaction to the enemy Tet offensives, especially in securing the vitally important Tan Son Nhut Air Base near Saigon. In April, the division participated in the largest operation in the Vietnam War, Operation Toan Thang (Certain Victory). In 1969 the division shifted to reconnaissance-in-force and ambush type operations, and it participated in the Battle of An Lộc. Later in the year, it became involved in operations intended to assist South Vietnamese forces to take a more active role in combat. In April 1970, the division redeployed back to the United States. Overall, between battle deaths and deaths from other causes, the 1st Infantry Division lost 3,145 men in Vietnam.¹⁸

Captain Edward L Gordon, Medical Corps.

Although not constituting an overview, some perspective on the psychiatric activities in the 1st Infantry Division during the buildup phase in Vietnam came from Gordon, the division psychiatrist (June 1967–June 1968), who published in the *US Army Vietnam Medical Bulletin* several of his interim reports to Colonel Matthew D Parrish, the senior theater Army psychiatrist (Neuropsychiatry Consultant to the CG/USARV) at the time. Among Gordon's reports was the 1st Infantry Division's Regulation No. 40-13, which detailed the division's mental hygiene program. Gordon also indicated that among the more than 1,000 soldier-patients seen in 1967 (Camp: estimated to be over a 6–7 month span) by him, his social work officer, or the enlisted social work/psychology techs, 6.8% required evacuation out of the division for additional care, and, of those, about one-third were further evacuated out of Vietnam (none of whom were combat exhaustion cases).¹⁷

Additional information from the same time frame comes from an article by Specialist 6th Class Dennis L Menard, one of Gordon's enlisted social work/psychology technicians. Menard observed that unusually high psychiatric referral rates usually came from units in the combat arms battalions. Believing that many of these referrals likely also represented dysfunctional units, the mental health service began a field consultation program in July 1967. Two social work/psychology technicians were assigned to the medical companies located at each of three brigade base camps—Di An, Lai Khe, and Quan Loi—and functioned under the technical supervision of the division psychiatrist. Through increased contacts with the unit cadres of problem units, early detection and effective intervention was improved at both the level of the individual soldier and with the unit's leaders.³⁰ (Menard also provided information on troop living conditions in the field [Chapter 1, Exhibit 1-2] and consultation to a combat battalion by a social work specialist [Chapter 10, Exhibit 10-1].)

Major Douglas R Bey, Medical Corps. A much fuller description of the psychiatric experiences during the transition phase of the war comes from civilian-trained Bey, the division psychiatrist for the 1st Infantry Division (April 1969–April 1970) who arrived in Vietnam a year after Gordon's departure. Bey (Figure 3-5), whose promilitary training and pre-Vietnam service background was mentioned in Chapter 2, was uniquely prepared to serve as a division psychiatrist. He



FIGURE 3-5. Major Douglas R. Bey, Medical Corps, Division Psychiatrist with the 1st Infantry Division. Bey, a civilian-trained psychiatrist, served with the 1st Infantry Division between April 1969 and April 1970. His many publications are noteworthy in themselves, but they are also unique because he was the only division psychiatrist assigned in Vietnam after 1968 to describe his professional experiences in detail. Photograph courtesy of Douglas R Bey.

provided a rich legacy regarding his tour in the form of a series of publications, an unpublished professional treatise, and a personal account published 35 years after he left Vietnam.³¹ His observations and impressions were especially valuable because he was the only psychiatrist deployed in Vietnam after 1968 to write about his experiences.

In his principle publication, he described the “tertiary preventive” care (ie, direct care) provided by him, his social work officer, and eight enlisted social work/psychology technicians. This involved the diagnosis and treatment of 180 to 200 new patients (plus 200 follow-up visits) per month who were either referred by battalion surgeons, chaplains, units, and the judge advocate's office, or were walk-ins. (“We are geared toward rapid evaluation and treatment near the soldier's unit—[a treatment] aimed at restoring him to duty as soon as possible.”^{15(p229)}) By routine, an enlisted technician took a detailed history of each new case before the soldier was interviewed by Bey or the social work officer. The soldier's unit was also contacted to provide further historical and observational data¹⁵

(initial interviews of officers and senior sergeants were conducted by Bey or the social work officer³²).

Bey also described various practical frustrations borne by all division psychiatrists in Vietnam.

[The division psychiatrist] is not officially provided with the wherewithal to carry out this mission. [W]hile consultation and prevention are urged, [he] is not provided . . . a jeep or other consistent means of land transportation. He is not provided with a typist, yet is expected to prepare reports. His staff [that is, social work officer and enlisted social work/psychology technicians] are under the command of the medical battalion who decide if and when they will be available for work with the psychiatrist.^{32(pIII-17)}

According to Bey, he found his first medical battalion commander to be a significant obstacle: “So you’re the new [division psychiatrist]. I’m not sure I believe in psychiatry.” Bey and his team had to resort to “midnight requisitions” (unofficial appropriation of materials) and procurement of personnel through means such as bartering in order to acquire a jeep, build their offices, and arrange to have a clerk typist assigned. As it turned out, subsequent medical battalion commanders were much more supportive of the mental health team’s mission as were the company commander and the executive officer of Headquarters and A Company (“[who] helped us to avoid pitfalls and bottlenecks and enabled us to devote ourselves to our work”³²). Overall, Bey indicated that he and his staff maintained high morale despite their manifold challenges “because we could see that we were providing a useful service to our comrades and because we made the effort to do out best under difficult circumstances.”^{32(pIV-1)}

The following was Bey’s description of the widely dispersed 1st Infantry Division’s medical battalion and requirements of the mental health component:

Headquarters and A Company were located at support command headquarters in Di An which was the location of our psychiatric headquarters. The patients requiring hospitalization in the Division were treated at the A Company clearing station for the most part. The psychiatrist, social work officer, a clerk typist and three or four social work psychology technicians were stationed at this base camp. B Company was originally in Di An,

TABLE 3-4. Estimated Diagnostic Distribution Among Referrals to the 1st Infantry Division Mental Health Service, April 1969–April 1970 (N = Average 180/mo)

Diagnosis	% of cases
Psychotic reactions (including drug induced)	5%
Psychoneurosis	10%
Character-behavior reactions	40%
Acute situational reaction (including combat exhaustion cases and “short-timer’s syndrome”)	20%
No psychiatric diagnosis	25%
	100%

Data source: Bey DR. Division psychiatry in Viet Nam. *Am J Psychiatry*. 1970;127(2):228–232.

but later moved to Dau Tieng with two social work psychology techs assigned to it. D and C Companies were located in Lai Khe and had two technicians assigned to each company. In addition, we provided supervision and back-up for a corpsman in Phu Lai who was interested in the mental health field, so that in fact we had mental health services available in that base camp as well.^{32(ppV-2–3)}

. . . The Division’s psychiatrist and/or social work officer traveled regularly by jeep or helicopter to Lai Khe to supervise the technicians, to see patients directly and to consult with units. Dau Tieng was visited infrequently because of difficulties arranging helicopter transportation there. Land transportation was not possible because the roads were unsafe. Thus the technicians at [B] Company at Dau Tieng functioned with less direct supervision but did an excellent job. Communication by radio and landline was available but often difficult to most base camps. . . [F]or example, after spending an hour getting the Di An operator to connect with Lai Khe and Lai Khe to connect with Dau Tieng and Dau Tieng to connect with the battalion radio frequency and the battalion to switch to get the company, one would hear a distant voice of the company commander who would then be cut off and the whole process would need to be repeated.^{32(pV-7)}

Table 3-4 presents Bey’s case distribution during his year. As indicated, combat exhaustion cases were subsumed in the category of acute situational reaction,

and there was no indication as to numbers of these cases who required treatment for combat stress reaction at either the 1st echelon of care (ie, at the battalion aid station, perhaps including treatment by a social work/psychology technician) or at the 2nd echelon of care (ie, the division clearing station). According to Bey, “[W]e did have a number of cases that were situational reactions precipitated by combat stress most of which were treated by their unit corpsman, the battalion surgeons, or our nearest social work/psychology technician.”^{32(pIX-2)} Thus despite the exacerbating “frustrations of the hot, hostile environment,” the evidence suggests a low combat stress reaction incidence for the 1st Infantry Division for this later year in the war, and this is consistent with the more defensive military posture adopted by American forces.³³ However, Bey’s case examples did include a “combat exhaustion” case as well as a case of a soldier who developed dissociation and mutism in the aftermath of his first fire fight.

Otherwise, the types of problems Bey described among his relatively high rate of referrals (approximately 127/1,000/year) appeared to be more consistent with troops in a demobilizing mode as opposed to those with a high combat intensity/stress quotient. Bey estimated that 25% of soldiers in Vietnam during his year used marijuana, primarily those in lower ranks. These included troops in the field who wished to reduce their fear and anxiety. However, although Bey did not provide statistics, incidents of misuse of alcohol (especially those contributing to acts of violence), acute alcohol-induced organic brain syndromes with paranoia and hallucinosis, as well as the more insidious problem of alcoholism (“the alcoholic sergeant”) were far more problematic for the division. Bey reported they had few referrals for suicidal behavior, and only one of those, a sergeant with a serious alcohol addiction, subsequently killed himself. Cases of barbiturate intoxication and addiction were occasionally treated, but evidence of narcotic use was rare. Bey underscored the need to distinguish functional psychotic disorders from organic/metabolic or toxic-delirious brain syndromes. As examples he recalled a patient with a combination of drug or alcohol intoxication and a skull fracture with subdural hematoma; a patient with severe hypoglycemia secondary to a pancreatic tumor; and patients with cerebral malaria or heat stroke.

Bey hospitalized 10% of referrals for up to 2 to 3 days at the division clearing station. Treatment strategies included the use of Thorazine for both nonpsychotic



FIGURE 3-6. 1st Infantry Division enlisted psychology/social work technicians Vincent Zecchinelli (left) and Louis Stralka. Zecchinelli and Stralka served in the 1st Infantry Division in 1969–1970 with the Division Psychiatrist, Major Doug Bey, and the Division Social Work Officer, Captain Ray Troop. Overall, enlisted “psych techs” proved invaluable in Vietnam as they provided roughly 80% of the treatment of psychiatric patients. Photograph courtesy of Douglas R Bey.

combat exhaustion and as sleep therapy (*dauerschlaf*) for more disorganized psychiatric states. Regarding final dispositions, 85% of all referrals were returned to duty, 14% were psychiatrically “cleared” for administrative separation from the Army (meaning no psychiatric diagnosis), and less than 1.0% were evacuated out of the division to one of the psychiatric specialty detachments for further treatment or evacuation out of Vietnam.

In other publications, Bey provided examples of command consultation regarding specific unit stresses affecting 1st Infantry Division troops, especially change of command³⁴ and the introduction of a new unit member³⁵ (see Chapter 6 and Chapter 8). He also wrote about soldier-on-soldier violence³⁶ (see Chapter 8),

and soldier use and misuse of marijuana³⁷ (both with Vincent A Zecchinelli, Figure 3-6) (see Chapter 9).

Bey collaborated with Specialist 5th Class William E Smith, an enlisted social work/psychology technician, on a pair of publications illustrating the mental hygiene unit's vigorous primary and secondary psychiatric prevention activities within the 1st Infantry Division.^{10,38} They described how they targeted especially stressed units by monitoring selected parameters (eg, sick call and mental hygiene referrals and rates for nonjudicial punishments and courts-martial, Inspector General complaints, accidents, venereal disease, and malaria) and employed a formal organizational case study and unit intervention method adapted from the civilian social psychiatry model. In so doing they demonstrated the enlisted social work/psychology technician's potential for providing both case-centered clinical approaches and organization-centered consultative ones for the often geographically separated units of the 1st Infantry Division. Attention was given to the process of educating unit commanders and others about special combat group stress points as well as stressors affecting individual soldiers (such as "short-timer's syndrome," having less education, being foreign born, or having a language handicap).

It is noteworthy that Bey did not describe a drop in troop morale or increased dissension in the 1st Infantry Division during his year, despite their occurrence more generally throughout the theater. Perhaps this is explainable on the basis that there was some measure of lag in the spread of the antimilitary sentiments to the combat divisions that was noted to be more prevalent in noncombat units. Yet scattered throughout his publications there are suggestions that morale was beginning to seriously sag and antimilitary sentiment was on the rise. For example, Bey and Smith provide the example of a black enlisted soldier who was described by his commander as "uncooperative, hostile, provocative, disrespectful, and incapable of soldiering."^{10(p367)} He became the center of a fruitful unit consultation in which they brokered an expanded tolerance by the unit cadre for "expressions of 'Black pride' and 'brotherhood.'"^{10(p368)} They similarly eased the tensions (and reduced referrals) through consultation to a commander who punished the "heads" (presumably habitual marijuana-using soldiers) in his unit unnecessarily—his "ten least wanted men."^{38(p404)} Over the course of the consultation process, a more flexible attitude emerged that served

to acknowledge "the stress they were all under and the command's recognition of the men's positive efforts under trying conditions"^{38(p405)}; and "[t]he men's provocative behavior diminished."^{38(p405)} Also, in Bey's paper regarding the stresses associated with a change in command, he referred to an incident when a claymore mine was placed in a new commander's quarters with a note warning him "not to try any chicken shit with this unit."^{34(p700)}

23rd Infantry Division/Americal

Background. The 23rd Infantry Division (Americal) was reactivated in Vietnam in September 1967 through the consolidation of three independent units—the 11th, 196th, and 198th Light Infantry Brigades—which had deployed in Vietnam to participate in Task Force Oregon. In spite of a large number of successful operations in and around Quang Ngai and Quang Tin provinces, the Americal Division's history ultimately came to be severely marred by the massacre of the villagers of My Lai on 16 March 1968 by one of the companies of the 11th Light Infantry Brigade (C Company, 1st Battalion, 20th Infantry), led by 2nd Lieutenant William Calley³⁹ (mentioned in Chapters 1 and 6). Further embarrassing the division, another company, part of the 196th Light Infantry Brigade, suffered severe casualties when it failed to rebuff an enemy attack on Fire Support Base Mary Ann in March 1971 (as described in Chapter 2).^{33,40}

The 198th and 11th Brigades were withdrawn from Vietnam in November 1971, and the division was inactivated. The 196th Brigade remained until June 1972, the last major combat unit to be withdrawn. The last battalion in Vietnam, its 3rd Battalion, 21st Infantry, left on 23 August 1972. Overall, between battle deaths and deaths from other causes, the 23rd Infantry Division lost 4,041 men in Vietnam.¹⁸

None of the psychiatrists who served with the 23rd Infantry Division (Americal) rendered an overview. However, some perspective on the psychiatric activities in its 11th Infantry Brigade in early 1968 came from a publication by Specialist 5th Class Paul A Bender, an enlisted social work specialist. More broadly illuminating was a 1970 directive issued by Captain Larry E Alessi, Medical Corps, the division psychiatrist, 2 years following Bender's tour.

11th Light Infantry Brigade and Specialist 5th Class Paul A Bender. The 11th Infantry Brigade (Light) was deployed in early 1968, and Bender and three other

mental health technicians were assigned to its base camp at Duc Pho on the northern coast of South Vietnam. They were under the technical supervision of the Americal Division psychiatrist who was based elsewhere with the division's other two brigades and divisional support units. The following is Bender's description of the impediments to communication and transportation he faced in providing clinical services for the troops of the 11th Light Infantry Brigade.⁴¹

Part of my [medical battalion] is located at Duc Pho, the 11th Brigade's base camp. One company is attached to a task force about forty miles north of Duc Pho. The other three line companies operate out of a fire base approximately fifteen miles from this task force and the final element is located about ten miles from the fire base. I am located with the latter element in an aid station within helicopter range of all the others. The medical aid men in these respective line platoons send in any psychiatric casualties with field medical tags describing the man's behavior and need for treatment. At this point, I interview the individual at the aid station. If necessary, I transport him [by helicopter] to the Americal Division Psychiatrist, Major Edmund Casper, for evaluation and necessary treatment, which includes advice as to how to handle the patient in my follow-up.^{41(p63)}

By necessity, the wide dispersion of these units meant that most soldiers had to be evaluated and counseled in one session and sent back to duty. According to Bender, it also meant that information as to a soldier's progress might come through his executive officer or first sergeant. Also, because the social work/psychology technician was in the medical platoon, he could easily get a report from the unit's medical aid man. Bender divided his caseload into: (1) passive-aggressive disciplinary problems; (2) anxious patients with secondary somatic symptomatology; (3) cases with functional somatic symptoms as primary symptoms; and (4) combat exhaustion cases, which he indicated were his most acute cases. His report especially illustrated the enlisted social work/psychology technician's critical place in the echelon system of medical care as the mental health representative for his battalion. As such he served both as a link between the primary care medical system and the division psychiatrist, and between the medical and psychiatric system and the soldier's unit. More



FIGURE 3-7. Captain Larry E Alessi, Medical Corps, Division Psychiatrist with the 23rd Infantry Division (Americal). Alessi, a civilian-trained psychiatrist, served with the 23rd Infantry Division from August 1970 to August 1971. His letter of instruction to the division's battalion surgeons, which provided advice regarding the treatment and referral of psychiatric and behavior problems, is especially notable because it is all that survives pertaining to the management of these problems during the drawdown phase of the war. Photograph courtesy of Larry E Alessi.

detail on Bender's approach can be found in Exhibit 3-2, "Problems Associated With One-Session Counseling," and in Chapter 7, Exhibit 7-3, "Counseling the Soldier With Combat Stress Symptoms in Vietnam."

Captain Larry E Alessi, Medical Corps. Alessi (Figure 3-7), a civilian-trained psychiatrist, served as the division psychiatrist for the 23rd Infantry Division (Americal) from August 1970 to August 1971. His November 1970 directive, "Principles of Military Combat Psychiatry," which was distributed to the division's brigade and battalion surgeons, provides a unique window into the psychiatric services available to the division during the drawdown phase of the war (provided as Appendix 9, "Principles of Military

Combat Psychiatry”). Alessi’s communiqué sought to discourage the primary care physicians from making a “large number of inappropriate referrals”^{42(p1)} to his mental hygiene team. Instead he urged them to screen “every soldier with an emotional or drug problem”^{42(p1)} and manage the ones they could using him as consultant.⁴² On the surface this appears to be an unremarkable directive. However, a closer look at it reveals that a very unusual pattern had developed by the fall of 1970:

- Army commanders, as well as the mental health component, were becoming overtaxed by the burgeoning emotional, behavioral, morale, and discipline problems;
- Rising levels of drug dependency, especially heroin addiction, had become an especially prevalent type of behavior problem among the troops of the 23rd Infantry Division (Alessi advised battalion surgeons to manage these soldiers using their unit’s rehabilitation program—with some cases also benefitting from treatment with the neuroleptic tranquilizer Mellaril);
- Psychophysiologic symptoms had become the most common combat-generated psychiatric reaction (he advised them to manage these soldiers in a fashion consistent with the military psychiatry treatment doctrine—with some cases also benefitting from treatment with Mellaril); and
- There were growing numbers of anxious combat soldiers with “non-psychiatric emotional problems,” that is, fear of the field and refusal to go to the field, who should be regarded as having normal aversion (and managed with reassurance, peer support, and firm opposition to claims of psychiatric impairment—again, with some cases also benefitting from treatment with Mellaril).⁴²

Further perspective on psychiatric challenges in the 23rd Infantry Division (Americal) can be derived from results of the 1968 marijuana use surveys of the division’s soldiers conducted by Edmund Casper, the division psychiatrist, and James Janacek, an Army psychiatrist with the 98th Psychiatric Detachment (with the assistance of Hugh Martinelli Jr, an enlisted specialist) (see Chapter 9).

101st Airborne Division

In July 1965, the 1st Brigade and support troops of the 101st Airborne Division arrived in Vietnam and saw much action before the remainder of the division arrived in November 1967. For most of the war the 101st was deployed in the northern I Corps region operating against ARVN infiltration routes through Laos and the A Shau Valley. Elements of the 101st participated in 15 campaigns including the Battle of Hamburger Hill in 1969 and the 23-day defense of Firebase Ripcord in 1970. The 101st withdrew from Vietnam in January 1972. It was the last US Army division to leave the combat zone. Overall, between battle deaths and deaths from other causes, the 101st Airborne Division lost 3,902 men in Vietnam.¹⁸

No available accounts of the provision of psychiatric care for the 101st Airborne Division exist. However, there is a report of a drug use survey conducted in the fall of 1970 by Major Jerome Char, the division psychiatrist, in which 41% of departing lower-ranking enlisted soldiers admitted to using drugs while in Vietnam, with roughly one-third of those acknowledging use of heroin or other “hard” drugs (see Chapter 9).⁴³ To get some further appreciation for the enormous morale and psychiatric challenges faced in the 101st Airborne Division during the drawdown phase, Char’s study can be joined with Linden’s disturbing report from late 1971 that described the unraveling military discipline in Vietnam (“Fragging and Other Withdrawal Symptoms”⁴⁴)—a journalist’s report that especially centered on the 101st Airborne Division and included a series of quotes from Captain Robert Landeen, Medical Corps (1971–1972), a civilian-trained Army psychiatrist who followed Char. Linden’s account highlighted rampant heroin use by soldiers, incendiary racial tensions, and leader assassinations (“fragging”) and threats; Landeen provided commentary on their psychosocial causes, but without reference to clinical challenges. According to Landeen, there were two enlisted factions who were most likely to resort to fraggings (what Linden referred to as a “lethal fad”)—(1) heroin users and dealers, and (2) black radicals. He felt this was partly explainable because the typical soldier of 1971 came from a lower socioeconomic strata and was more inclined to act out his frustrations, was opposed to serving in Vietnam, believed his work was purposeless, and felt “helpless and paranoid” because of the Army’s vacillating discipline (too much flexibility, followed by overly harsh punishments). On the other

EXHIBIT 3-2. Problems Associated With One-Session Counseling

Providing psychological counseling for soldiers in a combat zone presents additional challenges because of the preeminence of the combat mission and because of practical impediments to accessing treatment. In early 1968, a piece appeared in the USARV Medical Bulletin that described firsthand experience in attempting to surmount these challenges in Vietnam. This unique article was written by Specialist 5th Class Paul A Bender, an enlisted social work/psychology technician, who was assigned to the 11th Infantry Brigade (Light). Like many of the social work/psychology technicians operating in Vietnam, Bender functioned semiautonomously while under the technical supervision of Major Edmund Casper, the division psychiatrist for the Americal Division, who was based elsewhere with the division's other two brigades and divisional support units. The information provided by Bender is especially salient in that it is estimated that 80% of the direct psychiatric care in Vietnam was provided by "psych techs." In his report Bender emphasizes that by necessity, the typical counseling patient from a combat unit is seen, evaluated, and counseled in only one session and sent back to duty. That makes helping him achieve insight into his problem much more difficult. However, underscoring a basic paradox in doing counseling in a combat zone, Bender also surmises that even if repeated visits were possible, it might actually oppose therapeutic progress (because, under the special stresses of the combat zone, the soldier-patient has the potential for so-called secondary gain in illness). Furthermore, such a situation might also contribute to reducing his unit's combat effectiveness. The following are excerpted from Bender:

Initiating Short-Term Counseling

Rapport is relatively easy to develop between the individual and the technician since both persons are enlisted men from the same organization and experiencing many of the same problems in relation to the Army. The individual realizes that the technician can empathize with the situation. In essence he 'knows what is happening.' [Also] the technician should spend maximum time in the battalion area so that he is thought of as being part of the unit and not an outsider.^{1(p68)}

Defining the Problem

I first try to have the patient identify his primary problem while exploring his feelings and attitudes toward this problem. We explore ways of handling the specific enigma [that] is causing the trouble within the patient. If he is able to understand why he has reacted to a situation and what the consequences of this reaction are, he can usually change his maladaptive way of contending with environmental pressures.^{1(p63-64)}

Undoubtedly, the most often heard complaint from soldiers is that of being 'harassed' too much by his superiors in the unit. . . . I would rather think of it as self-devaluation on the part of the man concerned. When an individual is forced to perform a function [that] he considers below his self-concept, anxiety is produced. His self ideal is now incongruous with his real position, and [he] cannot accept it since he does not conceive of himself as one controlled to the extent that he is. When discipline reaches the point where he cannot act out without serious repercussions, the individual becomes angry and resentful. He can't rid himself of these feelings by directing them toward the source of his conflicts, and he becomes stymied. We now find the person in a perplexing dilemma with no solution to his problem and a great deal of anxiety.^{1(p68-69)}

Maladaptive Defenses, Resistance to Treatment, and Counseling Approaches

The individual's preconceived solution to his problem resisted the effects of counseling. Most often he attributed his conflict to outside sources and concluded that if the technician could change these environmental conditions his problem would be solved. . . . A job or area transfer is easier to accept than a basic personality defect.^{1(p66)}

The technician [must] impress upon the patient that this conflict was not just a product of his environment but was also a result of his own perceptions, attitudes, and the manner in which he coped with conflicts.^{1(p66)}

Most individuals do not realize that their conflicts can be resolved through change in their behavior and that this behavior or their coping techniques are the elements to be examined rather than merely an isolated incident when they were challenged. In other words, it's not just the 'what,' but also the 'why,' that must be explained.^{1(p68)}

[But] the technician has to maintain an atmosphere of reality. The patient will tend to pursue a solution colored with fantasy, but all illusions must be destroyed, no false hopes extended, and only pragmatic avenues followed.^{1(p68)}

Once the individual accepts this, the actual therapy can ensue. In essence, the technician takes away the individual's definition of the problem and presents an entirely different aspect to him which typically is not easily accepted.^{1(p66)}

EXHIBIT 3-2. Problems Associated With One-Session Counseling, continued

If [the patient] resists understanding, the technician must then define for him just what the conflict is and what his own behavior is doing for him. The technician finally has him explore various ways to adapt to this problem, and then it is up to the individual to take the initiative in adjusting his actions.^{1(p66-67)}

In dealing with psychosomatic symptoms I found it useful to treat them as being far less serious than the person had supposed they were. . . . Also, if the patient realizes that his own behavior is causing the ailment, additional impetus may be provided to resolve his conflicts.^{1(p68)}

If an individual complains of difficulties in peer relationships, we may explore his own attitudes toward people in general and discover a basic mistrust or dislike of them. We then attempt to get him to realize that feelings are transmitted to those he now associates with and are reciprocated. The individual usually then realizes how he must change his own attitudes to foster more amiable relations with his peers.^{1(p64)}

[Overall] this is a very difficult situation to resolve, and therapy must allow for much ventilation and empathy. The underlying purpose is to direct the patient toward accepting this period of his life as one which he must adjust to and even get some daily benefits out of so as to make life as pleasant as possible.^{1(p69)}

Psychological Stress on the Counselor

[I]t would be easier to sympathize with the patient, leave him in a relaxed mood, and have him return to duty temporarily relieved and convinced his behavior is not the cause of his problems. To project his difficulties onto the external environment is more palatable to the individual and provides an amiable atmosphere for interview. All these effects must be avoided. The conflict or problem has to be identified by both the patient and the technician before an attempt is made to work through it. This is going to involve resistance, denial, but hopefully insight in the end.^{1(p67)}

Many times when a patient leaves the interview, I wonder if I have helped him to understand himself since most of the time his problems persist, and the new knowledge gained must still be put into practice in his relationships. However, I am beginning to respect the will and resourcefulness of each person in solving his interpersonal problems when he really has to. I also respect his ability to accept parts of his behavior which, up to this time, he has been unable to understand.^{1(p69)}

Follow-Up

One of the drawbacks to the psychiatric patient's returning to duty is the stigma attached to the concept of mental illness. This stigma must be minimized as much as possible. It can best be accomplished by the technician [because] he, more than anyone else at the clinic, is in familiar communication with the unit. He must deemphasize the notion that the patient is dangerous, aggressive, or hostile and emphasize the best way to handle him. The soldier must be seen as a behavior problem expected to feel and respond like his peers and not as a psychotic patient.^{1(p67)}

In Vietnam continuous direct contact is not feasible, the resulting indications of a [soldier's] progress are gained through his unit executive officer or First Sergeant. The best source though, is the patient's medical aid man. Since the technician was in the medical platoon, he can easily get a report from the medical aid man.^{1(p66)}

1. Bender PA. Social work specialists at the line battalion. *US Army Vietnam Med Bull.* 1968;May/June:60-69.

hand, Landeen believed that many of the officers and noncommissioned officers who were fragged contributed to this outcome by excessive rigidity, pettiness, hypocrisy, or zeal for the war. (More on Linden's report can be found in Chapters 2, 8, and 9.)

Discussion of Reports by Division Psychiatrists and Allied Personnel

The foregoing review of the available written accounts of the Army's division psychiatrists and allied

mental health personnel deployed in Vietnam permitted some appreciation of the exceptional efforts expended by the psychiatric assets that were organic to the combat divisions. Unfortunately, at best these reports represent only a small portion of the Army's 30.25 division-years in Vietnam (from Table 3-2). Furthermore, they were mostly limited to the first half of the war. Explanations for the sparse number of reports would certainly include that to study, document, and write up observations for publication would rely on the personal initiative of the

deployed mental health practitioners—activities that might compete for resources with mission-required ones. However, the fact that the extant reports from Vietnam were limited to the earlier years of the war could also be explained by a lowered morale among the mental health representatives in the divisions over time as suggested in Chapter 2. Further discussion of these reports by stages of the war follows.

Early Buildup Phase Reports (1965–1966)

Reports by Jones (25th Infantry Division [ID]) and Byrdy (1st Cav) can be compared as they both deployed early in the buildup phase (1965–1966), and both provided details regarding the considerable practical difficulties they faced as their respective divisions established themselves in Vietnam. In general, their professional activities were more reflective of the psychosocial stress associated with deployment and the newness of each division to their specific combat environment than combat stress per se. Both Jones and Byrdy indicated that requisite troop morale in their respective divisions was sustained, and apparently this contributed to the overall low levels of psychiatric symptoms and referrals. Jones reported only mild combat stress symptoms among the soldiers of the 25th Infantry Division, whereas Byrdy diagnosed at least 22 1st Cavalry soldiers as “combat exhaustion” and 10 others with combat stress reactions in conjunction with other diagnoses; nonetheless, combat stress reactions were not predominant among psychiatric referrals to either psychiatrist.

Distinct differences existed as well. Jones had 50% more referrals per month than Byrdy, yet he only “hospitalized” 5.3% compared to Byrdy’s 23%. Also, Jones only evacuated a few psychotic soldiers out of the division for additional treatment. Byrdy evacuated 6% of all referrals, the majority of whom were not designated as psychotic. Finally, although presumably Jones and Byrdy had the same medications available, Byrdy mentioned prescribing Thorazine and Librium, but Jones made no mention of using medications. Aside from the prospect that Byrdy’s division had some greater combat intensity levels than Jones’s, another possible explanation for these differences may come from distinctions in pre-Vietnam military psychiatry training and experience. Jones’s extensive military background may have influenced him to see symptomatic soldiers as struggling to adapt to the unique rigors of a combat deployment (ie, less pathological), which in turn may

have led him to be more restrictive with regard to medications and hospitalization. Byrdy, on the other hand, with his civilian-based professional background, may have been somewhat more inclined to see soldier symptoms as representing fixed deficits needing more extensive treatment. (Important differences in clinical perspective stemming from military vs civilian medical orientation will be amplified below as well as discussed in Chapter 5 and Chapter 11.) Perhaps also influential was that Byrdy reported being understaffed in social work/psychology technicians. This would have limited the extent to which he could extend his psychiatric expertise closer to the fighting units and thus could have contributed to some greater morbidity among combat stress affected soldiers.

Peak Combat Activity Phase Reports (1967–1968)

Reports by four division psychiatrists—Bostrom (1st Cav), Motis (4th ID), Baker (9th ID), and Pettera (9th ID)—from the next 2 years, 1967 and 1968, centered on a rising incidence of combat stress reactions, which seemed to trump concern for other psychiatric problems. This coincided with the theater-wide increase in combat activity, as well as combat intensity, in those years. Nonetheless, the relatively low numbers of combat stress reaction cases these psychiatrists reported is still consistent with a generally low combat stress reaction incidence rate throughout the war.

It is interesting to note the variability in the diagnostic criteria utilized by these psychiatrists for combat-generated casualties. Bostrom’s taxonomy was consistent with the one Byrdy (1st Cav) utilized in the first year of the war, which coincided with the historically based spectrum of psychiatric and behavior symptoms: demonstrable apprehension but with retained combat performance; followed by moderate dysfunction; followed by severe disorganization/dysfunction (see Table 6-1). The last stage, severe disorganization/dysfunction, Bostrom referred to as combat exhaustion, and Pettera as combat fatigue (these terms were used interchangeably in the literature). In contrast, Baker’s “classic combat fatigue” cases were the less severe cases—those that were reversible at the 1st echelon care level; and he distinguished them from the more severe cases (no label) who required treatment by him and his staff at the 2nd echelon care level, the division clearing company. Baker also described the “modified combat stress reaction,” a

class of soldier-patient with over 10 months of credible combat experience in Vietnam who became combat-ineffective associated with an array of psychological and psychosomatic disturbances. Pettera, who followed Baker at the 9th ID, repeated this observation but renamed them “Vietnam combat reaction.” Together these two psychiatrists seemed to have identified the “old sergeant syndrome,” which was first described in World War II. This referred to the capable and responsible combat soldier who underwent a loss of his psychological resiliency after enduring months of sustained combat. This in turn caused him considerable depression and guilt at abdicating his responsibilities with his combat unit.⁴⁵ But inasmuch as the cases reported by Baker and Pettera were nearing the end of their year in Vietnam (as opposed to the soldiers who faced indeterminate combat exposure in World War II), they also resembled the short-timer’s syndrome, which arose for the first time in Korea after tour limits were instituted and again in Vietnam.

Still, labeling differences aside, these four psychiatrists reported the consistent application of the established military treatment doctrine for combat stress affected soldiers, which was augmented by judicious use of Thorazine (according to Motis, “to aid in rest and restraint”)—apparently with favorable results. They also valued the decentralized use of enlisted social work/psychology technicians as psychiatrist extenders. In fact there appears to have been an overwhelming consensus that these enlisted specialists proved critical to the smooth operation and effectiveness of the mental health contingent in the combat units. (In this regard, the publication by Bey, the 1st ID psychiatrist, and Smith, his social work/psychology technician, provided an especially rich review of background, training, deployment, utilization, and supervision of these paraprofessionals in Vietnam. The authors noted how the technicians’ medical/psychiatric responsibilities and activities often exceeded those performed in stateside settings because of the extremes of the combat situation. They also provided case examples illustrating both case-oriented clinical approaches and organization-oriented consultative ones.¹⁰) With regard to attrition secondary to combat stress reactions, both Pettera and Motis suggested that approximately 15% of referred soldiers could not be recovered for further combat duty but were able to assume other military duties in the division.

On the other hand, there was a fair amount of divergence among these division psychiatrists regarding

the pathogenic variables assumed to be responsible for the more acute combat-generated psychiatric disabilities (eg, specific combat events, features of the unit, personality elements, or other distinctions). The only division psychiatrist to provide a specific case example was Motis, and that soldier was felt to be especially susceptible because of personality deficits.⁴⁶

Finally, none of these four division psychiatrists provided figures for overall psychiatric evacuations out of their divisions. However, Gordon, who served as division psychiatrist with the 1st ID contemporaneously with them, did note that 6.8% of his over 1,000 referrals required evacuation beyond the division (presumably to the 935th Psychiatric Detachment), and that some were combat exhaustion cases. This figure is very close to the 6% reported by Byrdy with the 1st Cav among his over 500 referrals in 1965 to 1966 during the early buildup phase, and collectively they suggest very low rates for psychiatric attrition from combat divisions in an active theater of war.

Transition Phase Reports (1969 to Early 1970)

The inauguration of Richard Nixon as President of the United States in 1969 brought a change of command in Vietnam and a new strategy. The new strategy sought to insure area security while the primary combat roles were gradually shifted to South Vietnamese military forces. As a consequence the second half of the war took on a distinctly different character than that of the first half, with American combat operations steadily declining along with troop strength.

Regrettably, the reports from the 1st Infantry Division by Bey and his colleagues were the only descriptions from the combat divisions for this pivotal phase in the war. On the other hand, they do serve as an elaborate record because Bey was committed to providing and documenting a model of psychiatric care for a deployed combat division that included a full range of primary, secondary, and tertiary prevention activities. Highlights include that:

- Whereas USARV Regulation 40-34, *Mental Health and Neuropsychiatry*, stipulated that support (both material and personnel) would be made available for those who provided psychiatric services, it was not automatically supplied by the division (a complaint shared earlier by Jones and Gordon); consequently it was necessary for Bey to employ

improvisation and ingenuity in recruiting command support.

- The proportion of psychiatric cases with combat stress symptoms evidently had dropped from that of the preceding 2 years (an assumption based on the observation that they were statistically subsumed within the broader category of acute situational reactions), and “drug-induced” problems apparently became more prevalent.
- Bey’s mental health team devoted a great deal of attention to ameliorating stress-inducing group and interpersonal factors. Still, despite these preventive activities, his unit averaged 180 referrals per month. This is almost 3½ times the 53 per month reported by the shorthanded Byrdy and almost 2½ times Jones’s 75 per month—the only other division psychiatrists who provided these rates. Furthermore, Bey’s significantly higher referral rate 3 years after Jones and Byrdy cannot be explained by rising combat intensity. Thus the elevated rate and other indicators of rising stress and dysfunction levels, like his reference to racial tensions and problematic “heads” (the marijuana-using subculture), suggest that Bey and his staff were seeing the beginnings of the serious erosion of mental health and military order and discipline that was spreading throughout the theater.
- Like Bostrom earlier with the 1st Cavalry Division, Bey advocated the use of phenothiazines both for nonpsychotic combat exhaustion and for sleep therapy (*dauerschlaf*) for more disorganized psychiatric casualties.
- Bey’s reported psychiatric attrition rate (actually, proportion of referrals hospitalized or evacuated to a psychiatric specialty detachment) is intermediate between rates reported by Jones (25th ID) and Byrdy (1st Cav) (Table 3-5). Even though Jones and Byrdy served during the early buildup years, their experiences may be reasonably compared with Bey’s because during Bey’s year the overall combat stress levels in Vietnam (at least as measured by battle death rate) dropped to the levels seen when Jones and Byrdy were there. As mentioned earlier, a possible explanation for higher hospitalization and evacuation rates is the psychiatrist’s lack of military training or experience. Unfortunately, these are the only division psychiatrists who provided this data, so this hypothesis cannot be further tested. Gordon, who preceded Bey with the 1st ID, reported eva-

uating 6.8% of referrals out of the division, but his training and military experience background is not known. Again, the importance of the distinction between civilian and military training will be further developed in Chapter 5 and Chapter 11.

Drawdown Phase Reports (Late 1970 to 1972)

Following Bey, professional observations from the mental health component assigned to the combat units in Vietnam become scant. The evidence provided by Alessi (23rd Infantry Division, 1970–1971), followed a year later by Landeen (101st Airborne Division, 1971–1972), suggested morale and discipline had dropped to a new and dangerous low, and psychiatric and psychosocial problems continued to rise, especially in novel forms (eg, soldier dissent, open racial conflicts, widespread heroin use, and attacks on superiors).

US Marine Corps/Navy Experience in Vietnam

From March 1965, when the 9th Marine Expeditionary Brigade landed on the northern coast of the Republic of South Vietnam, until April 1971, when the last elements of the 1st Marine Division departed Vietnam, approximately 360,000 Marines fought in Vietnam,⁴⁷ mostly as members of the 1st and the 3rd Marine Divisions. Navy Lieutenant Ted D Kilpatrick, the division psychologist of the 3rd Marine Division, reported on the diagnostic, dispositional, and selective demographic data regarding 823 psychiatric admissions (14% of all medical admissions) to the 10-patient psychiatric ward of a division field hospital during 9 months of 1967.

Overall, approximately two-thirds of the casualties came directly from field units actively fighting well-trained North Vietnamese troops along the demilitarized zone. Kilpatrick and Harry A Grater, his coauthor, blamed the especially high out-of-country psychiatric evacuation rate (42% of referrals) on the high admission rate, inadequate staffing, the absence of 3rd echelon treatment facilities in-country, and the limited number of support billets that would allow patients to be reassigned to noncombat duty. Whereas some cases received 3rd echelon treatment offshore on either the USS *Sanctuary* or the USS *Repose* (the Navy’s two hospital ships), most were evacuated out of the combat zone.

The diagnosis of combat fatigue was reserved for the few Marines who conformed to the “classic” combat fatigue diagnostic criteria *and* had “experienced

TABLE 3-5. A Comparison of Division Psychiatrists' Pre-Vietnam Military Training and Experience, the Percentages of Referrals in Vietnam They Hospitalized, and the Percentages They Evacuated out of the Division

	Jones (25th ID) February 1966–September 1966	Bey (1st ID) April 1969–April 1970	Byrdy (1st Cav) August 1965–June 1966
Army Psychiatric Residency Training	Yes	No	No
Pre-Vietnam Army Assignment	Yes	Yes	No
% of Referrals Hospitalized in the Division	5.3%	10%	23%
% of Referrals Ultimately Evacuated out of the Division	"a few" ("psychotics")	1%	6%

ID: Infantry Division

Cav: Cavalry

intolerable stress over a prolonged period of time.” On the other hand, the diagnosis of “combat reaction” (which they regarded as a version of “situational maladjustment” as defined in the *Diagnostic and Statistical Manual of Mental Disorders*, 1st edition [1952]^{48(p802)}) was applied to all other acute psychiatric casualties referred from units actively engaged in combat (16.7% of referrals). The majority of these were returned to duty. Other categories of cases seen were: personality disorders (29.6%), most as passive-aggressive personality type; neurotic disorders (28.6%), most as anxiety reaction type; and “no diagnosis” (19.7%). It was the authors’ impression that the threat of combat was the basic precipitating factor for most of the psychiatric casualties, but in 75% of the cases, personality defects were contributory. They also noted that 10% of admissions had a previous psychiatric contact in Vietnam.⁴⁸

Further perspective on psychiatric challenges for the Marines in Vietnam include the reports in this volume by Navy medical personnel Robert E Strange and Ransom J Arthur, who recounted their psychiatric experience aboard the USS *Repose* during the ship’s first year stationed off the northern coast of South Vietnam (1966) (Chapter 4); Stephen W Edmondson and Donald J Platner, who reviewed the psychiatric evacuations from Khe Sanh during the siege (1968) (Chapter 6); Stephen Howard (1968) and Herman P Langner (1967–1968), who both reported on the rise in excessive combat aggression and atrocities (Chapter 6); John A Renner Jr, regarding the epidemiology of psychiatric and related difficulties among Marine and Navy personnel hospitalized aboard the hospital ship USS *Repose* (1969) (Chapter 6); and Howard W Fisher, who described the exceedingly high rate of personality disorders among his

referrals from the 1st Marine Division (March 1970–February 1971) (Chapter 2).

SUMMARY AND CONCLUSIONS

This chapter utilized the available reports provided by the Army mental health professionals and paraprofessionals who were assigned to combat units in Vietnam in order to construct a composite picture of the psychiatric problems they encountered, the conditions under which they worked, and their professional responses and results. When combined with the next chapter, which pertains to psychiatric care provided in the Army hospitals in Vietnam, a richly descriptive and informative story emerges depicting a mental health contingent that was trained, organized, and supplied to support the deployment of many thousands of troops into the combat theater and, in particular, to aid the recovery of large numbers of soldiers who were expected to be disabled by combat stress. Furthermore, the documentation indicates they met these challenges with commitment and effectiveness.

The chapter’s review began with an overview of the organization of psychiatric care implemented in South Vietnam in support of US Army forces—a system based on forward treatment of affected soldiers that replicated one utilized with good effect in World War I, in the later stages of World War II, and in the Korean War. The system in Vietnam was a component of the larger Army medical system, and its ultimate authority in Vietnam was the CG/USARV Surgeon. It centered on the (combat) division psychiatrists who were assisted by allied mental health personnel, that is, social work officers and enlisted mental health specialists, as well as

general medical assets, all of whom were assigned to the divisions. Beyond the divisions, specialized psychiatric care was provided by the mental health personnel assigned to the two psychiatric detachments (KO teams), and at times by the psychiatrists assigned to Army-level evacuation and field hospitals in Vietnam. The mental health assets at these hospitals and detachments also provided mental health care on a regional basis for the large numbers of nondivision personnel deployed throughout the theater, but often this system was thinly allocated. By the time the Army was fully deployed in Vietnam (1967) there were 23 psychiatrists rotating into and out of Vietnam each year, which included the seven division psychiatrists, and it is estimated that a total of 135 to 140 psychiatrist positions were assigned there over the course of the war. The Army Neuropsychiatry Consultant to the CG/USARV Surgeon provided the psychiatric leadership for this system. This was the senior Army psychiatrist in South Vietnam who served as staff officer and advisor for the Army commander in Vietnam and directed the coordination of Army psychiatric facilities and program planning throughout the country.

This chapter also reconstructed as much of the history of Army psychiatry in Vietnam as possible through the available reports provided by psychiatrists and other mental health personnel assigned to the combat divisions. In addition to their descriptive value, these reports suggested the following trends:

- Clinical challenges associated with combat stress reaction casualties were significantly lower than that seen in earlier wars. This held true despite the increased combat intensity in Vietnam through years 2 through 4, as well as episodic spikes in combat activity associated with specific campaigns.
- Division psychiatrists appeared confident in the effectiveness of the military doctrine of forward treatment, especially for soldiers with combat stress reactions.
- Troop morale appeared sustained in the early years, numbers of referrals were at manageable levels, and psychiatric conditions and behavior problems were generally more challenging than those stemming from direct combat exposure.
- For soldiers in combat roles, the chronic strain associated with fighting an elusive guerrilla/

counterinsurgency force appeared to produce more low-grade forms of combat stress reaction, especially psychosomatic symptoms and behavior problems. This is in contrast to the more extensive breakdown in psychological functioning seen in earlier wars under conditions of continuous operations and high intensity combat.

- Division psychiatrists utilized extensively, and highly valued, the capabilities of the psych techs (enlisted corpsmen with additional social work/psychology training), including those who were dispersed among the division's scattered brigades and battalions and functioned semiautonomously and effectively as psychiatrist extenders. The success of this arrangement confirmed the benefits of decentralized care.
- Division psychiatrists also utilized extensively, and highly valued (and encouraged other medical personnel to as well), the new anxiolytic and neuroleptic medications to accelerate the recovery of function of soldiers with disabling psychological and psychosomatic symptoms.
- Division psychiatrists, with one exception, rarely devoted mental health resources to command-centered social/community psychiatry prevention programs. Notably, the exception occurred after the US strategy shifted to a defensive one and combat intensity dropped.
- Very little record exists of the activities of the division psychiatrists during the last 2 years of the war, mid-1970 through 1972. This is regrettable because other data indicated that these were the most difficult years for Army psychiatry from the standpoint of low morale and a substantial rise in psychiatric conditions and behavior problems, especially soldier dissent, racial conflicts, widespread heroin use, and attacks on superiors.

The portrayal of the organization and experience of Army mental health assets resumes in the next chapter. It will review reports from psychiatrists who served in evacuation and field hospitals and in the two psychiatric specialty detachments (KO). It also presents available information describing the professional activities of the senior Army psychiatrists in Vietnam (Neuropsychiatry Consultant to the CG/USARV Surgeon).

REFERENCES

1. Byrdy HSR. In: Johnson AW Jr, Bowman JA, Byrdy HSR, Blank AS Jr. Panel discussion: Army psychiatry in Vietnam. In: Jones FD, ed. *Proceedings: Social and Preventive Psychiatry Course, 1967*. Washington, DC: GPO; 1968: 41–76. [Available at: Alexandria, Va: Defense Technical Information Center. Document No. ADA 950058.]
2. Copen EG. Discussed in: Jones FD, Johnson AW. Medical and psychiatric treatment policy and practice in Vietnam. *J Soc Issues*. 1975;31(4):49–65.
3. Allerton WS. Army psychiatry in Vietnam. 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: 1–17.
4. Neel SH. *Medical Support of the US Army in Vietnam, 1965–1970*. Washington, DC: GPO; 1973.
5. US Department of the Army. *Medical Service: Neuropsychiatry*. Washington, DC: DA; June 1959. Army Regulation 40-216.
6. Headquarters US Army Republic of Vietnam. *Medical Services: Mental Health and Neuropsychiatry*. 30 March 1966. USARV Regulation 40-34. [This material is presented as Appendix 2 to this volume.]
7. Jones FD, Johnson AW Jr. Medical and psychiatric treatment policy and practice in Vietnam. *J Soc Issues*. 1975;31(4):49–65.
8. Peterson DB. Discussion. In: Tiffany WJ Jr, Allerton WS. Army psychiatry in the mid-‘60s. *Am J Psychiatry*. 1967;123(7):810–821.
9. Tiffany WJ Jr, Allerton WS. Army psychiatry in the mid-‘60s. *Am J Psychiatry*. 1967;123(7):810–821.
10. Bey DR, Smith WE. Mental health technicians in Vietnam. *Bull Menninger Clin*. 1970;34(6):363–371.
11. Johnson AW Jr. Combat psychiatry, II: The US Army in Vietnam. *Med Bull US Army Europe*. 1969;26(11):335–339.
12. Colbach EM, Parrish MD. Army mental health activities in Vietnam: 1965–1970. *Bull Menninger Clin*. 1970;34(6):333–342.
13. McGrath JJ. *The Other End of the Spear: The Tooth-to-Tail Ratio (T3R) in Modern Military Operations*. Fort Leavenworth, Kan: Combat Studies Institute Press; 2007.
14. Hausman W, Rioch DMcK. Military psychiatry. A prototype of social and preventive psychiatry in the United States. *Arch Gen Psych*. 1967;16(6):727–739.
15. Bey DR. Division psychiatry in Viet Nam. *Am J Psychiatry*. 1970;127(2):228–232.
16. Motis G, Neal RD. Freud in the boonies, II: The 4th Infantry Division psychiatric field program at work in a sustained combat situation. *US Army Vietnam Med Bull*. 1968;January/February:27–30.
17. Gordon EL. Division psychiatry: documents of a tour. *US Army Vietnam Med Bull*. 1968;November/December:62–69.
18. National Archives and Records Administration, Archival Databases, Vietnam Conflict Extracts Data File. Available at: <http://aad.archives.gov>. Accessed 20 June 2013.
19. Jones FD. Experiences of a division psychiatrist in Vietnam. *Mil Med*. 1967;132(12):1003–1008.
20. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 2nd ed. (DSM-II). Washington, DC: APA; 1968.
21. Byrdy HSR. Division psychiatry in Vietnam (unpublished); 1967. [Full text available as Appendix 8 to this volume.]
22. Bostrom JA. Management of combat reactions. *US Army Vietnam Med Bull*. 1967;July/August:6–8.
23. Bostrom JA. Psychiatric consultation in the First Cav. *US Army Vietnam Med Bull*. 1968;January/February:24–25.
24. Baker WL. Division psychiatry in the 9th Infantry Division. *US Army Vietnam Med Bull*. 1967;November/December:5–9.
25. Pettera RL, Johnson BM, Zimmer R. Psychiatric management of combat reactions with emphasis on a reaction unique to Vietnam. *Mil Med*. 1969;134(9):673–678.
26. Pettera RL. What is this thing called “field consultation” in psychiatry. *US Army Vietnam Med Bull*. 1968;January/February:31–36.

27. Stern DB. The social work/psychology specialist with the Mobile Riverine Force. *US Army Vietnam Med Bull.* 1968;May/June:70–74.
28. Motis G. Freud in the boonies: a preliminary report on the psychiatric field program in the 4th Infantry Division. *US Army Vietnam Med Bull.* 1967;September/October:5–8.
29. Motis G. Psychiatry at the battle of Dak To. *US Army Vietnam Med Bull.* 1967;November/December:57.
30. Menard DL. The social work specialist in a combat division. *US Army Vietnam Med Bull.* 1968;March/April:48–57.
31. Bey D. *Wizard 6: A Combat Psychiatrist in Vietnam.* College Station, Tex: Texas A & M University Military History Series, 104; 2006.
32. Bey DR. *Division Psychiatry in Vietnam* (unpublished).
33. Stanton SL. *The Rise and Fall of an American Army: US Ground Forces in Vietnam, 1965–1973.* Novato, Calif: Presidio Press; 1985.
34. Bey DR. Change of command in combat: a locus of stress. *Am J Psychiatry.* 1972;129(6):698–702.
35. Bey DR. Group dynamics and the ‘F.N.G.’ in Vietnam: a potential focus of stress. *Int J Group Psychother.* 1972;22(1):22–30.
36. Bey DR, Zecchinelli VA. G.I.’s against themselves. Factors resulting in explosive violence in Vietnam. *Psychiatry.* 1974;37(3):221–228.
37. Bey DR, Zecchinelli VA. Marijuana as a coping device in Vietnam. *Mil Med.* 1971;136(5):448–450.
38. Bey DR Jr, Smith WE. Organizational consultation in a combat unit. *Am J Psychiatry.* 1971;128(4):401–406.
39. Dougan C, Weiss S, and the editors of Boston Publishing Co. *The Vietnam Experience: Nineteen Sixty-Eight.* Boston, Mass: Boston Publishing Co; 1983.
40. Sorley L. *A Better War: The Unexamined Victories and Final Tragedy of America’s Last Years in Vietnam.* New York, NY: Harcourt Books; 1999.
41. Bender PA. The social work specialist at the line battalion. *US Army Vietnam Med Bull.* 1968;May/June:60–69.
42. Alessi LE. 23d Infantry Division Mental Hygiene Consultation Service: Principles of Military Combat Psychiatry. November 1970 (unpublished). [Full text available as Appendix 9 to this volume.]
43. Char J. Drug abuse in Vietnam. *Am J Psychiatry.* 1972;129(4):463–465.
44. Linden E. The demoralization of an army: fragging and other withdrawal symptoms. *Saturday Review,* 8 January 1972:12–17, 55.
45. Johnson AW Jr. Psychiatric treatment in the combat situation. *US Army Vietnam Med Bull.* 1967;January/February:38–45.
46. Motis G, West HE. The case of the dumbstruck soldier. *US Army Vietnam Med Bull.* 1968;March/April:70–73.
47. US Military Personnel in South Vietnam 1960–1972. Department of Defense, Office of the Assistant Secretary of Defense (Comptroller), Directorate for Information Operations, 15 March 1974: 60.
48. Kilpatrick TD, Grater HA Jr. Field report on Marine psychiatric casualties in Vietnam. *Mil Med.* 1971;136(10):801–809.