CHAPTER 8

Deployment Stress, Inverted Morale, and Psychiatric Attrition: "We Are the Unwilling, Led by the Unqualified, Doing the Unnecessary, for the Ungrateful"

. . . [T]he need for clear and meaningful group missions . . . is simply another way in which good leaders can demonstrate to their units that they care—by seeing that their efforts and the risks (and losses) they incur are for something undeniably worthwhile. Certainly the discipline problems, wholesale drug abuse, and fraggings of the US Army in Vietnam came primarily in the latter years of the war, when it was clear that America had made the judgment that their task was not worth pursuing. Interpersonal bonding at the small unit level could not overcome the quite rational desire not to be the last one killed in an effort without glory or thanks.[1(pp1–2)]

Frederick J Manning, PhD
Military Social Psychologist

Graffiti left by "short" soldier. In this 1969 photograph, a soldier who had very little time left to serve in Vietnam, hence "short," taunted other soldiers who had more time than he. It illustrates a pernicious tension among troops that arose from the policy of individualized, annualized troop rotations in and out of Vietnam. Because of high turnover and staggered replacements, unit cohesion and commitment to the mission were weakened. Photograph courtesy of Richard D Cameron, Major General, US Army (Retired).

Combat-generated psychiatric conditions have traditionally been the most critical of the problems that military psychiatrists have faced; and, although a broad collection of stress-related factors have been determined to affect how well the soldier can withstand his combat ordeal, the predominant pathogenic one has obviously been its violent nature. However, there are additional challenges—deployment stress—that affect all who are sent to a theater of war, the majority of whom will not face combat directly. In fact history has shown that in a combat theater, commanders, medical personnel, and mental health specialists, as well as those in law enforcement and

military administration, must be prepared to respond to large numbers of psychiatrically and behaviorally dysfunctional soldiers who are not combat troops *per se*. Whereas the emergent difficulties may not be attributable to combat stress, nor for that matter always stem from predeployment personality defects, they are invariably linked to the unique stresses and sacrifices associated with assignment in a combat zone, which indirectly includes the primacy of the combat mission.

With respect to the US Army in Vietnam, the flood of combat exhaustion cases that was anticipated never materialized. Also, at least initially, rates for other types of psychiatric conditions and conduct problems were low. However, as already noted, the war passed the midpoint and combat intensity dropped, but soldier dysfunction and attrition nonetheless rose to unprecedented proportions and in unanticipated forms—racial conflicts, heroin use, soldier dissent, and attacks on officers and noncommissioned officers (NCOs)—behaviors that indicated that morale and allegiance to the military mission in the theater were at crisis levels and aligned with the broader antiestablishment spirit of young adults and the antiwar movement. This unraveling of morale and discipline was apparently more common among noncombat personnel,[2] but combat troops were not exempt. Some of this was predictable as a consequence of drawdown; however, the unacceptably high rates and provocative forms that emerged suggested that there were additional circumstances associated with the late Vietnam War and theater that served not just to lower morale but to actually invert it. The "commitment and cohesion" required of even a marginally functional military unit had fragmented to be replaced by loyalties to alternative affinity groups that rallied around opposition to military authority, disabling drug use, and other forms of misconduct and defiance.

Chapter 6 and Chapter 7 focused on combat stress-related psychiatric conditions and their management and treatment in Vietnam. This chapter will build on the overviews presented in Chapter 1 (historical, political, cultural, and military context) and Chapter 2 (accelerating rates for psychiatric conditions and behavior problems in Vietnam) and draw from the available professional literature to address more specifically the broad array of psychological and psychosocial disorders that affected the deployed troops more generally, especially during the second half of the war. It also will include selected clinical examples and relevant findings from the Walter Reed Army Institute of Research (WRAIR) survey of Vietnam veteran Army psychiatrists. Chapter 9 will review the drug and alcohol problems in Vietnam. Chapter 10 will explore the interactions of mental health personnel with commanders in primary and secondary prevention activities (command consultation).

BACKGROUND

History of (Combat Theater) Deployment Stress Reactions

It should be evident that the high levels and layered nature of the stressors that affect all individuals assigned in a combat zone will result in an increase in psychiatric conditions and behavior problems; but apparently this can be overlooked.[3] The following quotation from Brigadier General William C Menninger, the Army Surgeon General's Chief of the Neuropsychiatry Branch during most of World War II, is illustrative:

> Until [the war] was half over, we as psychiatrists, failed grossly in not appreciating the tremendous importance of distinguishing between emotional illness and faulty attitudes. We did not, until late, adequately grasp the relationship of mental health to group attitudes and pressure, nor did we understand how these could be molded, supported, and changed through leadership, orientation, and information. Too often did we discharge soldiers solely on the basis of the symptoms they presented, rather than consider how environmental support could counteract the cause of these symptoms.[4(pp40–41)]

In his own unique fashion, a senior military psychiatrist, Albert J Glass, offered a similar perspective from the Korean theater: "A majority of those cases are not [neuropsychiatric] conditions because medical officers wish to make patients out of them, but because the line officers have been unable to make soldiers of them."[5(p755)]

In fact, the deployment of troops in sufficient numbers to fight a major war in a remote and inhospitable setting halfway around the world, as proved to be the case in Southeast Asia, is an enormous logistical enterprise. In conjunction, sustaining the requisite morale and commitment to win under such circumstances is equally challenging. From a psychiatric

standpoint, in addition to the so-called classic combat stress reaction common in high-intensity warfare (eg, anxiety and psychological fatigue, progressing to gross disturbances in mood, thinking, and behavior), more insidious forms of dysfunction will predictably affect soldiers fighting in low-intensity combat situations as well as those serving in noncombat roles and rear echelon assignments. Similarly susceptible are standing armies in situations involving relative hardship and uncertainty as to justification for continued sacrifices and isolation from home and loved ones. The consequence is a lowering of morale and an increase in psychiatric conditions and dysfunctional behaviors—disorders that can become widespread and undermine combat readiness.[2]

Historically these have taken the form of elevated rates for alcohol and drug abuse, venereal disease, desertion, and disciplinary infractions; but they can be quite variable depending on a broad array of situational, group, and interpersonal influences, which in turn interact with predeployment personality characteristics.[6] Terms like guerrilla neurosis, garrison casualties, and disorders of loneliness or nostalgia have been used, with each label having a somewhat different etiologic emphasis. As an example, it has been estimated that there were approximately three cases of "nostalgia" (disabling homesickness) per 1,000 troops per year among Union soldiers during the US Civil War. Following the Civil War, alcoholism, venereal diseases, and disciplinary infractions continued to be problems for units fighting in the Indian Wars, the Spanish-American War, and the Philippine Insurrection, but these were not considered to be morale and mental health problems until World War I.[3] Data from World War II[7] and Korea[8] documented the rise in psychiatric and behavior difficulties among the large numbers of noncombat soldiers who were stationed far from home, living in confined and isolated groups, and serving primarily in service/support roles. Similar problems have been observed among constabulary forces and those in the process of demobilization in an overseas setting who resented being asked to sustain further sacrifices beyond the conclusion of hostilities.[2,9] Even a dramatic increase in the use of narcotics by US soldiers was seen at the close of the Korean War, which was attributed to drawdown service in an Asian theater.[10] As noted in Chapter 2, current Army doctrine refers to these conditions as misconduct stress behaviors. This author believes that it makes more sense to label them (combat theater) deployment stress reactions to draw attention to the ordeal of assignment in a combat zone as its own center of stress.

Special Role Requirements of Military Psychiatrists in Maintaining the Force

The Army Psychiatrist and Social Psychiatry

The US Army is a huge institution with a strict rank and authority hierarchy. As far as its personnel and culture, the central organizing principle is the subordination of individual values to those of the organization—presumably for the benefit of the larger society. The requirement that the soldier conform to the performance expectations of the Army becomes even more rigorous when the nation is committed to war; and, for obvious reasons, this is even more so when the soldier is assigned in the theater of combat operations. Psychiatry is one among the many Army functions concerned with manpower maintenance. As a consequence, Army psychiatrists are tasked with promoting soldier adaptation to the military's ways and means and, when deployed in a combat theater, to those serving combat objectives in particular. In other words, the military psychiatrist must not only seek to reduce the incidence and morbidity of conventional psychiatric conditions (symptom disorders), as in a civilian setting, but also support the prevention of, or to evaluate and make recommendations regarding rehabilitation of, or facilitate the discharge from the service of, those who would develop aberrant behavior. In this context, aberrant behavior refers to deviations from the military's performance expectations, that is, disciplinary problems—clashes between the soldier and military authority—as well as other behaviors that negatively affect individual and unit performance. In effect, the somewhat unique mission of the military psychiatrist is the reduction of unsatisfactory duty performance that may be due to psychological reasons and that may present in a wide variety of forms.[6] In fulfilling this mission he must not only seek to understand the soldier-patient as an individual, but he must also take into account the soldier's social/military context, which may even include a dysfunctional unit and leadership.

The Evaluating, Sorting, Certifying, and Clearing Functions of Military Psychiatry

During the Vietnam War newly commissioned physicians underwent an accelerated basic training at the Army's Medical Field Service School (MFSS) in

which they received instruction regarding the Army's triage model for psychiatric referrals.[11] This was necessary both from the standpoint of their providing clinical care and because they could be required to screen underperforming soldiers who were being processed for discharge from the Army—so-called "noneffectives"—under Army Regulation 635-212.[12] (A similar protocol would apply to officers,[13] but they were far fewer in number.) The triage model involved the following algorithm:

1. Is there evidence a soldier is undergoing a *personal crisis*? Many soldiers develop psychiatric symptoms and maladaptive behaviors in reaction to their individual circumstance and may warrant a psychiatric diagnosis such as a transient situational disorder [in today's nomenclature, they may fall within DSM-IV [*Diagnostic and Statistical Manual of the Mental Disorders*, 4th edition]: adjustment disorder[14,15]]. They may be treatable through counseling, medication, or rehabilitative transfer—as long as the objective is preservation of military function and not symptom elimination. The goal is "effectiveness, not happiness." The practicality of this option rests on unit mission requirements as well as the availability of mental health personnel. The premium is placed on early detection and treatment of the symptomatic soldier so as to avoid removing him from duty status for treatment. The decision whether to treat or not falls to the mental health specialist.
2. Do the soldier's symptoms and behaviors stem from a *disqualifying psychiatric condition*? Some soldiers develop more serious psychiatric conditions that warrant discharge from the Army based on medical and psychiatric fitness requirements for continued service.[16] If the soldier has (*a*) a diagnosable psychiatric condition [which by today's standards would roughly fall within DSM-IV: Axis I set[14,15]], and he has (*b*) substantial and untreatable functional impairment, he should be processed through medical channels for discharge from the Army. The final decision rests with a higher medical authority, that is, the Medical Board.
3. If the soldier's symptoms and behaviors don't conform to (1) or (2), are they expressive of a *character and behavior disorder* (or personality disorder[17])? In instances when an intractable pattern of poor performance or misconduct arises, and the soldier is not interested in, nor amenable to, corrective measures, a psychiatric opinion must be rendered as to whether the soldier's "faulty attitude"[11] is "characterologic" in nature. If he presents with sustained and untreatable functional impairment and if a pattern of dysfunction is in his preservice background, and if he receives a diagnosis of character and behavior disorder [which by today's standards would fall within DSM-IV: Axis II set], he would receive a psychiatric "certificate" and could be separated from the Army as *unsuitable* [Table 8-1]. The final disposition, however, would be at the discretion of the soldier's commander; but, if utilized, the character and behavior disorder diagnosis and "unsuitable" administrative separation would reduce the soldier's chances of being court-martialed and result in a less punitive type of discharge from the service. It also would allow the commander to bypass a lengthy process of counseling and rehabilitation so as to expedite his discharge from the Army.

If the answers to the questions above are all negative, by the parlance of the time the soldier is "cleared" by psychiatry, and it is presumed that he has the capacity to obey orders but is opposed. He then faces the possibility of judicial punishment or nonjudicial punishment and administrative elimination from the Army as *unfit*.

MOUNTING CHALLENGES IN THE VIETNAM ERA

Incidence of Psychiatric Conditions and Behavior Problems in Vietnam: Containment in the First Half of the War and Hemorrhage in the Second Half

In general, the complex array of psychosocial challenges for the soldiers sent to Vietnam, noncombat troops as well as combat troops, was expected. Technical Manual (TM) 8-244: *Military Psychiatry* provided an excellent depiction of these risks:

> The general problem confronting psychiatry in combat is related to the adjustment of the soldier to a life situation which is often unpleasant, and seemingly intolerable. The soldier finds himself deprived in many spheres, away from home, family and friends, in danger, fatigued, in a strange

TABLE 8-1. Schedule for Administrative Elimination of Noneffective Enlisted Soldiers Under Army Regulation 635-212

CATEGORY	UNFIT	UNSUITABLE
Characteristics	Failure to pay debts Drug addiction Discreditable incidents Shirking Sexual perversion Failure to support dependents Homosexual†	Inaptitude Character and behavior disorders Apathy Alcoholism Homosexual (class III)
Governing authority	General Court Martial	Special Court Martial
Dispositions*	Retain in the Army Separate as unsuitable Separate as unfit	Retain in the Army Separate as unsuitable
Type of discharge	Undesirable (Honorable or General in special cases)	Honorable General

Note: With the exception of "Homosexual"under Unfit, this is the schedule that was distributed to newly commissioned Army physicians July 1967.[1]
*Individuals could waive a board hearing. If not, they were provided counsel and could testify on their own behalf and call witnesses.
†Until March 1970, Army Regulation (AR) 635-212, *Personnel Separations, Discharge: Unfitness and Unsuitability*, included some selected cases of individuals with homosexual tendencies, desires, or interest but without homosexual acts during military service—Class III (latent[2]); individuals not so excluded, as well as individuals who engaged in homosexual acts during military service, were subject to administrative discharge from the Army as unfit under AR 635-89. In March 1970, the elements in AR 635-89 were included in AR 635-212.

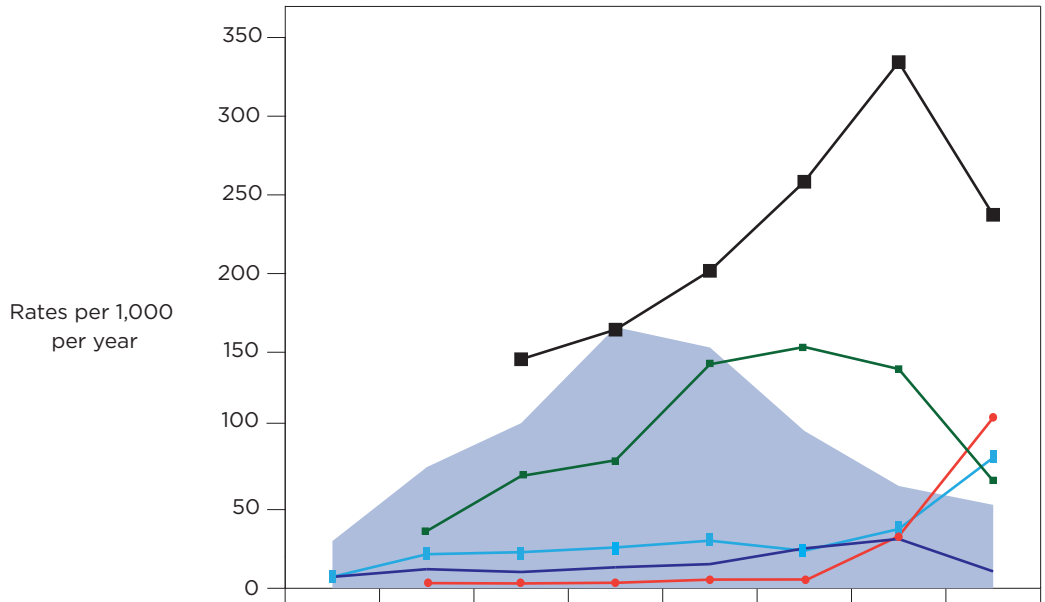
References: (1) Elimination of Noneffectives: AR 635-212. San Antonio, Tex: Medical Field Service School Department of Administration; (distributed July 1967). Training Document M 17-450-850-460; (2) Elimination of Noneffectives. San Antonio, Tex: Medical Field Service School Department of Administration; (distributed July 1967). Training Document M 13-360-120-1.

> milieu, torn by conflicting interests and desires, subject to military discipline, and emotionally supported principally by the small group with whom he lives and fights. The range of behavior of individuals in such a setting varies from cowardly shirking to heroic, selfless action. The use of the more primitive mental mechanisms in an effort to resolve the situation is a common solution, with the production of both classical and new constellations of symptoms as a result. Certain mechanisms aid in the performance of duty; others seem designed to produce incapacity; and the symptom complex produced by the latter generally takes a form locally likely to lead to evacuation.[18(p63)]

What was not anticipated was the additional strain on the sequential cohorts of replacement troops assigned in Vietnam consequent to the enemy's resolve and tenacity, the prolongation of the war, and the reversal of America's moral sanction for fighting there.

Early in the war, Army psychiatry leaders were impressed by the limited losses from the theater for all psychiatric causes. They surmised that adequate psychiatric resources had been deployed and that the lessons learned from earlier wars were being successfully implemented. For example, William S Allerton, by then the Psychiatric Consultant to the Army Surgeon General, reported that the psychiatric evacuation rate was two to three cases per 1,000 troops per year for the period, from mid 1967 to 1968, which matched the Army-wide rate for psychotic disorders for the preceding 50 years. He deduced that only psychotic individuals were being evacuated from Vietnam for psychiatric reasons, despite it being a theater of combat operations.[19] In other words, it was assumed that the etiology for these cases was endogenous as opposed to situational. Arnold W Johnson Jr, the second US Army Republic of Vietnam (USARV) Psychiatry Consultant, expressed his satisfaction regarding the "relative unimportance of the psychiatric inpatient population

FIGURE 8-1. US Army Vietnam rates (per 1,000 soldiers/year) for wounded in action (WIA), psychiatric hospitalizations, psychiatric outpatient visits, psychiatric out-of-country evacuations, courts martial, and nonjudicial punishments. [Note: These measures were confounded by rising soldier drug use, especially heroin, beginning in 1970.]



	1965	1966	1967	1968	1969	1970	1971	1972
WIA rate	30.1	77.7	105.1	166.3	152.9	100.7	65.0	52.6
Psychiatric outpatient visit rate	—	36.3	71.3	81.3	142.5	153.8	138.8	68.3
Psychiatric hospitalization rate	6.98	11.8	9.8	12.7	15.4	25.2	31.3	10.4
Psychiatric out-of-country evac rate	—	1.9	1.85	2.3	4.3	4.33	32.7	108.0
Court martial rate	6.97	21.25	22.58	25.6	30.0	23.5	37.3	77.8
Nonjudicial punishment rate	—	—	145.2	164.5	201.5	258.6	334.5	237.9

Sources: US Army Vietnam WIA rates (see Chapter 6, Table 6-3); Army psychiatric hospitalization rates (see Chapter 2, Figure 2-2); Army psychiatric outpatient visit and out-of-country evacuation rates from: Jones FD, Johnson AW Jr. Medical and psychiatric treatment policy and practice in Vietnam. *J Soc Issues*. 1975;31(4):49–65, Figures 3 and 2; and Army disciplinary actions—courts martial and nonjudicial punishment (Article 15)—rates from Prugh GS. *Law at War: Vietnam 1964–1973*. Washington, DC: GPO; 1975: Appendix K.

as far as numbers are concerned."[20(p305)] He also acknowledged that there were "strong efforts made to restrict psychiatric evacuations from Vietnam to those who are disabled with psychosis."[20(p305)]

However, despite this apparently commendable beginning, Army mental health and military discipline in Vietnam became severely compromised after the midpoint in the war. This can be demonstrated using the following gross epidemiologic trends:

- The psychiatric hospitalization rate began to increase throughout the theater beginning in 1968 and accelerated over the 4 years that followed (Figure 2-2 in Chapter2 and Figure 8-1).
- There was a parallel increase for the psychiatric evacuation rate from the theater (Figure 8-1).
- The psychiatric outpatient visit rate (a mix of evaluation and treatment) accelerated after 1966 to plateau in the years 1969 through 1971 at roughly four times the 1966 rate. In 1972, as the last of the troops were being pulled out, it dropped back to two times the 1966 rate (Figure 8-1). (The 1972 metric is undoubtedly misleading, as by then a policy shift had allowed drug dependent soldiers to be medically evacuated out of Vietnam, resulting in an out-of-country psychiatric evacuation rate of 129.8 per 1,000 troops per year or one out of every eight soldiers.)

- There was a parallel and equally dramatic trajectory for an array of discipline problems as measured by judicial and, especially, nonjudicial punishments (Figure 8-1).
- The increases in these indices were inversely correlated with the drop in combat intensity, which began after 1968 (measured both by the Army battle death rate (Figure 2-2) and the Army wounded-in-action (WIA) rate (Figure 8-1).
- Although the rate for psychiatric disorders during the period after 1967 also increased in the Army worldwide, the increase in Vietnam was significantly greater.[21(Figure 18)]

Army Psychiatrists as Specialized Human Resources Managers

As the war lengthened, Army psychiatrists of the Vietnam era and their professional and paraprofessional (enlisted specialists) colleagues were required to evaluate, sort, certify, or clear increasing numbers of command-referred soldiers, with and without psychiatric symptoms, who were failing to perform by military standards.[21(Figure 8)] (See Appendix II: Format for Psychiatric Reports for Administrative-Type Separation in Appendix 2, USARV Regulation 40-34, to this volume.) In the United States such referrals would spike locally in anticipation of a deployment alert[22]; but the greater problem arose in Vietnam as suggested by the rapidly rising rates for psychiatric outpatient visits and nonjudicial punishments (Figure 8-1).

For the Army overall, these psychiatric determinations assumed great importance in matters of military personnel management and enforcement of discipline. For example, about 7% (72,000) of all enlisted men released from military service in 1971 left with less than an honorable discharge, 40% of whom were diagnosed with character and behavior disorders.[23] Yet as the war became more unpopular, a growing dispute arose among psychiatrists regarding how the character and behavior disorder cases should be defined and managed.[24,25] Some argued that when the military psychiatrist renders a character and behavior disorder diagnosis while being naïve as to causative or aggravating circumstances within the soldier's unit, he serves not as a clinician but as both expert witness and judge in deciding the administrative, or even judicial, fate of the soldier—that the label implied that the soldier had moral defects, not medical/psychiatric difficulties.[23,26] Others felt the psychiatrist was overlooking true psychiatric conditions that warranted treatment instead.[27] In sharp contrast, the perspective of the Army was that soldiers labeled with a character and behavior disorder were simply being "fired" for failing to perform and that this outcome was without prejudice (see the letter from Hal Jennings Jr, Deputy Surgeon General, to Congressman Ogden Reid in Appendix 15 to this volume).

Functional Impediments to Diagnostic Specificity in Vietnam

With regard to the Army psychiatrists serving in Vietnam, especially those trained in civilian settings (roughly two-thirds), most were unprepared to manage these sorts of referrals for the following reasons:

1. Some of the disciplinary infractions and other offenses for which the soldier was referred for psychiatric screening would have scant civilian equivalency (ie, absent without leave [AWOL], desertion, and insubordination).
2. Some of the behavioral disturbances in question would not generally have been the focus of the psychiatrists' training (ie, racial incidents, violent outbursts, and group pathology, to include organizational dysfunction).
3. The task would be even more problematic for psychiatrists without a military background because the soldier-patient would typically present for the evaluation removed from the context of his specific military situation.
4. Finally, there were no operationally defined criteria established in the theater for the diagnosis of character and behavior disorder that would take into account the performance requirements peculiar to military service, especially in a theater of combat operations (similar to the deficit described in Chapter 6 regarding the lack of uniform diagnostic criteria for combat stress reactions).

Regarding the latter (ambiguous diagnostic criteria) for the most part the Army physicians assigned in Vietnam, including psychiatrists, had not been trained by the Army to reasonably distinguish the soldier with a true character and behavior disorder from the many referrals who were simply antagonistic to military service. For instance, in the summer of 1967, newly commissioned physicians in basic training at MFSS received a training document titled "Management of

TABLE 8-2. Hospitalized Army Neuropsychiatric Cases in Vietnam by Diagnostic Groupings

	USARV/Neel* (mid-1965 to mid-1970)[1]	Colbach and Parrish† (mid-1965 to mid-1970)[2]	Bourne (1966)[3]
Psychotic	16.2%	20%	20.9%
Neurotic	16.6%	15%	19.6%
Character or behavior disorder	29.1%	30%	38.4%
Combat exhaustion		7%	6.0%
NP observation; no psych diagnosis		28%	15.0%
Other psychiatric conditions	38%		
Total	100%	100%	100%

Shaded cells means no category was represented in the data set.

*Derived from Table 2-2, Army Incidence Rate for Psychiatric Hospitalizations in Vietnam [and in Europe] in cases /1,000 troops/year, in Chapter 2 in this volume.

†Colbach and Parrish did not collect data in Vietnam. Like Neel's data, the source would have been from raw data collected by USARV Medical Command; nonetheless what they published diverged from Neel's.

NP: neuropsychiatric

USARV: US Army Republic of Vietnam

Data sources: (1) Neel SH. *Medical Support of the US Army in Vietnam*, 1965–1970. Washington, DC: GPO; 1973; (2) Colbach EM, Parrish MD. Army mental health activities in Vietnam: 1965–1970. *Bull Menninger Clin*. 1970;34(6):333–342; (3) Bourne PG, Nguyen DS. A comparative study of neuropsychiatric casualties in the United States Army and the Army of the Republic of Vietnam. *Mil Med*. 1967;132(11):904–909.

the Noneffective Soldier."[28] It indicated that they may be required to render a medical opinion as to whether a soldier's failure to perform stemmed from preservice personality defects, immaturity, or an inherent lack of capacity to adjust (he "lacks pride," "is selfish," and "unwilling"); but it did not explicitly address character and behavior disorders as a diagnostic entity.[28] These physicians would have been better prepared had they received a copy of the Joint Armed Forces Psychiatric Nomenclature (in Special Regulations 40-1025-2[29]). It indicated that character and behavior disorders demonstrate "developmental defects or pathological trends in personality structure, with minimal subjective anxiety and little or no sense of distress"; that the disorder is typically manifested by a lifelong pattern of action or behavior ("acting out") rather than by mental or emotional symptoms; and that pathological personality types include those with borderline adjustment states, immature and regressive reactions to severe stress, and fixations of certain [adverse] character patterns. However, this publication was not widely distributed. (These stipulations for character and behavior disorder were consistent with the brief definition included in the American Psychiatric Association's 1952 taxonomy, DSM-I, and its 1968 taxonomy, DSM-II.)

As a consequence, diagnosing and labeling of soldiers may well have been subjectively influenced by the clinician, or through the soldier's military circumstance, rather than by clinical precision. As the war prolonged, polarized attitudes (even among doctors) about the war colored reactions to soldiers who expressed dissent. Furthermore, although it was common knowledge that commanders had final say as to whether the psychiatric diagnosis of a character and behavior disorder would be honored, it was not evident how influential the psychiatric opinion actually was. A study conducted in 1967 and 1968 at Walter Reed General Hospital revealed that not only did 92% of the soldiers diagnosed as character and behavior disorder receive a less than honorable discharge from the Army, but the psychiatrist prediction of performance failure if the soldier was not discharged was accurate only 40% of the time.[25]

Belatedly, at the very end of the war, an Army technical bulletin devoted to drug abuse (authored by Stewart L Baker Jr, a senior Army psychiatrist,) was published that included the following list of common features of the soldier with a character and behavior disorder[30]:

- [The character and behavior disordered individual exhibits] a combination of low self-esteem, limited coping skills, and high susceptibility to peer pressure.
- His history often reveals intellectual and social deprivation secondary to indifferent parenting, environmental circumstances, or both.
- Interpersonal relations with family and peers have frequently been strained, and in some cases military duty was seen as preferable to dealing with a family or judicial problem.
- Not surprisingly, military authority frequently becomes a new focus of conflict for this individual, which he sees as the source of all his difficulty. As a result, his allegiance to a given unit may be tenuous.
- Delinquent behavior, including illicit drug use, usually coexists with poor school and/or job performance.
- Peer relations may be confined primarily to an isolated subgroup within the unit (eg, other drug users).
- His previous military record often reveals a number of minor offenses (late for work, AWOL, uniform violations).
- Typically his immediate commander or supervisor is not eager to have him returned to the unit.

Some relief in the pressure on Army mental health clinics to evaluate, sort, certify, or clear huge volumes of underperforming soldiers came in the Vietnam theater in October 1970 when the USARV Supplement to AR 635-212[31] was revised to allow general medical officers to complete the mental evaluation portion of the medical evaluation when a psychiatrist was not readily available. On 12 April 1971 this became policy throughout the Army. Thereafter, a psychiatrist's evaluation was only required when it was requested by the soldier's commanding officer, the medical officer conducting the separation physical, the board of officers considering the case, or by the soldier. (See item 2-f in Appendix 14, "Bowen's End of Tour Report," to this volume.)

THE PSYCHIATRIC LITERATURE FROM VIETNAM: OBSERVATIONS AND INTERPRETATIONS

Epidemiology of Major Psychiatric Diagnostic Groups: Information Gaps and Overconfidence

During the early buildup years the field research in Vietnam by Peter G Bourne and the WRAIR Neuropsychiatry Research Team proved quite productive (as noted in Chapter 2 and described in Chapter 6). Among his projects he collected data regarding major diagnostic groups for Army troops hospitalized for psychiatric causes during the first 6 months of 1966 that served as an epidemiologic baseline for what was to follow (Table 8-2, column 3).

Bourne paid special attention to the large subset of soldiers diagnosed as character and behavior disorders (almost two of every five psychiatric hospitalizations). According to Bourne, their patterns of symptoms—dysfunction of attitude and behavior—had an uncertain relation to combat stress. They were described as emotionally unstable or immature personalities whose primary difficulty was that they were unable to function apart from their families, and they had become disciplinary problems, apparently as a means of manipulating a transfer out of Vietnam. To further expand the point, in 1966 Borne and Nguyen compared American with South Vietnamese military neuropsychiatric cases in the theater and speculated that the lower proportion of psychosis among the American soldiers (20.9% of psychiatrically hospitalized American soldiers vs 50.0% for Army of the Republic of Vietnam) and the higher rates for character and behavior disorders (38.4% of psychiatrically hospitalized American soldiers vs 13.8% for Army of the Republic of Vietnam) demonstrated how social/cultural and military policy features shaped the dysfunctional patterns of each group's clinical presentations, especially regarding their "manipulative" goals, that is, in pursuit of a socially permissible means for opting out of combat risk.[32] In other words, American soldiers who were hospitalized in Vietnam with character and behavior diagnosis were disabled by the interaction of endogenous influences (premilitary personality deficits) and exogenous ones (risk and privation, institutional requirements, and social dynamics).

In October 1970, Bourne summarized his research in Vietnam in a special section in the *American Journal of Psychiatry* heralding military psychiatry. Like others,

Bourne expressed satisfaction at the unusually low incidence of psychiatric conditions overall, and he attributed this in part to the exceptionally high morale in Vietnam. (He defined morale as "the general sense of well-being enjoyed by the group . . . a reflection of confidence in their ability to successfully survive environmental stress, faith in the quality of their leadership, and an overall sense of cooperation and cohesiveness among its members."[33(p482)]) Bourne concluded his review with confidence and optimism. "The Vietnam experience has shown that we have now successfully identified most of the major correlates of psychiatric attrition in the combat zone, [and] psychiatric casualties need never again become a major cause of attrition in the United States military in a combat zone."[33(p487)]

Remarkably, by the time Bourne made his way home from what in all respects should be considered a successful field research experience in Vietnam and submitted his findings and opinions to American psychiatry's most prestigious journal, little remained of the excellent morale and esprit that he and his colleagues observed. It is not just ironic that the year his piece was published, 1970, was also the year in which the most disturbing expressions of soldier demoralization and revolt in Vietnam made their appearance, specifically, the heroin epidemic and soldier assassinations of officers and NCOs; but it also was the year the American Psychiatric Association eliminated the military psychiatry section of its annual meeting in protest of the war.[34] (It should be noted that in the war's aftermath, Bourne reversed his perspective. After having become impressed with the magnitude of the adjustment problems among Vietnam veterans, he posited that, overall, troops in Vietnam had only appeared to be doing well because they had suppressed their psychological disturbances knowing that their obligation was limited to 1 year.[35])

From the standpoint of epidemiologic observation and interpretation, Edward M Colbach and Matthew D Parrish picked up where Bourne left off.[36] Their summary of mental health activities in Vietnam through mid-1970, mentioned in Chapter 2, included the first official acknowledgement of the rising psychiatric attrition following the enemy's surprise Tet offensives in 1968—the turning point in the war for the United States and the American public. Whereas Colbach and Parrish felt that morale in the theater was holding despite the growing antiwar movement in the United States, they noted the rising racial tensions and the decline in perception of military purpose within soldiers. They also mentioned increasing marijuana use among enlisted troops and expressed concern that some heavy users developed a transient toxic psychosis with paranoid features. Use of French barbiturate and amphetamine preparations were also seen, but use of hard narcotics was rare.

Nonetheless, the authors concluded that drug use had not seriously affected the overall military mission. Although older career soldiers tended to avoid illegal drugs—"the abuse of drugs has been considered a prerogative of the young soldiers . . ."[36(pp337–338)]—some resorted to alcohol to reduce their stress. Colbach and Parrish also mentioned that poor leadership was contributing to some declining morale and increases in specific psychiatric and related problems. However, they believed that these emergent problems were more likely the consequence of "boredom, loneliness and interpersonal conflicts, [which were] intensified due to the stresses of living a regimented group life in a hot foreign land where there has been a constant threat of bodily harm."[36(p337)]

Finally, in 1973, a year following the withdrawal of Army combat troops, Major General Spurgeon Neel's official synopsis of Army medical activities in Vietnam was released.[37] Unfortunately, this review fell far short of providing a proper overview of psychiatric problems in the theater for several important reasons: (*a*) like the summary provided by Colbach and Parrish, the data did not include the time period after mid-1970, effectively ignoring almost a third of the war (3 of 8 years); (*b*) the report included a limited taxonomy for hospitalized psychiatric conditions; (*c*) as previously noted, combat stress-related conditions received no specific mention; and (*d*) outpatient psychiatric data were not included. (As somewhat of a remedy, the Jones and Johnson overview, which was published in 1975, included quarterly incidence rates for psychosis and psychiatric inpatients, outpatient visits, and psychiatric medical evacuations throughout the war; however, it did not distinguish between diagnostic groups apart from psychotic disorders.[38])

Table 2-2 in Chapter 2 presented Neel's gross incidence rates for psychiatric hospitalizations of Army troops per year in Vietnam through mid-1970 distributed according to three broad diagnostic groupings (psychosis, psychoneurosis, and character and behavior disorders) as well as "Other Psychiatric

Conditions." As demonstrated, rates stayed low from mid-1965, when American ground troops were first deployed in Vietnam, until mid-1968. Thereafter there was a marked, steady increase in all of the psychiatric diagnostic groups. From Neel's data it is possible to average percentages of psychiatric hospitalized cases within these basic diagnostic groupings over the first 5 (of 8) years and compare them with similar data reported by Colbach and Parrish and that by Bourne for 1966 (Table 8-2).

It is uncertain what meanings to attribute to the differences in the sets of data presented in Table 8-2. In particular there were important discrepancies regarding the composition of some categories that make it difficult to reconcile Neel's data set with the other two. For example, Neel reported 38% of cases as "other psychiatric conditions," but he did not include the category of "NP [Neuropsychiatric] observation, no psych diagnosis." Bourne, as well as Colbach and Parrish, included large percentages of cases as "NP observation" (15% and 28%, respectively), but they did not include "other psychiatric conditions." However, "NP observation, no psych diagnosis" is clearly not synonymous with "other psychiatric conditions." USARV's taxonomy for the collection of morbidity statistics from Army hospitals in Vietnam included the former but not the latter (see USARV Regulation 40-34 in Appendix 2 to this volume). Evidently Neel created "other psychiatric conditions" to encompass two diagnostic groups initially represented in the hospital morbidity report data: (1) stress reactions and (2) combat exhaustion. For example, his 38% for "other psychiatric conditions" approximated the sum of Colbach and Parrish's "combat exhaustion" (7%) and "NP observation" (28%).

Because a category for drug abuse was not created before 1970,[36] for most of the war drug cases would likely have been represented in either the character and behavior disorder or "NP observation" groupings (or Neel's "other psychiatric conditions"). Even more uncertain was the fate of alcoholism and other alcohol-generated conditions. USARV Regulation 40-34 did not designate where they should be counted in the medical treatment facility morbidity reports for psychiatric cases, yet these problems were quite prevalent. Finally, as has already been noted, there were no widely distributed operational definitions for diagnostic groupings so that the categorization of any particular soldier-patient may have been influenced as much by bias of the clinician, or of the referring command, as by clinical determinants. Douglas R Bey, the 1st Infantry Division (ID) division psychiatrist, offered the following caveat after his return to the United States:

> [T]o follow the [DSM] rigidly might also force us to try to fit our observations into diagnostic categories that have questionable application to the [Vietnam] combat setting. This type of decision was always necessary when reporting our monthly [statistics to USARV Headquarters]. At the time we questioned whether some of the syndromes we were seeing were adequately described by the diagnostic categories we were asked to use. For example, was an individual who was unable to adjust to the military in Vietnam and who was given an administrative discharge really suffering from a personality disorder? . . . In many instances he had the same difficulties with teachers, employers and others in the past and probably did have some longstanding characterological problems. However, in some instances he could not tolerate the conditions peculiar to the combat assignment in Vietnam or his unit could not tolerate him and a decision was made…that he should be sent home [via psychiatric and medical evacuation or character and behavior disorder certificate and administrative discharge].
>
> . . . Investigators must be wary of reported statistics as to the number of cases of various diagnostic categories seen by military psychiatrists. In general, those diagnosed as "psychotic" are probably accurate figures. . . . In other instances it might be necessary to diagnose a man in a way that would assure his evacuation rather than by the most technically accurate diagnosis.[39(ChapVIII,pp1–3)]

Frank W Hays, a senior US Air Force psychiatrist who reported on aeromedical evacuations, including Army patients, from Vietnam through Travis Air Force Base, California (1 January 1967–30 June 1967) during the buildup period, illustrated the problem of taxonomic ambiguity. According to Hays, by regulation Air Force and Army psychiatrists recognized two distinct types of emotional and mental disturbances: (1) mental disorders (psychosis, neurosis, impairment of brain tissue function, and psychophysiological autonomic and visceral disorders) and (2) character and behavior disorders. Yet for statistical purposes he

and his colleagues lumped soldiers with the diagnosis of combat exhaustion (one case), alcoholism, and adult situational disorder under character and behavior disorders. In his estimation this was warranted because it was common to see military personnel with these diagnoses who had been medically evacuated from throughout the Pacific Theater no longer demonstrate the symptoms that originally brought them to psychiatric attention. Instead they "[manifested] primarily personality trait disturbances, usually of the passive dependent or passive aggressive hue."[40(p659)]

The Navy psychiatrists who took care of Navy and Marine psychiatric casualties in Vietnam used the same limited taxonomy and ended up with a contradiction with regard to some combat stress cases. As noted in Chapter 6, Robert E Strange vigorously reserved the diagnosis of classic combat fatigue (vs "pseudocombat fatigue") for Marines lacking in premorbid personality or psychoneurotic disorders.[41,42] Yet when he and Ransom J Arthur grouped all cases hospitalized on the USS *Repose* (according to psychotic disorder, psychoneurotic disorder, and character and behavior disorder), combat fatigue cases, along with situational reaction, were lumped under character and behavior disorder (actually, personality disorder).[43]

By way of conclusion, collectively the three Army data sets (Neel, Colbach and Parrish, and Bourne) are especially misleading in failing to capture data from the more psychiatrically difficult period in the war—the 2 years following mid-1970. Otherwise, of the three data sets, that provided by Colbach and Parrish appears to be more complete because it spanned the first two-thirds of the war (vs Bourne) and because it retained the original "combat exhaustion" and "NP observation" categories (vs Neel). However, if so, that would suggest that somewhere near 50% of Army psychiatric inpatients in Vietnam were not hospitalized for psychiatric "illness." Colbach and Parrish indicated that roughly a quarter of hospitalized psychiatric cases were ultimately deemed to not have psychiatric conditions ("observation neuropsychiatry—no psychiatric diagnosis"), and another 30% were inappropriately hospitalized (character and behavior disorder), at least according to the regulation. USARV Regulation 40-34 stipulated that:

> Hospitalization is to be avoided except where patients are potentially dangerous to themselves or others, and then only because of mental illness. It is not to be used when personnel, who for administrative reasons or convenience, need only to remain overnight or await some administrative action. With rare exceptions sociopathic soldiers [*sic*] (character and behavior disorders) are not to be admitted to hospitals. [Hospitals] will not serve as substitutes for administrative action. . . .[44(¶4(a),p2)]

An alternative conclusion might be that diagnostic precision was not a priority—that many soldiers initially presented with disabling stress-generated symptoms but recovered rapidly under a generic treatment regimen (ie, brief hospitalization, observation, milieu treatment, expectancy of rapid return to duty, and tapered psychotropic medications). It was concluded that these individuals had undergone an adjustment disorder, even if facilitated by drug or alcohol use, and they were counted under one of these two headings: (1) "observation neuropsychiatry—no psychiatric diagnosis" or (2) "character and behavior disorder." To make the point, Gary L Tischler, with the 67th Evacuation Hospital, utilized two additional categories: (1) "transient situational disorder" (18%) and "other" (10.5%).[45] Bey, with the 1st ID, added "acute situational reaction" (20%),[46] and H Spencer Bloch, with the 935th Psychiatric Detachment, did likewise (17.5%) as well as added a category for alcohol and drug problems (6.8%).[47]

The Psychotic Disorders

The psychiatric literature from the war indicated that despite induction standards intended to screen out disqualifying psychiatric conditions,[16] the deployed mental health personnel in Vietnam treated a variety of psychotic disorders. This was no surprise to Army psychiatry leaders, like Allerton, because over 5 decades, the Army-wide incidence rate for psychotic conditions was 2% to 3% of troops per year, regardless of the conditions of war or peace.[19] Those Army psychiatrists in Vietnam who provided data indicated that psychotic conditions represented a modest proportion of their referrals. This included three division psychiatrists: (1) Franklin Del Jones ("a few individuals"), (2) Harold SR Byrdy (2.4%), and (3) Bey (5%). Tischler, who also provided 2nd echelon treatment as a solo psychiatrist in an evacuation hospital, reported 3%. Although John A Bowman, the first 935th Psychiatric Detachment commander in Vietnam (3rd echelon care), reported less than 5% of referrals as psychosis, because it was at an early point

in the war and he and his team provided care for many combat units, they could be considered as functioning like a division psychiatry unit (providing 1st and 2nd echelon care).

Regarding hospitalized cases, Colbach and Parrish reported that approximately 20% of psychiatric inpatients in Vietnam through the years of mid-1965 through mid-1970 were psychotic disorders (Table 8-2). Consistent with that figure, cases of psychosis (schizophrenia and affective psychosis) were estimated to be 18.8% of the caseloads of the psychiatrist participants in the WRAIR survey (Table 5-3 in Chapter 5). The two reports from the psychiatric specialty units indicated a much higher proportion. Early in the war Louis R Conte, at the 98th Psychiatric Detachment, reported between 40% and 50% of their inpatients were schizophrenic. Later, Bloch, at the 935th Psychiatric Detachment, reported 44% as psychosis. Both of these are double Colbach and Parrish's reported theater-wide percentage for psychosis, but that would be expected because they were the definitive treatment sites in the theater for the more intractable cases.

But some ambiguity also arises because Conte appears to have used schizophrenia interchangeably with psychosis, although they are not synonymous. The soldier who presents with an acute disorganized or disoriented state may be undergoing a schizophrenic decompensation; but alternative possibilities include that of an acute, reactive psychotic episode, such as combat exhaustion, as well as brain trauma or toxic/metabolic conditions. In Vietnam, alcohol abuse and the increasing use of recreational drugs added to the diagnostic complexity. Bey mentioned seeing one intoxicated soldier who had sustained a skull fracture and subdural hematoma. He saw another who had severe hypoglycemia secondary to a pancreatic tumor. He also saw cases of delirium caused by cerebral malaria, heat stroke, alcoholic paranoia and hallucinosis (a mental state characterized by frequent hallucinations).[48]

With respect to drug use other than alcohol, making an accurate diagnosis could also be difficult because possession was a criminal offense, and a history of drug use could be withheld. The early identification and treatment of psychotic conditions was also challenging because soldiers had ready access to weapons. For example, Bey described a tragic incident in September 1969 when a 1st ID soldier walked into a bunker at a fire support base and, without provocation and without knowing his victims, shot all six occupants, killing two. The sanity board found him to be psychotic at the time. Upon review, his conduct had been quite bizarre for several days before the shooting.[48]

None of the reports by individual psychiatrists provided details pertaining to subcategories of psychoses and numbers seen. They seemed to take these cases in stride and appeared confident in treating them uniformly, primarily in inpatient settings, using milieu therapy and psychotropic medications. (See Case 8-1, PFC Yankee below and Case 8-5, PVT Easy, later in the chapter.) As previously indicated, division psychiatrists were more or less limited to 3 to 5 days of hospital-like care and evacuated unresponsive cases to the psychiatric specialty detachments for additional treatment. Solo psychiatrists at evacuation and field hospitals also were limited in the scope of their treatment and resorted to the psychiatric specialty detachments. In turn, the psychiatric specialty detachments provided more extensive and prolonged treatment but were limited to 30 days before evacuating intractable cases out of Vietnam. However, as already mentioned, the policy was to medically evacuate soldiers with unresponsive psychotic conditions out of Vietnam as soon as possible. Otherwise, psychiatric treatment within the various medical treatment facilities was consistent with the military psychiatry forward treatment doctrine reviewed in Chapter 7.[38]

In general, there was no system established that would inform the psychiatrists in Vietnam regarding the treatment provided and clinical course of their patients at the receiving hospitals out of the country and whether their clinical judgment was confirmed. However, two published reports shed some light on the fate of psychiatric patients evacuated out of Vietnam. Dave M Davis, an Army psychiatrist, noted that of 155 cases sent to his backup hospital in Japan over a 15-month period in 1966–1967, 66 (43%) received a schizophrenic diagnosis (73% of whom displayed prominent paranoid symptoms). Only five of these had a previous history of psychiatric hospitalizations, and the onset of disabling symptoms was not statistically related to any phase of the 1-year Vietnam tour.

The average hospitalization in Japan was 46 days for the schizophrenic patients, and they were returned to duty elsewhere in Asia.[49] The report by Elliot M Heiman, an Army psychiatrist in the United States, provided an intriguing contrast. He indicated that 10 of 12 patients evacuated from Vietnam to the treatment center at Fort Gordon, Georgia, for schizophrenia

(also 1967) had their final diagnosis there changed to character disorder (seven cases), depressive reaction (two cases), and stress reaction (one case). From his limited sample Heiman conjectured that many acute psychoses seen in Vietnam had chronic or excessive marijuana use as a critical and reversible etiologic factor in their pathogenesis.[50]

The case of Private First Class (PFC) Yankee is illustrative. Although a diagnosis of schizophrenia held upon discharge from Walter Reed General Hospital, his heavy use of marijuana and his underlying personality disorder were critical factors complicating the diagnosis and disposition.

CASE 8-1: PFC Who Threatened His Platoon Leader Secondary to Schizophrenia, Heavy Marijuana Use, and Personality Disorder

Identifying information: PFC Yankee is a 21-year-old single black male with 17 months of military service and 8 months in Vietnam who was hospitalized at the 95th Evacuation Hospital in Vietnam in the fall of 1967 after becoming confused and agitated and threatening his platoon leader with a knife.

History of present illness: PFC Yankee was initially treated and released with diagnoses of personality disorder and acute alcoholic intoxication. Continued bizarre and menacing behavior in his unit resulted in a second hospitalization. On examination at that time he was observed to be talking to himself while posing and grimacing. He admitted to heavy use of marijuana in Vietnam and complained that everyone was trying to get him, especially by leaving marijuana around him. His mental processes were extremely disorganized.

Past history: He was raised as the second of four children and denied family stress except financial. He dropped out of high school in the 12th grade because of conflicts with authorities. He worked as a painter's assistant before being drafted. He admitted to regular use of alcohol as a teen. His record indicated a long history of inability to adapt to military life, but he denied conflicts with military authority in Vietnam.

Examination: Initially he presented as withdrawn, sullen, and defensive. He was moderately anxious and easily irritated. He smiled inappropriately at times and appeared to be responding to internal stimuli. Thought processes were only mildly disordered. His thought content centered on his suspicions of the Army and of other soldiers. He also expressed angry feelings toward the sergeants, and he reported becoming very frustrated over a series of unsuccessful efforts to get transferred out of the country because his older brother was also in Vietnam. There was no evidence of intellectual impairment.

Clinical course: At the 95th Evacuation Hospital he received up to 600 mg of Thorazine/day with marginal results. After 3 weeks he was medically evacuated out of Vietnam to Walter Reed General Hospital. There he was treated with group and individual psychotherapy as well as moderate doses of Thorazine. He quickly adapted to the treatment milieu and his psychotic behavior gradually subsided. He was released after 3 months of treatment.

Discharge diagnosis: Schizophrenic reaction, unclassified, in remission. Stress: moderate, noncombat duty in a secure area of Vietnam. Predisposition: chronic, severe, history of schizoid traits and strong dependency ties to family. Impairment: marked, for military duty; minimal, for social and industrial adaptation.

Disposition: PFC Yankee was administratively separated from the Army as unfit.

Source: Narrative Summary, Walter Reed General Hospital.

The Psychoneuroses

In the psychiatric nomenclature of the times, the psychoneurosis (or neurosis) diagnosis referred to a broad category of psychiatric disorders that centered on a patient's experience of distress secondary to anxiety or depression, or to unconscious, automatic, psychological, and somatic means of controlling these painful affects, which were themselves disabling. Such individuals were typically distinguishable from those with psychosis in not manifesting gross misperception of external reality or significant personality disorganization.[51] A few of the Army psychiatrists in the field in Vietnam included data regarding neurosis cases in their individual reports. The proportion of their caseload diagnosed as neuroses included Byrdy's 13.9% and Bey's 10% in the divisions,

TABLE 8-3. Breakdown of Hospitalized Army Cases in Vietnam for Neuroses

US Army Hospitalizations for Neurosis, January–June, 1966*	
Anxiety Reaction	63.1% (41)
Depressive Reaction	24.6% (16)
Conversion Reaction	7.7% (5)
Other	4.6% (3)
	100.0% (65)

*Adapted with permission from Bourne PG, Nguyen DS. A comparative study of neuropsychiatric casualties in the United States Army and the Army of the Republic of Vietnam. *Mil Med*. 1967;132(11):905.

Tischler's 10% as a solo psychiatrist in an evacuation hospital, and Bloch's 12.3 % at the 935th Psychiatric Detachment. These are close to the estimates provided by the psychiatrist participants in the WRAIR survey for soldiers with neurotic disorder (averaging 9.6% of the cases they treated or care they supervised [Chapter 5, Table 5-3]). All these figures are somewhat below Colbach and Parrish's theater-wide percentage for neurosis of 15% (Table 8-2), but, again, there is reason to doubt the reliability of this diagnosis in Vietnam (refer back to the Case 6-8, PFC Mike, in Chapter 6).

Among the three data sets for hospitalized Army psychiatry cases in Vietnam in Table 8-2, Bourne's, which was limited to 1966, was the only one to include detail regarding subgroups within psychoneurosis. As indicated in Table 8-3, anxiety reactions were roughly two-and-a-half times more prevalent than depressive reactions and over eight times more prevalent than conversion reactions. However, because these percentages only pertain to the first year of the war, it can't be assumed that they held in subsequent years.

Anxiety and Depression

The individual psychiatrists' reports indicate that the terms "anxiety" and "depression" were often used loosely to allude to symptoms of psychological distress presenting among soldier-patients (with anxiety more common than depression) as opposed to representing diagnostic specificity. This is consistent with the impression of William E Datel, an Army research psychologist, who commented in his review of American military psychiatric epidemiology from World War I through the Vietnam period that "[p]sychoneurosis, at least in the Army, has waned considerably in fashion as a diagnostic descriptor since the days of World War II."[21(p7)]

Adding verification that anxiety overshadowed depressive symptoms in Vietnam, at least in the first half of the war, are results from the Datel and Johnson study of patterns of psychotropic prescription. Although it was limited to Army outpatients in Vietnam in 1967, it provided some measure of clinical challenge among ambulatory patients for anxiety and depression *as symptoms*.[52] Respondent Army physicians in primary care roles, including battalion surgeons, indicated that over the month of the study, 28.4% of their prescriptions were for anxiety (for the purposes of this calculation the combat exhaustion cases, which they regarded as a subtype of anxiety, have been excluded). This was second following gastroenteritis (45.0%); but recall from the earlier discussion of the study that the majority of the gastroenteritis cases treated with psychotropic medications were presumed to be anxiety-based. In contrast, less than 1% of their prescriptions were for depression. The eight respondent prescribing psychiatrists (two were Navy psychiatrists serving with Marine divisions) indicated that 42.3% of their prescriptions/cases were for anxiety, and this was the leading symptom treated by them (again, combat exhaustion cases have been excluded). Depression accounted for only 4.7% of their psychotropic prescriptions. (See Case 6-12, PFC Quebec, in Chapter 6 as a patient with symptoms of anxiety and depression.)

Conversion Reaction

According to the taxonomy provided in DSM-II, conversion reaction would refer to a subtype of the hysterical neurosis (itself characterized as "an involuntary psychogenic loss or disorder of function") in which the individual has psychologically based impairment of the special senses or the voluntary nervous system. Common symptoms include psychogenic blindness, deafness, paraesthesias, and paralysis (in a contemporary taxonomy, these would be called conversion disorders). Although these dramatic forms of stress-related psychopathology were common in the earlier, high-intensity wars,[3] there is very little in the professional literature from Vietnam to indicate that they were common there. Bowman, with the 935th Psychiatric Detachment, mentioned that such cases were seen among their caseload but without information as to frequency. Otherwise, Gerald Motis, a division psychiatrist, with West, described the Sodium Amytal treatment of a case

of hysterical mutism,[53] and Bey provided a case example of the treatment of a conversion/hysterical paraplegia using brief, supportive hospitalization and positive suggestion.[48] (See Chapter 7 for further details; also see Case Prologue-1, SGT Alpha as well as Chapter 6, Case 6-7, SGT Lima, a less clear-cut example.) Further evidence substantiating the low incidence of conversion disorders during the war, at least among combat-exposed troops, came from the respondent "combat" psychiatrists in the WRAIR survey who recalled them as between uncommon and very uncommon (Table 7-6 in Chapter 7 of this volume).

Additional information regarding conversion reactions evacuated from the theater came from Norman L Carden and Douglas J Schramel, US Air Force psychiatrists, who reviewed 12 cases of classical conversion treated at Clark Air Force Base in the Philippines very early in the war (1964–1965). Not all of their cases were combat troops, but it was their impression that fearfulness of enemy action was not limited to combat-exposed troops. The authors reported that no specific psychodynamic was common among their cases. Emotional immaturity and dependency were consistent premorbid findings, but parental characteristics and demographic variables were not. According to the authors, in exempting them from further duty in Vietnam, the conversion symptoms served to reduce the soldier-patient's conflicts associated with aggressive and erotic feelings as well as decrease his feelings of responsibility and death fears (secondary gain). Furthermore, symptom choice expressed a past identification with disease or trauma to the site of somatization. The incapacitating symptoms followed closely an alleged environmental stress, which the author's referred to as the face-saving event, but the full pathogenesis pointed to an underlying stress that preceded the symptoms by a prolonged period. Carden and Schramel predicted a high vulnerability to recurrence and recommended these patients not be returned to combat duty. The following example is extracted from a case synopsis they provided.[54(p25)]

CASE 8-2: Ammunition Handler With Pseudoseizures

Identifying information: Private (PVT) Zulu is a young enlisted soldier (ammunition handler) with 3 months service in Vietnam [who] was medically evacuated from Vietnam to Clark Air Force Base Hospital [in the Philippines] early in the war for additional psychiatric treatment for psychogenic nonepileptic seizures.

History of present illness: Since his arrival in Vietnam the patient's duty performance was noted to be marginal and he bonded poorly with his peers (in fact, he was scapegoated by them). Recently he developed seizure-like episodes that proved not to have a neurologic etiology.

Past history: He had a strict religious upbringing and developed an immature, dependent personality with primary psychological defenses of intellectualization, denial, and repression.

Examination: At Clark Air Force Base PVT Zulu did not show signs or symptoms of a psychiatric disability. He indicated that he was adamantly opposed to killing and war, and he even experienced his job in Vietnam as ammunition handler as his participating in the killing of his fellow man. He also admitted to being apprehensive that he might be ordered to go into active combat. Clinical course: No record provided.

Final diagnosis: Classical conversion reaction. ("The patient 'solved' his dilemma by triggering his medevacuation out of South Vietnam." [Author: in other words, his symptoms forced the Army to remove him from the combat theater, which in turn eliminated the environmental threat to his mental equilibrium.])

Disposition: Treated (no specifics) and returned to duty with recommendation that he not be returned to Vietnam.

Source: Adapted with permission from Carden NL, Schamel DJ. Observations of conversion reactions in troops involved in the Viet Nam conflict. *Am J Psychiatry*. 1966;123(1):25.

Character and Behavior (Personality) Disorders

Data From the Field

Quite notably, Table 8-2 indicates that among the three primary diagnostic groups responsible for psychiatric hospitalization during the war, character and behavior disorders, or personality disorders, predominated (Neel's 29.1%, Colbach and Parrish's

30%, and Bourne's 38.4%). Anecdotal reports from Army psychiatrists in the field, which were summarized in Chapter 3 and Chapter 4, further indicated that a large proportion of the mental health resources in Vietnam were devoted to evaluating and treating (and making recommendations to commanders) soldiers who were failing to perform to military standards—so-called "noneffectives"[28]—and that many of these ultimately received the diagnosis of character and behavior disorder. This appeared to be validated by the Army psychiatrist participants in the WRAIR survey who estimated that soldiers with personality disorder diagnoses represented approximately one-fourth of the cases for whom they provided clinical care or supervised the care—the largest proportion of their caseload (see Chapter 5, Table 5-3). (Although the participants who served in the second half of the war did not indicate they saw a significantly higher percentage of cases than those in the first half of the war, it can be reasonably assumed from the fact that the rates for psychiatric outpatient visits increased fourfold following the first couple of years in Vietnam [Figure 8-1] that referrals of this type rose rapidly as well.)

In 1966, very early in the war, Jones reported that two-thirds of his referrals in the 25th ID received a diagnosis of character and behavior disorder, but he indicated that he lumped "situational reactions" and "fright reactions" in that group (most of the remainder of his referrals were sent for psychiatric clearance in anticipation of disciplinary action, but they were diagnosed as "no disease"). Byrdy indicated that over 40% of his referrals in the 1st Cavalry Division warranted the diagnosis of personality disorder. Three years later, Bey reported that character and behavior disorders were also 40% of his cases with the 1st ID. With regard to solo hospital psychiatrists, very early in the war Robert E Huffman reported 26% of referrals in that group. Arthur S Blank Jr was less specific, but he did note that 17% of referrals were previously functional soldiers who were command-referred for overtly hostile behavior.

On the other hand, Conte reported that most of the hospitalized cases with the 98th Psychiatric Detachment "were in the character and behavior category" (Author: it could not have been more than 50%–60% because he also indicated that 40%–50% were psychotic). Two years later, Bloch, with the 935th Psychiatric Detachment, reported that only 11.2% of hospital admissions were character and behavior disorders; however, as mentioned in Chapter 4, he was vigorous in his opposition to the hospitalization of such cases (see Case 6-14, SGT Sierra, in Chapter 6). The only statistics reported from the field during the drawdown phase, which was rife with dissent and dysfunction, came from Howard W Fisher, a Navy psychiatrist with the 1st Marine Division. Remarkably he indicated that 96% of 1,000 consecutive referrals were diagnosed as personality disorders, mostly antisocial.[55]

It is difficult to discern a pattern from these reports. Certainly it reflects a lack of consensus regarding diagnostic criteria by the psychiatrists and other mental health personnel as suggested earlier. In some instances it may also have expressed a soldier's motivation to manipulate the system. As noted earlier, Bourne and Nguyen concluded from their study early in the war that US troops hospitalized for this diagnosis were unwittingly shaping their clinical presentation in an effort to be exempted from combat and military service in the theater. (Such soldiers would conform to Jones' concept of the "evacuation syndrome," ie, individuals who were motivated to manipulate the system to get relief from foreign deployment and, perhaps, combat risks.[56])

By way of a conspicuous example, the following case material is extracted from one provided by Bey from 1970.[48(pp53–54)]

CASE 8-3: PFC Processed for Administrative Discharge for Character and Behavior Disorder

Identifying information: PFC Able was single, white, had 4 months duty in Vietnam, and served in a transportation unit. He was sent by his commander for psychiatric evaluation as part of the procedure for a general administrative discharge under Army Regulation 212 for drug use and failure to perform.

History of present illness: He was identified as one of the unit's "heads" (drug users) and was felt to be a shirker and a troublemaker. He flaunted his drug use by displaying at various times a marijuana leaf badge, writing FTA (f--k the Army) on his helmet, and wearing a peace sign. His attitude and behavior weren't improved by punishment, counseling by his NCO and CO [commanding officer], or by threats of incarceration.

Past history: This young man had a long history of difficulties in civilian life. His academic record was poor, with a history of disciplinary problems, and he had dropped out of high school. He had a few minor scrapes with the law for drunken driving, possession of alcohol, possession of a controlled substance, and selling marijuana. The latter charge resulted in the judge giving him the choice of jail or the Army and he chose the Army. During basic and advanced infantry training he had received several Article 15s for disobeying orders and going AWOL. His medical record showed that he had sought discharge by complaining of a bad back.

Examination: When PFC Able came to division psychiatry accompanied by his NCO, he seemed to have a chip on his shoulder. He swaggered into the office, gave a half-hearted salute, and dropped into a chair by my desk. From a psychiatric standpoint he evidenced poor impulse control, poor judgment, difficulties with authority, and a low tolerance for stress. During the interview he was direct in blaming all of his difficulties on military leaders. "The dumb f--kin' lifers have it in for me, man. . . . They're a bunch of juicers [insinuating alcoholics]—they don't get it." He indicated that he preferred an administrative separation from the Army, even if it might hinder his employment opportunities as a civilian.

Clinical course: Not applicable (see disposition).

Final diagnosis: None recorded; probably character and behavior disorder.

Disposition: None provided. The description insinuated that the psychiatric report did not recommend treatment or further rehabilitative efforts, and that a certificate was provided that recommended an administrative discharge from the Army.

Source: Adapted with permission from Bey D. *Wizard 6: A Combat Psychiatrist in Vietnam*. College Station, Tex: Texas A & M University Military History Series, 104; 2006: 53–54.

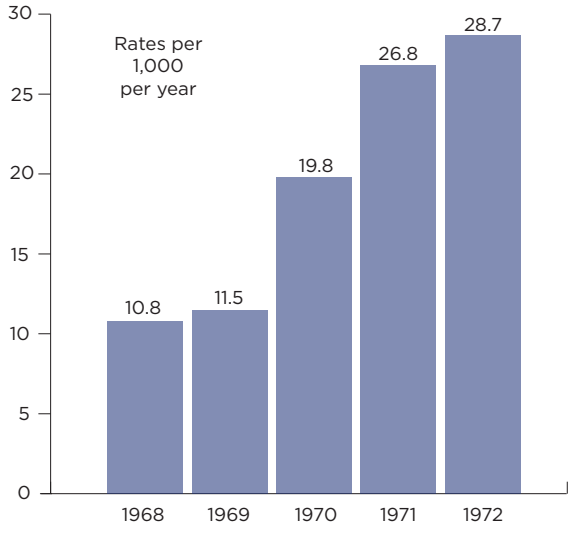
Interpreting the foregoing incidence figures for character and behavior disorders would also necessitate taking into account the efforts by some commanders to exploit the subjective nature of the character and behavior disorder diagnosis because they were eager to bypass the requirement for a lengthy process of counseling and rehabilitation in order to hasten the removal of the troublemaking soldier from the unit. Recall Byrdy's description from the 1st Cavalry very early in the war when he talked of some commander's wish to induce the division psychiatrist to be the "hatchet man" for his maladjusted troops by manipulating a character and behavior diagnosis.

In this vein, John A Renner Jr, the Navy psychiatrist who treated Marine and Navy personnel hospitalized aboard the hospital ship USS *Repose* off the coast of Vietnam in 1969, faulted military policies, as well as the collusion of military psychiatrists, for wrongfully discharging dysfunctional personnel administratively through the overuse of the character and behavior disorder diagnosis (as opposed to medical dispositions). In his opinion, many were in reality "hidden casualties" of the war.[27] He was followed in Vietnam by Fisher (on shore), noted earlier, who dispensed the character and behavior disorder diagnosis on a wholesale basis, but his perspective was diametrically opposed to Renner's. Fisher believed that the majority of the Marines he saw were cases of indiscipline—as opposed to mental disorder—and he blamed the commanders for neglecting their responsibility to hold them accountable. (Serving at the 98th Psychiatric Detachment contemporaneously with Fisher, this author sought to reduce command manipulation of psychiatric opinion by requiring that units provide documentation demonstrating the soldier's repeated failure to adapt and their efforts at counseling and rehabilitation—compare Appendix 5, "98th Medical Detachment Requirements for Psychiatric Evaluation Under the Provisions of AR 635-212," with "Appendix I: Format for Request for Psychiatric Evaluation," in Appendix 2, "USARV Regulation No. 40-34," in this volume.)

Outcome

During the Vietnam era, of the roughly 7.5 million personnel in uniform worldwide, approximately 563,000 (7.5%) received Less-Than-Honorable discharges. Of this group of noneffective servicemen, 258,000 (45.8%) received "Undesirable," "Bad Conduct," or "Dishonorable" discharges, with the remaining 305,000 receiving General Discharges. Furthermore, of the Less-Than-Honorable discharge group only 34,000 (6%) were Court-Martial discharges,

FIGURE 8-2. Worldwide rates for administrative discharge from military service (all branches) for maladaptive behavior/1,000 troops/fiscal year. Data source: Nicholson PT, Mirin SM, Schatzberg, AF. Ineffective military personnel II: An ethical dilemma for psychiatry. *Arch Gen Psychiatry*. 1974;30:406-410 (Table 1).



with the rest receiving more informal Administrative discharges. It should be noted that whereas the General discharge is technically a nonpunitive discharge (meaning the individual retains his full rights as a veteran), it still could limit the veteran's employment opportunities. There were only 24 proven cases of desertion in Vietnam; however, interestingly, 20,000 men served honorably there and then deserted after returning to the United States.[57] More specific to the country's changing attitude about the war, the rate of discharges for all categories of maladaptive behavior for all branches of service worldwide increased 150% over the last half of the war (1968–1972) (Figure 8-2), yet the proportion of those diagnosed as character and behavior disorder remained at around 40% for each of the years.[26(Table 2)]

Regarding psychiatric attrition from the theater through medical channels for character and behavior disorder among Army troops, statistics published for the first 6 months of 1967 can serve somewhat as a baseline: only 6.7% of soldiers evacuated to the United States from Vietnam had psychiatric diagnoses[40] and only 11.5% of these were for character and behavior disorder[40] (thus, 0.7% of medical evacuations to the United States were for soldiers diagnosed with character and behavior disorder). However, as noted in Chapter 2, the overall percentage of psychiatric cases among medical evacuations for the Army rose to 30% in late 1971, and by late 1972, it was at an unprecedented 61% of evacuations—primarily because of drug dependency—but according to some experts, for character and behavior disorder.[2]

Acute Situational Reactions

Specific operational criteria for this diagnostic entity were spare. DSM-II defined transient situational disturbances as temporary disorders "of any severity (including those of psychotic proportions) that occur in individuals without any apparent underlying mental disorder and that represent acute reaction to overwhelming environmental stress."[17(p49)] For the adult patient it included the label "adjustment reaction of adult life" and an analogous one for adolescents. A number of the case examples provided so far in this volume have proved to be only transiently disabling conditions. This would include many acute combat stress reaction cases that received timely and effective supportive care. Considering the intense collection of stressors encountered in Vietnam, perhaps taking a longitudinal perspective on many other cases might also have justified the use of the acute situational reaction (or adjustment reaction) diagnosis.

In Vietnam, Jones, while with the 25th ID, reported that he saw soldiers with "combat avoidance" and "fright reactions" that he concluded were situational reactions; however, he subsequently lumped them with the character and behavior disorders, even though the USARV taxonomy provided a category for stress reactions, which appears to be analogous to the acute situational reaction (or adjustment reaction). Blank, who saw more support troops than combat troops at the 3rd Field Hospital in Saigon, indicated that the predominant diagnosis was transient situational reaction, most usually among soldiers with passive-dependent personalities. As noted earlier, other Army psychiatrists also listed substantial numbers of cases under similar categories: Tischler (18%), Bloch (17.5%), and Bey (20%); but Bey also lumped combat exhaustion cases in this group.

Below is case material summarizing the outpatient treatment of an anxious soldier by Bey that may satisfy the definition of the adjustment reaction (mild). It is also provided because it is one of the few case reports that includes a description of psychotherapeutic interventions

by the psychiatrist in the field, in this case with apparent favorable results.[48(pp154–156)]

CASE 8-4: Congressional Inquiry Generated by Soldier's Worried Parents

Identifying information: E-4 Baker was an infantryman with 2 months in Vietnam.

History of present illness: He was sent to 1st ID mental hygiene for evaluation because of a Congressional Inquiry initiated by his parents (their fourth). They felt that he should not have been sent to Vietnam, much less a combat division, because he was "mentally retarded and brain damaged."

Past history: The patient had always been overprotected by his parents, who early in his life became convinced that he was mentally handicapped. They were surprised that he was able to complete high school, but would not permit him to apply for college because they believed it would be too much for him. The first Congressional Inquiry came when he was drafted into the Army, and another followed during basic training and advanced individual training. A third Congressional Inquiry was initiated upon his receipt of orders for service in Vietnam.

Examination: He said that he had been anxious about his assignment to Vietnam and was also increasingly tense about his current combat assignment. Previous psychological testing revealed that his IQ [intelligence quotient] was average and, other than mild apprehension, he had no other symptoms. He admitted that his parents had overprotected him throughout his childhood. He expressed resentment for their interference and was particularly irritated at their refusal to allow him to apply for college.

Clinical course: We discussed his assertions that he wished for more independence and responsibility at home. I indicated that it would not be too surprising if he might also miss the security of his parents' presence. He said this might be true, but he wanted to do well in his assignment in Vietnam to convince his parents (and himself) that he was not handicapped. He also revealed his wish that he would be able to attend college on the GI Bill without his parents' financial support. I supported his desire and told him that I felt that what he did in Vietnam might make a great difference to him in the future. We also discussed the normal interaction between the new guy and the combat unit. I asked him if he thought the other guys in the unit were less anxious than he (he said they were all nervous). I checked informally as to his function in the unit but did not indicate to his commanding officer (CO) that he was my client. I told the patient that I would meet with him any time he came in, but that I was not going to try to intervene in any way that would make his assignment easier. I explained that I felt this would defeat our efforts to increase his self-confidence.

Final diagnosis: None recorded.

Disposition: The patient functioned in a combat unit throughout his tour and stopped by to see me eight times when his unit was in from the field. He did very well during a stressful tour of duty and was decorated for valor. I told him there was no doubt in my mind that he could accomplish any goal he set for himself as he had demonstrated determination and guts during his tour of duty in Vietnam. At the completion of his tour, I wrote his parents to detail the types of hazardous duty he had endured and repeated that his psychological testing and psychiatric consultations had shown no evidence of any mental handicap whatsoever. I ended by saying I hoped that they shared our pride in his performance and courage in combat.

Source: Adapted with permission from Bey D. *Wizard 6: A Combat Psychiatrist in Vietnam*. College Station, Tex: Texas A & M University Military History Series, 104; 2006: 154–156.

Of course, as has been made clear, distinguishing between the character and behavior disorder and the acute situational reaction would require that the psychiatrist weigh confounding effects of the soldier's pre-Vietnam personality deficits and the stressors associated with his circumstance in Vietnam. (See Case 2-2, PVT Echo, in Chapter 2; and Case 6-9, SP4 November, in Chapter 6.) Regarding the latter, the next section will explore some of the more evident psychosocial and environmental risk factors in the Vietnam theater.

SPECIAL STRESS-INDUCING FEATURES IN VIETNAM

The psychiatric and related literature from the Vietnam War addressed a series of variables that were observed to have the potential to undermine soldier morale, military commitment and cohesion, and mental health.

Recruit Selection and Training

Throughout the war, new inductees into the Army were screened for disqualifying medical and psychiatric conditions based on standards codified in Army Regulation (AR) 40-501.[16] The psychiatric requirements were intended to limit the number of individuals who would become disabled under the predicable stressors associated with service performance in general, as well as assignment in a combat zone and participation in combat. Beyond that the Army assumed that the rigors of basic combat training and the challenges associated with advanced individual training would effectively screen out most soldiers who were psychologically unable to manage an assignment in Southeast Asia—whether through psychiatric conditions or limitations of personality; it therefore was assumed that the majority of military personnel assigned there would be stable and productive.[19,58] (Current Department of Defense policy requires that the military services conduct screening for deployment-limiting diagnoses, such as psychotic or bipolar disorders or other psychiatric or behavioral conditions, based on symptom severity, duration of treatment, stability of the condition, and level of care required. Individuals who would be unable to receive the necessary level of care in theater are not cleared for deployment.[59])

Early in the Vietnam era, Erving Goffman, a sociologist, proposed that the degradations, abasements, humiliations, and "profanations of the self" that recruits underwent in basic combat training served military objectives (ie, made them into soldiers) through disconfirming the recruit's premilitary belief system and identity, but that in the process they developed lingering mistrust and cynicism toward officers and senior sergeants.[60] A study of Army basic trainees conducted by Bourne in 1965 provided some general confirmation of Goffman's theory, but, at the time, Bourne wasn't convinced that the transformation of the basic trainee's identity was deleterious.[61] However, some firsthand accounts published during the Vietnam War were extremely critical of the methods and results associated with basic training—at least US Marine Corps basic training—for reasons reminiscent of Goffman.[62,63] Similarly, Shatan, a civilian psychiatrist who became a passionate advocate of Vietnam veterans with posttraumatic stress disorder (PTSD), complained that classical basic training served to systematically "smash and recast" the recruit's personality through institutionalized brutality, and that this not only contributed to "depersonalized slaughter" in Vietnam, but it also impaired postservice adjustment.[64] Ultimately, even Bourne expressed similar concerns. In particular he opined that instances of excessive combat aggression there followed the soldier's abandonment of his preservice civilian identity and values, which was the result of his basic combat training with its brutalization and socialization to war, specifically the killing.[65]

With regard to induction standards, Chapter 2 mentioned Project 100,000, colloquially referred to as "McNamara's 100,000," which was a Department of Defense recruitment program that lowered physical requirements as well as those for intelligence and level of education in order to bring on active duty men who would have otherwise been considered unqualified for military service.[66,67] (The program allowed men to serve who scored between the 10th and 15th percentile on the Armed Forces Qualification Test [AFQT]. Initially they were referred to informally as "US 67" soldiers because they were identifiable by that military identification number prefix.) Ultimately there were 354,000 Project participants.[67(p80)] Although many of the men who entered the service under this program repeated basic training or were released from the military as unsuitable, the majority performed satisfactorily. However, a study conducted in Vietnam by Crowe and Colbach at the 67th Evacuation Hospital in Qui Nhon found that Project soldiers were represented among mental health referrals at 10 times the rate for soldiers who were not in the program; however, the former were not distinguishable by specific diagnoses.[68] (See Case 6-12, PFC Quebec, in Chapter 6, for an example of the sort of soldier that may have represented this subset. Although it is not confirmed that he was a Project member, the evidence suggests that he could have been. Bey included a case example of a US 67 soldier who was borderline retarded and erupted in explosive violence toward fellow soldiers, apparently because he was scapegoated.[69])

Immersion Shock and Adjustment to Vietnam

Army psychiatrists who served during the first year of the war indicated that susceptibility to psychiatric disturbance was highest among recent arrivals. Byrdy, with the 1st Cavalry Division, commented that he often saw new troops during their second week in Vietnam. ("It must take a while before the novelty of the place wore off, before he finally became familiar with the routine of his unit and learned its expectations of him, and before compulsive mechanisms of adjustment were strained by the realization of a year of sad separation from home, tedious days of work and anxious nights."[70]) Bowman, with the 935th Psychiatric Detachment, indicated that the highest incidence of referrals to their mental hygiene clinic was between the 1st and 2nd months[71] (see Appendix 11, "Recent Experiences in Combat Psychiatry in Vietnam"). And Blank, at the 3rd Field Hospital in Saigon, reported a minor peak in referrals at around 4 weeks after a soldier's arrival, but a much larger one after 5 months in-country (Figure 8-3). (A similar diphasic pattern was reported by LE Morris, an Air Force psychiatrist, among 225 Air Force patients hospitalized in 1966 at the 483rd US Air Force Hospital at Cam Ranh Bay. Of the airmen who were hospitalized for adjustment reactions in the first 6 weeks of their tour, 29% were diagnosed with dependent personalities. In contrast, 39% were hospitalized with variations of depression and irritability between their 4th and 6th months and had rigid and overly conscientious personalities.[72])

The following year, three Army psychiatrists—Jones, Jerome J Dowling, and Tischler—provided additional insights into the challenges faced by newly arriving troops. Jones, when he served with the 3rd Field Hospital in Saigon (September 1966–January 1967), reported high numbers of referrals among soldiers in their first weeks in Vietnam and highlighted the unsettling effect of culture shock on the incoming soldiers who were suddenly faced with Vietnam's "poverty, prostitution and pestilence." Being stationed near Tan Son Nhut airfield, the entry point for new arrivals, Jones would treat many of the fresh casualties. Symptoms were fainting or agitation on first arrival, and later, sleepwalking, bedwetting, nightmares, and anxiety. Jones interpreted some of this as serving environmental manipulation, that is, to avoid the hazards of combat. He also noted that after the initial period of adjustment, most adapted and became productive.[38]

Dowling (Figure 8-4) described soldier patterns of adjustment with the 1st Cavalry Division through the course of the 1-year tour. He based his impressions on casual experiences and clinical observations. He especially noted the "trauma" sustained by the arriving soldiers as they encountered:

> the naked joy of the out-going troops, hearing their hair-raising stories, plus the sound of artillery, plus the mess halls, the latrines; why everyone doesn't turn around and go home still puzzles me. Death is suddenly very real. In one battalion a newly assigned PFC has a 50-50 chance of surviving.[73(pp45–46)]

According to Dowling, soldiers susceptible to psychosis and those with character and behavior disorders were most likely to require psychiatric attention in the first few months of the tour as a consequence of their inability to adapt to the challenges in this new and highly stressful environment. (Case 7-4, PVT X-ray, in Chapter 7 is an example.) Accommodation to the dangers, deprivations, long working hours, and incessant demands required most military personnel to adopt a mindset of "resignation," which lasted roughly until the last month of their tour. By this he meant a chronic, subclinical depression with interrupted sleep because of the heat and artillery, erratic appetite, and overreliance on alcohol.[73]

Tischler explored more systematically the epidemiology of psychiatric and behavior problems seen among the large collection of support units at Qui Nhon. He correlated demographic and diagnostic features of 200 enlisted soldier referrals to the 67th Evacuation Hospital with the phase of each patient's 12-month tour. Tischler was graphic in his portrayal of the new soldier's anxiety-provoking encounter with the exotic, dangerous, and ambiguous Vietnam. Those who successfully coped drew feelings of security from new group affiliations and subordination to authority; but all were somewhat psychologically depleted by being "exposed to death at first hand" and forced to surrender much of their autonomy to the military.

Nonetheless, the majority of troops were able to distract themselves by becoming absorbed in their military tasks and immediate life space and relationships. This commonly involved redirecting their attention from home and the past to that of seeking maximum pleasure through materialism, scrounging,

FIGURE 8-3A. Downcast soldier near the gate of the 8th Field Hospital in Nha Trang. The subject in this 1970 photograph appears to be either bored or homesick, or even depressed. The image is consistent with the deepening discontent and despair among replacement troops assigned in Vietnam during the second half of the war. Even though combat risks were gradually declining, the fighting continued and soldiers still had to contend with a year of military restrictions and sad separation from home, tedious days of work, and anxious nights. These factors, combined with the gradual repudiation of the war by fellow Americans and growing disaffection within the military, strained everyone to some degree and certainly contributed to increasing numbers of psychiatric and behavior problems in Vietnam. Photograph courtesy of Richard D Cameron, Major General, US Army (Retired).

FIGURE 8-3B. (Top) 1st Cavalry Division troops with pet dogs. This is a 1970 photograph of soldiers of the 1st Cavalry Division who have gathered at the 15th Medical Battalion medical clearing station so that dogs they had adopted in Vietnam could be immunized against rabies. This suggests that for some troops relief from deployment malaise and other stresses could be had by taking care of a pet (some adopted monkeys). Photograph courtesy of Richard D Cameron, Major General, US Army (Retired).

FIGURE 8-3C. (Bottom) Mileage marker somewhere on a US military post in South Vietnam. This 1969 photograph gives vivid testimony to the strong sense of physical dislocation and yearning for home that deeply affects troops assigned to fight a war halfway around the world and far from loved ones and the familiar. Any consideration of stress reactions occurring among soldiers deployed in Vietnam had to begin with measuring the weight of this risk factor. Photograph courtesy of Richard D Cameron, Major General, US Army (Retired).

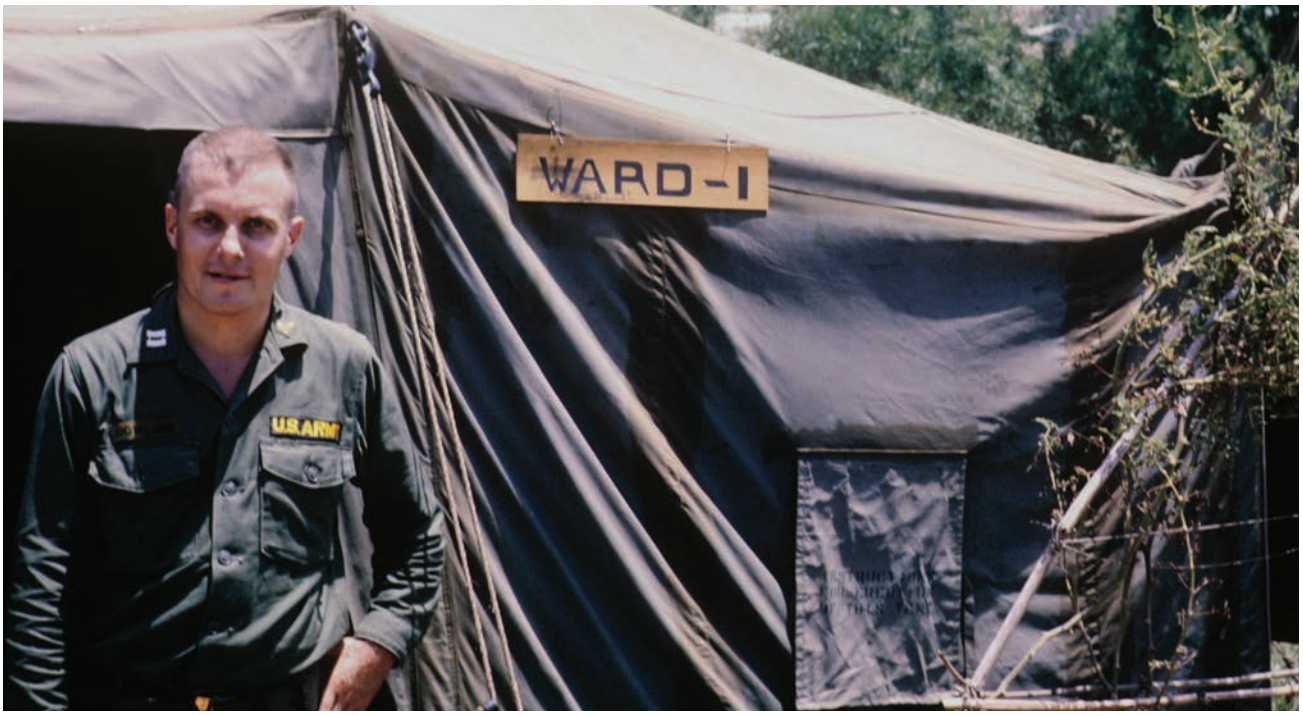


FIGURE 8-4. Captain Jerome J Dowling, Medical Corps, Division Psychiatrist with the 1st Cavalry Division. Dowling was a civilian-trained psychiatrist who served with the 1st Cavalry Division between June 1966 and March 1967, early in the war. He completed the remainder of his tour with the 17th Field Hospital in Saigon. He was the first psychiatrist assigned in Vietnam to describe the psychosocial stressors that commonly affected troops serving in a combat division, as well as patterns of maladjustment and dysfunction, that were coincident with phases of the 1-year tour. Photograph courtesy of Jerome J Dowling.

bartering, R & R (rest and recuperation leave), and frequenting the nearby bars and brothels (a "hedonistic pseudocommunity"). Especially challenging for the new soldier was "anomic anxiety," which was generated by his shock in realizing that preservice assumptions regarding the patterns of events and transactions were no longer predictable—an identity-threatening discovery that brought about intense longing for home and the familiar.

Tischler reported that almost half of his referrals came within the first 3 months of their tour, and that there was a progressively declining incidence over the remaining months until their DEROS (date expected return overseas). His overall impression was that, despite the variations in the forms of psychiatric problems seen, the common pathogenic model involved a mismatch between the soldier's specific personal resource requirements in Vietnam and his predeployment capacity for stress tolerance. He found that, although time eroded the capacity of the deployed troops to withstand the hazards and privations there in general, the more susceptible soldier's "neurotic predisposition" also affected the equation.[45]

Somewhat surprisingly, Tischler found that patients who required treatment during their first quarter in Vietnam had been successful in role tasks before Vietnam (both civilian as well as military) but were apparently unprepared for those associated with transition to serving in the combat zone. In contrast were the lower numbers of soldiers seen during the second and third quarters of their tour who were mostly referred by their commanders pending disciplinary actions. These soldiers had functioned relatively adequately in their civilian roles but had conflicts with military authority after entering the Army; then, over time in Vietnam they failed to withstand the emotionally depleting circumstances and developed behavior problems.[45]

Bloch, who served in Vietnam the following year, provided further insights into the psychosocial challenges faced by new arrivals based on his casual experiences and clinical observations at the 935th

Psychiatric Detachment. By that point in the war, the combat had intensified and circumstances in the theater had become even more stressful for the new replacement. According to Bloch, the result was a universal variation of depression (persistent loneliness, disgruntlement, moroseness, inertia and lethargy, hypersomnia, and frustration at not being able to alter one's situation)—an observation that seemingly contradicts the impression noted earlier that overall anxiety symptoms predominated over depressive ones, at least in clinical populations. For most everyone, excessive drinking and eating, preoccupation with material acquisitions, compulsive work activity, and maintaining correspondence with those outside Vietnam, were relatively adaptive modes of obtaining relief and distraction. For some, discharge of their personal dysphoria also involved an upsurge of licentiousness, or disabling inhibition, which, according to Bloch, was motivated by the activation of aggressive impulses.

Bloch provided a specific explanation for the strain associated with being sent to war in Vietnam, that is, that it produced an anomalous developmental crisis (ie, a psychological "foreign body"). By that he meant that the typical young soldier had to make radical personal and interpersonal adjustments because of the unnatural combination of: (*a*) the lengthy separation from family and loved ones, which provoked anxieties about separation and abandonment; (*b*) disruptions in expectable stateside life patterns, which aggravated these anxieties; and (*c*) the protracted exposure to the possibility of death and disfigurement. He, like Tischler, also noted that under optimal circumstances, healthy coping required intense bonding with the immediate group and partaking of its morale, which in many respects rested on the caliber of its leadership.

According to Bloch, troops with direct exposure to combat required additional psychological defenses of denial and magical belief in one's luck and indestructibility. Overall, clinical populations, which included combat troops and noncombat troops, were composed of individuals who failed in these adaptive tasks. They commonly presented with free-floating anxiety or psychosomatic conditions and preoccupations. He furthermore speculated on the likelihood that the policy of fixed, 1-year tour limits interfered with the commitment of soldiers to their combat groups and development of esprit de corps, thereby opposing adaptation and positive mental health.[74] (See Appendix 12, "Some Interesting Reaction Types Encountered in a War Zone." It provides a sophisticated analysis of several case examples on a spectrum of soldier maladaptation.)

Bey, who was division psychiatrist with the 1st ID (1969–1970) during the midpoint in the war, was explicit regarding the stress incurred by replacement troops. He reported that they were at high risk to develop symptoms if they resisted transitioning to the new life in Vietnam from their predeployment life at home. According to Bey,

> . . . Those individuals who could not develop the counterphobic defenses encouraged by their new units, were unable to give up their hold on "the world," or could not identify with the language and habits of their new peer group, developed symptoms and often didn't make it in Vietnam.[48(p141)]

As a preventive effort, Bey implemented a command consultation model aimed at reducing the incidence of failed integration of solitary green troops into seasoned combat units, which included inserting new unit members by pairs.[75]

To conclude, these reports by psychiatrists who served in the field in Vietnam were consistent in identifying a collection of stressors that challenged all troops there, especially new replacements who arrived in country on staggered schedules. However, because these reviews were limited to the buildup and transition years, they omitted the late war phenomenon of new arrivals being indoctrinated by disgruntled troops who had already established various affinity groups that were bonded through their antagonism to military authority (in defiance of the "green machine"[76(p98),77(p21)]) and devotion to use of illegal drugs.

Support Troops and "The Rear"

Chapter 2 provided some observations regarding the life and circumstances affecting the thousands of military personnel who served in noncombat roles in Vietnam. As noted in Chapter 1, these individuals constituted roughly two-thirds to three-fourths of Army troops in South Vietnam. They lived and worked throughout the country in an array of outposts, semipermanent operation bases (eg, An Khe and An Hoa), corps and division headquarters bases (eg, Phu Bai and Bien Hoa), vast logistics and support complexes (eg, Long Binh and Cam Ranh Bay), and the larger cities

FIGURE 8-5. City of Da Nang from across the Han River. In this 1970 photograph, Da Nang, South Vietnam's second largest city, is seen from 24th Corps Headquarters. Da Nang was located north along the coast of South Vietnam and was surrounded by US military installations. Although there was a US operated pedestrian ferry that crossed the river here, for most military personnel the city was off-limits. Consequently, whereas US troops assigned in the region could find themselves fighting for South Vietnam's freedom, the circumstances meant that they remained mostly remote from the people and their culture. Photograph courtesy of Norman M Camp, Colonel, US Army (Retired).

(eg, Saigon and Da Nang). Within the divisions, they served primarily in headquarters/administration or in the logistical elements.

Although assignment in a noncombat role was not invariably tantamount to serving in a safer and more comfortable circumstance, more often than not it was. Obviously, a conspicuous exception would be the combat medic. (Bey made note of the heightened stresses faced by soldiers who served in certain support jobs: corpsmen, who were prone to reactive depression; military police road guards, because of the long periods of isolation and vulnerability; and engineers, who were not allowed to fight back when attacked.) Of course, reiterating a point made previously, the designation of "the rear" was relative in Vietnam because the combat was very fluid and there was little territory that was completely safe. Michael Herr, the correspondent, described it in compelling fashion:

> . . . You could be in the most protected space in Vietnam and still know that your safety was provisional, that early death, blindness, loss of legs, arms or balls, major and lasting disfigurement—the whole rotten deal—could come in on the freaky-fluky as easily as in the so-called expected ways. . . . The roads were mined, the trails booby-trapped, satchel charges and grenades blew up jeeps and movie theaters, the VC [Viet Cong] got work inside all the camps as shoeshine boys and laundresses and honey dippers; they'd starch your fatigues and burn your shit and then go home and mortar your area.[78(pp13–14)]

However, noncombat troops and those living and operating in the rear had one expectable downside—they were treated with total disdain by combat troops who faced greater risk and hardship. Not only were they

FIGURE 8-6A. (Top) Entrance to the 80th Combat Support Group in Da Nang, 1970. Located on this compound was a very large and diverse collection of support units. The record suggests that rates for psychiatric disorders and behavior problems in Vietnam were generally higher among noncombat troops such as these. Part of the explanation comes from the fact that, outside of the larger installations, such as Long Binh and Cam Ranh Bay, support troops worked and lived in small, isolated, and heavily guarded compounds with few opportunities for escape. Also, compared to combat troops, they were more likely to suffer from the lack of a sense of purpose that could justify their restrictions and privations. For many troops these features combined to aggravate interpersonal conflicts with fellow soldiers and heighten tensions with military authorities. As an aside, although the Chapel of the Flags is prominent in the picture, it is noteworthy that spiritual or religious matters are not mentioned in the psychiatric literature from the theater. Photograph courtesy of Norman M Camp, Colonel, US Army (Retired).

FIGURE 8-6B. (Bottom) Fishing village seen through concertina wire. This is a 1970 photograph of a Vietnamese fishing village taken through the heavily guarded perimeter of the 95th Evacuation Hospital near the city of Da Nang on the coast of the South China Sea. It illustrates the view that the majority of nondivisional, support troops had of the Vietnamese people and their culture apart from incidental contact with Vietnamese day laborers on their compound or while hastily traveling on the roads with an armed escort. Photograph courtesy of Norman M Camp, Colonel, US Army (Retired).

FIGURE 8-6C. US military convoy with armed escort near Da Nang, 1970. Because of the dangerous conditions throughout most of South Vietnam, areas outside of military compounds and bases were designated off-limits to American military personnel except during combat maneuvers. This meant that, whereas the troops assigned to the larger, better equipped installations, such as Long Binh and Cam Ranh Bay, had off-duty access to recreational facilities, the majority of soldiers in Vietnam were more restricted in opportunities to escape the embrace of their immediate military setting and authority because of the need to travel in an armed escort or aircraft. Photograph courtesy of Norman M Camp, Colonel, US Army (Retired).

resented for their life of safety and ease (relative), but they were also often suspected of unfairly appropriating the best of the equipment and benefits for themselves. Support and service troops were aware of how they were regarded by "real" combat troops and invariably felt varying degrees of guilt in their presence.[79] Bey provided the following observations regarding the tension between combat troops and noncombat troops.

> . . . [T]here was the REMF [rear echelon mother f--ker] social order. This term was used to refer to anyone in a more desirable, comfortable, or safer assignment than your own. The men in the combat units with the most dangerous duties such as Rangers who were LRRPs (long-range reconnaissance patrol), were at one end of the continuum. Military personnel serving in the United States were at the other end. In between, the general hierarchy went from the men at the fire support bases, those at base camps, and those assigned to large support areas such as Long Binh or Saigon. I was as far forward as a psychiatrist could be assigned, but I was a REMF to the combat troops who fought the enemy out in the paddies. Similarly, Dau Tieng and Lai Khe received rocket and mortar attacks more frequently than Di An; therefore the men stationed at those bases regarded the men stationed at Di An as REMFs.
>
> There was a kind of one-upmanship that took place when forward- and rear-assigned individuals interacted.
>
> . . . Sometimes the anger toward REMFs produced explosive violence, especially when aggravated by factors such as the communication gap between white, inexperienced officers and black enlisted men from inner city environments.[48(pp158–159)]

To maintain morale, the US government went to great expense to supply the troops in Vietnam with material comforts and recreation/entertainment opportunities (Figure 8-7). According to Spector, a military historian:

> In general, the larger the base or headquarters, the greater were the amenities. As a minimum, however, troops at the major installations enjoyed beds with sheets, hot food, electricity, hot showers, a club, athletic facilities, movies, and plenty of beer. Barracks and hootches often had Vietnamese maids and laundresses. Many clubs were air-conditioned, and the larger ones featured dining rooms where hamburgers, French fries, fried chicken, or steak were always available.[79(p263)]

Still, large numbers of soldiers, especially support and service-support, were assigned to small, isolated compounds that weren't so well equipped. For most of them, the confines of their day-to-day life felt like being in a prison camp (Figure 8-5 and Figure 8-6).

Troops serving in the rear in general found themselves battling boredom and loneliness for home as opposed to fighting the enemy. For them, the stress-mitigating spirit of unit commitment and group cohesion characteristic of a combat unit was missing, and disputes and fights between soldiers were common; as the war progressed, these became increasingly racially centered and facilitated by drug use. (Indeed, according to Spector, racial problems, and then serious morale problems more generally, first appeared in the combat support and service support units in 1968.[79])

From his vantage point as a research psychiatrist in Vietnam during the first couple of years of the war, Bourne remarked that the bulk of psychiatric cases came from support units. Two years later, in 1969–1970, Bey, a division psychiatrist, made the same observation, that support units had a higher incidence of some problems, especially drug and alcohol problems and racial tensions, and he believed this was because they were not involved in the combat and had to contend with the routine and monotony of daily life and boredom.[46] However, reports by Blank[80] and by William F Kenny,[81] which centered mostly on the psychiatric problems of the thousands of support and service-support personnel who lived and worked in the Saigon area, suggest a more complex pathogenesis. They observed that most referrals were dependent and passive-aggressive individuals and felt their adjustment problems stemmed especially from heightened dependency needs, underlying separation anxiety, and primitive defense mechanisms; in other words, preservice personality susceptibility was a critical risk factor.

But even within the combat units, apparently the lulls could be as corrosive to the spirit as was the marginality borne by support troops. According to Dowling, a division psychiatrist, greater stress came from daily base camp routines than combat itself—often accompanied with preoccupations with problems back home.[73] Bowman, with the 935th Psychiatric

Detachment in 1966, was specific that although combat-centered stress was diffusely debilitating in the cases they treated, it was compounded by the more general stress of combat zone deployment.[71]

The only attempt to systematically compare combat and support troops among psychiatric patients came from Jones,[82] who collected diagnostic and demographic data regarding 120 consecutive enlisted referrals to the 3rd Field Hospital in the Saigon area in late 1966, the second year of the war. The median rank for these patients was E-4 (corporal), and they were only distinguishable by age (23 for combat troops vs 29 for support troops) and marital status (35% for combat troops vs 51% for support troops). Among the 98 support troops, the leading "symptom or behavior" was alcoholism (20%), followed by character and behavior disorder (18%), and anxiety (16%). Among the 22 combat troops (25% of referrals, compared to the 15% reported by Blank who preceded him), the leading "symptom or behavior" was character and behavior disorder (32%), followed by conversion symptoms (23%), and anxiety (18%).

Although Jones did not include denominator data that would permit establishment of incidence rates, he did offer the following summary of his findings: "the [combat support troop] casualty stands out as being very much more likely to be alcoholic, homosexual, or psychotic."[82(p14)] Jones felt that the type of psychological conflict borne by these men could only be determined with some degree of certainty in 47 cases (39%) (20 combat troops, 27 support troops). Still, thirteen of the 22 combat troops (59%) had a primary conflict over being in a combat zone versus only five of the 98 support troops (5%); but the two groups were otherwise similar regarding marital or family problems as a primary conflict (23% and 21%, respectively)[82] (see Appendix 16, "Vietnam Study: Reactions to Stress Comparing Combat and Support Troops").

Renner, a Navy psychiatrist who served aboard the hospital ship USS *Repose,* provided some general observations regarding the higher rates of disciplinary infractions among Marine support troops in 1969. According to Renner, despite the overall lower morale in Vietnam by that point in the war, members of the small combat unit were able to justify their dangers, hardships, and self-discipline based on a shared "primitive struggle for survival." By extension, as long as they were in the field, unit identity remained intact ("superficial closeness"), whereas military identity more generally was mostly irrelevant. However, once these Marines were rotated out of combat, conflicts between group members, or opposition toward military authority, erupted. "The reduced degree of external danger in the rear permitted these men to express dissent more openly . . . and reduces their need for conformity."[27(p177)]

Soldiers, Sex, and Romance

The inevitable sexual tensions generated among the several hundred thousand bored, lonely, and frustrated men serving in Vietnam was an important matter affecting morale and duty performance. Evidently from the first months of the war military personnel had access to local prostitutes based on combat circumstances, the unit's location, and the unit's culture. Byrdy, the Army psychiatrist who served with the 1st Cavalry when it was inserted into Vietnam in 1965, reported that "Vietnamese camp followers quickly moved into the area in a very well organized fashion and, depending on the attitudes of command, the troops variably had access to them."[70(p10)] (See Appendix 8, "Division Psychiatry in Vietnam," to this volume for a further discussion.) According to Spector, a Marine historian, sex inevitably became a major preoccupation for the deployed troops in Vietnam. "In practice, sex was relatively easy to obtain in the shanty towns surrounding many of the large bases."[79(p268)] Whereas these were almost always designated as off-limits, with threats of fines, demotions, and so forth, the venereal disease rate was high, which indicated that the troops found ways around these restrictions. Many units set up clubs on post, "recreational areas," ostensibly to showcase entertainers, but they typically also served as a venue for prostitution ("semiofficial brothels"). The advantage was that the women could be monitored by military medical personnel. In the field, soldiers could make a deal for quick sex using a C-Ration meal. Although military policy sought to restrict troop access to Saigon and the other big cities, this proved impossible, and sex, as well as drugs and black marketeering, became "growth industries."[79(pp268–269),83]

Gary K Neller, an Army psychiatrist, provided this description from his experience as a Special Forces medic in Vietnam in 1967:

> In many of the units that were away from populated areas and were heavily engaged, drinking and prostitution were even encouraged by [military

FIGURE 8-7A. (Top) Unit party at the 95th Evacuation Hospital (1971). Such activities were greatly prized as a means of stress mitigation by troops who had access. Furthermore, alcohol was openly available at functions like these and otherwise readily available to the troops through the system of post exchanges (PX) and noncommissioned officers' (NCO) and officers' clubs. Even in units whose commanders did not permit alcohol sales to lower ranks, there were manifold ways to bypass this restriction. Photograph courtesy of Norman M Camp, Colonel, US Army (Retired).

FIGURE 8-7B. (Bottom) Volleyball at the 15th Medical Battalion, 1st Cavalry Division base at Phouc Vinh. Sports and recreation were highly valued by troops as an antidote to stress and boredom. In general, the larger the compound or base, the greater the likelihood that there were facilities available for these activities. However, this predictably led to high tension between the combat troops who served in the more primitive forward positions and the noncombat, support troops who worked and lived in the better equipped and relatively safer bases such as this one. Photograph courtesy of Richard D Cameron, Major General, US Army (Retired).

FIGURE 8-7C. (Top) American beach at Vung Tau on the coast of the South China Sea east of Saigon. Many troops were lucky enough to be assigned near one of the American-controlled beaches and were periodically allowed to spend time there to relax and recreate. This had obvious morale-boosting effects. Photograph courtesy of Norman M Camp, Colonel, US Army (Retired).

FIGURE 8-7B. (Bottom) View from The Grand Palace in Bangkok, Thailand. The US military R & R (rest and recuperation) leave program, in which all personnel serving in Vietnam were permitted a week away from their unit and transportation to remote settings such as Australia, Hong Kong, Bangkok, and Hawaii, was very efficient and successful over the course of the war. Overall it served as a highly prized form of psychological release from the war. Photograph courtesy of Norman M Camp, Colonel, US Army (Retired).

> leaders]. This was true even in the elite units such as my Special Forces team. Even the taking of a Vietnamese wife, usually a RVN [Republic of Vietnam] widow, was acceptable. There were certain brothels you could visit in relative safety because the women were checked by our medics for VD [venereal disease], lice, scabies, TB [tuberculosis], etc. If you couldn't get to the women, the women could be brought to you. Certain helicopter pilots, in exchange for an AK-47 or an "original" Viet Cong flag, would ferry a supply of women out to the jungle camps under the guise of transporting body bags.[84(p48)]

Bey reported from his tour with the 1st ID, "The availability of prostitutes was ubiquitous. Units under fire would report girls riding up to them in the field, selling sex and cokes during the battle. . . . Steam baths were only slightly more scarce where sex was offered as part of their services."[39(ChapVIII,p24)] However, according to Bey, because soldiers in combat units had to deny feelings of compassion for the Vietnamese—dehumanize them—to carry out their mission ("blow away the dinks"), these psychological defenses interfered with the developing relationships with Vietnamese civilians; and, by extension, sex with prostitutes was especially fused with aggression and degradation. This was in stark contrast to soldiers in medical units and other support units who were prone to see the Vietnamese as being human and, in fact, forged durable friendships.[85(pp10–11)]

However, the sexual encounters between US forces and the local Vietnamese were not simply stolen interludes while the brass looked the other way. The health and fitness consequences surrounding venereal diseases or other communicable diseases threatened to be problematic. Dennis L Menard, an enlisted social work specialist with the 1st ID (1967), not only described one battalion's pass policy enabling soldiers to stay overnight in the nearby village, but he also referred to the necessity that they received regular treatment from their medics for venereal diseases.[86] Bey talked about the company commander who was vehemently against fraternization with the Vietnamese and imposed severe restrictions requiring that soldiers obtain a pass to leave the company area. Unknown to the commander was that his troops had an established code of membership that meant that new soldiers had to contract gonorrhea to be accepted.[87(pp404–405)]

Mention was made earlier that rising rates for venereal diseases had historically served as one measure of dropping morale, that is, as a "loneliness" element. According to Jones, in the Korean theater this relationship was linked to declining combat activity.[2] In Vietnam, the rates for venereal disease did not rise over the course of the war (through mid-1970) as did the other indices of psychiatric and behavior problems reviewed earlier. In fact, the years with the higher venereal disease rates, 1965 and 1966 (277.4/1,000 and 281.5/1,000 troops/year, respectively),[37] were the years with highest morale. However, evidently venereal disease incidence did rebound at the very end of the war, as a rate of 698.9 per 1,000 troops per year was reported for the first half of 1972, just before the remaining ground troops departed Vietnam.[2(Table 3-1)] It is interesting to note that a popular myth throughout the war was that one could contract an especially virulent and untreatable venereal disease, "black syphilis,"[83(p28)] perhaps indicating that sexual activities carried significant guilt for US troops. With regard to the impact on the Vietnamese generated by sexual contact with US troops, unofficial estimates of the number of Amerasian children born of American servicemen are between 15,000 and 35,000—children who ultimately suffered extreme discrimination within their culture.[83]

Army psychiatrists in the field in Vietnam became curious about the soldiers who became emotionally involved with Vietnamese women and wished to marry them despite the extensive bureaucratic process that was required. (According to one report, there were more than 6,000 Vietnamese–American marriages between 1965 and 1972.[83]) During the second year of the war (1966), Kenny, at the 17th Field Hospital in Saigon, studied 64 servicemen (nonpatients) who applied to marry Vietnamese women compared with a control sample. According to Kenny, the marriage-seeking soldiers were distinctly older, gave a history of less sexual activity, were more likely to have been previously married, and tended to come from broken homes where they grew up in dependent, ambivalent relationships with their mothers. His overall impression was that the study group's marital motivations expressed a combination of dependent personality characteristics and a fear of domineering women.[81] Two years later, Forrest, assigned to the 935th Psychiatric Detachment near Saigon, drew upon his clinical experience with a select group of soldiers seeking to marry Vietnamese women (15 referrals) and concluded that, although the

typical American–Vietnamese sexual liaison tended to be brief, stereotyped, commercial, and represented mutual exploitation, some couples did develop sustained intimacy. Although he observed that complimentary immature personality characteristics explained these couples' wish to marry, and he believed that the red tape they encountered was worthwhile in serving to test their resolve, those who persisted appeared to benefit from their intercultural marriage.[88]

Throughout the war and until December 1973, homosexuality was classified as a mental disorder in the American Psychiatric Association's *Diagnostic and Statistical Manual*.[17] Also throughout the war, consensual homosexual acts during military service were grounds for administrative discharge from the Army as unfit, and homosexual "tendencies, desires, or interest without homosexual acts during military service" were grounds for administrative discharge for unsuitability (Table 8-1). In the language of Army Regulation 635-89, *Personnel Separations, Homosexuality* (dated 15 July 1966), which applied to enlisted soldiers:

> Personnel who voluntarily engage in homosexual acts will not be permitted to serve in the Army in any capacity, and their prompt separation is mandatory. Homosexuality is a manifestation of a severe personality defect which appreciably limits the ability of such individuals to function effectively in a military environment.[89(§I,¶2,p1)]

This regulation also threatened the homosexual soldier with trial by court-martial at the discretion of his commander; but apparently this was rare in instances when the sex was consensual.[90] Nonetheless, the regulation stipulated that individuals under suspicion for homosexuality must undergo a Criminal Investigation Division investigation and an evaluation by an Army psychiatrist. The psychiatrist was required to provide a written report indicating whether: (*a*) the soldier was suffering from a more serious psychiatric condition, the illness was the primary cause of the acts in question, and the soldier warranted discharge from the Army based on medical/psychiatric fitness requirements for continued service[16]; or (*b*) the soldier warranted a diagnosis of homosexual, which meant he would face the administrative, and perhaps judicial, consequences mentioned above; or (*c*) the acts were the product of immaturity, curiosity, or intoxication, which meant the soldier was unsuitable for further military service. Officers were subjected to a comparable regulation.[13] In 1970, AR 635-89 was eliminated, and the regulation governing administrative discharges for enlisted soldiers, AR 635-212,[12] subsumed its requirements.

In fact, the psychiatric documentation from Vietnam said very little about homosexuality as a professional issue. WL Baker, division psychiatrist with the 9th ID (January 1967–September 1967) mentioned homosexuality as one type of issue that corrupted combat unit morale, but he provided no particulars.[91] Byrdy made the following comment in passing: "Homosexuality was most disorganizing to the group and [when cases presented] I recommended separation without exception"[70] (see Appendix 8, "Division Psychiatry in Vietnam"). Bey reported that he evaluated two soldiers accused of homosexuality. He was clear that he felt the Army should relax its opposition to them serving. Bey also talked about group defenses against latent homosexual impulses that were naturally stirred by the intense, intimate, all-male world of combat troops in Vietnam. This included incessant use of sexual language ("un-fucking-believable"), jokes about others being queer, the rampant exchange of heterosexual fantasies, and sharing of prostitutes by unit members and a preference for fellatio, ostensibly as a protection from venereal disease. He also reported that "there were a few incidents in which an individual became intoxicated and made overt homosexual advances toward a fellow group member. This resulted in great anxiety in the unit and the rapid, often violent, expulsion of the disruptive member."[85(pp10–11)] Strange, a Navy psychiatrist, described his experience aboard the USS *Repose* taking care of Navy and Marine casualties from Vietnam in 1966 and noted that, among his hospital ship population, there were "comparatively few with homosexual problems or similar concerns (4%)."[42] Finally, there are the findings from the Jones study mentioned earlier: that 12% of the support troop patients he treated acknowledged homosexuality as a primary or secondary symptom (vs none among the combat troops).[82]

It is interesting that there is so little in the psychiatric literature from Vietnam about homosexuals since shortly before the start of the ground war in Vietnam a report from an Army mental hygiene clinic in the United States indicated that 3.4% of all referrals between July 1963 and October 1964 were for psychiatric evaluation for homosexuality. Findings among the 38 enlisted referrals included: homosexuals (24), immature (12), and schizophrenic (two). Also, the two officers who were

referred refused to cooperate and were administratively discharged from the Army.[92] One explanation for the minimal references to homosexual referrals in Vietnam is that at that point in time the Army's concerns for identifying and eliminating homosexual soldiers were at a low ebb,[93] perhaps in conjunction with the necessity for maximizing troop strength.

Staggered 1-Year Tours and the Short-Timer's Effect

The overlapping psychosocial risk consequent to the staggered troop replacement policies and the fixed 1-year tours were explored in Chapter 6 with regard to combat troops, but their effects in Vietnam were far more widespread. The individual rotation and replacement policy that was utilized was an adaptation of a term-limitation policy initiated in Korea after the first year there. It was intended to counteract the excessive psychiatric attrition seen in World War II among soldiers who were deployed "for the duration" (an expression indicating that troops were committed until the end of hostilities). However, in contrast to tours with a predetermined length, as in Vietnam, in Korea soldiers were assigned for 9 to 12 months and rotated out based on a point system of exposure to risk. In fact, Stewart L Baker Jr credited the *earned* rotation system in Korea, along with the forward placement of mental health professionals and helicopter evacuation capability of the wounded, for greatly reducing the psychiatric percentage of medical evacuations within that theater.[94]

Observers in the field during the first couple of years in Vietnam, like Bourne (a psychiatric researcher), Moskos (a military sociologist), and Byrdy (a division psychiatrist with the 1st Cavalry Division), touted the benefits of the fixed, 1-year tour as stress reducing because of the soldier's sense of limitation of the hardship and risk. However, as the war progressed, the individual fixed tour developed offsetting negative effects because: (*a*) soldiers became preoccupied with the passage of their year as opposed to performance measures (according to Jones, "Everything [in Vietnam] occurred in the context of time-awareness"[38]); and (*b*) various causes of attrition within units (combat casualties, sickness, etc) meant that the troop replacements became increasingly randomly distributed.

Thus after the first couple of cohorts of troops had rotated back to the United States and their replacements began to arrive on a staggered basis, the fixed, 1-year tour meant that there was invariably a large measure of interpersonal dysynchrony because the timing for everyone's cycle in-country was different. As a result, these two force management policies (ie, the 1-year fixed tour and individual rotations) greatly impeded the maintenance of unit cohesion and commitment. This was truer for support troops because it was not necessary that they bond for the sake of combat efficiency, as was the case for combat troops. However, this effect was otherwise very evident throughout the theater as, with every new encounter, sooner or later a comparison was made as to how much time each party had remaining in their tour.

As a corollary, a soldier's self-esteem rested to some degree on how "short" he was, that is, how much time he had left in his tour in Vietnam. Soldiers ritualistically marked their personal DEROS calendars, and they adopted a variety of expressions serving to gloat over someone who was not as short (ie, a "two-digit, midget!" boast meant that one had fewer than 100 days remaining). Although the soldier's status increased with every passing day because new arrivals began at day 365, he was still vulnerable to feeling pangs of envy when he encountered another soldier who had less time remaining in his tour. In effect, these rotation policies meant that too much importance became attached to the differences between individuals as opposed to their interdependent needs as soldiers fighting to win a war. Unfortunately, apparently the Army never systematically studied the policy's negative effects on unit morale and performance.

Also problematic, earlier in the war, Bourne had argued that traditional unit cohesion was not as necessary in Vietnam because of the ease with which the soldier could stay in contact with home during his assignment (speedy mail, tapes, periodic phone calls, and a stateside R & R leave). This may have been true as long as family and loved ones supported the war. However, when their attitude reversed as the war became increasingly despised, the opposite outcome arose: those on the home front fostered tremendous resentment within the soldier who felt forced to face unjustified risks, hardship, and losses.

The problems faced by commanders regarding soldiers who were nearing their DEROS and who were becoming progressively ineffective, or even combat averse—the so-called short-timer's syndrome—was mentioned in Chapter 2 and further elaborated in Chapter 6 (illustrated with Case 6-9, SP4 Kilo). To reiterate, the short-timer's syndrome consisted of a

low-grade form of emotional and behavior disability commonly seen in soldiers nearing the end of their tour and manifested by sullen, irritable, or withdrawn behavior; a preoccupation with fears of being killed or injured; and a general resistance to duty.

With regard to combat units, Dowling, who was with the 1st Cavalry Division, observed clinically that soldiers were commonly affected by mounting apprehension during the weeks leading up to DEROS; and that this could lead to a syndrome of emotional distress in which irritability alternated with euphoria, and obsessions about "returning intact" took such forms as anxious requests for X-rays, VDRL testing (Venereal Disease Research Laboratory test for syphilis), and the removal of genital warts.[73] Jones, who was with the 25th ID, suggested that the combat soldier became symptomatic when approaching his DEROS because, in emotionally withdrawing and turning his attention to life after Vietnam, he was relinquishing a critical psychological defense based on combat group identification because he could no longer share in the group's illusion of immortality.[38] Jones also said that, whereas the short-timer's syndrome was worse among combat troops, it rarely required psychiatric attention.[22] Bloch, who saw both combat and support troops at the 935th Psychiatric Detachment, speculated that variations on the short-timer's syndrome were best understood as ways that soldiers "buttress themselves against the waves of strong internal reactions to external stresses . . . ,"[74(p625)] which were character-specific for them.

Tischler, who was with the 67th Evacuation Hospital, also reported from his study mentioned earlier that during the last few months of the soldier's tour, emotional withdrawal from both the environment and the group was inevitable, and that the dominant challenge he faced was that of psychosocial disengagement. Even among support units, soldiers became especially cautious and fewer were willing to leave the safety of the compound. According to Tischler, combat troops increasingly suffered from "[a] feeling of resentment that approaches loathing and hatred . . . when combat missions are called for."[45(p39)] Although the last quarter of the tour brought the fewest psychiatric referrals, in part because of each soldier's tendency to draw strength from an idealized future, some troops required psychiatric attention because they had difficulty separating from their "exquisitely interdependent" group of combat buddies.

Tischler found that soldiers seen in the last quarter were individuals from disrupted families with poor educational and service records who struggled with the process of reorienting to a post-Vietnam future (home, family, friends, and things forgotten). Although there were more married soldiers in this group than those seen in the previous three quarters, more than half (57%) of these cases had not been receiving letters from home. According to Tischler, overall these cases could be regarded as "role failures," and many experienced "apathetic disenchantment" because they assumed that they would continue to fail after they returned to the United States.[45]

The preceding observations have centered on the problematic effect on the soldiers because they rotated in and out of units on a 1-year tour basis; however, greatly aggravating this policy's potential to impair unit morale and bonding, as well as unit combat effectiveness, was that leadership elements—officers and NCOs—were also entering and leaving the theater on a random basis.[79,95] Remarkably, the resultant churning and depletion of experienced Army officers consequent to their serving 1-year tours was doubled by the theater policy of rotating officers from command to staff positions after 6 months to increase opportunities to command.[96] Bey, to his credit, discovered that a rise in some indices of unit dysfunction in the 1st ID correlated with leadership turnover, and he instituted a preventive, command consultation project aimed at reducing the associated stress on unit members.[97]

LATE WAR PROBLEMS IN VIETNAM: PLUMETTING MORALE, DISCIPLINE, AND MENTAL HEALTH

The second half of the war brought with it a dramatic rise in soldier dissent with widespread behavior problems that seriously compromised military order and discipline. Although primarily representing challenges to Army leadership, four of the emergent problem areas overlapped with the mission of Army psychiatry, certainly that pertaining to social and community psychiatry: (1) racial tension and conflicts; (2) suicides; (3) soldier violence, especially the targeting of military leaders; and (4) use of dangerous drugs, primarily heroin. This section will summarize the available professional information regarding items

(1) through (3), and Chapter 9 will address the available information regarding drug use in the theater.

Racial Tension and Conflicts

Despite its prior successes in desegregation, the Army was not exempt from racially based tension and strife as new recruits entered the military from an increasingly polarized American society. The combination of the burgeoning black-pride/civil rights movement in the United States and the general disaffection among enlisted soldiers corrupted the morale and military allegiance of many black soldiers in Vietnam during the second half of the war. Aggravating the problem, 40% of the 320,000 men brought into the service under the previously described Project 100,000 program, with its lowered intelligence and educational standards, were nonwhite. Furthermore, a disproportionate number (37%) of Project soldiers served in combat roles (vs 14% for non-Project soldiers).[66]

By way of backdrop, The National Advisory Commission on Civil Disorders, known as the Kerner Commission, was established in July 1967 by President Lyndon Johnson to investigate the causes of the recent upsurge in race riots in the black neighborhoods of major US cities. After 7 months of proceedings, the Commission's final report was released. Among its conclusions, which generally underscored the economic and social hardship borne by African Americans, was that racial tensions and polarization in the United States had increased to unprecedented levels, and, if unaddressed, would ultimately lead to "the destruction of basic democratic values."[98] On 4 April 1968, 1 month after the release of the Kerner Report, the inspirational civil rights leader Martin Luther King Jr was assassinated. This provoked an upsurge of racial violence, prompting riots in 169 cities and resulting in $130 million in property damage, 24,000 arrests, and 43 deaths.[99(p102)]

The riot in the Long Binh Jail the following August was emblematic of the incendiary level of black–white tensions in Vietnam. The rebellion, which ultimately destroyed the facility, started when a group of black inmates attacked the guards, ostensibly over unacceptable living conditions. However, clearly indicating its racial roots, bands of black prisoners roamed through the compound, beating white prisoners and setting fire to their tents. One white inmate was killed.[100]

In 1970, Colbach and Parrish's semiofficial summary of mental health activities in Vietnam to that point in the war acknowledged that "the racial problem" in the United States had extended to Vietnam:

> Black power feelings have become quite strong at times, and such things as Afro haircuts, extreme clannishness, and black power signs have become commonplace. There have been some outbreaks of black-white violence, and everyone has become increasingly edgy about the situation. . . . [A]ny incident involving black and white soldiers has been considered to be of racial origins. The whole situation has had an adverse effect on morale.[36(p338)]

That same year Wallace Terry, a war correspondent, surveyed soldiers in Vietnam regarding racial perceptions and attitudes. His findings made it clear how much race relations had deteriorated there compared to a survey conducted 3 years earlier. He found a "very deep layer of bitterness" among black soldiers. In particular (*a*) they were averse to fighting in a war they considered to be the white man's war; (*b*) their anger was fueled by the racial prejudice in America; (*c*) they believed their fight was really in the United States against repression and racism; (*d*) they were "schooled in the violent art of guerrilla warfare"[101(p222)]; and (*e*) many declared their intention to align themselves with radical groups upon return home, join riots, and take up arms in the United States to achieve rights and opportunities previously denied them.[101]

Results of a similar survey administered by Fiman, Borus, and Stanton to 126 black and 359 white enlisted soldiers returning from Vietnam between 1968 and 1971 generally confirmed Terry's findings. Black soldiers, primarily the younger ones, held a more negative view of race relations than did whites. Interestingly, black–white relationships were perceived as better in Vietnam than in the United States, especially among soldiers who served in combat.[102] Borus also interviewed 64 Vietnam returnees who served there between June 1969 and December 1970 and concluded that, when compared with combat units where the goal of survival necessitated a spirit of trust and cooperation, racial relations were far more strained among those serving in the rear echelons. This took the form of racially segregated groupings, discrimination, tension, and open interracial conflicts.[103]

Regarding serious crimes in Vietnam, Kroll, an Army psychiatrist, conducted an in-depth study at

the Fort Leavenworth Disciplinary Barracks (also known as the United States Disciplinary Barracks [USDB]) of soldiers transferred there from Vietnam between February 1968 and November 1969, that compared white soldier-prisoners (n = 149) with black soldier-prisoners (n = 127).[100] (The USDB was the only confinement facility for soldiers and airmen convicted by court-martial and required to serve more than a 6-month sentence.) Kroll's methodology included clinical interviews, psychological testing, extensive background reviews, and longitudinal observations. The two groups were indistinguishable regarding age (mean = 22.3), educational level (mean = 10.6 years), and GT (General Technical; roughly equivalent to IQ) scores (mean = 99.5), but the average time in service was greater for the white prisoners (3.3 years vs 2.2 years for black prisoners).

However, overall rates for incarceration of black prisoners significantly exceeded those for white prisoners. Black prisoners were twice as likely to be convicted for AWOL, 10 times as likely to be convicted for combat refusal, and 7.5 times as likely to be convicted for violence against a US soldier, that is, assault or murder. Rates for violence against Vietnamese nationals were roughly equal.[100(Table 4)] Kroll offered no conclusions as to individual psychiatric or personality factors that would explain how these men were different from the other soldiers who served in Vietnam without incident. However, he provided other impressions along the lines of social determinants:

- Although Kroll sought to remain neutral regarding their guilt or innocence for specific crimes, he argued for the underlying innocence of these black soldier-prisoners because of their being victims of the extremely stressful social influences and circumstantial pressures in Vietnam at that time.
- Regarding the higher rates for most crimes among black prisoners, this was explained in part by "[t]he emergence of a strong anti-military attitude among the present draft-eligible generation, combined with…a black identity movement that ridicules obedience to a white system [like the military] . . . and a war that seems vicious, pointless, and endless."[100(p59)]
- Regarding those convicted of murder, the finding that over 50% of the murder victims were buddies or friends and that the murders occurred in the rear was combination of the inherently ambivalent nature of combat buddy relationships and the regression-inducing nature of combat. "This raises the problem of whether men who become [black/white] buddies of necessity in the combat field can safely remain buddies in base camp, where the factors pushing each away from the other [in this instance, racial polarization] may be stronger than the ties pulling them together."[100(p59)]

It should be underscored that Kroll reported there was only one case of leader assassination among the cohort he studied (1968–1969). This will be contrasted with a later study conducted at the USDB by Gillooly and Bond of 24 such cases.

In 1971, following a worldwide increase in interracial conflicts on American military installations, the Secretary of Defense and Secretary of the Army declared that improving race relations was of the highest priority.[104] As a result educational courses in race relations were piloted throughout the chain of command. Small group discussion seminars ("rap sessions") were introduced at several posts. In November the first Department of the Army Race Relations Conference was held to implement Army-wide planning of programs to deal with racial tensions. Nonetheless throughout the remaining years of the war the programs remained inconsistent, partly because they were dependent on local initiative and support. At a number of posts these were impeded by commanders who either vehemently denied existence of any racial difficulties in their units, or the opposite—feared that introduction of race relations programs would cause bloodshed between black and white soldiers.[104]

In the Vietnam theater, the low morale and growing racial tensions affecting the military forces prompted the Military Assistance Command, Vietnam (MACV) to establish a Human Relations Branch. In turn, USARV created its Human Relations Branch, which was under the direction of Chaplain (Lieutenant Colonel) Benjamin E Smith, and required that each company-level Army unit in Vietnam establish a human relations council. By October 1971, there were 725 such councils meeting at least monthly—typically in unstructured discussions—in an attempt to improve relationships within the unit between blacks and whites as well as between enlisted men, NCOs, and officers. Commanders were responsible for facilitating the exchanges and obligated to act upon legitimate complaints. In addition, at least six major subordinate commands appointed officers or

NCOs to serve as full-time human relations specialists. Unfortunately, the stability of the councils was often undermined by the rapid turnover in personnel brought about by the contracting force structure.[105]

From the perspective of the psychiatrists in Vietnam, references to racial tensions or incidents do not appear during the first 3 years of the war. Later, Colbach, who served as a solo psychiatrist at the 67th Evacuation Hospital (November 1968–November 1969) acknowledged feeling ill-equipped to defuse racial tensions.[106] The following year, Bey (1969–1970) alluded to problems within the 1st ID, which were primarily seen among units in base camp:

> . . . Most of the black men in Vietnam were high school dropouts from ghetto neighborhoods. The officers, on the other hand, were mostly white, college-educated, newly trained lieutenants who had little or no experience at commanding troops or dealing with inner-city blacks. . . . Some company commanders and cadre tended to respond to their fears by bearing down on the black soldiers. They would issue orders prohibiting symbols of black identity, such as music, clothing, and power salutes. This led to further anger and resentment on the part of the blacks, who viewed such acts as provocations.
>
> Combat units did not have many racial problems when in the field. . . . When the soldiers were faced with a common enemy who was trying to kill them all, racial differences were mostly ignored. The problems arose when units left the field for stand down at base camps.[48(p80)]

Although having to improvise, Bey appeared to have some measure of success in intervening through the mental hygiene unit's program of primary and secondary psychiatric prevention activities. In so doing, he had a distinct advantage over Colbach as he was organizationally connected to the units within his division and had a social work officer and enlisted specialists to help. According to Bey:

> Reducing racial tensions was not officially part of the psychiatric unit's mission, but since many psychological issues were linked to racial problems, we did what we could to improve the situation in the division. I had no formal training in race relations, and I am white. A black psychiatrist trained to deal with race relations and capable of making policy changes would likely have been more helpful to the division than I was able to be. However, there was little time to work with the black inner-city troops and the white suburban lieutenants who led them. Had there been more time and resources, we could have done more to help them reach a better understanding and working relationship. Nonetheless, we did what we could and succeeded some of the time.[48(pp80–81)]

Bey also noted that

> We only tried it (organizational case study) on a few units, but the feedback, i.e., about the racial tensions in the unit, did seem to have some positive results in terms of command loosening up about allowing black music in the enlisted men's area, tolerating their symbols of black solidarity, taking down the confederate flags, etc. I think we were able to achieve a little better understanding by both parties. Some of the techs were more knowledgeable and helpful.[107]

(See descriptions of primary prevention activities in Chapters 3 and 10; Chapter 3 includes a summary of a publication by Bey and Smith[108] that describes combined primary and secondary prevention activities surrounding racial tensions.)

In the remaining years of the war it became clear that racial tensions had become even more divisive, as well as dangerous.[109] Although the antagonism to military authority in the theater was widespread among soldiers of both races, some data suggested disproportionate numbers of black soldiers targeted their military leaders (all white) for assassination.[110,111] Under these conditions, it is not surprising that for some psychiatric cases, symptoms centered on racial differences and suspicions. (See Bloch's "Some Interesting Reaction Types Encountered in a War Zone" in Appendix 12.) The following case of paranoid schizophrenia is illustrative.

CASE 8-5: Private With Paranoid Schizophrenia and Racist Genocidal Preoccupations

Identifying Information: PVT Easy was a 19-year-old single black male with 12 months of active duty service and 7 months in Vietnam (noncombat, supply). He

was treated in a succession of four medical treatment facilities. He was initially hospitalized at the 71st Evacuation Hospital in Vietnam in early 1968. He was next transferred to 8th Field Hospital, then to the 249th General Hospital, Japan, and finally to Walter Reed General Hospital (WRGH) in Washington, DC. He was discharged from WRGH 6 weeks after his initial hospitalization.

History of present illness: PVT Easy was initially hospitalized because of homicidal thoughts and grandiose delusions. ("I heard God.") At that time he related that he had been chosen "to lead my people" and that his mission was to "kill all the whites in Vietnam." These symptoms arose after he had been in Vietnam for 3 months, apparently during a period of considerable racial tension in his unit. Two days prior to admission he was reduced in rank following an incident of insubordination toward an officer (he alleged that the officer had addressed a black sergeant as "boy"). Complicating the diagnosis was that, since his arrival in Vietnam, PVT Easy frequently used marijuana. His emotional problems apparently began while he was on leave in anticipation to being assigned in Vietnam and were precipitated by the breakup with a girlfriend and the murder of his cousin by a white man. He became depressed and made several suicide attempts. He finally deduced that, since he could not be killed, God had a greater purpose for his life.

Past history: The patient was raised in the South as the youngest of four siblings. His father left the family when he was a year old and his mother worked as a secretary to raise the family. He denied significant childhood adjustment difficulties, however, in his teens he was involved in delinquent behaviors (fights, muggings, and breaking and entering). He also acknowledged deep resentment of his father for abandoning the family. His military performance history was marginal. He had received a summary Court Martial for being AWOL and an Article 15 in Vietnam for the length of his mustache.

Examination: When PVT Easy was admitted to the field hospital in Vietnam, he was observed to be euphoric, irritable, and hostile. He was grandiose in speech and manner, disoriented as to date, and had delusions of a militant, genocidal nature. Upon his transfer to WRGH and after a month of hospitalized treatment he was described as a large, muscular, mustachioed black male who appeared drowsy and without evident anxiety. He was mildly suspicious and distant, but his thinking was mostly clear, coherent, and rational. His thoughts centered on explaining how his delusions had led to his hospitalization. He was eager to minimize his earlier symptoms, prove his normalcy, and return to duty.

Clinical course: At the 8th Field Hospital he was mostly observed for a few days before his transfer to Japan. In Japan he was treated with phenothiazines, milieu therapy, and psychotherapy, resulting in abatement of his symptoms. A brief exacerbation occurred consonant with the news of the assassination of Martin Luther King Jr and the rioting in the United States. He was evacuated to WRGH on 150 mg of Thorazine and 5mg of Stelazine per day. At WRGH his hospital course was unremarkable.

Final diagnosis: Schizophrenia, paranoid type, acute, severe. Stress: moderate, recent personal losses plus duty in Vietnam. Predisposition: moderate, chaotic family background. Impairment: none, in complete remission.

Disposition: Returned to duty (in the United States) with temporary profile; to continue his medications and be reevaluated in 30 days.

Source: Narrative Summary, Walter Reed General Hospital.

Suicide

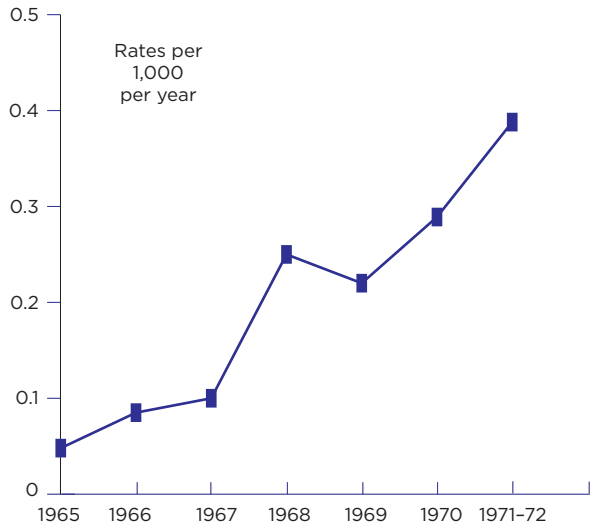
The DoD's most comprehensive records for military personnel assigned in Southeast Asia, the Combat Area Casualties Current File (CACCF), list the total number of casualties within South Vietnam for all service branches as 58,193, with 10,787 (18.5%) recorded as not being the direct result of hostilities.[112] Among the 10,787 nonhostile deaths, 382 records (3.5%) are designated as suicides. It can be reasonably assumed that this number significantly underrepresents the suicides in the theater because the CACCF also lists counts for accidental self-destruction (842); vehicle loss, crash (1,187); drowned, suffocated (1,207); misadventure (1,326); and "other accident" (1,371)—categories of death for which lowered morale and other types of psychological difficulties and psychiatric conditions may have directly or indirectly been contributory.

However, there is little in the documentation from the war in Vietnam to indicate that Army psychiatrists were utilized to conduct a psychological autopsy on any of the suicides or otherwise suspicious deaths. (Byrdy mentioned without details that once he was asked to conduct a postsuicide investigation; and Bey reported that he was asked by the division surgeon to look into the unexpected death of a 19-year-old E-4 cook. Bey's conclusion was that he died after accidentally ingesting twice the recommended dose of malaria prophylaxis, chloroquine/primaquine, while intoxicated.[48(p124)]) Such reviews might have led to the conclusion that some among the almost 6,000 nonsuicide, noncombat, violent deaths were unwitting suicides or suicides that were purposefully disguised to avoid consequences such as stigma, religious guilt, or adverse financial consequences. Illustrative of the latter is the following material that was provided in correspondence to the author many years after the war by Phillip W Cushman, who served as division psychiatrist for the 25th ID in the fall of 1970:

> One of my first experiences with the 25th Infantry Division was a young 18-year-old man whose unit had brought onto the base a prostitute to service the men. He was unable to get an erection and/or did not want to participate. His fellow soldiers pursued him relentlessly with every derogatory name imaginable. This had gone on a week or so prior to my arrival in the division and the corpsmen at the Mental Hygiene Clinic would put the soldier up in the infirmary when his anxiety level became intolerable. I approached his Captain and told him the young man had to be transferred to a different unit where his history would hopefully not follow him. The Captain was appalled that a soldier would be so rewarded for being unable to function sexually like other "normal" males and absolutely refused my recommendation. The next evening while the soldiers were at mess the young man put his M16 in his mouth and blew out his brains. I suspect his Officer felt justice had prevailed and I suspect his family was never told the nature of his death.

The possibility of undercounting aside, according to an analysis of an earlier version of the CACCF data, the suicide rate among the US military personnel assigned in Vietnam was 0.16 per 1,000 troops (based on a total of 378 suicides), which the authors indicated was approximately double that for the general population. Surprisingly, whereas Army troops accounted for 65.7% of the total deaths in Vietnam, 92.6% of the suicides were Army soldiers—a rate that was 7 times that for the other branches combined. In contrast, the Marines accounted for 25.5% of the total deaths in Vietnam but only 6.1% of the suicides. A multivariate analysis revealed the best predictor for suicide compared to all other deaths was being single, older, serving more time in Vietnam, not having been drafted, service in Vietnam in 1968 or later, and serving in the Army.[113] Regarding the latter, Figure 8-8 illustrates the rising suicide incidence rate among Army troops in Vietnam.

FIGURE 8-8. Estimated US Army Vietnam suicide incidence rates/1,000 troops/year.



Data sources: Numerator data for rate calculations are derived from Adams DP, Barton C, Mitchell GL, Moore AL, Einagel V. Hearts and minds: suicide among United States combat troops in Vietnam, 1957-1973. *Soc Sci Med*. 1998;47:1687–1694 (Tables 3 and 4). Denominator data are from Department of Defense, OASD (Comptroller). Directorate for Information Operations. US Military Personnel in South Vietnam 1960–1972;15 March 1974;60.

There is no published record of official concern among Army leaders, including psychiatric leaders, for this rising suicide incidence rate. From the field, Bey provided a II Field Force, Vietnam, Talking Paper that included the following: "During a 4½ month span (5 July 68 through 13 Nov 69) there were thirty-one II Field Force, Vietnam (FFORCEV II) soldiers who committed suicide—a serious problem. Gunshot (24); drug overdose (5); grenade (1); stabbed self = (1)."[39(ChapVIII,pp49–50)] (According to Bey, the number of troops represented

in II Field Force's area of operations, III Corps Tactical Zone [later renamed Military Region 3], at that time was 140,000 troops.[48(p193)] If these figures are correct, the 31 suicides represented an incident rate of 6.1 suicides/1,000 troops/year.)

From the perspective of the psychiatrists who served with the Army hospitals in Vietnam, Huffman (May 1965–1966) indicated that 6.1% (37) of his patients had suicide attempts or gestures, and that there was one completed suicide in a 49-year-old master sergeant who had a depression complicated by alcoholism.[114] Blank also reported one completed suicide of a chronically depressed alcoholic sergeant.[80] During the same timeframe, Strange reported that 8% of the Navy/Marine psychiatric caseload aboard the USS *Repose* (February and August, 1966) included suicide attempts and threats as symptoms, but that overall, "the externalization of aggression in combat is important in decreasing the comparative frequency of self-directed violence."[42(p87)]

In the combat divisions, Bey reported a few referrals for suicidal behavior in the 1st ID, and one did result in a completed suicide. In that instance it was again an alcoholic sergeant.[48] Byrdy indicated that there were no suicides among his patients at the 1st Cav, but that he knew of three "offhand."[115] He also commented:

> No systematic effort was made in chronicling suicidal gestures. In fact, there were very few suicide gesturers that were directly referred [in] to me. Some soldiers with self-inflicted wounds were sent for evaluation after they had healed and were ready to return to duty. Completed suicides were the province of the military police. Only once was an effort made to involve me in a post-suicide investigation.[70]

Tischler, with the 67th Evacuation Hospital, alluded to the frequency of alcoholic intoxication in conjunction with suicidal and assaultive behavior, but he did not indicate that he was aware of any completed suicides. The case of E-4 Fox below is a summary of some illustrative material Tischler provided; however, he did not include follow-up information on the treatment.

CASE 8-6: Suicide Attempt in a Recent Arrival

Identifying Information: E-4 Fox was a 20-year-old, married, white soldier with 9 months of Army service and 3 weeks in Vietnam. He was assigned to a transportation unit.

History of present illness: Patient was hospitalized following an incident in which he drank a bottle of whisky and then slashed his wrists in his tent.

Past history: Patient had a good military record. Since his arrival in Vietnam he had not received mail from his pregnant wife. She was living with his parents and most of his pay went to her. He was working 15 hours/day. Soon his sleep became erratic and his appetite fell off. He became obsessed that something was wrong with her and desperate to get home. His company commander was sympathetic but reminded him that everyone was in the same boat. The Red Cross and Chaplain's office personnel told him the same thing.

Examination: Patient shuffled into the appointment; his eyes were downcast and his face was a "mask of despair." He burst into tears and said, "I can't do it. Without her, I'm nothing. Since I've been here I've never felt so all alone, so cut off." All indications were that he was highly interdependent with his wife.

Clinical course: No record.

Diagnosis: No record of a formal diagnosis. Informally—"He failed to master the psychosocial task of transition associated with being newly assigned in Vietnam."

Final disposition: No record.

Source: Adapted with permission from 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: 34.

It seems reasonable to conclude that soldier complaints of suicidal urges and ideation were common enough among the referrals to the mental health services that they were taken seriously as clinical matters but not tracked statistically. More reportable would be the instances when the act was completed, but because those individuals were no longer in need of psychiatric care, the mental health personnel may have remained unaware of the fatal outcome.

Gartner, a political science professor, recently utilized a statistical analysis of the rising suicide rate

among US troops in Vietnam, which he noted to be a historically unique phenomenon, and found it strongly correlated with the shift in US strategy to that of Vietnamization of the fighting and the growing unpopularity of the war. He argued that when combat success measures became defensive in Vietnam, that is, to avoid casualties, that, along with public disapproval of the war, created a motivational contradiction within solders (ie, challenged the individual and the collective "warrior" identity); soldiers, in turn, reverted to a psychological "learned helplessness" (a condition associated with higher rates of depression and suicide[116]). According to Gartner, "It is not [simply] the fear of dying that drives dysfunctional behavior [ie, suicide]. I expect factors driving dysfunction stem from the fear of failure, the inability to do a job successfully, and the fear of dying and killing in an unpopular war."[117(p18)] In other words, Gartner theorized that a set of highly disturbing late war factors produced sufficient strain among solders that some would have succumbed to an urge to kill themselves as if to control the means of permanently eliminating their dysphoria. As a corollary, Gartner is also critical of the US military for its persisting belief that soldier suicide during wartime is a problem of individual psychology rather than a function of the political and strategic environment.[117]

Soldier Violence and the Targeting of Military Leaders

Early War Baseline

It is evident from material presented earlier that Army psychiatrists assigned in Vietnam in the second half of the war were more likely than their predecessors to be required to assess and manage soldiers exhibiting a broad array of conduct and behavior problems, including violent, antimilitary threats and behavior. Aggressive, antagonistic soldiers were encountered during the first half of the war, but violence was not usually directed at leadership personnel. But there were exceptions. As early as 1966 Bowman, with the 935th Psychiatric Detachment, noted that his team managed a large group of soldiers referred for behavioral problems such as indiscriminate firing of weapons, insubordination, assaults, and threats of violence against their officers and NCOs, which were typically associated with heavy drinking.[71,118] Mentioned earlier, Blank, also from the first year of the war (at the 3rd Field Hospital in Saigon), reported that 17% of his patients were command-referred soldiers who were being administratively separated from the service because of repeated incidents of either verbal abuse or physical assault on superiors, usually while armed and often intoxicated.[80] And Jones told of a "gung ho" major in the Medical Service Corps who received death threats (finding bullets with his name on them) because he was felt to be too "STRAC"[2(p76)] (1960s era US military acronym, meaning "strategic, tough, and ready around the clock"). Finally, Langner, a Navy psychiatrist who served aboard the hospital ship USS *Sanctuary* (1967–1968), described often having to evaluate the individual who "came in or was sent to me with the fear or threat of killing one of his superior officers who he felt had harassed him or treated him unfairly."[119]

Two years later Bey, with Zecchinelli, studied 43 soldiers (July 1969–December 1969) who were responsible for explosive violence toward other soldiers in the 1st ID. The composite picture was that of a young, immature, action-oriented soldier with a history of limited or punitive upbringing, marginal intellect or education, and deficient social skills. Early in his Vietnam tour this soldier remained remote from his peers, or worse, was the object of scapegoating, and failed to identify with his unit and its mission. He ultimately resorted to using the available weaponry and his heightened combat reactions to vent accumulated frustrations, which were worsened by the hot, hostile, and deprived environment. He reached a flashpoint because of his exaggerated passivity and the reduced availability of alternative release behaviors such as AWOL or sick call attendance. The authors also acknowledged the compounding influence of the combat group culture in which violent behaviors commonly served to defuse group tensions (including derivatives of latent homosexuality aroused by the intense closeness of peer groups). However, a confounding variable was that African American soldiers were overrepresented among the violence-prone soldiers in the study (25%), which raises the specter of racially based grievances as well.[69] Regarding the role of intoxication, Bey provided the following:

> In our division it appeared that acts of violence were more often associated with alcohol abuse than with drug abuse. However, it was noted that men were more likely to admit to alcohol abuse than to drug usage because during that period in Vietnam a reduction in sentence could be obtained

> if the man could demonstrate that the extent of his intoxication precluded his being able to premeditate the crime of which he was accused. In comparison, drug abuse did not result in mitigation of sentence and was more likely to result in additional punishment and certainly no sympathy from the military court.[39(ChapVII,p10)]

Quite notably, although Bey and Zecchinelli provided a case example of a soldier who shot to death a supply sergeant, even by 1969 there was no trend toward soldiers attacking superiors. The plausible explanation is that the study took place the year before fraggings (leader assassinations and threats) became common in Vietnam. It also may reflect that their study was conducted with combat troops who may have had somewhat lower rates of boredom and feelings of purposelessness (as noted earlier), which served to reduce resentment of military leaders compared to troops serving in support units.

During roughly the same time frame, Pasternack, a Navy psychiatrist, studied 22 Marines who were evacuated from Vietnam to a Navy hospital in the United States (late 1969–early 1970) following acts of violence, or threats to commit them, against fellow Marines. Although indicating there was considerable diversity, Pasternack noted that common trends among the subjects were the presence of psychotic or near-psychotic mental states and severe and brittle underlying character pathology. Family backgrounds included extensive chaos with parental alcoholism, mental illness, criminality, or brutality toward the patient. These patients had been poor students, socially inept, and rigidly defended with projection, denial, and reaction formation; they sought combat service to prove their masculinity. Furthermore, like Bey and Zecchinelli's study, no reports of attacks on military leaders were reported.[120]

Late War Enmity

After early 1970, the deteriorating morale and esprit in Vietnam was accompanied by rapidly rising levels of discipline problems, racial conflicts, drug use (especially heroin), and threats or attacks on officers and NCOs specifically. Linden's alarming description of the "class war" he saw as a journalist in late 1971, mentioned in Chapter 2, warrants elaboration. Linden reported that fraggings (assault using an explosive device) and threats of violence were commonly used as a means of controlling officers and NCOs through intimidating the intended victim and his peers—primarily by enlisted soldiers who opposed performance expectations, black activists who claimed racial prejudice, and drug users who wished to pursue their heroin use without interference. According to Linden, troops serving in the rear were "acutely aware of the authoritarian nature of the system and the privileges and luxuries enjoyed by officers; yet they saw little justification . . . because both officers and enlisted men are doing essentially nothing."[109(p13)] He surmised that for most military personnel, fighting the war in its latter stages was so meaningless and bewildering that it took on a dreamlike quality—an unreality that paved the way for acts like fraggings and using heroin—behavior that would otherwise be unacceptable in other environments.[109]

There is very little in the professional literature from Vietnam to document the involvement of mental health personnel with the late-war antagonism toward military authority by lower-ranking enlisted soldiers. It was certainly evident from Linden's description that this was a big and very disruptive problem for the 101st Airborne Division and a challenge for Robert Landeen, a psychiatrist who served with the division. Contemporaneously, David J Kruzich, a social work officer who served with the 1st Cavalry Division (Airmobile) far to the south, provided a similar depiction:

> Usually superiors had advance notification that their lives were in danger. Units with which I was familiar, the usual "warning" procedures were: (1) One or more gassings of the person's living quarters with a tear gas grenade; (2) Placing a fragmentation grenade, with the detonation pin intact, under the person's pillow or in some other area where it would be readily discovered and unmistakably interpreted as a serious warning; (3) If the initial measures failed to result in the desired response, then one evening a frag would be lobbed at the individual or slipped into his sleeping bag or living area.[121(p8)]

Kruzich reported that the soldiers who resorted to fragging tended to be "antisocial." These were individuals "with little stake in either the Army or society. They were often societal rejects who had joined (or been coerced into joining by legal authorities) the Army after a succession of failures in adjusting to life as a civilian."[121(p9)] However, he gave no indication of the

response by the mental hygiene staff of the 1st Cavalry Division to these problem soldiers.[121(p9)] Finally, Fisher indicated that 22 Marines among his 960 consecutive referrals in 1970–1971 were seen "in association with the charge of murder." Unfortunately, his description was not specific regarding assassination attempts on military leaders, although he included the following, "Fraggings of authorities seemed to occur in commands intimidated by threats or who were ambivalently permissive and tacitly encouraging hostile behavior in their troops."[55(p1166)]

Although official figures for fraggings were never released by the military services, it was reported that Senator Mike Mansfield (D-MT) was able to get the Pentagon to disclose that fraggings in Vietnam totaled 209 during 1970, which more than doubled those in 1969.[76(p101)] Officially, the following numbers are included in the CACCF data for the war: intentional homicide (234) and accidental homicide (944).[122] These are not broken out by year or branch of service, but some estimation can be made as to the numbers of Army soldiers affected because Army troops represented roughly two-thirds of the deployed force. Unofficial data collected by Gabriel and Savage identified a total of 1,016 incidents among all branches for the years 1969–1972 ("actual assaults" combined with incidents where "intent to kill, do bodily harm, or to intimidate" was suspected).[123(Table3)] However, there is no indication as to the proportion of these incidents that were in fact directed at officers and NCOs. Assassinations of unpopular officers and NCOs had been seen in earlier wars, typically during combat; but in Vietnam, not only was the incidence of fragging exceptionally high, but these attacks mostly arose in the phase of the war after the combat intensity had declined. They were also more common in rear areas and with the tacit approval of peers.[110] Also alarming, it is estimated that only 10% of fraggings ever came to trial because of the extreme difficulty in identifying the perpetrators.[76]

Charles Moskos, a military sociologist, provided the following impressions of the dominant patterns of late-war fragging incidents. According to Moskos, roughly 20% were "personal vendetta" fraggings in which a solitary soldier acted on his resentment of the military system by targeting a representative. Such an individual was psychologically impaired at the time and seemed to act on impulse, usually with his own weapon. Furthermore, he made no effort to hide his identity. However, the majority of fraggings, which he referred to as group-engendered, resulted from small-group process and were the result of soldier groups believing that their integrity had been violated in some way. Within this type, he identified three varieties: (1) racially inspired fraggings—usually by black soldiers against a white superior who was regarded as racist; (2) "dope hassle" fraggings—by drug using soldiers who were reacting to a superior who was seeking to enforce antidrug regulations; and (3) fraggings by combat soldiers who regarded a superior as having excessive combat enthusiasm, which in turn exposed them to unwarranted danger. The character of these incidents differed from those based on personal vendetta in that the assault was group sanctioned, often included an escalation of threat (in order to intimidate the targeted authority figure into conforming to the group's will), and the actual perpetrator was less easily identifiable. Unfortunately Moskos' data was limited to anecdotal accounts of veterans.[124]

One study did address the perpetrators of fragging incidents in Vietnam. Gillooly and Bond examined 24 soldiers confined at the USDB regarding the circumstances and attitudes surrounding their assaults on superiors with an explosive weapon.[110] (Gillooly and Bond did not indicate when these incidents occurred, however, the authors were at the USDB about 2 years after Kroll, and their findings present a striking contrast with his earlier study that included only one case of leader assassination among soldiers confined over a 10-month span for crimes committed in Vietnam.) Most of the attacks occurred at a base camp, in darkness, and with unauthorized weapons. Among the offenders, 87.5% acknowledged being intoxicated and 90% had direct confrontational interactions with the victims up to 3 days prior; 67% had made no effort to avoid getting caught. They reported feeling scapegoated by the targeted leader, who was perceived as insensitive to the frustrations of his troops. Quite striking, as noted above, was the evidence that these assassinations were often associated with concurrence, or even collaboration, with fellow enlisted soldiers. The authors found that 62.5% of offenders reported that other soldiers knew of their plans for the attack, and 46% indicated they acted with cohorts serving as accessories.

The authors reported that according to their interviews with the offenders, racial tensions were of minor importance in the incidents. However, they also noted that nonwhite soldiers (four) only targeted white officers or NCOs. Otherwise, perhaps the most alarming

finding of all was that "very few felt remorse and still did not at the time of the study."[110(p701)] Later Bond published additional analysis of the personality features of these men and gave more detail on contributory social dynamics. He described how the restive lower-ranking soldiers in Vietnam commonly held open discussions about fragging, collected cash bounties on various targets, and participated in a macabre ritual of anonymously warning potential victims so as to control them through intimidation. Apparently captains and sergeants were more common targets than lieutenants because they were more responsible for discipline or implementing the punishments.

Common background and personality features were found that indicated these soldiers had defective character formation. These included family histories of deprivation and/or brutality, poor self-image, chronic feelings of insecurity or vulnerability, poor object relations, lack of critical self-observation, excessive use of the defense mechanism of externalization, and poor impulse control. In Vietnam their drug use joined with these and other factors pertaining to their local "predicament" to create a lethal combination in which they perpetrated an assault on a leader they perceived as powerful and threatening. Still, Bond felt his sample was not necessarily typical of the lower-ranking soldiers in Vietnam, especially because two-thirds of these individuals had made almost no effort to avoid being caught. He also reiterated that racial tension and political activism were not primary factors in their motivation. What did seem especially relevant was their expectation that, by eliminating the authority figure, they would gain greater self-esteem and acceptance among their peers.[111]

WALTER REED ARMY INSTITUTE OF RESEARCH PSYCHIATRIST SURVEY FINDINGS: THE NONCOMBAT PSYCHIATRIC CHALLENGES IN VIETNAM

The following material extends the presentation begun in Chapter 5 of findings from the WRAIR post-war survey (1982) of Army psychiatrists who served in Vietnam that pertains to the overall psychiatric challenges in Vietnam, that is, ones not specifically tied to combat exposure. In particular this section explores the respondents' recollections of the prevalence of behavior problems that required their professional attention, impressions of troop morale, and factors they perceived as lowering morale.

Estimates of Professional Involvement with Behavior Problems

As was presented in Table 5-3 in Chapter 5, WRAIR survey respondents estimated that diagnosable behavior problems—specifically personality disorders and drug and alcohol dependence syndromes—accounted for over half of their patients; and that of those, only drug dependence syndromes rose significantly in the second half of the war. To further clarify the picture of psychiatric challenge in Vietnam, survey respondents were also asked to indicate how common it was for them to be involved in the evaluation and diagnosis of soldiers manifesting problematic behaviors in 17 categories. Results are presented in Table 8-4.

These results have particular utility in making comparisons across the two halves of the war and between psychiatrists who provided care mostly for combat troops and those who provided mostly for noncombat troops. Visual inspection reveals that the five most common behavior problems encountered—(1) characterological maladaptation; (2) excessive use of alcohol; (3) violent, antisocial behavior; (4) excessive use of marijuana; and (5) nonviolent, antimilitary behavior—are not specific for a combat theater, and a high incidence could be found among garrisoned troops almost no matter where they were located. The mean for individual combat avoidance behaviors—obviously only a problem in a combat theater—ranked 6th, slightly below nonviolent, antimilitary behavior, and subgroup analyses revealed it to be the only behavior problem that appeared significantly greater among psychiatrists who served *only* in a combat assignment compared to their colleagues who served *only* in the hospital setting.

However, more notable is the collection of behavior problems that rose significantly after the war passed the midpoint (violent, antisocial behavior; violent, antimilitary behavior; use of addictive, illegal drugs; and racial conflicts). These findings are consistent with the theater-wide metrics indicating accelerating morale and discipline problems after 1968 and the emergence of novel forms of opposition to military authority (Figure 8-1). Furthermore, with respect to the means for these 6 items among the psychiatrists who served in the second half of the war, there were no significant differences

TABLE 8-4. Survey Psychiatrist's Estimates of Their Professional Involvement With Behavior Problems in Vietnam

Behavior Problem	Overall mean N = 65	"Early" assignment mean (n = 35)	"Late" assignment mean (n = 30)
4 = COMMON			
Characterological maladaptation	3.55		
Excessive use of alcohol	3.36		
Antisocial behavior (violent)	3.02*	2.67	3.31
3 = INTERMEDIATE			
Excessive use of marijuana	2.97		
Antimilitary behavior (nonviolent), eg, insubordination, combat refusal, etc.	2.89		
Individual combat avoidance, eg, malingering, self-inflicted wound, etc.	2.83‡		
Antisocial behavior (nonviolent), eg, theft, corruption, etc.	2.41		
Use of heroin via smoking	2.27†	1.57	2.83
Use of Binoctal or other barbiturate	2.20†	1.62	2.69
Other drug use, eg, LSD, amphetamines, etc.	2.11*	1.76	2.42
Use of heroin via IV or inhalation	2.08†	1.48	2.59
Antimilitary behavior (violent), eg, attack NCO; fragging, etc.	2.00*	1.68	2.26
2 = UNCOMMON			
Group racial conflict	1.95*	1.55	2.29
Excessive combat aggression, eg, to civilians, prisoners; souvenirs of the dead	1.76		
Neglect hygiene, eg, venereal disease, antimalarial, footcare, etc.	1.74		
Group combat refusal	1.28		
Antiwar demonstrations and tensions	1.25		

Means of survey participants' estimates as to their involvement (evaluation and diagnosis) with 17 behavior problems in Vietnam ranked along a 5-point scale where 1 = very uncommon and 5 = very common (N = 65). Adapted with permission from Camp NM, Carney CM. US Army psychiatry in Vietnam: preliminary findings of a survey, II: Results and discussion. *Bull Menninger Clin*. 1987; 51(1):19–37.

*Statistically significant difference comparing war stage difference ("early" and "late" refer to those who served before or after mid-1968) with $p < .05$.

†Statistically significant difference comparing war stage difference with $p < .005$.

‡ Statistically significant difference comparing psychiatrists by assignment type with $p < .05$. The mean value for the 14 psychiatrists who served only with combat units was 3.36 versus a mean value of 2.49 for the 36 psychiatrists who served only with the hospitals.

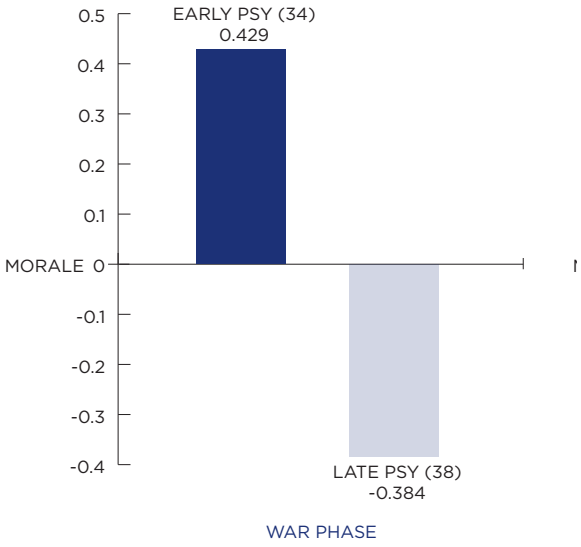
IV: intravenous
LSD: Lysergic acid diethylamide
NCO: noncommissioned officer

TABLE 8-5. Perceived Causes of Soldier Demoralization

Factor Loadings	Soldier Demoralizing Influences	Mean value
	4 = HIGH EFFECT	
0.49 (B)	Vagueness of military objectives or lack of apparent success	3.85
	Vulnerable feelings associated with enemy guerrilla tactics	3.48
0.73 (A)	Antiwar attitudes	3.38
0.74 (B)	Soldiers perceive they have meaningless jobs	3.36
0.36 (A)	Soldier heroin use	3.33
	Soldier marijuana use	3.31
	Leader alcohol use	3.28
0.32 (C)	Isolation from home and loved ones	3.26
	Individualized rotation schedules diminish bonding with unit members	3.26
0.61 (A)	The media overstated the war's destructiveness	3.25
0.65 (B)	Perceive inequality of hardship and risk (resent "REMF"s)	3.09
0.57 (C)	Individualized rotation schedules weaken belief in military objectives	3.03
0.78 (B)	Too strict enforcement of rules and regulations	3.01
	3 = INTERMEDIATE EFFECT	
0.79 (A)	Soldier antiestablishment, antimilitary attitudes	2.96
0.60 (A)	Racial polarity and tension	2.96
	Officers' 6-month rotation in/out of the field reduced unit cohesion	2.92
0.80 (A)	Soldier repudiation of traditional, conservative American values	2.88
0.57 (A)	Soldier belief that the war was immoral and exploitive	2.85
	South Vietnamese perceived as ungrateful and exploitive	2.80
	Combat operations within an alien culture and setting	2.79
0.69 (C)	Soldiers too restricted; Vietnam beyond perimeter was off-limits	2.79
0.65 (A)	"Generation gap" polarization and animosities	2.75
0.68 (B)	Leaders seen as uncommitted to the troops, incompetent, or unethical	2.74
0.70 (C)	Limited recreational opportunities	2.70
0.63 (A)	Media represent soldiers as destructive villains	2.61
0.58 (C)	Too easy contact with home (tapes, calls, leave) promotes homesickness	2.54
	Too lax enforcement of rules and regulations	2.51
0.60 (A)	Class polarization and reciprocal resentment	2.50
0.44 (C)	Severe living and working conditions	2.49
	2 = LOW EFFECT	

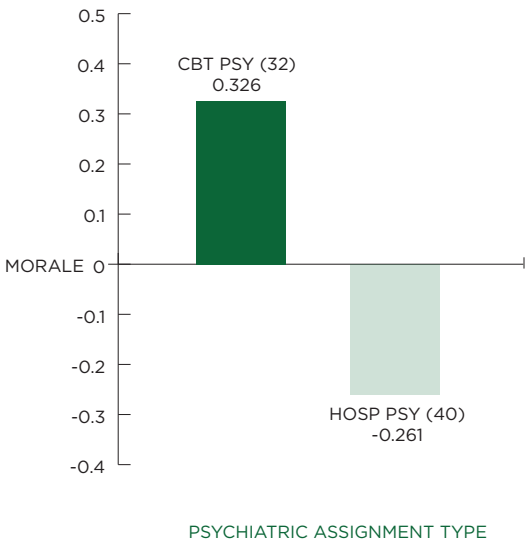
The WRAIR Psychiatrist Survey contained 29 items ranked by means of survey participants' perception as to the negative effect on the average soldier's morale using a 1-to-5 scale where 1 = very low effect and 5 = very high effect. [N = 74–82] Also presented are three factors formed from factor analysis of responses (21 items) interpreted and named as: Factor A: perception of societal blame; Factor B: alienation from the Army; and Factor C: isolation and loneliness.
REMF: "rear echelon mother f--ker"

FIGURE 8-9A. Multiple regression results for psychiatrists' estimates of troop morale, generally and for combat, support, and medical units, by war phase (p.<.001). Low score means low morale.



EARLY PSY: psychiatrist arrived in Vietnam before mid-1968
LATE PSY: psychiatrist arrived in Vietnam after mid-1968

FIGURE 8-9B. Multiple regression results for psychiatrists' estimates of troop morale, generally and for combat, support, and medical units, by psychiatrist assignment type (p.<.05). Low score means low morale.



CBT PSY: psychiatrist served with any combat unit in Vietnam
HOSP PSY: psychiatrist served only with a hospital or psychiatric detachment in Vietnam

found when comparing those who served with combat units with their counterparts who served with support hospitals and saw more noncombat troops.

The relatively low means for this latter group of behavior problems should not take away from their overall seriousness in Vietnam. As mentioned earlier, Army psychiatrists in Vietnam were often required to determine whether these types of conduct, discipline, and behavior problems represented a diagnosable mental disorder, character disorder, or willful misconduct. Furthermore, even if the soldier's deviant behavior was determined to not be the product of a mental disorder/character defect, that is, it was simple misconduct, mental health personnel may have still been called upon to intervene or offer advice and propose solutions. In fact, some survey psychiatrists acknowledged the range and complexity of these issues. One noted, "I was often called upon for crisis intervention purposes, [that is], disarming troops, defusing racial situations, etc." Another psychiatrist made a general observation, noting that "some of the problems [in the list of behavior problems] occurred very rarely, [such as] violence to other soldiers, but when they did occur, the degree of psychiatric involvement was high." It is worth highlighting again that standard psychiatric training of the times—certainly in civilian programs—did not typically encompass intervention strategies for many of the behavior problems represented on this list (and of course, several are unique to military and combat circumstances).

Troop Morale

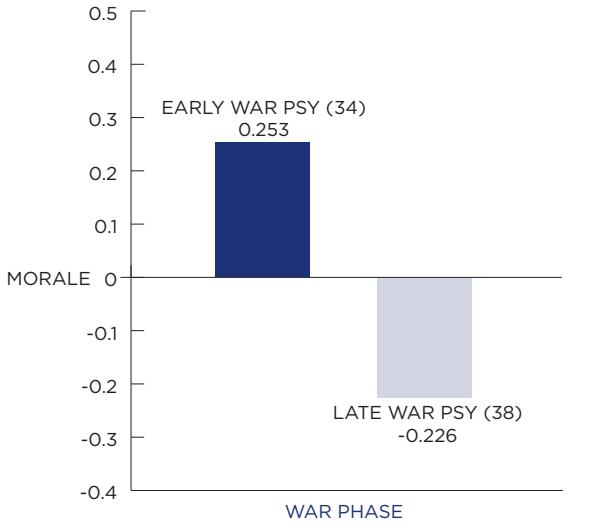
The survey psychiatrists were asked about troop morale for the period they served in Vietnam. In particular they were asked to estimate troop morale in their catchment area in four categories using a 1-to-5 point scale where 1 = very low and 5 = very high. Means of results for morale estimates were: overall (2.78), combat troops (2.70), support troops (3.18), and medical units (2.78). These items were subsequently combined into one four-item factor, and a regression analysis was conducted using three principle psychiatrist dichotomous variables: (1) phase of the war served (early vs late); (2) type of assignment in Vietnam (with any combat unit vs only with a hospital); and (3) site of psychiatry residency training (military vs civilian). The

regression model included the main effects of these three predictors as well as two- and three-way interactions.

Two statistically significant main effects involving this factor were found and presented in Figures 8-9A and 8-9B (the factor is scaled such that a value of "0" corresponds to average or the "typical" psychiatrist's score). Figure 8-9A depicts the relationship between phase of the war and perceived level of troop morale and indicates a dramatic drop in troop morale between the early and late phases of the war. This coincides with the overwhelming body of information presented thus far pointing to the same conclusion.

The other main effect is depicted in Figure 8-9B and demonstrates that the level of morale perceived by hospital-based psychiatrists was lower than that perceived by combat-based psychiatrists. ("Combat-based psychiatrists" includes all psychiatrists who spent any time with a combat unit during their year in Vietnam.) This suggests that, in addition to the overall dropping morale as the war extended, throughout the war the morale among support troops in Vietnam (who would have represented the majority of soldiers seen by the hospital psychiatrists) was lower than troops assigned in combat units.

FIGURE 8-10. Multiple regression results for Factor A: Low morale as a function of perceived blame from American society by war phase ($p < .05$). Low score means psychiatrists reported soldiers perceived blame from American society.



EARLY WAR PSY: psychiatrist arrived in Vietnam before mid-1968
LATE WAR PSY: psychiatrist arrived in Vietnam after mid-1968

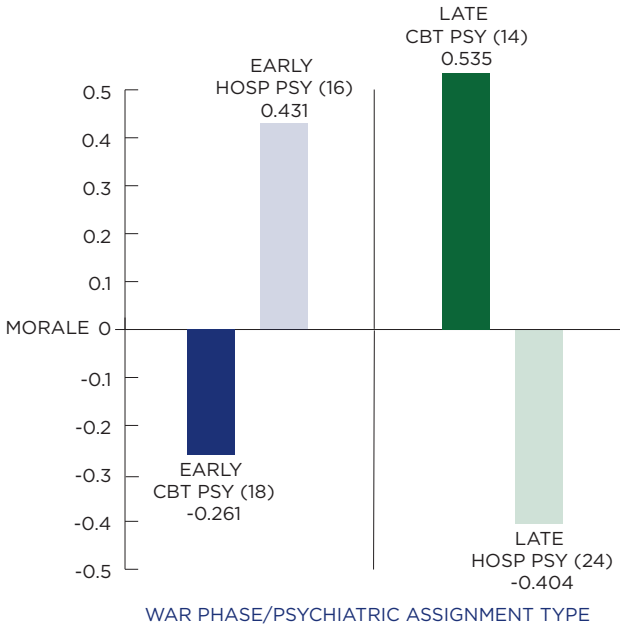
Perceptions Regarding Causes of Low Morale in Vietnam

The WRAIR survey participants were also provided 29 forced-choice statements intended to address a range of potentially morale-undermining features in Vietnam and asked to indicate the extent of their agreement as to their frequency. The means of responses for these items are presented on the right side of Table 8-5. Considering the close grouping of the results for many of the individual items, little can be concluded from visual inspection. The results of the responses to these items were statistically submitted to factor analysis, which yielded three factors composed of 21 items. (These factors are indicated on the left side of Table 8-5.) Four of the eight items not included in the three factors deserve to be highlighted as morale depleting because of their relatively high means: (1) vulnerable feelings consequent to the enemy's guerrilla tactics—a finding that is consistent with anecdotal observations; (2) soldier marijuana use; (3) alcohol use by officers and NCOs; and (4) the impact of the individual rotation schedules, which potentially interfered with bonding with other unit members and commitment to the military mission.

Results of the factor analysis seem quite salient in indicating that soldier morale was balanced on three dimensions (factors) and that the items comprising the factors could be interpreted as alluding to compromises in relatively independent sources of social support. The three factors were labeled as follows: Factor A = low morale as a function of perceived blame from American society (42% of the variance); Factor B = low morale as a function of alienation from the Army (30% of the variance); and Factor C = low morale as a function of isolation and loneliness (27% of the variance). Perhaps morale would have been less precarious in Vietnam if one, or even two, of these morale-sustaining dimensions could have remained positive. However, if all three were compromised, severe demoralization may have been inevitable.

Additional analysis was performed using regression analyses in which each of the three factors was regressed on the three aforementioned principle psychiatrist dichotomous variables plus two- and three-way interactions of the three variables. Following are the main and interaction effects that reached the level of significance of < .10 and below.

FIGURE 8-11. Multiple regression results for Factor B: Low morale as a function of alienation from the Army by interaction of war phase and psychiatrist assignment type ($p < .004$). Low score means psychiatrists reported soldiers as more alienated from the Army.



EARLY CBT PSY: psychiatrist arrived before mid-1968 and served with any combat unit in Vietnam
EARLY HOSP PSY: psychiatrist arrived before mid-1968 and served only with a hospital or psychiatric detachment in Vietnam
LATE CBT PSY: psychiatrist arrived after mid-1968 and served with any combat unit in Vietnam
LATE HOSP PSY: psychiatrist arrived after mid-1968 and served only with a hospital or psychiatric detachment in Vietnam

Factor A: Low Morale as a Function of Perceived Societal Blame

For the first morale factor—low morale as a function of perceived blame from American society—low score means soldiers believed they were forced to fight in an immoral war yet felt blamed by American society and the media for being destructive killers, with many soldiers reacting through passionate dissent and polarization along such natural cleavage lines of racial, class, value, and generational differences as well as the use of heroin. Figure 8-10 depicts the statistically significant main effect of psychiatrist phase of the war, with morale perceived as dropping among troops throughout the theater during the second half of the war based on this factor. It also may be especially noteworthy that "soldier heroin use" is a component only of Factor A.

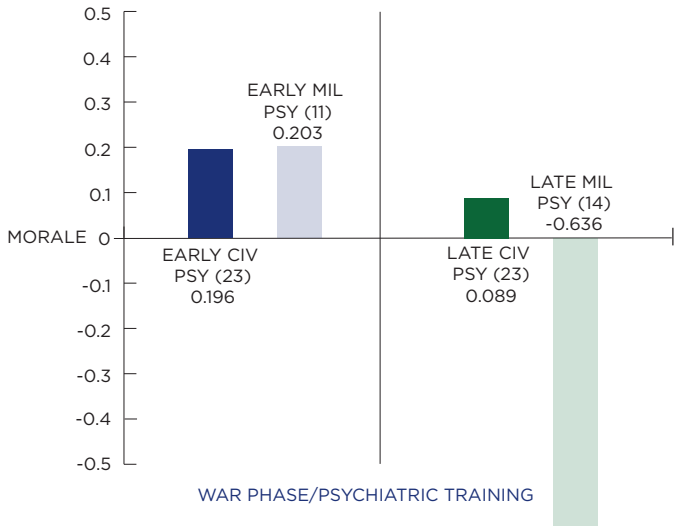
Factor B: Low Morale as a Function of Alienation From the Army

With respect to the second morale factor—low morale as a function of alienation from the Army—low score means soldiers were distressed by vague and unsuccessful military activity, meaningless and redundant tasks, apparent inequalities of hardship and risk, excessive rules and enforcement, and disinterested or self-serving leaders. Figure 8-11 depicts the statistically significant interaction between the phase of the war and the type of psychiatrist assignment. For those Army psychiatrists with combat unit assignments, low troop morale attributable to alienation from the Army appears to have improved from the early to the late half of the war. Conversely, for Army psychiatrists with a hospital assignment, morale attributable to alienation from the Army appears to worsen as the war progressed. These results suggest a strong shift in soldier alienation from the Army among combat units during the first half of the war when combat intensity was high, to support units after the war passed the midpoint and the combat intensity dropped.

Factor C: Low Morale as a Function of Isolation and Loneliness

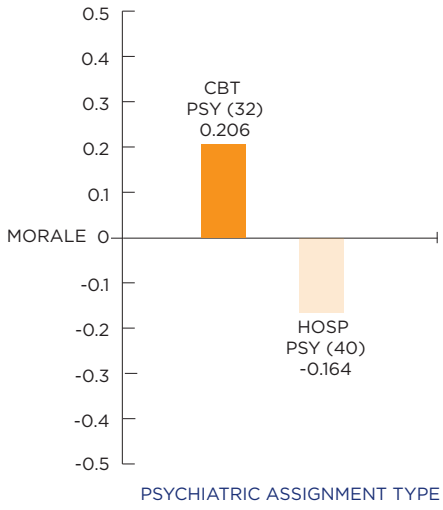
Regarding the third morale factor—low morale as a function of isolation and loneliness—low score means soldiers are beset with homesickness and loneliness for family and loved ones, sequestered in scattered and austere compounds, restricted in such outlets as recreation, and uncommitted to the military mission because of the individualized rotation schedules. Figure 8-12A depicts a statistically significant interaction between phase of the war and respondents' psychiatry residency type. Civilian- and military-trained psychiatrists alike report relatively little degradation of morale during the early phase of the war secondary to soldier isolation and loneliness; and although both groups report increased degradation of morale during the second half of the war, the increase for these reasons is much more noticeable for the military-trained psychiatrists. Figure 8-12B also depicts a trend associated with psychiatrist assignment type. Regardless of phase of the war, the psychiatrists who served in the hospitals were more likely to note the morale to be degraded by the factor of soldier isolation

FIGURE 8-12A. Multiple regression results for Factor C: Low morale as a function of isolation and loneliness by interaction between war phase and psychiatry residency training ($p < .05$). Low score means psychiatrists reported soldiers as more demoralized by isolation and loneliness.



EARLY CIV PSY: psychiatrist arrived before mid-1968 and received psychiatry training in a civilian program
EARLY MIL PSY: psychiatrist arrived before mid-1968 and received psychiatry training in a military program
LATE CIV PSY: psychiatrist arrived after mid-1968 and received psychiatry training in a civilian program
LATE MIL PSY: psychiatrist arrived after mid-1968 and received psychiatry training in a military program

FIGURE 8-12B. Multiple regression results for Factor C: Low morale as a function of isolation and loneliness by psychiatrist assignment type ($p < .10$). Low score means psychiatrists reported soldiers as more demoralized by isolation and loneliness.



CBT PSY: psychiatrist served with any combat unit in Vietnam
HOSP PSY: psychiatrist served only with a hospital or psychiatric detachment in Vietnam

and loneliness. Taken together these results suggest that degradation of morale secondary to isolation and loneliness increased in the second half of the war, but it was more noticeable to the psychiatrists with military training and by the hospital psychiatrists who saw more soldiers assigned to support units.

In conclusion, these questions regarding morale were intended to transcend psychopathology affecting the individual soldier to focus on circumstances influencing his group. Although the results are invariably impressionistic, they may still be useful as they permit the reader to see this dimension through the eyes of those especially qualified to report on it—the behavior science specialists operating in the field. Furthermore, they provide an especially useful longitudinal perspective by comparing and contrasting the perceptions of psychiatrists who served at the beginning of the conflict with their counterparts who served later. The results of the multiple regression suggest that morale took a severe downward course after the midpoint in the war; that all those deployed in the second half of the war had their morale depleted by the sense of public blame; that the propensity for the soldiers to fault the military was greater among those serving in support units as combat intensity waned and earlier military objectives became doubtful; and that psychiatrists with military training were more likely to perceive that the isolation from home and restricted living conditions in Vietnam had a seriously negative impact on troops in the second half of the war. (Unfortunately it cannot be ruled out that lowered morale among some survey psychiatrist participants influenced their responses to these items.)

SUMMARY AND CONCLUSIONS

Chapter 6 and Chapter 7 centered on combat exhaustion and related psychiatric and behavior conditions apparently generated by the stress of combat. This chapter reviewed the overlapping stresses that affected the soldiers serving in Vietnam more generally (combat as well as noncombat troops), the emergent patterns of psychiatric conditions and behavior problems that were not directly associated with combat exposure, and the responses of Army psychiatry and Army leaders. Sources were the available psychiatric/behavior science and military documentation from the war; however, the skew favoring the first half of the war was a major impediment in drawing conclusions. This was somewhat offset with results from the WRAIR survey of veteran Army psychiatrists, but that study had its limitations.

The only official synopsis of Army medical care in Vietnam, *Medical Support of the US Army in Vietnam 1965–1970*, is critically misleading regarding psychiatric care because it omits the last 3 years of the war (mid-1970–1973). It also is unrepresentative because it does not include rates for combat exhaustion or certain other important diagnostic groups, that is, stress reactions (adjustment disorders), alcohol-related disorders, and drug dependency—conditions whose collective incidence probably averaged 25% to 35% of hospitalized cases and far overshadowed that for combat stress casualties. As it turned out, psychiatric and behavior conditions that were mostly unrelated to combat exposure, especially the upsurge in soldier heroin use, became the most challenging medical problems that the Army faced in the last years of the war.

Reiterating from earlier chapters, the Army psychiatric inpatient rate, which hovered between 10 and 12 per 1,000 troops per year until 1968, quadrupled by July 1971, before dropping sharply after new policies were instituted that allowed soldiers with heroin dependency to be medically evacuated back to the United States. Concordantly, the Army psychiatric evacuation rate remained under four per 1,000 troops per year until July 1969; less than five per 1,000 troops per year from then through April 1971; and then skyrocketed to 129.8 per 1,000 troops per year by April 1972. The absence of epidemiologic information pertaining to soldier attrition from alcohol-related conditions is also problematic. The WRAIR survey psychiatrists indicated that these represented about 10% of their overall caseload and caused as much dysfunction and disability throughout the war as did heroin dependency late in the war. (Drug and alcohol problems will be addressed in Chapter 9.) Impressions derived from this review are as follows:

- **Soldier attrition for diagnosable psychiatric conditions (hospitalized or confined to quarters) for the first 5 years in Vietnam, mid-1965 through mid-1970, assumed roughly these proportions: one-third as psychosis and neurosis, one-third as character and behavior disorders, and the remaining one-third as stress reactions, including combat exhaustion and drug and alcohol-related conditions. After mid-1970 heroin dependency predominated.** Confidence in these figures is reduced by the lack of psychiatrist reports from the second half of the war, variability in the diagnostic criteria utilized by the psychiatrists, and lack of clarity in some instances as to whether reported patient counts were limited to hospitalized soldiers.

- **Army psychiatric personnel appeared confident in the diagnosis and treatment of symptom disorders such as psychosis, neurosis (anxiety, depression, and conversion reaction), acute stress reactions, and brain syndromes secondary to drugs and alcohol because these clinical challenges were aligned with their professional training—training that centered on biological and psychological disturbances within the individual patient.** In general, the treatment provided for the noncombat psychiatric cases followed the traditional principles of the Army doctrine for the care of acute combat stress casualties. This was augmented with the judicious use of psychotropic medications and appeared to produce favorable results.

- **The available clinical data from Vietnam, including that pertaining to combat stress casualties, emphasized anxiety as the primary dysphoric affect experienced by symptomatic soldiers as opposed to depressive affect.** Despite a rising Army suicide rate in Vietnam, the available psychiatrist reports, which are primarily from the first half of the war, said little about the treatment of depression or suicidality. Of course, as suggested in the Prologue as well as the WRAIR survey findings regarding late war demoralization, the rising rates for behavior

disorders can be interpreted as actions serving a defensive function against depressive affect.

- **Regarding behavior disorders:**
  - The psychiatrists' reports from the first half of the war indicate a steady and sizable stream of command-referred soldiers for evaluation for misconduct and maladjustment. Whereas the mental health personnel evidently undertook the psychiatric "clearing function" required by the regulations, no data indicate that any particular treatments were successful with these soldiers.
  - Although there are few reports from those who served in the second half of the war, it can be inferred from the results of the WRAIR survey, the documented rise in Army rates for outpatient psychiatric visits generally and for drug use more specifically, and the dramatic increase in administrative discharges from military service worldwide, that the Army psychiatrists in Vietnam were increasingly challenged by referrals for misconduct and maladjustment as the war lengthened, especially in new forms: defiance and dissent; racial conflicts; violent, antimilitary behaviors; and drug dependency and addiction. There are no data indicating that any particular treatments were successful with these soldiers either. In this vein the wholesale medical evacuation of soldiers with heroin dependency out of Vietnam in the last 2 years of the war served as a remedy if not a treatment, per se. Some considered these soldiers to be "evacuation syndromes," that is, they were seeking to manipulate the system to get relief from their assignment.

- The psychiatric literature and related documentation from Vietnam centered around a series of overlapping risk factors that predicted soldier maladjustment and the emergence of psychiatric and behavior problems:
  - The enemy's strategy of guerrilla/terrorism warfare.
  - Soldier immaturity. The typical first-term enlisted soldier in Vietnam was 19 to 21 years of age.
  - Preinduction personality deficits.
  - Lowered induction standards for intelligence and education.
  - The staggered, individual, 1-year, replacement policy for enlisted troops. Throughout the war force management policies exempted Reserve and National Guard units and relied heavily on young, conscripted troops who were randomly rotated into the theater for 12-month tours. The Army psychiatrists who served in Vietnam believed these policies proved to be enormously corrosive to the cohesion of military units and the adaptation of individual soldiers, including promoting the development of widespread, if subclinical, "short-timer's" dysfunction. It seems obvious in retrospect that if group membership and identification serve as a critical stress-mitigating factor for soldiers, it must be assumed that this would especially apply to troops serving in a theater of combat operations, especially replacement troops.
  - The staggered, individual, 1-year, replacement policy for officers and NCOs. The harmfulness of this policy was compounded by rotating officers out of the field after 6 months.
  - The African American soldier. Because of increasing racial discord in the United States, antimilitary attitudes and behaviors found their fullest expression among the large numbers of black troops in Vietnam—mostly young, first-enlistment soldiers from lower socioeconomic backgrounds. As the war prolonged and the force became increasingly demoralized, disruptive, sometimes violent, behaviors by frustrated, angry young African Americans became increasingly common.
  - Serving in a support role. The reports suggested there was a higher incidence of psychiatric casualties among noncombat soldiers, and this impression was reinforced by the WRAIR survey data. This evidently occurred because of the lack of clearly defined (safe) rear areas in Vietnam and because these troops could not utilize the stress-mitigating bond, that is, survival-necessitated commitment and cohesion, that was available to soldiers in small combat units.
  - Service after Tet '68. Even before the troop withdrawal gained momentum following the political and military events in 1968 and 1969, the morale of the troops in Vietnam began to decline; but after 1969 the replacement soldiers

found themselves in a steadily deteriorating circumstance compared with their counterparts who served earlier. By 1970, enthusiasm in America for the war had dissolved, and a growing opposition to military authority by the troops in Vietnam resonated with the virulent antiwar feelings of those at home. Along with needing to adapt to assignment in the theater and the stress of combat, the second half of the war brought successive cohorts of soldiers to Vietnam to face an additional, and what proved to be more insidious, collection of stressors that were mostly unrelated to combat. These troops were quite far from home, part of a large retrograding Army of resentful conscripts and disillusioned career soldiers—some of whom were on their second or third tour—fully armed but mostly serving in a defensive role, impatiently waiting for their year to pass while feeling vulnerable to attack from communist forces or even hostile South Vietnamese who were apprehensive about being abandoned by the Americans. For the diminishing numbers of troops who were still required to face combat, they were surrounded by a military culture that had become preoccupied with the attainment of individual safety, status, and comfort. Although combat refusal incidents were not reported officially, most accounts of the late-war morale problems include references to their rising numbers. Less confrontational were the "search and avoid (or evade)" missions carried out by troops. Especially important, soldiers who served during the drawdown were bombarded by the media and loved ones in the United States that their mission in Vietnam was dishonorable. The result was sagging morale and a severe unraveling of military order and discipline. This is demonstrated not only by unprecedented rates of psychiatric disorders and misconduct, but also by their extreme nature, that is, violent threats on military leaders and widespread heroin use. As the Prologue attested, late-war soldiers had become an embittered and desperate aggregate of young men who deeply resented being asked to take risks and make sacrifices in order to salvage America's lost cause there while being surrounded by the moral outrage of the American public. In response they bonded around their anger at feeling exploited, abandoned, and blamed and took refuge in alternative affinity groups, which were based on race or drug of choice and fueled by subversive attitudes toward military authority and enmity toward rival enlisted men groups. A senior Army research psychiatrist, Holloway, referred to the turn of events in late-Vietnam as a "human tragedy."[125] Jones and Johnson opined that these psychosocial casualties and the associated rock-bottom morale jeopardized combat readiness in Vietnam as much as the high incidence of combat stress casualties in earlier wars.[38]

- **Pathodynamic consideration regarding the deterioration of morale and mental health of the drawdown Army in Vietnam requires approaches at both the level of the affected soldier and that of his primary group (buddies).**
  - **At the level of the individual soldier.** Many of the soldier-patients who received mental health attention in Vietnam can be understood as manifesting a situation-specific stress response pattern, that is, a failure of adaptation arising in previously functional men who evidently sustained an intolerable interaction of personal circumstance and disturbing biological (often including drug- and alcohol-induced), psychological, and social stressors (in Vietnam, as well as from home)—stressors that became more onerous for sequential cohorts of replacement soldiers as the war wound to its disheartening conclusion. In effect, they underwent a (combat theater) deployment stress reaction.
  - **At the level of the military group.** Although many of the conspicuously misbehaving soldiers in Vietnam brought preservice personality susceptibility to the theater that facilitated their acting out their frustrations, the unprecedented rise in the incidence of psychiatric disorders and nonpsychiatric behavioral problems during the drawdown phase of the war suggests these soldiers were only the tip of an iceberg of discontent and resentment shared by the majority of first-term troops there. In other words, a social stress

reaction resulted—a failure of adaptation at the level of the collective.

Some have assumed that the disgruntled, disintegrating Army in Vietnam was a predictable consequence of government promises of withdrawal and the perception of demobilization. This review suggests a more complex bio\psycho\social model of deployment stress and dysfunction that includes service in a combat zone as a specific and critical variable—a model that psychiatrists who'd not been there could not fully appreciate.

On the social level, Rose, a sociologist, proposed that during the final years in Vietnam the Army experienced a collective "macromutiny," which represented a collapse of the requisite mutual allegiance and cooperation between military leaders and soldiers, and the ascendance of individual self-interests. In other words, the deteriorating morale and military order and discipline exceeded the tipping point, with troops expressing by various means their antagonism toward military authority and an unwillingness to make further sacrifices—the inversion of morale[126]—clearly an unacceptable and dangerous situation.

REFERENCES

1. Manning FJ. Morale and cohesion in military psychiatry. In: Jones FD, Sparacino LR, Wilcox VL, Rothberg JM, eds. *Military Psychiatry: Preparing in Peace for War*. In: Zajtchuk R, Bellamy RF, eds. *Textbooks of Military Medicine*. Washington, DC: Department of the Army, Office of The Surgeon General, Borden Institute; 1994: 1–18.
2. Jones FD. Disorders of frustration and loneliness. In: Jones FD, Sparacino LR, Wilcox VL, Rothberg JM, Stokes JW, eds. *War Psychiatry*. In: Zajtchuk R, Bellamy RF, eds. *Textbooks of Military Medicine*. Washington, DC: Department of the Army, Office of The Surgeon General, Borden Institute; 1995: 63–83.
3. Jones FD. Psychiatric lessons of war. In: Jones FD, Sparacino LR, Wilcox VL, Rothberg JM, Stokes JW, eds. *War Psychiatry*. In: Zajtchuk R, Bellamy RF, eds. *Textbooks of Military Medicine*. Washington, DC: Department of the Army, Office of The Surgeon General, Borden Institute; 1995: 1–33.
4. Menninger WC. *Psychiatry in a Troubled World: Yesterday's War and Today's Challenge*. New York, NY: Macmillan; 1948.
5. Glass AJ. Lessons learned. In: Mullens WS, Glass AJ, eds, *Neuropsychiatry in World War II*. Vol 2. *Overseas Theaters*. Washington, DC: Medical Department, United States Army; 1973: 732–737.
6. Glass AJ, Artiss KL, Gibbs JJ, Sweeney VC. The current status of Army psychiatry. *Am J Psychiatry*. 1961;117:673–683.
7. Tureen LL, Stein M. The base section psychiatric hospital. In: Hanson FR, ed. *Combat Psychiatry*. Washington, DC: US Government Printing Office; 1949: 105–134.
8. Harris FG. Some comments on the differential diagnosis and treatment of psychiatric breakdowns in Korea. *Proceedings of Course on Recent Advances in Medicine and Surgery*. Army Medical Service Graduate School. Washington, DC: Walter Reed Army Medical Center; 30 April 1954: 390–402.
9. Lee RA. The army "mutiny" of 1946. *J Am History*. 1966;53(3):555–571.
10. Froede RC, Stahl CJ. Fatal narcotism in military personnel. *J Forensic Sci*. 1971;16(2):199–218.
11. Medical Field Service School. *Philosophy of Military Psychiatry*. Fort Sam Houston, Tex: Department of Neuropsychiatry, Medical Field Service School; distributed July 1967. Training Document GR 51-400-006, 045.
12. US Department of the Army. *Personnel Separations, Discharge: Unfitness and Unsuitability.* Washington, DC: DA; July 1966. Army Regulation 635-212.
13. US Department of the Army. *Personnel Separations, Officer Personnel.* Washington, DC: DA; February 1969. Army Regulation 635-105.
14. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed (DSM-IV). Washington, DC: APA; 1994.
15. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed, text rev (DSM-IV-TR). Washington, DC: APA; 2000.

16. US Department of the Army. *Medical Services: Standards of Medical Fitness*. Washington, DC: DA; December 1960. Army Regulation 40-501.
17. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 2nd ed (DSM-II). Washington, DC: APA; 1968.
18. US Department of the Army. *Military Psychiatry*. Washington, DC: HQDA; August 1957. Technical Manual 8-244.
19. Allerton WS. Army psychiatry in Vietnam. In: Bourne PG, ed. *The Psychology and Physiology of Stress: With Reference to Special Studies of the Viet Nam War*. New York, NY: Academic Press; 1969: 1–17.
20. Johnson AW Jr. Combat psychiatry, I: A historical review. *Med Bull US Army Europe*. 1969;26(10):305–308.
21. Datel WE. *A Summary of Source Data in Military Psychiatric Epidemiology*. Alexandria, Va: Defense Technical Information Center; 1976. Document No. AD A021265.
22. Jones FD. Experiences of a division psychiatrist in Vietnam. *Mil Med*. 1967:132(12):1003–1008.
23. Mirin SM. Ineffective military personnel, I: A psychosocial perspective. *Arch Gen Psychiatry*. 1974;30(3):398–402.
24. Atkinson RM. Ineffective personnel in military service: a critique of concepts and rehabilitation practices from a psychiatric viewpoint. *Am J Psychiatry*. 1971;127(12):1612–1618.
25. Wichlacz CR, Jones FD, Stayer SJ. Psychiatric predictions and recommendations: a longitudinal study of character and behavior disorder patients. *Mil Med*. 1972;137(2):54–58.
26. Nicholson PT, Mirin SM, Schatzberg, AF. Ineffective military personnel, II: An ethical dilemma for psychiatry. *Arch Gen Psychiatry*. 1974;30(3):406–410.
27. Renner JA Jr. The changing patterns of psychiatric problems in Vietnam. *Compr Psychiatry*. 1973;14(2):169–181.
28. Medical Field Service School. *Management of the Noneffective Soldier*. Fort Sam Houston, Tex: Medical Field Service School, Department of Neuropsychiatry; distributed July 1967. Training document GR 51-400-100, 096.
29. US Army, US Navy, US Air Force. *Joint Armed Forces Nomenclature and Method of Recording Psychiatric Conditions*. Washington, DC: DA; October 1945. Special Regulations 40-1025-2.
30. US Department of the Army. *Drug Abuse*. Washington, DC: DA; January 1973. Technical Bulletin Medical 290.
31. US Department of the Army. Headquarters, US Army Republic of Vietnam. Memo dated 4 June 1971. Subject: Interim changes to AR 635-212 and AR 635-206. Source: DA Message for AGPO, 122117Z.
32. Bourne PG, Nguyen DS. A comparative study of neuropsychiatric casualties in the United States Army and the Army of the Republic of Vietnam. *Mil Med*. 1967;132(11):904–909.
33. Bourne PG. Military psychiatry and the Viet Nam experience. *Am J Psychiatry*. 1970;127(Suppl 4):481–488.
34. Brown DE. The military: a valuable arena for research and innovation [Editorial]. *Am J Psychiatry*. 1970;127(Suppl 4):511–512.
35. Bourne PG. Foreword. In: Figley CR, ed. *Stress Disorders Among Vietnam Veterans: Theory, Research, and Treatment*. New York, NY: Brunner/Mazel; 1978: vii–ix.
36. Colbach EM, Parrish MD. Army mental health activities in Vietnam: 1965–1970. *Bull Menninger Clin*. 1970;34(6):333–342.
37. Neel SH. *Medical Support of the US Army in Vietnam, 1965–1970*. Washington, DC: GPO; 1973.
38. Jones FD, Johnson AW Jr. Medical and psychiatric treatment policy and practice in Vietnam. *J Soc Issues*. 1975;31(4):49–65.
39. Bey DR. Division Psychiatry in Vietnam (unpublished); undated.
40. Hays FW. Military aeromedical evacuation and psychiatric patients during the Viet Nam War. *Am J Psychiatry*. 1969;126(5):658–666.
41. Strange RE. Combat fatigue versus pseudo-combat fatigue in Vietnam. *Mil Med*. 1968;133(10):823–826.
42. Strange RE. Effects of combat stress on hospital ship psychiatric evacuees. 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: 75–93.

43. Strange RE, Arthur RJ. Hospital ship psychiatry in a war zone. *Am J Psychiatry*. 1967;124(3):281–286.
44. US Department of the Army. *Medical Services: Mental Health and Neuropsychiatry*. APO San Francisco, Calif: Headquarters, US Army Republic of Vietnam; March 1966. US Army Republic of Vietnam Regulation 40-34. [Full text available as Appendix 2 to this volume.]
45. 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: 19–44.
46. Bey DR. Division psychiatry in Viet Nam. *Am J Psychiatry*. 1970;127(2):228–232.
47. Bloch HS. Army clinical psychiatry in the combat zone: 1967–1968. *Am J Psychiatry*. 1969;126(3):289–298.
48. Bey D. *Wizard 6: A Combat Psychiatrist in Vietnam*. College Station, Tex: Texas A & M University Military History Series, 104; 2006.
49. Davis DM. Special problems of psychiatric patients evacuated from Vietnam to a back-up hospital. *US Army Vietnam Med Bull*. 1967;July/August:17–20.
50. Heiman EM. Marihuana precipitated psychoses in patients evacuated to CONUS. *US Army Vietnam Med Bull*. 1968;May/June:75–77.
51. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 2nd ed (DSM-II). Washington, DC: APA; 1968.
52. Datel WE, Johnson AW Jr. *Psychotropic Prescription Medication in Vietnam*. Alexandria, Va: Defense Technical Information Center; 1981. Document No. AD A097610.
53. Motis G, West HE. The case of the dumbstruck soldier. *US Army Vietnam Med Bull*. 1968;March/April:70–73.
54. Carden NL, Schamel DJ. Observations of conversion reactions in troops involved in the Viet Nam conflict. *Am J Psychiatry*. 1966;123(1):21–31.
55. Fisher HW. Vietnam psychiatry. Portrait of anarchy. *Minn Med*. 1972;55(12):1165–1167.
56. Jones FD. Traditional warfare combat stress casualties. In: Jones FD, Sparacino LR, Wilcox VL, Rothberg JM, Stokes JW, eds. *War Psychiatry*. In: Zajtchuk R, Bellamy RF, eds. *Textbooks of Military Medicine*. Washington, DC: Department of the Army, Office of The Surgeon General, Borden Institute; 1995: 37–61.
57. Baskir LM, Strauss WA. *Chance and Circumstance: The Draft, the War, and the Vietnam Generation*. New York, NY: Alfred A Knopf; 1978.
58. Medical Field Service School. *Introduction to Military Psychiatry*. Fort Sam Houston, Tex: Department of Neuropsychiatry, Medical Field Service School; distributed July 1967. Training Document GR 51-400-004, 064.
59. Warner CH, Appenzeller GN, Parker JR, Warner CM, Hoge CW. Effectiveness of mental health screening and coordination of in-theater care prior to deployment to Iraq: a cohort study. *Am J Psychiatry*. 2011;168(4):378–385.
60. Goffman E. Characteristics of total institutions. *Symposium on Preventive and Social Psychiatry*. Washington, DC: Walter Reed Army Institute of Research; 15–17 April 1957: 43–84. Expanded as Goffman E. *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. New York, NY: Doubleday; 1990.
61. Bourne PG. Some observations on the psychosocial phenomena seen in basic training. *Psychiatry*. 1967;30(2):187–196.
62. Eisenhart RW. You can't hack it little girl: a discussion of the covert psychological agenda of modern combat training. *J Soc Issues*. 1975;31(4):13–24.
63. Regan DJ. *Mourning Glory: The Making of a Marine*. Old Greenwich, Conn: Devin-Adair; 1981.
64. Shatan CF. Bogus manhood, bogus honor: surrender and transfiguration in the United States Marine Corps. *Psychoanal Rev*. 1977;64(4):585–610.
65. Bourne PG. From boot camp to My Lai. In: Falk RA, Kolko G, Lifton RJ, eds. *Crimes of War: A Legal, Political-Documentary, and Psychological Inquiry Into the Responsibility of Leaders, Citizens, and Soldiers for Criminal Acts in Wars*. New York, NY: Random House; 1971: 462–468.

66. Starr P. *The Discarded Army: Veterans After Vietnam*. New York, NY: Charterhouse; 1973.
67. Dougan C, Lipsman S, Doyle E, and the editors of Boston Publishing Co. *The Vietnam Experience: A Nation Divided*. Boston, Mass: Boston Publishing Co; 1984.
68. Crowe RR, Colbach EM. A psychiatric experience with Project 100,000. *Mil Med*. 1971;136(3):271–273.
69. Bey DR, Zecchinelli VA. GI's against themselves. Factors resulting in explosive violence in Vietnam. *Psychiatry*. 1974;37(3):221–228.
70. Byrdy HSR. Division psychiatry in Vietnam (unpublished); 1967. [Full text available as Appendix 8 to this volume.]
71. Bowman JA. Recent experiences in combat psychiatry in Viet Nam (unpublished); 1967. [Full text available as Appendix 11 to this volume.]
72. Morris LE. "Over the hump" in Vietnam. Adjustment patterns in a time-limited stress situation. *Bull Menninger Clin*. 1970;34(6):352–362.
73. Dowling JJ. Psychological aspects of the year in Vietnam. *US Army Vietnam Med Bull*. 1967;May/June:45–48.
74. Bloch HS. The psychological adjustment of normal people during a year's tour in Vietnam. *Psychiatric Q*. 1970;44(4):613–626.
75. Bey DR. Group dynamics and the "F.N.G." in Vietnam: a potential focus of stress. *Int J Group Psychother*. 1972;22(1):22–30.
76. Lipsman S, Doyle E, and the editors of Boston Publishing Co. *The Vietnam Experience: Fighting for Time*. Boston, Mass: Boston Publishing Co; 1983
77. Ratner RA. Drugs and despair in Vietnam. *U Chicago Magazine*. 1972;64:15–23.
78. Herr M. *Dispatches*. New York, NY: Avon Books; 1980.
79. Spector RH. *After Tet: The Bloodiest Year in Vietnam*. New York, NY: The Free Press; 1993.
80. Blank AS Jr. In: Johnson AW Jr, Bowman JA, Byrdy HS, Blank AS Jr. Panel discussion: Army psychiatry in Vietnam. In: Jones FD, ed. *Proceedings: Social and Preventive Psychiatry Course, 1967*. Washington, DC: GPO; 1968: 41–76. [Available at: Alexandria, Va: Defense Technical Information Center. Document No. AD A950058.] [Full text available as Appendix 10 to this volume.]
81. Kenny WF. Psychiatric disorders among support personnel. *US Army Vietnam Med Bull*. 1967;January/February:34–37.
82. Jones FD. Reactions to stress comparing combat and support troops. Presentation to: World Psychiatric Association; 29 August 1977; Honolulu, Hawaii.
83. Doyle E, Weiss S, and the editors of Boston Publishing Co. *The Vietnam Experience: A Collision of Cultures*. Boston, Mass: Boston Publishing Co; 1984.
84. Neller G, Stevens V, Chung R, Devaris D. Psychological Warfare and Its Effects on Mental Health: Lessons Learned From Vietnam (unpublished); 1985.
85. Bey DR. In: Forrest DV with commentary by Bey DR, Bourne PG. The American soldier and Vietnamese women. *Sex Behav*. 1972;2:8–15.
86. Menard DL. The social work specialist in a combat division. *US Army Vietnam Med Bull*. 1968;March/April:48–57.
87. Bey DR Jr, Smith WE. Organizational consultation in a combat unit. *Am J Psychiatry*. 1971;128(4):401–406.
88. Forrest DV, with commentary by Bey DR, Bourne PG. The American soldier and Vietnamese women. *Sex Behav*. 1972;2:8–15.
89. US Department of the Army. *Personnel Separations, Homosexuality*. Washington, DC: DA; July 1966. Army Regulation 635-89.
90. Dynes WR, Donaldson S, eds. *Homosexuality and Government, Politics and Prisons*. New York, NY: Garland Publishing; 1992.
91. Baker WL. Division psychiatry in the 9th Infantry Division. *US Army Vietnam Med Bull*. 1967;November/December:5–9.
92. Druss RG. Cases of suspected homosexuality seen at an Army Mental Hygiene Consultation Service. *Psychiatr Q*. 1967;41(1):62–70.
93. Shilts R. *Conduct Unbecoming: Gays and Lesbians in the US Military: Vietnam to the Persian Gulf*. New York, NY: Ballantine Books; 1993.
94. Baker SL Jr. Traumatic war disorders. In: Kaplan HI, Freedman AM, Sadock BJ, eds.

Comprehensive Textbook of Psychiatry. 3rd ed. Baltimore, Md: Williams & Wilkins; 1980: 1829–1842.
95. Sorley L. *A Better War: The Unexamined Victories and Final Tragedy of America's Last Years in Vietnam*. New York, NY: Harcourt Books; 1999.
96. Fulghum D, Maitland T, and the editors of Boston Publishing Co. *The Vietnam Experience: South Vietnam on Trial, Mid-1970 to 1972*. Boston, Mass: Boston Publishing Co; 1984.
97. Bey DR. Change of command in combat: a locus of stress. *Am J Psychiatry*. 1972;129(6):698–702.
98. Kerner O, Lindsay JV, Harris FR. *Report of the National Advisory Commission on Civil Disorders*. Washington, DC: GPO; 1968: Abstract. Available at: http://www.eisenhowerfoundation.org/docs/kerner.pdf. Accessed 28 May 2013.
99. Dougan C, Weiss S, and the editors of Boston Publishing Co. *The Vietnam Experience: Nineteen Sixty-Eight*. Boston, Mass: Boston Publishing Co; 1983.
100. Kroll J. Racial patterns of military crimes in Vietnam. *Psychiatry*. 1976;39(1):51–64.
101. Terry W. The angry blacks in the army. In: Horowitz D and the editors of Ramparts, eds. *Two, Three . . . Many Vietnams: A Radical Reader on the Wars in Southeast Asia and the Conflicts at Home*. San Francisco, Calif: Canfield Press; 1971: 222–231
102. Fiman BG, Borus JF, Stanton MD. Black-white American-Vietnamese relations among soldiers in Vietnam. *J Soc Issues*. 1975;31(4):39–48.
103. Borus JF. Reentry, I: Adjustment issues facing the Vietnam returnee. *Arch Gen Psychiatry*. 1973;28(4):501–506.
104. Borus JF, Stanton MD, Fiman BG, Dowd AF. Racial perceptions in the Army: an approach. *Am J Psychiatry*. 1972;128(11):1369–1374.
105. Williamson E. From both sides now. *Army Reporter*. 25 October 1971:5.
106. Colbach EM. Ethical Issues in combat psychiatry. *Mil Med*. 1985;150(5):256–265.
107. Bey DR. Personal communication, 23 March 2010.
108. Bey DR, Smith WE. Mental health technicians in Vietnam. *Bull Menninger Clin*. 1970;34(6):363–371.
109. Linden E. The demoralization of an army: fragging and other withdrawal symptoms. *Saturday Review*, 8 January 1972:12–17, 55.
110. Gillooly DH, Bond TC. Assaults with explosive devices on superiors: a synopsis of reports from confined offenders at the US Disciplinary Barracks. *Mil Med*. 1976;141(10):700–702.
111. Bond TC. The why of fragging. *Am J Psychiatry*. 1976;133(11):1328–1331.
112. National Archive Records Administration (NARA). Statistical information about casualties of the Vietnam War: [Southeast Asia] Combat Area Casualties Current File (CACCF), 2007.
113. Adams DP, Barton C, Mitchell GL, Moore AL, Einagel V. Hearts and minds: suicide among United States combat troops in Vietnam, 1957–1973. *Soc Sci Med*. 1998;47(11):1687–1694.
114. Huffman RE. Which soldiers break down. A survey of 610 psychiatric patients in Vietnam. *Bull Menninger Clinic*. 1970;34(6):343–351.
115. Byrdy HSR. In: Johnson AW Jr, Bowman JA, Byrdy HSR, Blank AS Jr. Panel discussion: Army psychiatry in Vietnam. In: Jones FD, ed. *Proceedings: Social and Preventive Psychiatry Course, 1967*. Washington, DC: GPO; 1968: 41–76. [Available at: Alexandria, Va: Defense Technical Information Center. Document No. AD A950058.]
116. Klein DC, Fencil-Morse E, Seligman ME. Learned helplessness, depression, and the attribution of failure. *J Pers Soc Psychol*. 1976;33(5):508–516.
117. Gartner SS. Strategic and political factors affecting suicidality in the armed forces. Paper presented at: American Political Science Association; September 2010; Washington, DC.
118. Bowman JA. In: Johnson AW Jr, Bowman JA, Byrdy HS, Blank AS Jr. Panel discussion: Army psychiatry in Vietnam. In: Jones FD, ed. *Proceedings: Social and Preventive Psychiatry Course, 1967*. Washington, DC: GPO; 1968: 41–76. [Available at: Alexandria, Va: Defense Technical Information Center. Document No. AD A950058.]

119. Langner HP. The making of a murderer. *Am J Psychiatry*. 1971;127(7):950–953.
120. Pasternack SA. Evaluation of dangerous behavior of active duty servicemen. *Mil Med*. 1971;136(2):110–113.
121. Kruzich DJ. *Army Drug Use in Vietnam: Origins of the Problem and Official Response* (unpublished manuscript). University of Minnesota, School of Public Health; May 1979.
122. National Archive Records Administration (NARA). Statistical information about casualties of the Vietnam War: [Southeast Asia] Combat Area Casualties Current File (CACCF), 1998.
123. Gabriel RA, Savage PL. *Crisis in Command: Mismanagement in the Army*. New York, NY: Hill and Wang; 1978: Table 3.
124. Moskos CC Jr. Surviving the war in Vietnam. In: Figley CR, Leventman S, eds. *Strangers at Home: Vietnam Veterans Since the War*. New York: Praeger; 1980:71–85
125. Holloway HC. Vietnam military psychiatry revisited. Presentation to: American Psychiatric Association Annual Meeting; 19 May 1982; Toronto, On.
126. Rose E. The anatomy of a mutiny. *Armed Forces Soc*. 1982;8(4):561–574.