CHAPTER 5

The Walter Reed Army Institute of Research Survey of Army Psychiatrists Who Served in Vietnam

Conversion [r]eactions and [m]alingering . . . are not of major importance to the civilian psychiatrist whose patients exchange money, inconvenience, time, and in some cases an initial loss of self-esteem for the hope that the physician will relieve his discomfort. In the military, where cost is not a factor (and in fact illness could provide compensation), where time out of the field is a convenience (the longer the better), and where any medical procedure is preferable to the dangers and stress of combat, these topics become extremely important in the medical officer's daily workload.[1(ChapIX,pp5–6)]

Major Douglas R Bey
Medical Corps, Division Psychiatrist
1st Infantry Division (April 1969–April 1970)

Major Nathan Cohen, Medical Corps, 98th Psychiatric Detachment (back seat), prepares to travel with an armed convoy 80 km north from Da Nang to Quang Tri near the demilitarized zone in Spring 1971 to provide care for troops of the 1st Brigade, 5th Infantry Division (Mech). Cohen was drafted into the service immediately following his civilian psychiatry training and, like the majority of psychiatrists who served there after 1968, Vietnam was his first post-residency assignment. Photograph courtesy of Norman M Camp, Colonel, US Army (Retired).

Construction of an official and, one might argue, essential history of Army psychiatric care in the Vietnam theater by the Army Medical Department was never accomplished, even if it was evidently intended.[2] Some documentation exists in conventional published sources; however, critical shortcomings persist, especially because of the drop-off in professional publications by assigned Army psychiatrists and other mental health professionals after the war passed its midpoint. Furthermore, the opportunity to develop a comprehensive history has been missed due to the passage of time and the loss of primary documents and personnel. The review of individual reports by Army psychiatrists who served in Vietnam and their mental health colleagues (Chapters 3 and 4) is very illuminating; however, large gaps remain. In an attempt to establish a more complete picture of the psychiatric challenge, practices, and

results in Vietnam, albeit a decade after American ground troops were finally withdrawn, Walter Reed Army Institute of Research (WRAIR) conducted a survey in 1982 of all locatable psychiatrists who had served with the Army there. This chapter will describe that survey as well as present selected results. Additional findings will also be presented throughout this work.

THE WALTER REED ARMY INSTITUTE OF RESEARCH STUDY DESIGN, RESPONSE, AND MODE OF ANALYSIS

Study Rationale and Objectives

While assigned to WRAIR in the early 1980s, this author conducted a comprehensive review of the available psychiatric and behavioral science literature surrounding military psychiatry in the Vietnam war[3] and found it to be regrettably spotty and even misleading in places—especially in its limited perspective regarding the psychosocial and psychiatric deterioration of the deployed force in the second half of the war. Equally problematic, primary documents from the war such as clinical records or prevalence data could not be located by the Army at that time and evidently did not still exist.[4] Eight of the nine (one was deceased) psychiatrists who served as senior Army psychiatrist in Vietnam (US Army Neuropsychiatry Consultant to the Commanding General/US Army Republic of Vietnam [CG/USARV] Surgeon) were contacted personally and all acknowledged that they did not retain records from their tour; several commented that it was against Army policy to return to the United States with professional documents.

In 1982 the author developed and distributed a survey instrument to all who served as Army psychiatrists in Vietnam inquiring about their preparation, training, and assignments in Vietnam; their professional activities while in the theater; and their reactions regarding their tour. It was hoped that this alternative approach of systematically collecting the recollections of these trained professional observers could complement the fragmented record from the war and allow for a more comprehensive portrait of the dominant patterns of perceived psychiatric need, practices, and results.[5,6]

Survey Questionnaire

The questionnaire consisted of fill-in items and forced-choice questions regarding 10 aspects of Vietnam service. The fill-in questions addressed three areas:

1. professional background and preparation, such as the length and type of formal psychiatric training (ie, civilian or military), extent of pre-Vietnam military experience, and information on Vietnam assignments (ie, units, duties, and dates);
2. estimates of time commitments to military and professional duties in various types of assignments as well as estimates of the percentages of their clinical time devoted to categories of patients across a spectrum of diagnostic groups; and
3. recollections of the indications for prescribing psychotropic medications in the treatment of combat stress reactions as well as for psychiatric symptoms presenting among combat-exposed troops in general.

The forced-choice questions were grouped in seven additional areas for which the participants were asked to indicate extent of their agreement/disagreement along a 5-point scale regarding:

1. the perceived efficacy of various types of therapy for treating combat reactions;
2. circumstantial factors perceived as contributing to the pathogenesis of combat breakdown at both the level of the individual soldier and the level of the group;
3. estimates of troop morale and impressions of situational factors perceived as lowering morale;
4. perceptions of professional requirements regarding the treatment and management of behavioral problems;
5. estimates as to the utility of primary prevention activities, that is, command (program) consultation;
6. perceptions regarding the dominant patterns of substance abuse among troops; and
7. recollections regarding participants' operational frustrations and ethical dilemmas while assigned in Vietnam.

Interested readers can review the original questionnaire through the Defense Technical Information Center (http://handle.dtic.mil/100.2/ADA556223).

Survey Population

The first step—that of determining how many psychiatric positions there were in Vietnam and identifying who served in those positions—proved much more difficult than anticipated. Official Army sources

yielded only 51 names, yet it could be estimated that the number of Army psychiatric positions over the 7 years of combat activity was in the range of 135 to 140 (taking into account that psychiatrist tours, as with all Army personnel deployed in the war, were limited to 1 year).[7] The sole remaining course was to build a personnel list from unofficial sources. This led to extensive correspondence with those already identified, inquiring as to whether they could help identify colleagues who also served there. Gradually, and with many false starts, the list of Vietnam Army psychiatrists grew to reach 123. Of the 123, three were not located and five were deceased, reducing the study's population to 115 (113 men, two women).

Survey Response

The response from the study population to the survey was robust in that 85 (74%) provided useable responses. Seventy-four psychiatrists completed the entire questionnaire and 11 completed an abbreviated version (sections 1–2 of the fill-in parts and sections 5 and 7 of the forced choice parts). Regarding response distribution, neither the stage of the war served, nor the setting of the psychiatrists' primary training (civilian or military), apparently introduced a skew in the willingness to participate in the survey. Respondents were evenly distributed over the years of deployment in Vietnam (60%–80% of psychiatrists who served during the advisor and build-up periods of the war [1962–1967], as well as the transition [1968–1969] and the withdrawal [1970–1972] stages). Also, it had been previously determined that the original target population of 115 consisted of 30% with military psychiatric training and 70% with training in civilian programs; a military-to-civilian training ratio of 1:2 was found for the 85 study participants.

Data Analysis

The retrospective and inferential nature of the study meant that it would primarily serve various descriptive or hypothesis-generating purposes as opposed to hypothesis testing. Thus an analytic approach to the data was utilized that primarily centered on descriptive categorization or simple inferential statistical analyses. In several instances, small sample sizes precluded more complex statistical approaches. However, on occasion, such approaches were utilized. Specifically, multi-item batteries were submitted to data reduction procedures, that is, factor analysis, for the purpose of trying to summarize the information contained in those batteries. By so doing, regression analyses based on the composites derived from various subsets of items were not only likely to be more robust, but the overall analysis could also proceed more efficiently than would be the case if the analyses focused only on the individual items.

Because the survey questionnaire was designed to allow participants to skip sections that did not apply to their experience in Vietnam, numbers of respondents in various sections of the analysis are often less than 85. In this work the most definitive results are presented. Selected findings from the survey have been published in a preliminary form.[5,6]

Study Limitations

This research was not intended to replace studies that should have been conducted during and immediately after the war. As an alternative approach, the findings from this structured "debriefing" are subjective, requiring retrospection many years after the war ended. Nonetheless, the study's qualitative and quantitative results strongly indicated that, in most instances, the psychiatrists' recollections of their Vietnam experiences remained vivid, even if in some instances their interpretations of the meaning of those events have changed. Thus it is informed recollection. The "felt experience" of the war to the psychiatrists who were charged with "picking up the pieces," as it were, is critically important to understanding the psychological costs of the conflict as perceived by those most qualified to understand them. In other words, other than from first-person accounts of the war, which are by definition limited in their generalizability, the expert opinion distilled from the WRAIR psychiatrist survey is as close as a reader can get to obtaining a real "feel" for the emotional and behavioral effects of the war on those who fought it.

WALTER REED ARMY INSTITUTE OF RESEARCH SURVEY RESULTS: PRINCIPAL DISTINCTIONS AMONG ARMY PSYCHIATRISTS IN VIETNAM

Before addressing the WRAIR survey participants' recollections of the psychiatric challenge in Vietnam, it is important to acknowledge certain potentially confounding variables centered on the psychiatrists themselves. Whereas it may be convenient to think of Army psychiatrists as a single group, that is, inter-

changeable physicians with specialized training, three key differences have the potential to affect their experience in Vietnam as well as their perception of it: (1) phase of the war served in Vietnam, which takes into account associated changing social and military contexts; (2) military familiarity, which refers primarily to whether the psychiatrist received his or her psychiatric training in a military program versus in a civilian program, but in some analyses includes those with civilian training who had some stateside military experience before serving in Vietnam; and (3) combat unit assignment in Vietnam vs assignment to a hospital or psychiatric detachment there.

Phase of the War Served in Vietnam and Changing Social and Military Contexts

The survey psychiatrists' recollections could have been influenced by the half of the war in which they served. The preceding chapters have illustrated that later cohorts of replacement psychiatrists assigned in Vietnam faced an accelerating array of more complex, and in many ways unique and unanticipated, problems in Vietnam—while surrounded by a fractious American society and a hostile professional climate. Also suggested is that some of the deployed mental health personnel, primarily those serving in the later years, may have shared to some degree the demoralization and antimilitary passions of the soldiers whom they treated or may have even become uncertain of their own goals, procedures, and the Army's forward treatment doctrine for management of troops under those circumstances. A critical question then follows: were the clinical perceptions and decisions of these later Army psychiatrists affected by doubt and demoralization? As the nation turned progressively against the war, did later psychiatrists lean more in the direction of a protective, sympathetic overdiagnosis (ie, from the military's point of view) and overevacuation of soldiers[8]—even though in past wars such a clinical posture threatened force conservation and military success, as well as contributed to sustained disability among individual soldiers? Ethical and moral reactions to a war and its politics can measurably influence military psychiatrists regarding the diagnosis and management of their cases.[9]

Because of the small numbers of survey participants, the three phases of the war mentioned earlier were collapsed into two. Using a somewhat arbitrarily chosen dividing line, Army psychiatrists were categorized by their service during either of the two halves of the war, with "early" or "late" referring to whether they arrived in Vietnam before or after May 1968—before and after the pivotal 1968 enemy Tet offensives. Forty survey psychiatrists (47%) served in Vietnam in the first half of the war ("early" psychiatrists), and 45 (53%) were assigned in the second half ("late" psychiatrists). Some of the WRAIR survey data will be explored dichotomously from the standpoint of the effect of this variable.

Military Familiarity: Pre-Vietnam Training and Military Psychiatry "Orientation"

As suggested in the preceding chapters, there are several important experiences in the Army psychiatrist's pre-Vietnam professional background that had the potential to influence their reactions to the war and their professional perspective. These include: (*a*) setting of psychiatry residency training (ie, civilian or military); (*b*) extent and nature of the orientation and training provided by the Army; and (*c*) having a military assignment in the United States before deployment in Vietnam.

Military vs Civilian Psychiatry Training

In World War I, World War II, and the Korean War the mounting need for psychiatric manpower fell largely upon civilians. In the most dramatic example, on VE (Victory in Europe) Day in 1945, a total of 2,402 Army officers were in psychiatry positions. Yet, before the World War II mobilization began, there were fewer than 20 Army medical officers with training in psychiatry.[10] As was noted earlier, matters were distinctly more favorable for Vietnam in that roughly 30% of Army psychiatrists assigned in Vietnam were graduates of Army psychiatry training programs.[6]

As will be discussed here, before Vietnam the Army learned to be cautious with regard to the civilian-trained psychiatrist because of the critical leadership role demanded of every military psychiatrist in the treatment and restoration of the soldiers who succumb to battle stress (ie, because the requisite medical priority was that of force conservation). The history of military psychiatry repeatedly highlights a fundamental difference in clinical perspective that distinguishes psychiatrists with military professional training from those with civilian professional training. In particular it underscores the necessity that the "military inexperienced" civilian-trained psychiatrist accept the modified treatment goals that underlie the military doctrine of forward treatment for psychiatric and behavior disorders, especially

combat stress reactions.[11] As articulated by Albert J Glass, a senior Army psychiatrist, and his colleagues:

> [The effective military psychiatrist] renders decisions and recommendations which are meaningful and relevant from a military standpoint. . . . The psychiatrist, new to the service, cannot hope to achieve such military sophistication by limiting his professional activities to a traditional office or hospital practice. [H]e must acquaint himself with the military environment, its rules, regulations, culture, mores and operational procedures.[12(p674)]

In a military setting, especially a combat situation, the civilian-trained psychiatrist is required to transcend his customary prioritization of the individual in the service of supporting the needs of "the group" (referring not only to the soldier's combat group and its combat mission, but also, by implication, American national interests more broadly). In practical terms, for the soldier who develops psychiatric or behavioral symptoms while in combat or anticipating combat, the clinical emphasis should be on his recovering sufficiently to return to combat duty or to function within the military structure—even if he has some residual symptoms or is reluctant.[13] Johnson, a senior Army psychiatrist, summarized the requisite attitude of the effective military psychiatrist as it relates to the rationale for the doctrine of forward treatment:

> If prompt treatment can be given in the individual's combat unit . . . this tends to catch the patient while the reaction is still in conflict between the interest in his group and his self-preservative interest. Appropriate handling at this level tends to preserve the group identification and submerge the self-preservative feelings which promote the symptoms. . . . An attitude of expectancy on the part of the physician and the other treatment personnel can be adequately implemented only if these personnel identify with the needs of the combat group [while also acknowledging] the discomfort of the person who presents with symptoms. . . . The criterion for return to duty is not comfort or complete absence of symptoms but rather ability to perform.[14(p307)]

Harris comments similarly from the Korean War, but he is more direct in distinguishing the problematic civilian perspective:

> The psychiatrist gets his expectations from his orientation—from others and his own experience he rather quickly learns what the score is. I doubt if many patients could ever be returned to duty if the division psychiatrist did not "expect" it. It is . . . a problem of the psychiatrist's own orientation and the means he finds for 'handling' (in contrast to what is usually called [in civilian practice] treating) patients.[15(p399)]

An example of the effects of this distinction from Vietnam can apparently be seen early in the war when comparing the reported experiences of Conte (a civilian-trained psychiatrist who indicated that the 98th KO treatment center returned only 40% of hospitalized soldiers back to duty in Vietnam) with Bowman (an Army-trained psychiatrist whose 935th KO treatment center returned 90% of hospitalized soldiers back to duty during the same timeframe), as discussed in Chapter 4. (Also see Exhibit 5-1, "Potential Identity Problems Facing the Drafted, Civilian-Trained Psychiatrist.")

Preassignment Military Orientation

To address these problems, early in World War II the Army created a 4-week School of Military Neuropsychiatry designed to systematically "indoctrinate" newly inducted psychiatrists. Until an acute shortage of trained psychiatrists later in the war forced conversion of these programs to provide basic psychiatric training for general physicians, over 400 civilian psychiatrists underwent this training.[16] A similar program was instituted for psychiatrists who were new to the Korean combat theater.[17]

The case of Vietnam revealed a much more limited preassignment training and indoctrination.[13] It had apparently been assumed from the beginning that Vietnam-bound psychiatrists would receive sufficient expertise from the generic, 5-week medical officer's basic training required of all physicians new to the Army (Medical Field Service School, Fort Sam Houston, San Antonio, Texas).[7,18,19] In that program, successive cohorts of Army Medical Corps officers received familiarization in the Army's medical mission and its associated structures and procedures as well as specific preparation for various combat environments, especially Vietnam (at least through July 1967). For example, they participated in exercises in traumatic wound debridement using goats wounded with an M16A1 rifle, and

EXHIBIT 5-1. Potential Identity Problems Facing the Drafted, Civilian-Trained Psychiatrist

Many "noncareer" [military] psychiatrists, finding themselves in an alien, time-limited situation (usually two years), prefer to maintain a degree of social and occupational isolation as a means of defending against the realization that they are, in fact, a part of the military system. Having deferred the issue of military service through the three years of residency training, many are reluctant to subordinate their personal and therapeutic efforts to an organization whose values they may not share. Under these circumstances, there is a tendency for [some] psychiatrists, and noncareer physicians in general, to huddle together in shared paranoia and distrust of the "line" military. Thus isolated, there is ample opportunity to construct a skewed image of those outside the hospital as belligerent, insensitive, and ill-informed, particularly when it comes to mental health matters. There is a tendency to cling to familiar therapeutic modalities (eg, office-based psychotherapy) despite indications that the overall mental health of the [military] community might be better served by efforts toward primary prevention. Where persons are referred for administrative, rather than therapeutic, purposes, a great deal of energy [should instead be] directed toward expediting the evaluation procedure and, on occasion, manipulating the bureaucracy in the patient's behalf (most commonly in the area of assignment change and discharge requests).

Understandably, those who practice in [the former] manner soon begin to doubt the magnitude of their therapeutic impact. As in the case of the young draftee, the psychiatrist's self-esteem is closely tied to a positive work identity. As one feels less "therapeutic" and more like a "tool" of the organization, there develops a propensity to identify with the "oppressed" patient. The result may be tacit support for continued "acting out" on the part of the patient, or the psychiatrist may expedite his premature discharge without examining the implications for future (civilian) adjustment. In either case, the patient may suffer. Many of those referred for psychiatric evaluation have already been subject to minor disciplinary action. Further belligerence not uncommonly precipitates courts-martial proceedings or administrative discharge. Where such a discharge is accompanied by a character and behavior disorder diagnosis, the psychosocial consequences can be quite severe. . . .

For [other] psychiatrists, the anxiety of being controlled by a powerful, sometimes unpredictable, system fosters identification with the perceived aggressor. Command values are quickly introjected, resulting in moralistic, as opposed to psychiatric, judgments. Adaptive failure is viewed solely as the result of a serviceman's psychopathologic disorganization, with little or no consideration for the environmental context. Concurrently, there is a tendency to think in administrative, rather than therapeutic, terms. This is not to deny that there are those cases where all concerned would be well served by prompt separation from military service. Rather, it is to point out that in a military setting, the doctor/patient relationship is subject to a number of dynamic pressures that may [be] characteristic of psychiatry in an institutional setting.

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they belly-crawled beneath live machine gun fire in a simulated night combat situation.

All attendees at this training received a few general hours of instruction on selected aspects of military psychiatry, which included key differences between the military and civilian practice of psychiatry. Beyond that, however, the new Army psychiatrists who would be assigned in Vietnam were relegated to on-the-job training there. However, in Vietnam their situations varied widely regarding the extent of their initial on-site supervision through overlap with the psychiatrists who preceded them. Overall it was quite limited if at all (per information collected separately from participants in the WRAIR Vietnam psychiatrists survey). Finally, throughout the war there was no effort made to debrief the Army psychiatrists returning from Vietnam so as to distill the collective wisdom for dissemination to the psychiatrists who were replacing them in Vietnam or to the Army residency training programs in the United States.

Practical Alternatives to Military Psychiatry Training

Because of the haste to mobilize the forces during World War I and World War II, civilian-trained psychiatrists (most) typically had no prior military experience before they assumed their new positions as military psychiatrists. Army residency training programs

EXHIBIT 5-2. The Jones-Dr A Correspondence

The following profiles and correspondence serve to illustrate the growing differences between the military trained and civilian trained psychiatrists who served with the Army in Southeast Asia during the war—differences that had the potential to affect clinical decisions in the theater and may have shaped American psychiatry and military psychiatry after the war. This subject will be amplified in Chapter 11. The identity of one of the correspondents has been disguised. His specific name is not as important as his view on military psychiatry.

Upon completion of his medical and psychiatric specialty training, Dr A was drafted into the Army. His first assignment was to Vietnam (early in the war) where he served with a psychiatric detachment near Saigon, followed by service with the 3d Field Hospital in Saigon. For his service in Vietnam he was awarded the Bronze Star Medal. His professional publications substantiate his valuable clinical contributions there. Upon his return to the United States and discharge from the Army, Dr A became politically active in the antiwar movement, including serving on the national steering committee of the Vietnam Veterans Against the War. In the intervening years following the end of the war, he achieved considerable professional distinction through his vigorous work on behalf of the psychiatric needs of the seriously mentally ill. In the late 1970s, he was instrumental in the development of the 3rd edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), the new psychiatric nomenclature that revolutionized the field of psychiatry. By the mid-1980s, Dr A had become the president of a major national professional organization, the editor of a prominent professional journal, and chairman of a Department of Psychiatry at a medical school. In a newspaper interview at the time of his appointment as department chair, he remarked that when he was drafted into the Army, he was so opposed to the war that he was tempted to move to Canada to avoid serving; yet the experience there was pivotal for him. In particular he was impressed there by the larger picture as opposed to dealing with the individual patient—the need to comprehend the overriding effects of the social and societal situation. Simultaneously in a journal column, he spoke of Vietnam as a national tragedy that represented America's political and economic decline.

Dr A's mostly civilian personal/professional trajectory and orientation can be contrasted to that of Franklin Del Jones, MD. Upon completion of his psychiatric specialty training at Walter Reed General Hospital in 1965, Jones was assigned as division psychiatrist with the 25th Infantry Division in Hawaii. After 5 months of familiarization time, Jones traveled with the advanced elements of the division when they deployed to Vietnam (see Chapter 3). Following his tour of duty in Southeast Asia, Jones served as the Assistant Psychiatric Consultant, Office of The Surgeon General, US Army, and 10 years later, as the Psychiatric Consultant, the senior psychiatrist in the US Army. In his field as a career military psychiatrist, Jones was as prolific as was Dr A in his area of specialization and achieved great distinction as the principle spokesperson for the heritage of military and combat psychiatry. This culminated in his becoming President, Military Section of the World Psychiatric Association and serving as senior editor and primary contributor to two landmark volumes (*War Psychiatry and Military Psychiatry: Preparing for Peace in War*) in the Army Surgeon General's series, *Textbooks of Military Medicine*. Jones retired from the US Army at the rank of Colonel in 1988 following over 26 years of active service. He was awarded the Bronze Star Medal for his service in Vietnam and the Meritorious Service Medal with Oak Leaf Cluster for his outstanding contributions to military medicine and psychiatry.

in psychiatry were not instituted until after World War II. When considering Vietnam it is more complicated. Some of the psychiatrists assigned there were trained in psychiatry in military hospitals and received some familiarization with the Army there; and some of the civilian-trained psychiatrists, although a minority, served at stateside Army posts before going to Vietnam. The latter arrangement created an optimal preparatory situation for the civilian-trained psychiatrists as they could incorporate military goals and priorities through their demonstrated utility with military populations; however, this arrangement was far more common in the first half of the war. Overall, most of the civilian-trained psychiatrists went straight from civilian life and civilian training to service in Vietnam.

The divergence in perspective between the military-trained psychiatrists and civilian-trained psychiatrists, especially those without a predeployment military assignment—divergence that has been noted in past wars to shape clinical decision making—likely became magnified over time in Vietnam because of the growing polarization within American society regarding justification for fighting in Southeast Asia. This is illustrated in the correspondence between John

EXHIBIT 5-2. The Jones-Dr A Correspondence, continued

The following correspondence was triggered by the appearance of David Crane on the "Dick Cavett Show." At that time, Cavett had a 90-minute show on ABC that ran in the same time slot as "The Tonight Show."

Dr A to Lieutenant Colonel Jones:

July 1, 1970

Dear Dr Jones:

I got so goddam mad after seeing Dave Crane [who served as division psychiatrist with the 25th ID in Vietnam] on the [Dick] Cavett show tonight that I wrote the enclosed letter to him. . . .

If you saw the show, I'd appreciate your dropping him and Dick Cavett a note. . . .

As psychiatrists and analysts, I'm sure we all have grave reservations about speaking out on public issues. But irrational rhetoric must be answered. If we, as psychiatrists who have served in Viet Nam, cannot rebut one of our own who uses national TV to preach continuation of this futile war—I think we truly deserve what we get. . . .

Yours in something constructive,

Dr A

Dr A to Dr Crane:

July 1, 1970

Dear Dave:

I [am writing] to express my disgust, anger and disappointment about the statements you made on the Cavett show tonight.

Scientific discretion, analytic neutrality, and mature skepticism—all have a place in discussing vital national issues. But Dave, if you really think there were few or minimal atrocities, if you think free fire zones are good for the country, if you think few Viet Nam returnees are exhibiting adverse opinions about the war—I think you are exhibiting the same outlandish political rhetoric that the militant revolutionaries are displaying.

If you want to join the irrational elements in American society, I suppose you have the freedom to do so—but don't lie—and don't parade yourself on National TV as a representative psychiatrist and Viet Nam veteran. Call yourself a politician, a shouter, someone who "having been there, knows the real story."

But remember, there are many psychiatrists—patriotic, not given to rhetoric and exaggeration, and trying to be truthful to ourselves, who saw and heard of atrocities, who knew and know "nationalistic" Vietnamese, and who know and treat Viet Nam returnees—who know you distort the facts.

An ego trip is quite a thing . . . but there are 17 million people who are pretty sick and tired of American ego trips—and 44,000 Americans who no longer know what that means.

Sleep well,

Dr A

EXHIBIT 5-2. The Jones-Dr A Correspondence, continued

Lieutenant Colonel Jones to Dr Crane

16 July 1970

Dear Dave:

I received an emotional and impulsive letter . . . from Dr A , seemingly urging me to castigate you for your appearance on the Dick Cavett Show. . . . I did not see the program . . . but if you expressed an unwillingness to surrender in the face of a totalitarian enemy; if you don't want another Munich; if you found, as I did, that most of the atrocities were performed by the communists; if you found that Viet Nam veterans exhibited no more adverse opinions about the war than veterans of any war express about war; and if you still hold to the conservative orientation which was present when we were in the 25th [ID] together, then I must vote "yea" on your appearance.

Sincerely,

FRANKLIN DEL JONES, LTC, MC
Asst. Chief, Psychiatry Service
[Walter Reed General Hospital]

Lieutenant Colonel Jones to Dr A:

28 July 1970

Dear Dr A :

First, I took to heart your suggestion to write Dave Crane and Dick Cavett, not about what Dave said [on TV] because I missed the program, but rather my response to your letter. In general, I indicated [to them] that I would like for the U.S. to be out of Viet Nam but not by surrender. After all if the war continues, I'll likely find myself back in Viet Nam. But Dr A, don't you think our government wants this as well? If we have learned little from the lessons of World War I & II and Korea, surely one thing must be clear: weakness and conciliation to an aggressor nation is an invitation to later conflict. . . .

I admire your initiative in taking a stand on what you believe . . ., but surely you need not rely on name-calling to castigate Dave for doing the same thing. You seemed to feel that Dave was misleading people by presenting himself as a Viet Nam veteran and psychiatrist who espoused a view of the war different from your own . . . but . . . what are you doing if not the same by lending your name in endorsement of the Viet Nam Veterans Against the War . . .?

Sincerely,

FRANKLIN DEL JONES, LTC, MC
Asst. Chief, Psychiatry Service
Walter Reed General Hospital

EXHIBIT 5-2. The Jones-Dr A Correspondence, continued

LIEUTENANT COLONEL JONES TO DICK CAVETT

28 July 1970

Dear Dick:

Thank you for allowing Dr David Crane to present his view on the Viet Nam War. I was the psychiatrist who preceded Dave in the 25th Infantry Division and I got to know his views, which are in general agreement with my own. We did not see disaffection with the war different from that with any war; atrocities were mostly committed by the communists; psychiatric casualties were no different from such casualties found in any stressful environment with one exception: they tended to be fewer than in the support troops such as troops in the Continental United States. . . .

While the majority of our youth answer the call to arms at least with resignation if not enthusiasm, a pampered, vociferous few who have not known that freedom has a cost nor suffered the consequences of conciliatory policies toward aggressors would have us turn our eyes away from this unpleasantry, Viet Nam.

I want the war to end; . . . But Dick, let's end it in a way that won't lead to our return to Asia in Burma, Thailand, Indonesia or even India. Return then would find us fighting communists in those countries no doubt augmented by "volunteers" from a unified communist Viet Nam–Cambodia–Laos.

Sincerely,

FRANKLIN DEL JONES, LTC, MC
Asst Chief, Psychiatry Service
Walter Reed General Hospital
Washington, DC

A Talbott, MD, and Lieutenant Colonel Franklin Del Jones (see Exhibit 5-2, "The Jones Correspondence"). In their passionate interchange, Jones, a career military psychiatrist, argued a conser-vative, promilitary, pro-Vietnam War position, and Talbott, a drafted psychiatrist, represented the opposing perspective. Despite the charged rhetoric between Jones and Talbott, there are no certain measures of patterned clinical decision making stemming from their espoused differences in perspective about the war. Chapter 3 did suggest that Jones demonstrated a military-centered clinical conservatism regarding diagnosis, treatment, and evacuation. However, the only evidence suggesting that Talbott functioned at the other extreme came from the interview he gave upon his return from Vietnam in which he noted the rather universal opposition to the war he saw among the soldiers there and expressed his belief that although patients may have been labeled as psychiatric problems they really expressed a "widespread negative sociologic phenomenon."[20] These value distinctions and their possible clinical effects will be explored in Chapter 11.

Professional and Military Backgrounds

Among the 85 psychiatrist participants of the WRAIR Survey, 27 (32%) received their psychiatry training in military programs, and 58 (68%) were trained in civilian programs. However, beyond this primary distinction, an additional finding pertains to the extent of formal psychiatric training. Whereas all 27 psychiatrists from military residencies had completed 3 or more years of psychiatry training, six (10%) of the 58 civilian-trained group completed only 2 years of training, and another eight (14%) completed only 1 year. The standard length of psychiatry residency training programs in both civilian and military programs was 3 years, not counting the internship year, but Army policy allowed partially trained individuals to serve in unsupervised positions of full clinical responsibility. Otherwise, the military-trained and civilian-trained

TABLE 5-1. WRAIR Survey Psychiatrist Distribution by Training and Pre-Vietnam Field Experience (N = 85)

	"EARLY" PSYCHIATRIST (40)			"LATE" PSYCHIATRIST (45)	
Military-Trained (27)	12	YES Field Experience	10	3	15
		NO Field Experience	2	12	
Civilian-Trained (58)	28	YES Field Experience	19	6	30
		NO Field Experience	9	24	

Note: "Field Experience" refers to a pre-Vietnam, post training, military assignment.

groups averaged similar amounts of elapsed time between cessation of training and assignment to Vietnam (6 and 4 months, respectively). With a few notable exceptions, on average they were assigned in Vietnam with little posttraining experience.

The data regarding practical military experience before Vietnam, apart from military residency, cut across residency type to a significant extent (Table 5-1). Twenty-five civilian-trained psychiatrists (43%) had at least 1 year of a pre-Vietnam military assignment, whereas the remaining 33 went to Vietnam as their first Army assignment. Also, 13 (48%) of the Army-trained group had a postresidency military experience before their tour in Vietnam vs 14 who did not.

Most importantly, there was a dramatic decline in preassignment military familiarity among all psychiatrists as the war lengthened. In particular, among the Army-trained psychiatrists who served in the second half of the war, there is a sharp reduction in their practical military experience base derived from a posttraining assignment compared with those who served in the first half (Figure 5-1). Furthermore, whereas psychiatrists with military residency training combined with the civilian-trained psychiatrists who had a pre-Vietnam military assignment accounted for over three-quarters (78%) of those deployed in the "early" war, they were less than half (47%) of those who served in the "late" war.

WRAIR survey data collected separately also revealed a proportional reduction in relevant background experience—though not rank—of the Vietnam theater Army Neuropsychiatry Consultants to the CG/USARV Surgeon, that is, the senior Army psychiatrist in country, in the last 3 years of the war (1970–1972) (see Chapter 4). Consistent with this finding is the following remark by Matthew D Parrish, former Chief Psychiatry and Neurology Consultant to the Army Surgeon General:

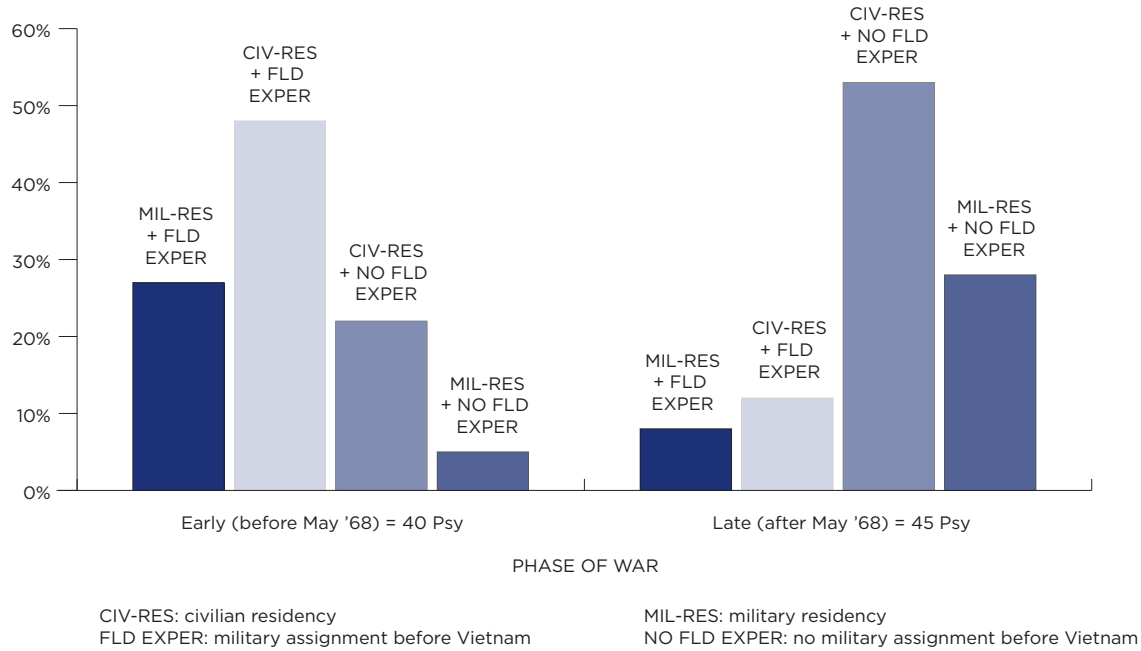
> I found out that assignments of the USARV Consultants were not made on the basis of rank, and probably not on the basis of skill or of proper career development but rather on the basis of what influential psychiatrist [lobbied] to be assigned in Hawaii or to Letterman General Hospital in San Francisco, or wanted to get out of doing DA [Department of the Army] staff work. (See Parrish correspondence in Appendix 13.)

The study questionnaire did not explore psychiatrists' motives for joining the Army or serving in Vietnam. Obvious possibilities include that of volunteering versus having received an assignment to serve there. More particularly, civilian psychiatrists could have been drafted into the service or could have voluntarily entered, including under the Berry Plan (The Armed Forces Physicians' Appointment and Residency Consideration Program), which allowed draft deferment during civilian residency training. Information as to whether a psychiatrist had been a volunteer or draftee was not sought because, whether civilian-trained or military-trained, ultimately serving in Vietnam was, in most instances, the consequence of earlier and only partly related decisions. Neither accepting the Berry Plan deferment nor military residency training constituted a decision to serve in Vietnam. In fact, it was substantiated from official sources apart from the study (ie, not data from the survey) that only 22.5% of the psychiatrists who graduated from Army psychiatry training programs (Walter Reed General Hospital, Washington, DC, and Letterman Army Medical Center, San Francisco, California) during the war years were subsequently assigned there.

Combat Unit Assignment in Vietnam

Army psychiatrists serving in Vietnam can also be distinguished as to whether they were assigned to a

FIGURE 5-1. WRAIR survey psychiatrists by phase of war served (percentages of psychiatrists within the first or second half of the war), residency type, and practical military background before assignment (N = 85).



combat unit vs a hospital or a psychiatric detachment; a few had nonclinical positions at some point during their tour. Psychiatric observers from previous wars have described a critical difference in clinical perspective as a consequence of this distinction,[21,22] which is similar to the distinction drawn earlier between the military-trained psychiatrist and the one who trained in a civilian setting. The psychiatrist who functions near the actual combat as a member of the combat group develops a commitment to his unit, its mission, and its welfare. He therefore more readily aligns his clinical perspective with that of force conservation than the psychiatrist who is assigned to a hospital or KO team. In this respect he is prone to see his goal as that of supporting the symptomatic soldier who has developed a "failure to adapt," that is, one who is symptomatic because his self-preservative feelings have temporarily eclipsed his commitment to the welfare of his combat unit and the achievement of its mission.[19] This is in contrast to a more civilian-based perspective, or hospital-based perspective, in which the symptomatic soldier is perceived as having an underlying psychiatric condition and who requires protection from further combat exposure.

In summarizing his experiences in World War II and Korea, Glass noted that the civilian-trained or otherwise inexperienced Army psychiatrist and the psychiatrist who has not become affiliated with the combat forces are similarly ineffective in treating the military psychiatry casualty:

> Most newcomers to combat psychiatry and those psychiatrists who operate in rear areas are prone to identify with the needs and wishes of the patient. They were therefore readily made insecure when deciding that a patient was fit for return to combat duty, even though aware from a technical and intellectual standpoint that such a decision was correct. Because of anxiety from over-identification and from conscious feelings of guilt for the seeming responsibility of sending a patient to hazardous duty, the psychiatrist vacillated in his clinical judgment, thus impairing his usefulness. But as he worked in the combat zone, observed men who adjusted to battle situations, noted the usual discomforts of combat participants, and decreased his own feelings of guilt by participation,

> an inevitable emotional reorientation occurred, namely, [he] became identified with the welfare of the group, rather than the wishes of the individual. . . . He became convinced that it is for the best interest of the individual to rejoin his combat unit . . . to regain his confidence and mastery of the situation and prevent chronic tension and guilt. This attitude of the division psychiatrist, stemming from participation with the combat group, makes it possible for him to assume the traditional role as an exponent of reality which insists that the individual continue functioning despite anxiety rather than allowing withdrawal or a disabling neurotic compromise.[21(pp730–731)]

As a corollary, Glass also observed that until they undergo the military reorientation or indoctrination, the civilian-trained psychiatrist will also be ineffective in influencing Army commanders with psychiatric advice:

> [Gradually, most civilian-trained] psychiatrists . . . became identified with the needs of the military service rather than with only the needs of the individual. In turn, line commanders came to know psychiatrists as *exponents of reality* (emphasis added) rather than as persons with impractical theories.[23(p750)]

An example of such a reorientation from Vietnam can be found in Chapter 3 in the reported experiences of Pettera, the 9th ID division psychiatrist.

Assignment Patterns in Vietnam

Over the 8 years of the war, Army personnel were individually phased in and out of Vietnam in 1-year assignments. Consequently, psychiatrists, like most other soldiers, typically joined military units that were already deployed. However, nine (11%) survey participants indicated that they had accompanied their unit into Vietnam. With the exception of one individual who stayed an additional 6 months at his own request, all the survey participants served in Vietnam no longer than 12 months. However, during the late drawdown phase of the war, a few psychiatrists, like other soldiers, received some curtailment of their tour. None of the survey participants reported serving in Vietnam for more than one tour. This is despite that fact that as the war extended, some Army personnel with specialized skills were redeployed back to Vietnam.

In terms of physical danger, by expectable combat theater standards Army psychiatrists in Vietnam functioned in a relatively safe circumstance. The sole fatality was that of Captain Peter B Livingston who died on 19 November 1968 when the helicopter in which he was a passenger crashed near Saigon as a consequence of mechanical failure.

Combat vs Hospital (Combat-Service Support) Assignments. Although it is straightforward to designate Army psychiatric positions by the previously described distinction of combat unit assignment vs hospital assignment (ie, hospital and psychiatric medical specialty detachments), the psychiatrists cannot be so easily categorized themselves. This derives from the policy of rotating psychiatrists at midtour from one to the other of these two assignment types to even the load and the hardship.[13] However, practically this was only possible for about two-thirds in any given year. For example, during the period of the greatest troop concentration (1967–1969), among the 22 Army psychiatrists assigned in Vietnam each year (excluding the position of USARV Neuropsychiatry Consultant), the seven division psychiatrist positions could only be shared by a maximum of 14 rotating psychiatrists (eg, 2 x 7); thus the remaining eight psychiatrists (one-third) would necessarily serve their year-long tour with a hospital or a psychiatric detachment.

Yet interestingly, the WRAIR data show that almost half of the survey psychiatrists served exclusively in hospital assignments (vs the predicted one-third), and only a quarter served in both types of units (vs the predicted two-thirds). There is at least a partial explanation: findings indicate that 18 (21%) psychiatrists remained in their original combat division and declined a midtour rotation to a safer, more comfortable hospital facility.[18] These individuals were almost exclusively civilian-trained and served during the first half of the war. Several volunteered that they had developed a strong allegiance to their combat units and preferred not to rotate out. This observation was confirmed by Colbach and Parrish in their review of mental health activities in Vietnam through mid-1970[18] and seems consistent with the earlier reference to psychiatrists who serve with a combat unit developing a commitment to the members of that unit and its mission. As it turned out, 38 (45%) survey participants spent at least some of their tour in Vietnam with a combat unit (Table 5-2).

TABLE 5-2. Patterns of WRAIR Study Participants' Assignments in Vietnam (N = 85)

Clinical Assignments of Army Psychiatrists	Only with a combat ("line") unit (ie, with a division or brigade)	21% (18)*
	Only with a hospital (ie, with an evacuation/field hospital or psychiatric medical specialty detachment)	49% (42)
	Alternatively with a combat unit and with a hospital	24% (20)
Nonclinical Assignments of Army Psychiatrists	Neuropsychiatry Consultant to the CG/USARV Surgeon	5% (4)
	As a medical battalion commander	1% (1)
		100%

*Three respondents served only part of their year as division psychiatrist but did not serve any time in a hospital.
CG/USARV: Commanding General, US Army Republic of Vietnam
WRAIR: Walter Reed Army Institute of Research

Otherwise, a third of psychiatrists (29) indicated that they served in more than one unit in Vietnam. Of that group, nine had a third assignment, two of whom served with yet a fourth unit.

Other Assignments of Psychiatrists. To complete the picture, 11 (13%) survey participants had assignments that deviated from the two basic psychiatric clinical roles thus described ("combat" vs "hospital"). Besides the four who served exclusively as the Neuropsychiatry Consultant to the CG/USARV Surgeon, seven psychiatrists reported serving some part of their tour in other medical or administrative assignments (eg, as a division or brigade surgeon [four], as a flight surgeon [two], or as a medical battalion commander [one]). These psychiatrists were included in the study either because they indicated that a significant portion of their tour was nonetheless spent providing clinical psychiatric services, or, as in the case of the USARV Neuropsychiatry Consultants, because they were dealing with the psychiatric problems in a secondary fashion.

Professional Activities by Type of Military Assignment

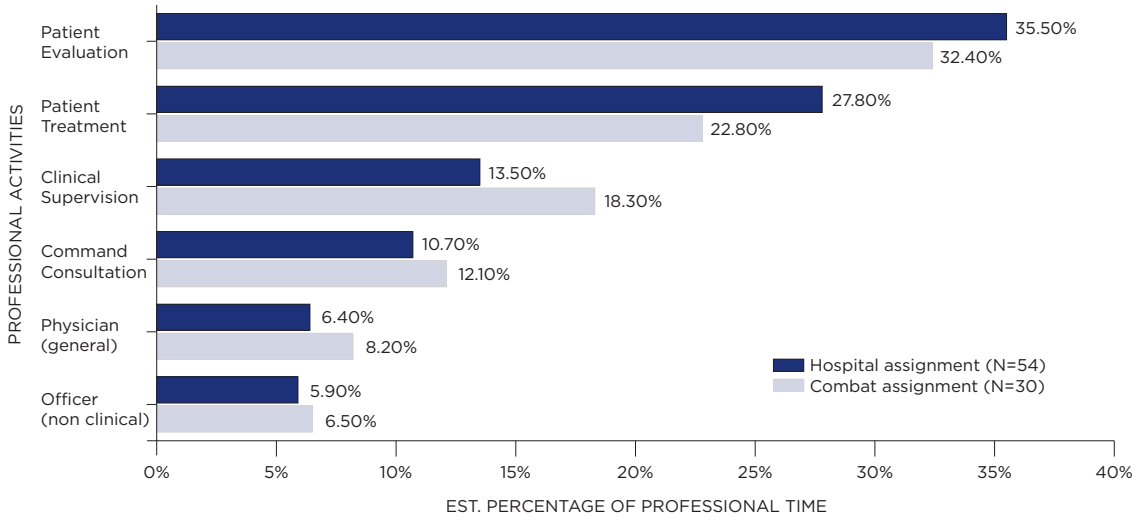
The WRAIR survey psychiatrists who had experience in a clinical assignment were asked to allocate for each of their Vietnam assignments the percentage of their professional time spent among six major activity categories. Figure 5-2 groups the means of their percentage estimates for each activity by the basic military unit type of each assignment, that is, "combat" vs "hospital."

As demonstrated in Figure 5-2, the overall trend is for survey respondents to report being most often utilized in clinical capacities, primarily those involving the provision of psychiatric care. Direct psychiatric care (patient evaluations and treatment) overshadowed indirect care (supervision of other providers and consultation with commanders), psychiatric clinical duties overshadowed general medical duties, and clinical duties overshadowed those associated with being an officer. When the psychiatrists' experiences in combat unit assignments are compared with those in hospitals or psychiatric medical detachments regarding extent of time allocated for these six basic types of duties, the following trends are also discernable:

- When psychiatrists served with combat units they reported spending somewhat more time providing *indirect care*, that is, clinical supervision and command consultation, compared to when they served with hospitals (30.4 % vs 24.2%, respectively).
- When psychiatrists served with hospitals and psychiatric specialty detachments, they reported spending somewhat more time providing *direct care,* that is, patient evaluation and treatment, compared to when they served with combat units (63.3% vs 55.2%, respectively).

Although these values are not statistically significant, as trends they are consistent with Army psychiatry's efforts to prioritize primary and secondary prevention efforts with combat troops (ie, to incorporate theories and practices of social/community psychiatry).

FIGURE 5-2. Estimates of WRAIR survey psychiatrists' percent of time devoted to professional activities by unit type, in means of percentages (N = 84 psychiatrist assignments) [modified from Camp and Carney].



Data source: Camp NM, Carney CM. US Army psychiatry in Vietnam: preliminary findings of a survey, II. Results and discussion. *Bull Menninger Clin*. 1987;51:19–37.

WALTER REED ARMY INSTITUTE OF RESEARCH SURVEY RESULTS: CLINICAL CHALLENGES FOR ARMY PSYCHIATRISTS

This chapter begins the presentation of the WRAIR study psychiatrists' recollections of the clinical challenges they encountered in Vietnam by utilizing the more conventional diagnostic groupings. More detailed data regarding their professional involvement with combat stress reactions will follow in Chapter 6 and Chapter 7; with low morale and associated conduct and behavior problems in Chapter 8; with drug and alcohol problems in Chapter 9; and with command cadre as consultants in Chapter 10. Finally, Chapter 11 will explore operational frustrations and ethical strains associated with performing these professional duties in Vietnam.

Distribution of Clinical Conditions by Diagnosis

Survey psychiatrists were provided a list of nine psychiatric diagnostic groupings along with brief functional definitions and were asked to "estimate the percentage of the patients that you evaluated or treated during your Vietnam service that fell within each category." Results are displayed in Table 5-3. Except for combat reaction, the groupings on the list were intended to coincide with the civilian diagnostic nomenclature that existed during the war. For simplicity purposes, the definitions for the diagnostic categories used in the survey were extracted from the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM),[24] which was published in 1979 by the World Health Organization.

The term combat reaction was selected for use in lieu of combat exhaustion, the official military term adopted at the close of World War II and utilized throughout the Vietnam War (see Appendix IV—USARV Psychiatry and Neurology Morbidity Report—of Appendix 2: USARV Regulation 40-34). Combat exhaustion refers to a typically reversible, stress-generated psychological regression arising among combat-exposed soldiers—somewhat irrespective of predeployment psychological difficulties. In many respects it is the equivalent of civilians who are grossly affected by an extreme and emotionally traumatizing ordeal, however, there are also important distinctions, which will be discussed in Chapter 6. To avoid confusion, WRAIR survey participants were provided a spectrum of possible signs and symptoms for defining

TABLE 5-3. WRAIR Survey Psychiatrists' Estimates of Percent of Patients They Evaluated or Treated by Diagnostic Groups

Diagnostic Grouping	Mean % (N=65)	"Early" assignment mean % (N=35)	"Late" assignment mean % (N=30)	Combat assignment mean % (N=14)	Hospital assignment mean % (N=36)
Personality disorder	27.1				
Drug dependence syndrome	15.0*	8.1	19.0		
Combat reaction	12.6†			20.9	9.7
Schizophrenic psychosis	11.7†			4.9	13.9
Alcohol dependence syndrome	10.4				
Neurotic disorder	9.6				
Affective psychosis	7.1†			4.2	8.0
No disease found	7.0				
Organic psychotic condition	6.4				
Total	99.9				

*Statistically significant difference comparing war stage, that is, "early" and "late" refer to those served before or after mid-1968.

†Statistically significant difference comparing psychiatrist by assignment type, that is, those serving *only* with combat units vs *only* with hospitals.

Data source: Camp NM, Carney CM. US Army psychiatry in Vietnam: preliminary findings of a survey, II. Results and discussion. *Bull Menninger Clin*. 1987;51:19–37.

the combat reaction (see Table 6-1), which was drawn from a schema developed at the close of World War II.[25]

Responses of the survey participants who provided clinical care in Vietnam were compared by whether they served in the first or second half of the war in Vietnam. Also, responses of those who served *only* in combat units were compared with those who served *only* in a hospital or in psychiatric detachments. Only statistically significant subgroup findings are presented.

Predominance of Conduct and Behavior Problems Throughout the War

The findings presented in Table 5-3 appear to strongly confirm the overall impressions garnered from published theater-wide incidence measures and psychiatrists' anecdotal reports that, using the standards of World War II and Korea, Vietnam was a psychologically low (combat) intensity war. The survey respondents' mean percent of their patients seen for combat reactions was only 12.6%. In contrast, survey psychiatrists recalled that maladjustment and misconduct cases in the form of personality disorders, drug dependence syndromes, and alcohol dependence syndromes comprised over half of their diagnosable patients (52.5%). (To further verify the relatively low incidence of overt combat stress reactions, a third of the WRAIR survey psychiatrists acknowledged they had only rare exposure to combat-induced psychiatric casualties and consequently passed over the survey sections regarding combat reactions as instructed.)

Predominance of Drug Dependency During the Second Half of the War

Also quite illuminating from Table 5-3, when comparing the mean percentages of the diagnostic groups for the psychiatrists who served in the first half of the war with those who served in the second half, only drug dependence syndrome emerged as significantly more frequent in the second half. This is not surprising considering the amassed evidence, medical and otherwise, that indicates a marked upswing in the use of drugs by soldiers (especially heroin after mid-1970). What is intriguing is that it is the only diagnostic group to be elevated, considering how the sense of national purpose in Vietnam had waned and morale there plummeted. Also interesting is that alcohol dependence syndrome is relatively high throughout the war and does not correlate with the late-war demoralization and dissent.

Implementation of the Army Forward Treatment Doctrine

Subgroup analyses in Table 5-3 compared responses from 14 psychiatrists who served *only* in combat unit assignments with 36 who served *only* in hospital assignments and revealed significant differences for only three diagnostic groups:

1. Combat reactions had a higher reported caseload percentage by the "combat" psychiatrists compared with the "hospital" psychiatrists (20.9% and 9.7%, respectively).
2. Schizophrenic psychosis had a higher reported percentage by the "hospital" psychiatrists compared with the "combat" psychiatrists (13.9% and 4.9%, respectively).
3. Affective psychosis also had a higher reported percentage among the "hospital" psychiatrists compared with the "combat" psychiatrists (8.0% and 4.2%, respectively).

In themselves, these results are expectable. Even if combat reactions stayed at a low ebb over the course of the war, they should have been treated more commonly in combat units in conjunction with the military psychiatry doctrine that encouraged early diagnosis and crisis-oriented treatment of those casualties within the area of the soldier's parent unit and discouraged their evacuation out of the divisions to the hospitals. On the other hand, with respect to the two types of major psychoses, the doctrine encouraged expeditious evacuation of the more intractable cases out of the combat divisions to the more definitive treatment centers. Thus these findings are consistent with the intended clinical load differential between the combat unit (with its prioritization of primary and secondary prevention care) and the hospital (with its prioritization of tertiary prevention care). Also suggested is that they appear to validate the WRAIR study's approach to filling in the picture of Army psychiatry in Vietnam through the recollections of the participants despite their retrospective nature.

SUMMARY AND CONCLUSIONS

This chapter described the WRAIR postwar study (1982) of the Army's psychiatric activities in Vietnam using a survey of Army psychiatrists who served there. The inaccessibility of primary records tying individual soldier service records and health records from Vietnam, as well as the lack of basic epidemiological studies regarding psychiatric conditions and behavior problems in Vietnam, necessitated that WRAIR take an alternative approach to filling in significant omissions in the surviving history of Army psychiatry in the war. The survey located most of those who had been assigned in Vietnam, and it used a structured instrument to explore their: *(a)* professional training and extent of preassignment military experience; *(b)* estimates of the relative prevalence of psychiatric problems; *(c)* recollections of the psychiatric intervention efforts designed to prevent, treat, or counteract these conditions along with the degree of success obtained; and *(d)* impressions of factors perceived as pathogenic variables. The survey also inquired as to the participants' subjective reactions to their service in Vietnam and the operational doctrine of forward treatment, and it asked about ethical dilemmas inherent in the practice of military and combat psychiatry there.

Of the 115 locatable psychiatrists (of an estimated 135–140 who served), 85 (74%) responded to all or parts of the survey. Results provided some description of the psychiatrist contingent who served with the Army in Vietnam through the course of the war regarding: (*a*) phase of the war served—with assumptions as to the influence of changing military and social contexts ("early" vs "late" war); (*b*) variations in preparatory training and experience—with assumptions as to the value of military familiarity (whether through having had military psychiatry training or having a predeployment assignment after training); and (*c*) types of assignments in Vietnam ("combat" unit vs "hospital"/psychiatric detachment)—with assumptions as to the influence of combat unit affiliation and identification. The survey results also indicated patterns regarding participants' role demands and clinical challenges.

Findings from the survey presented in this chapter that were especially salient include:

- Over the course of the war, roughly 30% of the assigned Army psychiatrists had military psychiatric training and 70% had training in civilian programs; yet fewer than one in four graduates of Army psychiatry training programs during the war served a tour in Vietnam.
- In the second half of the war a much larger number of civilian-trained psychiatrists with no practical military background and a much larger number of military-trained psychiatrists with no posttraining military experience were assigned in Vietnam compared with the first half. This represents a sizeable drop in the pool of practical military expertise in the theater despite the fact that the rates of psychiatric conditions and behavior problems were climbing.

- Through the course of the war, almost half (45%) of survey respondents reported being assigned to a combat division at some time during their tour.
- Regardless of assignment type (combat unit or hospital/psychiatric specialty detachment), survey respondents reported they were most often utilized in clinical capacities, primarily those involving the provision of psychiatric care; and when they were assigned to a combat unit they more often provided indirect care (supervision of others or consultation to military leaders) than when they were assigned to a hospital/psychiatric specialty detachment.
- Frank combat reactions were reported as a more prevalent clinical challenge for the psychiatrists assigned to combat units compared to those assigned to hospitals/psychiatric specialty detachments; overall, however, combat reactions, as well as the major psychotic disorders, were distinctly overshadowed by various behavior problems (eg, personality disorders and, especially in the second half of the war, drug dependence problems). Collectively these diagnoses represented over half of psychiatric referrals.

In the chapters that follow, additional findings from the WRAIR survey will be utilized to augment data from other sources regarding the psychiatric challenge in Vietnam.

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