CHAPTER 4

Organization of Army Psychiatry, II: Hospital-Based Services and the Theater Psychiatric Leadership

A frequent source of contention between [division] psychiatrists and the KO team involves patients who are seen as psychotic . . . in the division setting, but who present essentially characterologic problems [on] our ward. Problems potentially get worse because of the . . . fact that character disorders are not removed through medical channels in the Army. . . . [W]e are [thus] left with a man who we feel is character disordered and cannot evacuate [from Vietnam] through medical channels with good conscience, but on the other hand [he is] a man whom [you] feel is psychotic and cannot be returned to duty with good conscience. . . . So, what to do??[1(pp1–2)]

Captain H Spencer Bloch, Director, Inpatient Psychiatry Service
935th Psychiatric Detachment (KO)
August 1967 to August 1968

At the peak of the buildup phase there were 10 Army-level evacuation hospitals in Vietnam, such as the 95th Evacuation Hospital pictured here (1970), and five field hospitals, each of which had a psychiatrist position. There were also two psychiatric treatment centers, the Neuropsychiatric Medical Specialty Detachments (KO), which were staffed by psychiatrists, allied mental health professionals, and enlisted technicians. Photograph courtesy of Norman M Camp, Colonel, US Army (Retired).

This chapter extends the description of Army psychiatry in Vietnam begun in Chapter 3 by reviewing the published accounts by hospital psychiatrists and those assigned to the Neuropsychiatric Medical Specialty Detachments ("KO teams"). It concludes with a review of the available record of the professional activities and recollections of the senior psychiatrists deployed in Vietnam as Neuropsychiatry Consultant to the Commanding General, US Army Republic of Vietnam Surgeon.

ARMY-LEVEL PSYCHIATRIC SERVICES IN VIETNAM: EVACUATION AND FIELD HOSPITALS AND THE TWO NEUROPSYCHIATRIC MEDICAL SPECIALTY DETACHMENTS (KO)

Army-level hospital care was abundantly provided for Army personnel in South Vietnam through a collection of semipermanent, air-conditioned, 200- to 400-bed, medical treatment facilities and their associated dispensaries. These hospitals had sophisticated equipment, surgical suites, and intensive care wards and were located throughout the country in secure base camps. Because the ecology of the battlefield meant that there was no front line, and because of the advent of the heliborne medical evacuation capability, there was little reason to have hospitals physically follow the combat units in the war. These hospitals and their various medical specialty detachments were rapidly introduced in Vietnam as the war progressed, commensurate with the escalating troop strength. By the end of 1968, there were 23 Army hospitals in South Vietnam with a bed capacity of 5,283 (11 evacuation hospitals, five field hospitals, and seven surgical hospitals, augmented by the 6th Convalescent Center at Cam Ranh Bay).[2] At various times, Army patients, including psychiatric patients, were hospitalized and treated at the 483rd US Air Force Hospital, which was also located in the Cam Ranh Bay area. Psychiatrists were assigned to the Army hospitals in either of two arrangements: (1) as a solo psychiatrist assigned directly to an evacuation hospital or a field hospital, or (2) as a member of the one of two neuropsychiatric specialty detachments: the 935th (KO) or the 98th (KO).

Data collected in the Walter Reed Army Institute of Research survey of Vietnam veteran psychiatrists indicated there were at least eight Army field or evacuation hospitals with solo psychiatrists assigned at one time or another:

- 3rd Field Hospital (Saigon)
- 17th Field Hospital (Saigon)
- 8th Field Hospital (Nha Trang)
- 36th Evacuation Hospital (Vung Tau)
- 67th Evacuation Hospital, which sometimes had two psychiatrists (Qui Nhon and later, Pleiku)
- 85th Evacuation Hospital (Qui Nhon and later, Phu Bai)
- 71st Evacuation Hospital (Pleiku)
- 95th Evacuation Hospital (Da Nang)

In 1970–1971, at least one Army psychiatrist was assigned to the 3rd Surgical Hospital (Binh Thuy), and another was attached to the 483rd US Air Force Hospital (Cam Ranh Bay).

Also, the two psychiatric detachments were located as follows:

- The 935th Psychiatric Detachment was attached to the 93rd Evacuation Hospital on Long Binh post near Saigon from December 1965 until near the end of the war. In April 1971, its inpatient unit became attached to the 24th Evacuation Hospital, also on Long Binh post.
- The 98th Psychiatric Detachment was attached to 8th Field Hospital at Nha Trang from May 1966 through mid-1970 (Figure 4-1), when it moved further north on the coast to the Da Nang area where it became attached to the 95th Evacuation Hospital. It remained there until it was inactivated near the end of the war.

EVACUATION AND FIELD HOSPITALS STAFFED WITH SOLO PSYCHIATRISTS

Structure of Psychiatric Services in the Evacuation and Field Hospitals

The evacuation and field hospitals without attached neuropsychiatric specialty detachments were allocated only one psychiatrist position and none for social work officers, psychologists, psychiatric nurses, or mental health paraprofessionals (enlisted specialists).[3] Psychiatrists were assigned to these hospitals depending on anticipated need and psychiatrist availability. There they functioned solely in a clinical capacity, providing mostly inpatient care and consultation for the soldiers who were referred from the various nondivisional units in their area. The fact that they had no specialized staff meant they could not typically provide a dedicated psychiatric inpatient ward. However, local deviations did occur in some instances when hospital commanders were faced with unmanageable clinical demand.[3]

Soldiers who failed to respond within approximately 10 days to simple inpatient treatments at these hospitals were evacuated to one of the two psychiatric detachments in Vietnam. Staffing limitations also reduced the capacity of these psychiatrists to provide outpatient services and mental health consultation to the command cadre of nearby units. Command consultation

FIGURE 4-1. Entrance to the 8th Field Hospital, Nha Trang, midway along the coast of South Vietnam, 1969. The 98th Psychiatric Detachment was attached to the 8th Field Hospital from May 1966, when it was first deployed in Vietnam, through early 1970 when it moved farther north to the Da Nang area and became attached to the 95th Evacuation Hospital. Photograph courtesy of Richard D Cameron, Major General, US Army (Retired).

was additionally constrained by the fact that the hospital psychiatrists were not organizationally connected to these units as they were in the combat divisions. As a result of these shortcomings, some areas, especially those containing large numbers of nondivisional units, experienced chronic difficulties in the management and outpatient treatment of soldiers with psychiatric and behavior problems (this was especially true for the Qui Nhon and Cam Ranh Bay areas—See Johnson's panel remarks in Appendix 7).

Accounts by Psychiatrists Assigned as Solo Specialists to Field and Evacuation Hospitals

Among the estimated three dozen psychiatrists who served as solo specialists with the Army field and evacuation hospitals during the ground war, only a few provided an overview of their experience. These are summarized below, and selected aspects will be reviewed in more detail in subsequent chapters. Also, a few Army psychiatrists published reports of circumscribed problems treated at these facilities, and they will be mentioned in subsequent chapters as well. Reports by psychiatrists who were assigned to the two psychiatric detachments are summarized in the next section.

During the advisor phase, Army-trained Major Estes Copen was assigned in South Vietnam to provide psychiatric care for US military personnel (October 1962 and February 1963). Although Copen did not provide an account of his professional activities, the following quote survived:

> Support troops, although exposed to little physical danger or hardship, nevertheless were stressed by separation from family, boredom, and job frustration. These men were frequently seen because of excessive drinking, psychosomatic complaints, and behavioral problems. [These] individuals . . . were contrasted with advisors to combat units in which there was constant physical danger and far less comfortable environmental surroundings. These stresses resulted in casualties referred to as combat fatigue, although this entity tended frequently to be disguised in the form of antisocial behavior or vague physical symptoms.[4]

There is no record of Copen's treatment of these casualties, but he did indicate that those with significant emotional or behavioral problems were transferred out of South Vietnam to avoid "unpleasant relationships with the host government."[4]

8th Field Hospital (Nha Trang) / 3rd Field Hospital (Saigon)

Captain Robert E Huffman, Medical Corps. Huffman was the first Army psychiatric specialist assigned in Vietnam (May 1965–May 1966) following the commitment of American ground troops. He published an account of his professional activities in Vietnam—initially with the 8th Field Hospital at Nha Trang, midway up the coast (before the 98th Psychiatric Detachment arrived), and then with the 3rd Field Hospital in Saigon.[5] Huffman had not received formal training in psychiatry, but he had received 14 weeks of on-the-job training at an Army hospital in the United States. Nonetheless, he expressed dismay at discovering that he was the only physician representing Army psychiatry through the first 4 months of his assignment in the theater. Until August, when additional Army psychiatrists began to arrive in Vietnam, he was responsible for all cases from units in the northern half of South Vietnam, whereas Army troops in the southern half were treated at the Navy hospital in Saigon.

Among his cases at the 8th Field Hospital and subsequently at the 3rd Field Hospital (N = 573 American military personnel), 74% were referred by battalion surgeons and dispensary physicians, with the remainder in trouble and sent by their commanders to insure that there was no psychiatric condition that would preclude administrative or judicial proceedings. Demographic data indicated that 97% of referrals were from enlisted ranks and 11% were draftees; 62% had not completed high school; 15.6% had previous psychiatric consultation; and 28% reported previous legal difficulties. Huffman also provided the following clinical observations:

- for 8%, "the stress of combat was related to the onset of emotional difficulties";
- 18.5% were diagnosed as having severe problems with alcohol intoxication;
- fewer than 1% had drug-induced reactions; and
- 6.1% had suicide attempts or gestures (one was completed).

3rd Field Hospital (Saigon)

Captain Arthur S Blank Jr, Medical Corps. Blank was a civilian-trained psychiatrist who served with the 1st Infantry Division and later with the 935th Psychiatric Detachment before being assigned to the 3rd Field Hospital (April 1966–September 1966). A record of Blank's experiences with the 3rd Field Hospital can be found in his remarks in a 1967 panel discussion (Appendix 10).[6] The 3rd Field Hospital shared responsibility with the 17th Field Hospital for the medical care of the US military personnel in the Saigon area. These two facilities, along with the 93rd Evacuation Hospital (with its 935th Psychiatric Detachment), which was located 20 miles away on the American post at Long Binh, also provided direct care for combat units operating in the Mekong Delta (support and combat).

Although Blank's referrals came from a wide variety of primary care sources, that is, from battalion surgeons in the field, dispensaries in Saigon, doctors assigned to ships off the coast, and flight surgeons in aviation battalions in the Delta, the evacuation system at that time was in a state of flux, and soldier-patients were just as likely to be taken to the 17th Field Hospital Saigon or the 93rd Evacuation Hospital/935th Psychiatric Detachment. During his first 3 months with the 3rd Field Hospital, Saigon was unusually tense because of the clashes between the Buddhists and the Catholics as well as episodic Viet Cong terrorist activity in the form of grenades thrown in jeeps, sniping, burning of vehicles, and mortar attacks on US facilities. However, only one individual was admitted to either hospital in Saigon with an apparent psychiatric reaction to these events. Blank was left with the impression that the terrorist behavior did not generate significant psychiatric problems among the assigned American military population.

According to Blank, his workload at the 3rd Field Hospital was manageable, but matters of administration and communication took an inordinate amount of time. During his 6 months there he saw approximately 300 outpatients and treated 61 inpatients (length of stay averaged under 5 days; daily census averaged two patients). Blank provided only a little clinical information regarding his inpatients. Demographically, only two (3%) were combat soldiers (whereas 20% of all psychiatric referrals were from combat units, indicating that noncombat troops from combat units were overrepresented). Also, 25 (41%) inpatients had psychiatric histories before Vietnam, and 12 (20%) were initially admitted by other physicians for psychosomatic problems. This last observation led him to speculate there may be substantial numbers of covert psychiatric casualties in Vietnam who are in the care of nonpsychiatrists. Also, he reported there was one

completed suicide of a chronically depressed alcoholic sergeant.

Blank noted that his referrals had a minor peak at around 4 weeks after a soldier's arrival in Vietnam, with a much larger peak at about 5 months in-country. The predominant diagnosis overall was transient situational reaction. Approximately one-fourth of his referrals (70–80) were categorized as passive-dependent personalities who developed an anxiety syndrome within 4 to 6 weeks of arrival in Vietnam as a consequence of difficulties separating from mothers or wives and the extraordinary hours that most personnel worked (12–16 hours/day, 7 days/week). With the help of psychotherapy and Librium these individuals were able to maintain their duty performance levels.

Another 50 (17%) referrals were from commanders seeking psychiatric clearance for administrative separation from the service. These were overtly hostile soldiers who had repeated incidents of either verbal abuse or physical assault on superiors, usually while armed and often with some degree of intoxication. These soldiers were mostly untreatable. Although tending to have had an absent or inadequate father in their development, because they were careerists and had good military records before Vietnam, Blank was puzzled. "There was something about being in Vietnam, something about the situation, something about the war, something about the invitation to violence, which had changed their attitudes with respect to the military."[6]

However, Blank refuted an explanation centered on demoralization secondary to antiwar sentiment. (To illustrate the extreme challenge of these types of soldiers, in the panel proceedings Jones added: "Reference is made to an incident in which one of Blank's patients brought a grenade into his office and exploded it after warning him to leave. Although Blank was uninjured, the patient sustained frontal lobe brain damage."[6 (p58)]) Also see Chapter 8 for results of Jones' review of diagnostic and demographic data for 120 consecutive enlisted referrals at the 3rd Field Hospital during the 6 months following Blank.

Captain John A. Talbott, Medical Corps. A limited follow-on to Blank's experience with the 3rd Field Hospital came from Captain Talbott, a civilian-trained psychiatrist, who served there (February 1968–May 1968) almost 2 years later. Talbott reported observations and psychiatric incidence figures surrounding the intense fighting waged in and around Saigon in conjunction with the enemy's 1968 surprise Tet offensives (January 31st through the end of February 1968). He recalled the common characterization of the "Saigon Warrior" ("an overweight, contented man working decent hours at a regular jobs, surrounded by bars, bar-girls, restaurants, taxis, and all the trappings of civilization") and noted that, "in one night [it all] changed from the Paris of the East to the Algiers, from war stories to war experiences, and from luxury to horror. Street-fighting, dive-bombing, snipers, and nightly mortars and rockets replaced the entertainment."[7(p60)]

Among his first 100 patients, 18 manifested anxiety related to the fighting, and another six he labeled combat reactions (a "transient disorganized" syndrome). Among the latter, he indicated that the incidence rate for these was 6 times that of the preceding 6 months. Of the remaining cases, 44 were diagnosed as character and behavior disorders, with 26 of those subcategorized as alcoholics. Still, the number of individuals psychologically affected by the fighting was smaller than predicted, which led Talbott to conclude that the personnel who lived and worked in the relative luxury of Saigon were at no greater risk for combat reactions than would have been predicted for a similar sized infantry unit.[7]

17th Field Hospital (Saigon)

Captain William F Kenny, Medical Corps. Blank's psychiatric counterpart in Saigon, Kenny, a civilian-trained psychiatrist, came to Vietnam in May 1966 and was assigned to the 17th Field Hospital. Kenny's account of the psychiatric challenges he faced over his 8 months there was limited to the types of psychiatric disorders that presented among Saigon's urban (support) personnel, and he did not refer to the combat troops in the area. In fact, he categorically stated that he saw almost no cases where precipitating factors included the strain of combat.

According to Kenny, his daily inpatient caseload averaged two or three (with an average stay of 3–4 days), which was similar to that of Blank's at the 3rd Field Hospital. If a patient's condition did not respond to acute care, he was evacuated to the nearby 93rd Evacuation Hospital/935th Psychiatric Detachment on Long Binh post. Kenny's outpatient visits averaged 110 to 120 per month, or roughly four each day (40% for evaluation and 60% for treatment). They often presented as acute, transient, anxiety states—including under the influence of alcohol—but many were diagnosed as depressions, chronic anxiety states,

emotionally unstable personalities, or psychopathic personalities. Their difficulties stemmed from heightened dependency needs, underlying separation anxiety, and primitive defense mechanisms.

Psychotherapeutic strategies involved encouraging them to verbalize their angry feelings toward the authorities whom they perceived were responsible for their situation, setting firm limits, and the therapist offering himself as a figure for positive identification—as well as use of a mild tranquilizer (no specifics). Kenny also conducted a study of 64 soldiers (nonpatient) seeking official permission to marry Vietnamese women and found them to be mostly immature, dependent men who had fears of being dominated by women and a consequent preference for a presumably submissive Vietnamese wife.[8]

67th Evacuation Hospital (Qui Nhon)

Captain Gary L Tischler, Medical Corps. Contemporaneously with Blank and Kenny in Saigon, Tischler (Figure 4-2), an Army psychiatrist who was also civilian-trained, was assigned to the 67th Evacuation Hospital at Qui Nhon (March 1966–March 1967), which was located on the coast of South Vietnam, midway between Saigon to the south and Da Nang to the north. In contrast to the large urban population surrounding the Saigon hospitals, the catchment area for the 67th Evacuation Hospital consisted of a sprawling collection of nondivisional, mostly support, units. In a brief publication, Tischler noted that most of the patients he saw fell into three types: (1) those affected by combat stress; (2) those with dependent, symbiotic personalities who were disabled by the requirement for functioning overseas; and (3) those with preservice patterns of conflict with societal norms.[9]

Much more extensive was Tischler's description of the dominant patterns of stress and adaptation affecting all those deployed in that area of the combat zone in 1966 and 1967, primarily as seen through the perspectives of the patients he treated.[10] What impressed him most were the phases of adaptation (or in some instances, maladaptation) of the typical soldier as he struggled with the environmental hazards and privations attendant to the individualized 1-year tour in Vietnam. The peak psychiatric casualty rate was in the first 90 days, which gradually diminished over the next 6 months, followed by a rapid drop over the last 90 days. Although Tischler did not provide an overview of the psychiatric activities at the 67th Evacuation Hospital, in reviewing the demographic features of 200 enlisted referrals and their diagnostic breakdown, he did permit a view of the psychiatric challenge there (Table 4-1).

FIGURE 4-2. Captain Gary L Tischler, Medical Corps, psychiatrist with the 67th Evacuation Hospital in Qui Nhon. Early in the war, between March 1966 and March 1967, Tischler was assigned to the 67th Evacuation Hospital, which had recently deployed in Vietnam to Qui Nhon, located on the coast of South Vietnam between Nha Trang to the south and Da Nang to the north. The primary mission for the 67th Evacuation Hospital was to provide medical care for a large collection of nondivisional, mostly support, units in the area. Tischler, who was civilian-trained, was the only psychiatrist who served solo in an Army hospital that was not located in Saigon who published an account of his professional experiences. Photograph courtesy of Gary L Tischler.

Whereas Tischler alluded to soldiers affected by combat stress ("[a] number of men were referred after being overwhelmed in an encounter of high hazard potency"), short-timer's syndrome, and combat aversion, it is not evident where these cases fit in his diagnostic groupings. They may have been included under the transient situational disorder category; however, their numbers may have been very low anyway because most of the troops treated at the 67th Evacuation Hospital were support troops. Like the reports from hospital psychiatrists from early in the buildup phase (Blank and Kenny), Tischler did not explicitly mention illegal drugs. On the other hand, also like them, he indicated that alcoholic intoxication was frequently found to be associated with suicidal and assaultive behavior.

TABLE 4-1. Estimated Diagnostic Distribution Among Enlisted Referrals to the 67th Evacuation Hospital, March 1966–March 1967 (N = 200)

Diagnosis	% of referrals
Psychotic reactions	3%
Psychoneurosis	10%
Transient situational disorders	18%
Character-behavior reactions	58.5%
Other, including neurological disorders	10.5%
	100%

Data source: Tischler GL. Patterns of psychiatric attrition and of behavior in a combat zone. In: Bourne PG, ed. *The Psychology and Physiology of Stress: With Reference to Special Studies of the Viet Nam War*. New York, NY: Academic Press; 1969: 26 (Table 1).

Additional perspectives on psychiatric challenges at the 67th Evacuation Hospital came from Colbrach (Figure 4-3), who summarized findings from his study (with Crowe) described in Chapter 8 that demonstrated an increased incidence of psychiatric problems among soldiers inducted into the Army under a program of relaxed educational and physical requirements ("Project 100,000"); a clinical report by Colbach (with Crowe) described in Chapter 9 regarding marijuana psychosis cases and increasing use of barbiturates by troops in the region; and Master's report on the growing polydrug use problems seen the following year, Chapter 9.

Discussion of Documentation by Those Who Served as Solo Psychiatrists With Field and Evacuation Hospitals

These accounts permit some appreciation for the psychiatric challenges early in the war and the commendable service these psychiatrists provided; however, it is unfortunate that only five individuals provided a record of their experiences while assigned to Army field or evacuation hospitals as solo psychiatrists. Furthermore, generalizability is not possible because, except for Talbott's circumscribed observations from early in 1968, the other reports are limited to the initial 2 years of the war (1965 and 1966). As noted previously, combat intensity and associated stress increased after that point, and deployment stress levels accelerated after 1968. The value of these reports is also somewhat limited because, with the exception of Tischler's from the 67th Evacuation Hospital, they

FIGURE 4-3. Captain Edward M Colbach, Medical Corps, psychiatrist with the 67th Evacuation Hospital in Qui Nhon. Colbach was a civilian-trained psychiatrist who was assigned to the 67th Evacuation Hospital at Qui Nhon between November 1968 and October 1969, the peak year for Army troop strength in Vietnam. He is notable for his publications (with Crowe) describing clinical experiences with marijuana psychosis cases and reviewing the psychiatric problems presenting among soldiers inducted into the Army under a program of relaxed educational and physical requirements. Also, Colbach's post-war overview (with Parrish) of the Army's psychiatric experience in Vietnam through 1970 permitted a fuller appreciation of the dominant forms of morale and psychiatric problems seen by the midpoint of the war. Photograph courtesy of Edward M Colbach.

center on experiences at the 17th Field Hospital and the 3rd Field Hospital, both of which were in Saigon. The 25,000 to 30,000, mostly noncombat, personnel operating in Saigon served in a crowded and hectic Vietnamese urban environment and were occasionally subjected to guerrilla attacks by the enemy—a distinctly different combat ecology than was faced by soldiers operating in the rest of South Vietnam.

FIGURE 4-4. The 98th Neuropsychiatric Medical Specialty Detachment (KO) headquarters and mental hygiene clinic, which was attached to the 95th Evacuation Hospital outside of Da Nang, in the fall of 1970. Earlier in the year the 98th "KO Team" had relocated there from Nha Trang, farther south along the coast, where it had initially been attached to the 8th Field Hospital. The 98th (KO) was one of two definitive psychiatric treatment facilities in Vietnam. Its principal mission was to provide specialized hospital-level care (up to 30 days) for troops evacuated by Army psychiatrists operating in the northern half of South Vietnam and to stage out-of-country evacuations for patients needing additional care. It also provided outpatient services for the large number of nondivisional units in the area and scattered along the northern coast of South Vietnam. Photograph courtesy of Norman M Camp, Colonel, US Army (Retired).

Each of the psychiatrists in this set included rather different types of information with little apparent synchronization regarding diagnostic criteria and groupings or measures of psychiatric attrition (rates or proportions of those hospitalized, returned to duty, or evacuated to the psychiatric specialty detachments). Still, the data suggest that the incidence of inpatient-level psychiatric problems was relatively low, and that, despite having few or no specialized staff available, these hospital-based psychiatrists were able to reasonably manage a steady stream of referrals representing a mix of problems more centered on combat theater stress than combat stress. (See Johnson's panel remarks in Appendix 7 for contrary evidence with respect to the Qui Nhon support area/67th Evacuation Hospital.) In fact, there is little mention of combat stress casualties per se among this group except for Tischler's passing reference to combat stress as etiologically significant in some cases, and Talbott's observations and demographic data pertaining to the psychiatric casualties generated among noncombat personnel in Saigon because of the Tet fighting in 1968. In contrast, Blank, who served at the 3rd Field Hospital during the first year of the war, noted that over a 6-month span, only two soldiers were transferred to him from the combat divisions.

Although Huffman mentioned drug abuse very early in the war (<1% of referrals), he is the only one; however, all five psychiatrists reported substantial alcohol-related problems. Notably, none suggested they maintained any consultative dialogue with unit commanders. This is not surprising given the limitations of psychiatric staffing in these hospitals and the fact that the hospitals were organizationally distinct from the surrounding units. However, because all of these psychiatrists received their psychiatric training in civilian programs, they may also have favored a model of individual pathogenesis as opposed to one embracing the interplay of the soldier's psychological dynamics with the small group dynamics within his unit.

THE TWO NEUROPSYCHIATRIC MEDICAL SPECIALTY DETACHMENTS (KO TEAMS)

Structure of Psychiatric Care in the Neuropsychiatric Medical Specialty Detachments: The 935th (KO) and the 98th (KO) Teams

The Neuropsychiatric Medical Specialty Detachments, the so-called KO teams, primarily treated soldiers who failed to respond sufficiently to short-term hospital treatment by the division psychiatrists or the solo psychiatrists at the evacuation or field hospitals (Figure 4-4). The mission for the KO detachments was to establish 3rd echelon psychiatric treatment and evacuation centers that would provide the full range of inpatient care for up to 30 days.[11] Cases requiring additional specialized care were evacuated out of Vietnam to Army treatment facilities in Japan, Hawaii, and the continental US.[12] If the KO detachment staff members concluded a soldier-patient was unlikely to recover within 30 days or be able to return to duty within Vietnam, they could evacuate him as soon as it could be arranged.[11]

KO teams also provided outpatient psychiatric care, referred to as mental health consultation services (MHCS), for the nondivisional units in their coverage area and hospitalized their soldiers when necessary. Overall, referrals from nondivisional units were either command-directed or were from the primary care physicians assigned to the various hospital-based dispensaries who provided 1st echelon medical and mental healthcare.

Because the 935th and the 98th Psychiatric Detachments were terminal psychiatric treatment facilities in the in-country evacuation chain, an important service they provided was a second level of psychiatric review regarding the medical necessity for evacuation out of Vietnam (US Army Republic of Vietnam Regulation No. 40-34[13]). As far back as the British experience in World War I, psychiatric observers noted a dramatic increase in psychiatric morbidity associated simply with removal from the combat theater.[12] Army medical planners for Vietnam also imposed this system of reassessment to minimize unnecessary manpower losses (including through what later became referred to as evacuation syndromes, ie, soldiers who may exaggerate their symptoms to be removed from the theater[14]). According to SL Baker Jr, a senior Army psychiatrist, in anticipation of such a possibility, "clear and firm policies [restricting] medical evacuation were issued early by the [military medical] authorities there."[15(p1831)] However, as this chapter's introductory quotation indicated, this arrangement was not always popular.

Army TO&E 8-500D provided for the psychiatric detachment to be organized with the following professional staff: three psychiatrists, one neurologist, two social workers, one clinical psychologist, and one psychiatric nurse. The unit also was staffed with 12 to 15 enlisted corpsmen ("techs") who had additional military mental health training, for example, those with military occupational specialty (MOS) codes: 91-F (neuropsychiatric specialists), 91-G (social work specialists), and 91-H (clinical psychology specialists).[16] The psychiatric detachments were also allocated an electroencephalograph machine, and, because the psychiatric detachments were designated to be semi-mobile, three vehicles (two jeeps and a 2½-ton truck) and other specialized equipment, such as tents, which would permit rapid relocation to areas with greater need. However, like the Army hospitals in Vietnam, both of the psychiatric detachments operated as fixed facilities throughout the war. The one exception was the relocation of the 98th Psychiatric Detachment from the 8th Field Hospital in Nha Trang to the 95th Evacuation Hospital in Da Nang in early 1970. Finally, the inpatient wards were typically run as open units, and physical restraints were used on a brief and selective basis; the staff did not have the capability for providing electric convulsive therapy.

Reports by Psychiatrists and Allied Mental Health Personnel Assigned to Neuropsychiatric Medical Specialty Detachments (KO)

Below are summaries of the overviews provided by deployed Army psychiatrists that permit some appreciation of the professional challenges faced in the KO teams. Selected aspects will also be noted in subsequent chapters. A few psychiatrists published reports of circumscribed problems seen in these facilities, and these will be mentioned in subsequent chapters as well.

935th Neuropsychiatric Medical Specialty Detachment (KO) During the Early Buildup Phase (1965–1966)

The first KO team deployed in Vietnam was the 935th. It was formed at Valley Forge General Hospital in Pennsylvania in preparation for overseas movement. The staff and their equipment traveled to Vietnam by

ship and arrived on 23 December 1965, and it became attached to the 93rd Evacuation Hospital on the Long Binh post 20 miles outside of Saigon.

Major John A Bowman, Medical Corps. Bowman was the first commander of the 935th Psychiatric Detachment (December 1965–October 1966). He had trained in psychiatry in an Army program, and his overview of the experiences of the 935th can be found in a transcript of a panel discussion held in 1967,[17] his unpublished manuscript,[18] and his "Unit History of the 935th Medical Detachment (KO), 20 September 1965 to 1 September 1966,"[16] also unpublished. Bowman's account, which mostly spanned his first 6 months in Vietnam, described how the 935th provided specialized psychiatric inpatient care for soldiers from Army combat and noncombat units throughout the country, 24 hours per day outpatient care, consultation services for noncombat units on a regional basis, and psychological services and consultation to the stockade. At that early point in the war, the combat units for whom the KO team provided 2nd and 3rd echelon psychiatric care included the 25th Infantry Division, the 1st Infantry Division, the 1st Cavalry Division (Airmobile), and the 173d Airborne Brigade of the 101st Airborne Division. According to Bowman, these were primarily Regular Army professional soldiers who were well motivated and skillfully led. Overall troop morale was reportedly high, despite the fact that combat units regularly conducted search and destroy missions, and no area was considered safe from ambush, terrorist activities, or sniper fire.

> However, the practical impediments the 935th KO team had to surmount were substantial: [Y]ou really don't have enough supplies to get along. For instance, we didn't have any electricity so we couldn't run a ward very well at night; we had no generators. . . . We had no lanterns. When we put in our request for supplies, we found out how snarled things really could be.[17(p61)]

The 935th KO team averaged about 300 referrals per month and carried a daily inpatient census of 10 to 12. Bowman and his staff rarely saw uncomplicated combat exhaustion cases because most such cases were effectively treated at the level of 1st echelon care, that is, by field medics and battalion aid station personnel within the combat units. Bowman's staff used two criteria in the diagnosis of combat exhaustion: (1) history of exposure to actual combat, and (2) evidence of fatigue, whether produced by physical causes such as exertion, heat, dehydration, diarrhea, and loss of sleep, or by psychological causes such as anxiety and insomnia.

Overall Bowman and the KO team encountered a very low rate of combat exhaustion and an increase in character and behavioral disorders as time progressed. Fewer than 5% of referrals were for psychosis, usually paranoid schizophrenia or manic depression, and fewer than 2% were for combat exhaustion. The remainder consisted of stress reactions, including those secondary to separation from home, which were commonly expressed through psychosomatic symptoms or manifestations of anxiety, depression, agitation, or behavior problems, especially aggressive behavior problems. Regarding the behavior problems, Bowman stated, "In almost every case the soldier was defined as somebody that his unit could no longer tolerate."[17(p65)]

Bowman indicated that because their ward (census of 10–12 patients) was visibly open to the other wings housing convalescing medical and surgical patients, peer pressure served to reduce patient acting out. His inpatient staff included a nurse and 12 corpsmen. They utilized brief psychotherapy, "sedation when appropriate,"[17(p6)] and a therapeutic ward milieu whose emphasis was rapid recovery of function and return to duty in Vietnam. New admissions were given clean clothing, a shower, a warm meal, and told they were expected to assist the staff in maintaining an orderly ward. They were to keep their area clean, help police up the ward, and participate in outside details (fill sand bags, help build bunkers, etc). A patient NCOIC (noncommissioned officer-in-charge) was appointed to manage a "buddy" system wherein soldier-patients helped each other as well as exerted controls on each other's behavior. According to Bowman:

> Treatment of soldiers admitted to the inpatient ward reflected proven principles of preventive psychiatry. An atmosphere of expectancy of return to duty was maintained for all soldiers, and at the same time each man was expected to display the same military bearing, behavior, and courtesies as he would in his own unit. At all times the soldier was reminded that he was a part of the US Army in a combat situation and was expected to behave accordingly.[16(p2)]

He also emphasized that despite the remoteness of tactical units, the 935th KO Detachment placed a priority on maintaining the soldier-patient's military identity through having his unit make regular visits to him, bring him his mail, and pay him on the ward; and that thanks to helicopter mobility, line commanders were fully cooperative, even though a unit might be 250 miles away. About 90% of all hospitalized soldiers were returned to duty, a high rate that Bowman in part credited to the military-centered clinical perspective held by the psychiatrists of the 935th. ("Unless, upon evaluation the soldier proved to be frankly psychotic, the presenting symptom was rarely considered sufficient reason to evacuate the soldier from Viet Nam. . . . In most cases the soldiers gave up their symptoms . . . and returned to duty asymptomatic or with less severity of symptoms."[16(p2)]) (See Appendix 11, "Recent Experiences in Combat Psychiatry in Viet Nam," for a further discussion.)

Bowman was especially appreciative of the support provided by the enlisted specialists assigned to his team:

> These men always worked an 8-hour shift, sometimes . . . they worked 12 hours. After their work was over they had all kinds of details. There was guard duty, latrine duty, KP ["kitchen patrol"], vehicle maintenance, maintenance on their weapons, etc. So, these men were really soldiers, and they were well trained. . . . I just can't say too much about the school at Ft. Sam [Fort Sam Houston, Texas] and the kind of men that they sent us. They really made the KO team function.[17(p62)]

The 935th KO During the Peak Combat Activity Phase (1967–1968)

Chapter 3 reviewed the observations from four division psychiatrists (Bostrom, Baker, Pettera, and Motis) who served during 1967–1968—a period in which the troop buildup reached its peak and American troops engaged in some of the most intense fighting of the war. Collectively their reports provided some appreciation of the growing numbers of combat stress casualties seen at the level of 1st and 2nd echelon care in the combat divisions. Fortunately three Army psychiatrists assigned to the 935th (KO) also served in that time frame and provided further documentation of the professional challenges associated with these events. Their reports are summarized below. By that point the other psychiatric detachment, the 98th KO, had arrived and assumed responsibility for psychiatric referrals in the northern half of the country (I and II Corps); thus the 935th was only responsible for units in the southern half (III and IV Corps).

FIGURE 4-5. Captain H Spencer Bloch, Medical Corps, Director, Inpatient Psychiatry Service, 935th Neuropsychiatric Medical Specialty Detachment (KO). Bloch, a civilian-trained psychiatrist, served in Vietnam between August 1967 and July 1968 with the 935th KO team, which was attached to the 93rd Evacuation Hospital on Long Binh post near Saigon. Through his publications and notes he retained from his tour he played a critical role in documenting the more serious psychiatric challenges faced by the Army in Vietnam during the period of highest combat intensity. Photograph courtesy of H Spencer Bloch.

Captain H Spencer Bloch, Medical Corps. Bloch (Figure 4-5), a civilian-trained Army psychiatrist, served as Director, Inpatient Psychiatry Service at the 935th Psychiatric Detachment between August 1967 and July 1968. He arrived a year after Bowman left. Two publications by Bloch permit a rich review of the psychiatric experience at the 935th during his year.[19,20] The outpatient service of the 935th provided care principally for nondivisional units and saw roughly 750 psychiatric patient visits per month. The inpatient service averaged 60 new cases per month, with a mean daily census of 12. Inpatients typically came in the form of admissions from the outpatient psychiatric service and refractory cases from the combat divisions and brigades and the other evacuation and field hospitals. Direct admissions also came from combat units in the area when it was necessitated by the tactical situation. Table 4-2 presents Bloch's diagnosis and disposition

TABLE 4-2. Diagnostic Groupings Among 600 Consecutive Admissions to the 935th Medical Detachment (KO) Inpatient Service Between 21 August 1967 and 27 July 1968*

Diagnosis	% of admissions (n)	Average hospital stay (days)	% returned to duty in Vietnam
Psychosis†	44.0% (264)	14	56%
Acute situational reaction	17.5% (105)	8	90%
Psychoneurosis	12.3% (74)	6	85%
Character-behavior reaction	11.2% (67)	8	90%
Alcohol and drug problems	6.8% (41)	2	98%
Combat exhaustion	5.7% (34)	3	100%
Observation/no NP disease (includes neurology patients)	2.5% (15)	N/A	80%

*59 patients (10%) were admitted a second time, and nine were admitted a third time. It is unclear whether these nine were included in the 59.
†32 psychosis patients were admitted a second time, and six were admitted a third time. It is unclear whether those admitted a third time were included in the 32.
N/A: not applicable
NP: neuropsychiatric
Data source: Bloch HS. Army clinical psychiatry in the combat zone 1967–1968. *Am J Psychiatry*. 1969;126(3):289–298,

breakdown among 600 consecutive admissions to the 935th Detachment/93rd Evacuation Hospital.

Although Bowman did not provide a comparable set of inpatient statistics from 2 years earlier, Bloch's 5.7% for combat exhaustion cases among his inpatients compared with Bowman's 2% is consistent with the sharp rise in combat intensity between 1966 and 1968.

Bloch and his staff sought to provide "psychiatrically sophisticated" treatment that took into account the context of this new type of war—a low-intensity conflict dominated by counterinsurgency/guerrilla tactics. The design of their inpatient service combined the traditional principles of the combat psychiatry doctrine ("immediacy, proximity, and expectancy") with concepts of milieu therapy to create a therapeutic community for all patients—not just those affected by combat stress (Exhibit 4-1, "The Therapeutic Milieu in the 935th (KO) Neuropsychiatric Specialty Detachment"). The ward routine included group therapy, work details, recreation programs, and a patient government—all within a quasimilitary atmosphere intended to reestablish the soldier-patient's military group identity and underscore the preeminence of the military mission ("conserve the fighting strength"[19(p292)]). The premium was placed on environmental manipulation and interpersonal techniques, versus intrapsychic approaches.

> Professional military psychiatrists are essentially interpersonal psychiatrists, whose approach is oriented toward interventions in the interpersonal dimensions of the patients' problems. Their experience has proven that they can most efficiently utilize their time and skill by intervening in this manner rather than concentrating on underlying internal emotional conflicts, which are often thought to take much longer periods of time to resolve. [Thus] in helping a man back to a more functional state and maintaining him there, military psychiatrists work in two directions: aiding the man in developing behavior that is more tolerable to others, and getting his unit to become more accepting of idiosyncratic behavior that does not impede its mission.[19(p292)]

For selected inpatients the 935th KO provided psychoactive medications (especially Thorazine and Librium), as well as individual psychotherapy. In particular, Bloch and his colleagues, like division psychiatrists Bostrom and Bey, advocated a sleep therapy protocol (*dauerschlaf*) as the initial intervention for disorganized, agitated, or violent soldiers, regardless of the provisional diagnosis on admission.[20]

Finally, Bloch compared their results with those from the year before as follows: In the first 6 months of 1968, their military-centered milieu treatment program discharged 78% of patients back to duty in Vietnam. During the same time period the year before, when their predecessors operated what Bloch characterized as a diagnosis and disposition center, only 53% were

EXHIBIT 4-1. The Therapeutic Milieu in the 935th (KO) Neuropsychiatric Specialty Detachment

. . . [I]n establishing the treatment program it was decided to apply the three principles of combat psychiatry to all hospitalized patients. That is, the ideas of immediacy, proximity, and expectation were combined with concepts of milieu therapy to establish the ward as a therapeutic community aimed at the restitution of all men to duty.

The hospital in which this ward was located was composed of a series of one-story quonset buildings, each constructed in the form of a cross with four 16-bed wings diverging from a central area. The psychiatric ward comprised one wing in one of these buildings; the other three wings . . . were for preoperative and convalescent surgical patients. . . . The ward was completely open, without seclusion rooms, although all kinds of patients were treated there—psychotic and nonpsychotic, violent and withdrawn, officers and enlisted men, civilians, occasionally foreigners, and (rarely) women.

With such a diversity of patient type and lack of facilities for seclusion and isolation, expectation became vitally important in the ethos of treatment. A very high level expectation was maintained: patients were there to get well and to conduct themselves appropriately. Restraints and medications were available when patients' behavior was out of control or not controllable by other means, but actually restraints were required infrequently and rarely for more than a few hours at a time.

Regarding the milieu treatment program, all of the ward patients, even the sickest, got up together in the morning. They dressed in fatigue pants, T-shirts, and combat boots. . . . They ate together in the mess hall and then went to group therapy for one and a quarter hours, five mornings each week. Group therapy was run by the corpsmen and supervised by psychiatrists; it was oriented around the immediate difficulties that precipitated each patient's hospitalization. Following the group therapy session the patients cleaned up the ward together while the psychiatrist who had observed the meeting conducted a teaching session for the corpsmen who had led it. Then the patients went on a two-hour work detail together, . . . ate together, rested briefly, and then had a two-hour recreation period. Following this they showered, washed their clothes, and relaxed in a lounge playing cards, pool, or talking until dinner. Afterwards they held a patient government meeting on the ward.

They themselves decided about each patient's privilege status. A three-class system was utilized: Class I patients could not leave the ward without a corpsman; Class II patients could go off the ward with Class III patients; Class III patients could leave the ward unaccompanied when no group activity was scheduled. After the patient government meetings, the men watched television or wrote letters until bedtime.

The program was highly structured and geared toward much group activity as well as toward individual patient responsibility. Our rationale was that these men had run into some difficulty in interpersonal relationships in their units that caused them to be extruded from those groups. The therapeutic endeavor of this program was to facilitate the men's reintegration into their own groups (units) through integration into the group of ward patients. . . . [Although] we can consider intrapsychic psychopathology—that is, symptoms of emotional conflict and unrest within the individual . . . [since the aim of military psychiatry] . . . is to conserve the fighting strength . . . [we] want the man only to be able to function optimally, or as close to it as possible, in his or some other unit.

Reproduced with permission from Bloch HS. Army clinical psychiatry in the combat zone: 1967-1968. *Am J Psychiatry*. 1969;126:291–292.

discharged back to duty in Vietnam—a spread that suggests strikingly different clinical philosophies with significant outcome consequences. (See also in Appendix 12, Bloch's paper, "Interesting Reaction Types Encountered in a War Zone.")

Captain John A Talbott, Medical Corps. Before his assignment to the 3rd Field Hospital (mentioned earlier), Talbott served with the 935th Psychiatric Detachment (May 1967–February 1968). While there he participated in an ambitious community psychiatry program intended to extend primary and secondary prevention care to the troops in the catchment area, primarily those in units that were located on the sprawling post at Long Binh. The program, which utilized six mental health professionals (psychiatry, psychology, and social work) and 10 enlisted social work/psychology technicians, offered outreach services and consultation for the Army stockade, 10 primary care medical dispensaries, the post chaplains, and units showing elevated rates for sick call or psychiatric referral. The program especially sought to identify military units that were experiencing internal difficulties to understand group factors contributing to individual psychopathology and to reduce the incidence of both individual and unit problems through active consultation/liaison with unit cadres. Although no outcome measures were presented by Talbott, he indicated that when commanders were open to consultation, the program was generally successful in

increasing early psychiatric referrals of appropriate cases and reducing inappropriate referrals.[21]

Lieutenant Colonel Jack R Anderson, Medical Corps. Anderson, an Army-trained psychiatrist, served as the commanding officer of the 935th Psychiatric Detachment (September 1967–September 1968) at the same time Bloch and Talbott were assigned. Prior to obtaining his medical training, Anderson was an Army medical administrator in Europe in World War II and a clinical psychology officer stateside during the Korean War. His assignment in Vietnam immediately followed the completion of his psychiatry training at Letterman Army Hospital. Although his comments were general in nature, some appreciation of Anderson's experience in Vietnam could be gleaned from an interview soon after he returned to the United States. He spoke of becoming concerned with the "new breed" of delinquent and noneffective soldiers; soldiers exhibiting a schizophreniform toxic drug reaction (presumed secondary to marijuana use); and rising numbers of previously performing soldiers who became "dropper-outers."[9] In these observations, he appeared to have noticed early expressions of the demoralization and dissent that were gradually building in the theater.

Also, in a brief article published in the *USARV Medical Bulletin*,[22] Anderson expressed his opposition to assigning psychiatrists to the combat divisions in Vietnam and in effect offered a distinctly contrasting perspective to that prevailing in Army psychiatry. He believed the social psychiatry/unit consultation model had proved marginally successful within the combat divisions. His opinion derived from observations that there had been a low incidence of combat-generated psychiatric casualties, battalion surgeons had used phenothiazines effectively to treat these conditions, and helicopters had rapidly evacuated those who didn't respond to nearby hospitals. In Anderson's estimation the division-based social workers, social work/psychology technicians, and battalion surgeons appeared to be fully capable of handling the psychiatric problems in the divisions; consequently the division psychiatrists in the southern half of Vietnam would be more efficiently utilized if they were reassigned to the 935th Psychiatric Detachment.[22]

Additional perspectives on psychiatric challenges at the 935th Medical Detachment/93rd Evacuation Hospital in 1967 to 1968 came from Bloch regarding the soldier's adjustment during a year's tour in Vietnam (further discussed in Chapter 8); and Fidaleo on marijuana use patterns and problems, Talbott on "pot (marijuana) reactions," and Talbott and Teague on marijuana-induced psychosis cases (in Chapter 9). The following year (September 1968–September 1969), Imahara described the increasing morale and behavior problems seen among the confinees of the US Army Republic of Vietnam Stockade (in Chapter 2); and Forrest described indicators of growing soldier polydrug use (in Chapter 9), as well as provided observations on the commercial sexual relationships between soldiers and Vietnamese women and the challenges faced by those who wished to marry (Chapter 8). From the drawdown years, Ives (August 1970–August 1971) described the heroin treatment provided for Army troops at the 483rd US Air Force Hospital at Cam Ranh Bay (Chapter 9), and Ratner (August 1970–August 1971) provided observations on the characteristics of heroin-using soldiers admitted to the Long Binh Post Amnesty Center (Chapter 2 and Chapter 9).

98th Neuropsychiatric Medical Specialty Detachment (KO)

In May 1966, 5 months after the 935th Psychiatric Detachment (KO) came ashore in Vietnam, its counterpart, the 98th Psychiatric Detachment (KO), arrived. It also traveled by troop ship, and it became located in Nha Trang in the central coastal region of South Vietnam. Initially the 98th was not attached to a hospital as the 935th was attached to the 93rd Evacuation Hospital. The 98th operated out of a medical clearing company, including its inpatient unit, a couple of miles from the 8th Field Hospital. This turned out not to be administratively and logistically practical so it was subsequently attached to the hospital and its inpatient ward relocated there; however the clinic/mental health consultation services (MHCS) activity stayed in the troop area some distance from the hospital. As already mentioned, once operational the 98th concentrated on serving Army units in the northern half of South Vietnam (I and II Corps) while the 935th continued to serve the units in the southern provinces. Three years later, in early 1970, the 98th relocated farther up the coast to the Da Nang area and became attached to the 95th Evacuation Hospital where it remained. Although there were an estimated two dozen psychiatrists assigned to the 98th KO team over its 6 years in Vietnam, except for its first year, little documentation of its activities is available.

Captain Louis R Conte, Medical Corps. Conte, a civilian-trained psychiatrist, was the first commander of the 98th Psychiatric Detachment (May 1966–May 1967). His overview of the activities of the 98th Detachment[23] suggested important differences from that of its sister detachment to the south, the 935th. First, evidently the caseload of the 98th was about a third lighter. Conte acknowledged the relatively low overall psychiatric casualty rate, made little mention of combat exhaustion cases specifically ("a relative minority of the problems that presented related directly to combat experience"[23(p167)]), and compared the outpatient caseload of the 98th Detachment, which averaged between three and four patients per day, to that found on a stateside post. Their outpatient catchment area was estimated by Conte to be 25,000 troops. Apparently most outpatients initially received an intense, multiday evaluation, often involving psychological testing, but ongoing outpatient treatment was rare because of transportation impediments. The 98th returned to duty 80% to 90% of the 1,000 or so outpatients they were referred ("[M]ost of the diagnoses were in the character and behavior disorder category"[23(p167)]). Their consultation service primarily provided secondary prevention (assessment of referrals, which, in some instances led to interaction with units), but team members also regularly visited the "community caretakers" (dispensary physicians, chaplains, Red Cross personnel, etc). Additionally, a psychiatrist, social worker, and technicians flew weekly to Cam Ranh Bay to conduct a satellite clinic for the many nondivisional Army units located there.

The 98th KO team averaged about one new inpatient admission per day, and, like the 935th, their bed capacity was 12. Most strikingly, they diagnosed 40%–50% of hospitalized patients with schizophrenia—an extremely high proportion—and they returned only 40% of inpatients to duty—an unusually low percentage. By Conte's account,

> [A]bout 50% of the patients we received were essentially untreatable from the perspective of rehabilitation for duty within 30 days. The ward then, for them at least, became little more than a way station preliminary to evacuation [out of Vietnam].[23(p165)]

Their inpatient therapeutic program included work therapy, recreational therapy, group therapy, a patient government, and one unique feature: the detachment psychologist was regularly embedded into the ward milieu as a therapeutic participant-observer. Nonetheless, Conte reported considerable frustration associated with the "rapid influx of patients,"[23(p165)] burgeoning treatment requirements, and "much, much, paperwork."[23(p165)] Whereas his intention was that the ward "should be a place of humanness, giving, and feeding,"[23(p165)] the turnover pressure resulted in the ward becoming "more military and bureaucratically depersonalized,"[23(p165)] and the psychiatrist "felt more and more like a custodian administrator and less like a healer."[23(p165)] Finally, Conte was frank in acknowledging that he and his colleagues at the 98th "struggled to cope with our ambivalence toward the war, with anxieties and depression upon separation from our families . . . and with the exquisite frustrations from the primitive circumstances in which we lived."[23(p167)]

Captain Joel H Kaplan, Medical Corps. Kaplan was a civilian-trained psychiatrist who served as the commander of the 98th Psychiatric Detachment (November 1968–1969) while it was still located in Nha Trang and attached to the 8th Field Hospital. Some appreciation for the deteriorating clinical circumstances faced by him and his staff were provided through his publication regarding the drug problems in the northern half of Vietnam during his year[24] and his 1970 testimony before the Senate Subcommittee to Investigate Juvenile Delinquency.[25] According to Kaplan, 70% of psychiatric outpatients and 50% of psychiatric inpatients were drug abusers (defined as "using drugs heavily day in and day out"), with both combat and noncombat troops equally represented. To try to meet the demand, the 98th initiated a nightly group therapy program, but successes were mostly limited to soldiers close to the end of their tours. Kaplan acknowledged that there was no easy answer to the growing "subculture of drugs" in Vietnam, and he implored Congress to take action to address this serious and unacknowledged problem.[25]

Major Norman M Camp, Medical Corps. Camp [the author] was an Army-trained psychiatrist who served his tour in Vietnam (October 1970–October 1971) as the commander of the 98th Psychiatric Detachment, 4½ years after it arrived in Vietnam and a year following its relocation to Da Nang (Figure 4-6). This volume's Prologue presented Camp's account of the drawdown's bottoming morale in Vietnam and the rampant psychiatric and behavior consequences that greatly challenged the 98th KO team. These included

FIGURE 4-6. The author, Major Norman M Camp, Medical Corps, was an Army-trained psychiatrist who served in Vietnam between October 1970 and October 1971 as the commander of the 98th Neuropsychiatric Medical Specialty Detachment (KO), which was outside of Da Nang on the coast of the South China Sea. This photograph was taken in fall of 1970 while he was touring a Catholic-sponsored leper colony outside of Qui Nhon. Photograph courtesy of Norman M Camp, Colonel, US Army (Retired).

the rapidly spreading heroin epidemic and antimilitary behaviors, particularly soldiers threatening to assassinate their leaders.

Major Nathan Cohen, Medical Corps. Cohen was a civilian-trained psychiatrist who served with Camp as the Deputy Commander of the 98th Psychiatric Detachment (August 1970–1971). A record of Cohen's experience, which serves to corroborate Camp's observations, comes by way of a speech he made to the I Corps Medical Society (Da Nang, January 1971). In his remarks Cohen acknowledged the "raging (heroin) epidemic"; however, he was also frankly critical of the disjointed countermeasures by the Army in Vietnam, especially the poorly conceptualized and implemented Drug Amnesty Program and command's expectation that the solution should primarily be a medical and psychiatric one. According to Cohen, the majority of drug users in Vietnam had stable use patterns as long as their supply remained uninterrupted, and their day-to-day functioning was unimpaired, even if, to varying degrees, some were addicted. More critically, these soldiers did not agree with the Army that they had a problem. They blamed their drug use on being assigned in Vietnam and being "hassled by the lifers," or they maintained that the drug was controlling them.

Cohen also observed that the majority of heroin users who were referred to the 95th Evacuation Hospital/98th Psychiatric Detachment were not physically dependent (as tested with a narcotic antagonist). They exaggerated their symptoms so as to be hospitalized to evade duty responsibilities and disciplinary action ("ersatz R & R [ie, rest and recuperation]"). Compared to nonreferred users, those who were seen at the 98th KO either had character and behavior disorders or they were individuals with adolescent turmoil who were seriously maladapted to their circumstance in Vietnam. Cohen categorically refuted the general impression that they were psychiatrically ill and argued that this problem would not yield to the methods of clinical medicine or psychiatry. He recommended a broad-based, command-centered approach—with medical support—that assumed drug abuse was an expression of a much wider morale problem. Such an approach would emphasize "limit setting and the instilling of realistic models for dealing with the inherently frustrating nature [of serving in Vietnam]."[26(p9)]

Further perspectives on psychiatric challenges at the 98th Psychiatric Detachment are found in the Prologue and in the summary of social work officer Meshad's narrative describing his ethical struggle in 1969–1970 (in Chapter 11).

Discussion of the Documentation by Psychiatrists Who Served With the Neuropsychiatric Medical Specialty Detachments

Just as the earlier effort to reconstruct the history of Army psychiatry in Vietnam from the reports of the division psychiatrists and those assigned as solo psychiatrists to the evacuation and field hospitals was limited by the many gaps in information, the record provided by those who served with the specialized psychiatric detachments is similarly incomplete. Not only were the available reports inconsistent in the types of information provided, they also tended to be skewed toward the first half of the war and the southern psychiatric detachment, the 935th. Otherwise, with the exception of Ratner's portrayal of the clinical ordeal associated with the heroin epidemic at the Army Amnesty Center on Long Binh Post in 1971, there was little to represent the 935th between 1969 and 1972 when the last combat units left Vietnam. With regard to the 98th, Conte's description of circumstances there during its first year in Vietnam stands alone until the late war years when Kaplan's depiction of the clinical challenges associated with the growing marijuana problem, this author's postwar account (Prologue),

and the talk by Cohen convey a picture of a hectic, dysfunctional drawdown Army.

The available information did indicate that the deployed mental health personnel assigned to the two KO teams worked very hard under very challenging circumstances, both physically and clinically, and provided commendable service. In fact, Bloch's description of his inpatient service at the 935th during the most intense period of combat activity served as a model treatment program given the circumstances. Similarly, Talbott's description of the consultation-liaison program spawned by the 935th that same year set an example for the provision of preventive services for a large collection of nondivisional support and service-support units in a combat zone. (Notably, his program is the only reference to command consultation activities provided by the psychiatric personnel assigned to the psychiatric detachments.)

With regard to clinical outcomes, Conte indicated that the 98th Detachment's inpatient service only returned 40% of patients to duty during its first year deployed (1966–1967). This was dramatically discrepant from Bowman's report that the 935th Detachment returned to duty 90% of hospitalized patients during roughly the same year of the war. Similarly remarkable, Conte reported that 40% to 50% of their patients were hospitalized for schizophrenia compared to the 5% reported by the 935th for "psychosis" (obviously not identical). It seems reasonable to speculate that the much higher rates for schizophrenia diagnosis by the 98th Detachment, as well as their much higher rates for evacuation out of Vietnam, in large part resulted from Conte's team's acknowledged civilian-centered clinical perspective ("healer"), in contrast to the military mission-centered one espoused by Bowman and the 935th—an emphasis derived from Bowman's strong military training and experience background (like the earlier comparison of division psychiatrists Jones, Bey, and Byrdy). However, Bloch's 78% return-to-duty rate a couple of years later was also much higher than Conte's, yet like Conte, Bloch was new to Army service and had no predeployment military experience. When asked about this, Bloch acknowledged that he was undoubtedly influenced by his father, who had combat experience in World War II, and by Anderson, his commanding officer at the 935th, who was trained in psychiatry by the Army and who had an extensive pre-Vietnam military background.[27] Chapters 5 and 11 will provide a fuller discussion of such potentially divergent clinical philosophies that may stem from such background differences.

US Marine Corps/Navy Experience Offshore in Vietnam

The Navy did not establish 3rd echelon care hospitals in South Vietnam. Marines and Navy personnel who required treatment beyond that provided in the medical units ashore or the field hospitals were evacuated to either of the Navy's two hospital ships, the USS *Sanctuary* and the USS *Repose*, or out of the combat zone (to Okinawa, the Philippines, Japan, or the United States). Two Navy psychiatrists, Robert E Strange and Ransom J Arthur, published a report summarizing their experience aboard the USS *Repose* treating 143 psychiatric cases admitted between February 1966 and August 1966. Notably, at that early point in the war they highlighted the overall low psychiatric attrition rate in Vietnam for which they credited the "high sense of purpose and commitment on the part of the individuals facing combat." Their daily census averaged 12 to 15 patients. Intakes averaged 1.7 cases per day. The length of stay averaged 13.5 days, and they returned to duty approximately 50% of cases. (Subsequently, Strange said that 62% were returned to duty and 38% were evacuated out of the theater.[28]) In contrast with reports from the Army psychiatrists, their report presented additional demographic information as well as that pertaining to extent of combat exposure as a potential risk factor. They were also more explicit regarding use of pharmacotherapy and differences in return-to-duty rates comparing psychotic, psychoneurotic, and character and behavior disorders (Table 4-3).[29]

THE ARMY'S SENIOR THEATER PSYCHIATRIST: THE NEUROPSYCHIATRY CONSULTANT TO THE COMMANDING GENERAL/US ARMY, REPUBLIC OF VIETNAM SURGEON

The Position of US Army, Republic of Vietnam Neuropsychiatry Consultant

The position of USARV Neuropsychiatry Consultant, typically referred to simply as the Psychiatry Consultant, completes the description of the Army psychiatrist assignments in Vietnam. This individual was the senior Army psychiatrist in Vietnam and served on the staff of the Commanding General, US

FIGURE 4-7. Colonel Matthew D Parrish, Medical Corps, being awarded the Legion of Merit in Vietnam. Parrish served in Vietnam between July 1967 and July 1968 as the third Neuropsychiatry Consultant to the Commanding General, US Army Republic of Vietnam Surgeon. In this position he monitored psychiatric casualties and treatment capabilities throughout the theater, directed the coordination of psychiatric facilities and program planning, and advised the Army commander regarding psychiatric matters. Photograph courtesy of Marilyn Parrish.

Army, Republic of Vietnam (CG/USARV) Surgeon. The Psychiatry Consultant's principle tasks were to monitor psychiatric casualties and treatment capabilities throughout the theater, direct the coordination of psychiatric facilities and program planning, and advise the Army commander regarding psychiatric matters. Although based at US Army Headquarters on the post at Long Binh, they traveled extensively throughout Vietnam, visited psychiatrists and programs, provided clinical leadership, and consulted with senior military leaders about issues affecting mental health and fitness.

The psychiatry consultant was also required to coordinate mental health operations with the US Air Force and Navy medical systems, which had their own psychiatric elements. At times there was a similar necessity to coordinate with counterparts within the Korean Army and the few psychiatrists serving with the Army of the Republic of Vietnam. Ultimately, nine Army psychiatrists served in this position between November 1965 and November 1972. Regrettably, none of the psychiatry consultants published accounts of their tour in Vietnam. However, some perspective can be gleaned from information from four of them provided through other means.

The US Army Republic of Vietnam Neuropsychiatry Consultants

Lieutenant Colonel John Gordon, Medical Corps

Gordon was the first USARV Psychiatry Consultant (November 1965–September 1966). He was a graduate of an Army psychiatry-training program and had over 12 years of experience as an Army psychiatrist before assuming this position in Vietnam.

Lieutenant Colonel Arnold W Johnson Jr, Medical Corps

Johnson was a Korean War veteran and received his psychiatric training in an Army residency program. He served as the second Psychiatry Consultant (July 1966–July 1967). In a 1967 panel discussion, Johnson provided an extensive overview of the psychiatric challenges faced by the Army early in the war, especially those consequent to the inevitable confusion attendant to the rapid influx of troops under combat conditions and the practical problems involving housing, communications, and especially transportation.[3]

With regard to combat troops, Army units were often widely scattered, ground transportation was risky, and the medical evacuation helicopters were not assigned directly to the combat units but operated on a regional basis. This meant the pattern of medical evacuation frequently deviated from the Army's echelon structure in which medical treatments were to be provided closest to the soldier's parent unit. The often-improvised area coverage of medical and psychiatric care that arose as a consequence did not seem to present major problems regarding combat-generated psychiatric problems because they were relatively infrequent. Most of those that did occur did not require evacuation as they were effectively handled at the 1st echelon care level by enlisted corpsmen in tandem with the battalion surgeons (at times assisted by enlisted social work/psychology technicians).

TABLE 4-3. Major Diagnostic Groupings for 143 Navy and Marine Admissions to the Psychiatric Service of the USS *Repose* Between February 1966 and August 1966*

Diagnosis	Character and Behavior Disorder (67%)	Psychoneurotic Disorder (20%)	Psychotic Disorder (13%)
Age in years	21.4	25	22.6
Rank	Majority were E-2	E-4 and above	Mostly E-3 and E-4
Military experience	Short, with disciplinary problems	> 3 years	No information provided
Married	35%	52%	23%
History of agitation, violence	45%	18%	18%
Combat exposure	63%	79%	32%
Combat judged to be a major precipitant	49%	47%	16%
Those treated with drugs	54%	82%	90%
Those returned to full duty	52%	75%	none

*By selected demographics, extent of exposure to combat, etiologic importance of combat stress, percentage treated with pharmacotherapy, and percentage returned to full duty.
Data source: Strange RE, Arthur RJ. Hospital ship psychiatry in a war zone. *Am J Psychiatry*. 1967;124(3):281–286.

According to Johnson, the Army mental health asset allocation in Vietnam favored the combat divisions despite the fact that the noncombat personnel outnumbered combat troops by 3-4:1. This disadvantaged the very large concentrations of support troops, especially in the Cam Ranh Bay and Qui Nhon areas, because of the formidable distances separating them from the psychiatric specialty teams. These challenges notwithstanding, Johnson spoke of his own job satisfaction, which was consistent with the overall "excellent level of morale and motivation" he noted throughout the theater and the unexpectedly low levels of psychiatric attrition, including from combat stress.

Colonel Matthew D Parrish, Medical Corps

Parrish (Figure 4-7) was the third USARV Psychiatry Consultant (July 1967–July 1968). He had served over 20 years as an Army officer before his assignment in Vietnam, including a tour in World War II as a bombardier and one in Korea during the war as an Army psychiatrist. He received his psychiatric training at Walter Reed General Hospital in the early 1950s. In his correspondence with the author 17 years after he returned from Vietnam, Parrish provided glimpses into his experience as the senior Army psychiatrist in Vietnam, as well as in the aftermath (see Appendix 13, "Parrish's Postwar Recollections"). Parrish indicated that he was somewhat dismayed that no history of psychiatry in Vietnam had been forthcoming from the Army and that there was no repository of the monthly reports he and the other psychiatry consultants in the Vietnam theater of operations were required to send to the Army Surgeon General's Office. On the positive side, he recalled that the psychiatrists who were assigned during his year—a year that included some of the most intense fighting of the war—were in ample numbers and adequately trained.

Parrish also approved of the regular use of neuroleptic tranquilizers in the theater and believed that there were no significant adverse consequences. On the other hand, he expressed regret that prescribing such drugs was part of a trend toward training psychiatrists to diagnose and medicate patients as opposed to clinical approaches that would provide (in Vietnam) more psychological support for the soldier's recovery, including reintegrating him into his military unit ("enmembering"). Parrish reflected a measure of cynicism in his thoughts on how the war was waged. In particular he worried that it became unwinnable because of a failure of the administration and the military to stay in touch with human dimensions as opposed to conducting the war as a "management war" (ie, overvaluing quantifiable elements). In this regard, he suspected there was "upper echelon" resistance to the analysis of psychiatric statistics coming out of Vietnam because it might be interpreted critically. As an example, he noted that the results of a 1967 soldier drug use survey, the first theater-wide study of marijuana use, was suppressed by the USARV Surgeon's office because of its negative findings.

Lieutenant Colonel George Mitchell, Medical Corps

Mitchell served as the fourth USARV Psychiatry Consultant (July 1968–July 1969). He was a graduate of an Army psychiatry-training program and had over 8 years of experience as an Army psychiatrist before assuming his position in Vietnam.

Colonel Thomas "Brick" Murray, Medical Corps

Murray (Figure 4-8) served as the fifth USARV Psychiatry Consultant (1969–1970). In 1960 he completed his training in psychiatry at Letterman General (Army) Hospital. This was followed by assignments at the US Military Academy at West Point, at Madigan General Hospital, and at Walter Reed General Hospital (Chief of Psychiatry), before he was assigned to Vietnam. Although Murray did not provide a summary of his tour of duty in Vietnam, Bey included the following description from contacts with him while serving as division psychiatrist with the 1st Infantry Division:

> Col. [Colonel] Murray reviewed the psychiatric statistics from the various units in Vietnam and passed on information of epidemiological significance both to the psychiatrists in Vietnam as well as to BG [Brigadier General] Thomas who was the USARV Surgeon. Col. Murray held a conference on alcohol and drug abuse in Vietnam in conjunction with the Judge Advocate's Office and the CID [Criminal Investigative Division]. At this meeting the medical and legal branches had an opportunity to exchange information and to share their experiences in attempting to reduce the casualties resulting from drug abuse. Col. Murray regularly visited all of the psychiatric services in Vietnam. He provided direct professional supervision to us and shared his extensive knowledge of military psychiatry. . . . Col. Murray also set an example to his supervisees to keep on the go and to fly and consult and supervise their [social work/psychology] technicians and to visit units in their divisional areas. Col. Murray was well schooled as a military psychiatrist and felt at home consulting with outlying units. Through his rank and military experience he could consult with the generals and brigade commanders in the combat division in a way that was most helpful to the division psychiatrist's efforts to establish an effective unit consultation program. Through his continual contact with the psychiatrists in Vietnam and their units, Col. Murray obtained much information which could not be learned from the monthly statistical reports sent to his office. Col. Murray was well liked by officers and men in the First Infantry Division and was a frequent and welcome guest in our Division. He did a great deal to support and ease our efforts within the Division.[30(Chap5,pp3–4)]

Colonel Clotilde D Bowen, Medical Corps

Bowen holds the distinction of being the first black female physician to serve in the US Army. Initially trained as a specialist in pulmonary medicine, she completed her civilian psychiatry training in the early 1960s and ultimately became the sixth USARV Psychiatry Consultant (July 1970–July 1971). She recalled receiving her orders to serve in that position, "[with] surprise and dismay," as she had only 3½ years of experience as an Army psychiatrist—considerably fewer than her predecessors. In her position as Psychiatry Consultant in Vietnam, Bowen not only monitored the work of the deployed mental health personnel in Vietnam as had earlier consultants, but in addition she was required to plan and coordinate the Army's hastily developing drug and race relations programs, submit reports about the morale and mental health of troops there, and brief congressmen, visiting foreign dignitaries and ranking officers, and representatives of the news media "who wanted to know what was really happening as we were losing the war."[31(B-11)]

Bowen's official End of Tour Report (see Appendix 14) was appropriately constrained, but it nonetheless provided a striking contrast to Johnson's optimistic overview from 4 years earlier. In particular Bowen provided a window into the enormous difficulties borne by the Army leadership in Vietnam during the last years of the war in trying to keep up with rapidly deteriorating soldier morale, discipline, and mental health while maintaining a capable fighting force. By her account Bowen did a commendable job in orchestrating the mental health assets amidst the drawdown's shortages of trained personnel, turbulence of military personnel more generally, and the rising incidence of psychiatric and behavior problems. Her report appeared to substantiate command's mixed results in counteracting these unprecedented problems:

- Bowen noted that the first autopsy confirmation of a heroin overdose death among Army troops occurred in August 1970—which suggested the

FIGURE 4-8. Colonel Thomas "Brick" Murray, Medical Corps, and his escort, Captain Ross Guarino, Medical Corps, 1st Infantry Division, visiting a Vietnamese psychiatric hospital. Murray served in Vietnam between July 1969 and July 1970 as the fifth Neuropsychiatry Consultant to the Commanding General, US Army Republic of Vietnam Surgeon. Photograph courtesy of Douglas R Bey.

soldier heroin problem had reached a new and disturbing level.

- She alluded to the "crash" project to publish a medical technical guidance manual about drug abuse in Vietnam (with Major Eric Nelson, Medical Corps, commanding officer of the 935th Psychiatric Detachment) for distribution to newly arriving physicians (implemented in January 1971)—which suggested how unprepared the Army in Vietnam was for the heroin problem.
- She described the shift of heroin detoxification centers from medical and psychiatric authority to command/disciplinary authority—which suggested the relative failure of the medical approach in reducing soldier heroin use.
- She mentioned persistent problems with the medical/psychiatric reporting system, especially for alcoholism, drug abuse, and psychosomatic conditions—which appeared to reflect disagreement as to whether soldier drug abuse should be regarded as a discipline problem, a medical condition, or a psychiatric disorder. It also indicated that the traditional measures of psychiatric morbidity had become distorted.
- She referred to the elimination of the Army Regulation 635-212 requirement that psychiatrists evaluate every soldier for whom a commander recommended administrative separation from the Army (implemented in October 1970)—which suggested an overwhelming rise in command referrals to psychiatry for soldiers with disciplinary problems or unsatisfactory performance.
- She advocated that nondivisional units have unprecedented access to the mental health assets of the combat divisions—which suggested the disproportionate prevalence of problems regarding racial incidents, drug abuse, and soldier dissent within support units.
- She advocated an unprecedented elevation of the (staff) status of the division psychiatrists to be the equivalent with the division surgeons—which suggested a growing tendency for division commanders and division surgeons to disregard the expertise of their division psychiatrists, especially regarding racial incidents, soldier dissent, and drug abuse.

Major Francis J Mulvihill Jr, Medical Corps

Mulvihill was a recent graduate from a civilian psychiatry-training program and had no experience as an Army psychiatrist before his assignment in Vietnam. In Vietnam he served as a solo psychiatrist at the 67th Evacuation Hospital for 8 months before being reassigned to USARV HQ to serve as interim USARV Psychiatry Consultant (June 1971–September 1971).

Colonel Niklaus J A Keller, Medical Corps

Keller not only served as the eighth USARV Psychiatry Consultant (August 1971–April 1972), but he was also Chief of Professional Services for the CG/USARV Surgeon. He received partial training in psychiatry in a civilian program before he entered the Army in 1950. This was followed by 4 years of training in a combined neurology/psychiatry program at Walter Reed General Hospital. During most of the intervening years between his training at Walter Reed and his

assignment in Vietnam, he served as a neurologist or in medical administration, including in Korea in 1964.

Major Ralph Green, Medical Corps

Upon completion of his Army psychiatry-training program in the Fall of 1971, Green was assigned to Vietnam to the Cam Ranh Bay Detoxification Center. Six months later he was reassigned to be the ninth USARV Psychiatry Consultant (May 1972–November 1972).

Discussion of the Documentation of the Activities of the Psychiatrists Assigned as USARV Psychiatry Consultant

Each of the available portraits of the senior Army psychiatrists in Vietnam is descriptively interesting. Johnson appeared to reflect confidence that Army psychiatry was doing its part in medically supporting the escalating war effort; and Murray (through Bey's description) appeared to be the model of the effective psychiatric advisor for command and mentor for the deployed mental health component. In contrast, Parrish (who preceded Murray but whose comments must be considered to be influenced by the negative postwar zeitgeist in America) and Bowen (who found herself in the middle of the war's most difficult drawdown problems) suggested a far more negative view. However, because these four individuals represented fewer than half of those who held the critical position of Neuropsychiatry Consultant to the USARV CG/Surgeon, and inasmuch, perhaps with the exception of Johnson's panel presentation, none of these accounts were drafted by the principals as reports summarizing their experiences, one again is left to speculate on all that is missing. This is even more disturbing when Parrish noted that the consultants were required to forward a monthly psychiatric report to the office of the Army Surgeon General in Washington, which were evidently discarded or destroyed.

SUMMARY AND CONCLUSIONS

This chapter, combined with the preceding one, featured the available records provided by 24 Army psychiatrists and paraprofessionals who fought the war in the psychological trenches 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. Taken together, these two chapters tell a story of a mental health contingent that was trained, organized, and supplied in a fashion 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 predicted to be disabled by combat stress. The extant documentation indicated they met these challenges with commitment and effectiveness.

This chapter presented more specifically summaries of the publications by some of those assigned as solo psychiatrists with the field and evacuation hospitals and some of those who served in the neuropsychiatric medical specialty detachments. It also reviewed the available information pertaining to the work of four (of nine) psychiatrists who were the Neuropsychiatry Consultants to the CG/USARV Surgeon. In addition to their descriptive value, these reports suggested the following trends:

- **The solo psychiatrists assigned to the field and evacuation hospitals treated a steady stream of referrals representing a mix of problems more centered on combat theater stress than combat stress.** Each psychiatrist provided basic inpatient care for a large catchment area of support troops, and the psychiatric conditions requiring such treatment were mixed in nature and mostly manageable despite the lack of additional specialized staff. Although only one (of five overviews) mentioned drug abuse as etiologically significant, this was clearly a consequence of the group serving during the first couple of years of the war. On the other hand, all of them reported substantial alcohol problems. Finally, none of them indicated they provided consultation to unit commanders or other Army agencies.
- **The psychiatrists assigned to the 935th and the 98th Neuropsychiatric Medical Specialty Detachments (KO)—the definitive psychiatric treatment facilities in Vietnam—verified that, as designed, they had a more challenging caseload than the other hospital psychiatrists.** Their cases included some soldiers with combat-stress generated psychopathology (fresh casualties, as well as treatment-resistant ones from the division psychiatrists), but most cases had conditions not primarily connected with combat. Inpatient programs provided an array of treatment elements including milieu therapy, psychotropic

medications, and, especially, the therapeutic relationships provided by the enlisted specialists. Inpatient treatment outcomes varied widely between these two specialized units; the percent of hospitalized soldiers recovered for duty in the theater ranged from 40% to 90%, with the higher recovery rates coinciding with the implementation of the combat psychiatry treatment doctrine. Very little was said regarding the treatment of outpatients, and only one report described a program of command and agency consultation.

- **The record from the psychiatrists assigned as USARV psychiatry consultant is both quantitatively and qualitatively sparse.** Although the available information regarding those who served as psychiatry consultant in years 2, 3, 5, and 6 of the war was mostly indirect, the composite strongly indicated how personally, professionally, practically, and ethically challenging this important leadership job became as the war lengthened.
- **Except for fragments derived from unconventional sources, the individual professional accounts mostly stopped after 1968 to 1969—the midway point in the war.** As a result, the collection of records provided by the psychiatrists assigned with the hospitals, those who served in the psychiatric medical specialty detachments, and those who served as USARV Psychiatry Consultant fell short of representing the psychiatric services provided throughout the war. As the surviving record, this is especially unsatisfactory because theater-wide indices of psychiatric and behavior dysfunction among the troops began to rise in 1968, a trend that accelerated sharply through 1969–1972 and was unrelated to the dropping levels of combat activity.

The chapters that follow will consider these resources in more depth, examine additional information from other sources, and present findings from the Walter Reed Army Institute of Research survey of Army psychiatrist veterans of Vietnam in an attempt to fill in some of the blanks left by this review.

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