Chapter 2

US ARMY PSYCHIATRY LEGACIES OF THE VIETNAM WAR

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INTRODUCTION

The US ground war in Vietnam (1965–1972) began on March 8, 1965, when over 3,500 men of the 9th Marine Expeditionary Brigade made an unopposed amphibious landing on the northern coast of the Republic of South Vietnam. This was in response to intensification in the fighting between South Vietnam—an ally of the United States—and indigenous communist forces (Viet Cong guerrillas) and those from South Vietnam's neighbor to the north, the Democratic Republic of Vietnam (North Vietnam). In early May, the first US Army troops (the 173rd Airborne Brigade) arrived in South Vietnam, landing at the mouth of the Saigon River at Vung Tau. Thus began an enormous military effort by the United States and other allies who sought to block the spread of communism in Southeast Asia.

Considering the limited resources of the enemy and the superior military might of the United States, it was anticipated that the threat could be quickly contained. Only belatedly was it discovered that the resolve of the communists had been underestimated. The war became a drawn out, mostly "low intensity," "irregular," counterinsurgency/guerrilla conflict, which was far more challenging than expected. The United States and its allies had become intractably ensnared in Vietnam's simultaneous and protracted social revolution, civil war, and nationalistic opposition to foreign domination. In time, the cost of the war far exceeded the tolerance of the American people (over 58,000 Americans died and over 300,000 were wounded) and produced great national agony and incalculable cultural aftereffects. Finally, just over 2 years after the last US military personnel were withdrawn (March 29, 1973) under a negotiated truce, North Vietnam violated the truce and overran South Vietnam, which surrendered on April 30, 1975.

The war effort also assumed a central role in a decade of social and political upheaval in the United States—a nightmare that threatened its most basic institutions, including the US military. Through the second half of the war (1969–1972), an increasing proportion of US troops in Vietnam came to question their purpose there. They expressed, in every way except for collective mutiny (including psychiatric conditions), their inability or unwillingness to accept the risks of combat, acknowledge the authority of military leaders, or tolerate the hardships of an assignment in Vietnam. This all occurred in a setting where combat objectives were still in effect, weapons were ubiquitous, violence was adaptive, and illicit drugs were effectively marketed and widely used by US troops. The attitudes of these young replacement soldiers, most of whom were draftees or reluctant volunteers, were strongly resonant with the growing opposition to the war in the United States. A radicalized, liberal, "counterculture" youth movement emerged, along with antagonism toward American institutions and, especially, military service among younger, black Americans. Facilitative, but also emblematic, this dissenting subculture especially rallied around the burgeoning drug culture of the times.

The severe breakdown in soldier morale and discipline suffered by the US Army during the drawdown years in Vietnam struck at the heart of military leadership. It also overlapped with the mission of Army psychiatry. From the outset, the organization of psychiatric services in Vietnam was especially weighted in favor of the treatment and rehabilitation of combat stress casualties. These did not materialize in the numbers envisioned, however, and instead an unprecedented flood of psychosocial casualties emerged. These consisted of disciplinary problems, racial disturbances, attacks on superiors, drug abuse, and the rising prevalence of soldiers diagnosed with character disorders, especially for those in noncombat units and with assignments relatively unrelated to combat risks.[1] Military leaders, as well as law enforcement, administrative, and medical/psychiatric elements, were all severely tested until the remaining US ground forces were withdrawn.

Following the war, the Army Medical Department did not commit to developing a historical summary of psychiatry in Vietnam or study these problems for "lessons learned." Furthermore, the Army evidently lost, abandoned, or destroyed documentation at the conclusion of hostilities that could serve as primary source material.[2] Vietnam has been referred to as America's first computerized war. Ironically, however, the Army apparently emerged from this experience with far fewer records pertaining to the provision of military psychiatric services than in earlier and less "sophisticated" times. In lieu of a more systematic approach, this chapter will draw upon the extant literature from the war to provide a composite of the stressors affecting soldiers sent to Vietnam. It will provide an overview of the emergent trends in psychiatric conditions and behavioral problems faced by Army leaders and the deployed psychiatric specialists and their mental health colleagues. It also will raise important questions that seem to linger despite the three-and-a-half decades since US troops left Vietnam—questions for which the answers may have considerable bearing for such troops in similar wars in the future.

THE INCOMPLETE HISTORY OF ARMY PSYCHIATRY IN THE VIETNAM WAR

Spanning approximately a decade, from late 1962 through early 1972, an estimated 135 psychiatrists served with the US Army in Vietnam in successive cohorts, typically for 1-year assignments.[3] Roughly one third of these psychiatrists were trained in Army residency programs; the other two thirds received their psychiatric education in civilian settings. The number of psychiatrists who served in Vietnam was considerably fewer than the more than 2,400 psychiatrists who served in World War II. However, those who served in Vietnam participated in a war that became surrounded with unparalleled social and political discord. The associated polarization and tensions of the period, especially later in the war, clearly affected attitudes within psychiatry and particularly challenged the role and ethics of psychiatry in support of the military.

A few publications summarize Army psychiatry experience in Vietnam. They primarily focus, however, on observations from the advisor period and the buildup phase of the war (1962–1969)[3–6] and fail to draw sufficient attention to the rampant psychiatric and behavioral problems that subsequently developed there. Also misleading is the commonly published Army psychiatric admission rate for the Vietnam War of 12–16/1,000 soldiers per year,[7–10] which appears quite favorable compared to Korea (28/1,000/y)[10] and World War II (28–101/1,000/y).[11] Utilizing a single outcome measure and averaging all 7 years of experience in Vietnam effectively dilutes the 4-fold increase in the last few years and minimizes both the breadth and the depth of the intersecting morale and psychiatric problems in Vietnam.

In 1975, Jones and Johnson published a preliminary overview of Army psychiatry in Vietnam when Johnson was serving as the psychiatric consultant to the Office of The Surgeon General, US Army.[7] They described common clinical entities and provided gross prevalence data, which they associated with changing theater circumstances and policy features of the war. They left greater detail and synthesis for other accounts that, regrettably, failed to materialize.

Other circumstances also help explain the absence of a more complete Vietnam military psychiatry history. Until it was forced to study heroin use among soldiers late in the war,[12–14] the Army undertook relatively little formal psychiatric field research in Vietnam after regular forces were committed in 1965. Notable exceptions are the study of physiological, psychological, and social correlates of stress by Major Peter Bourne, Medical Corps, and his colleagues from Walter Reed Army Institute of Research (WRAIR), conducted in 1965 and 1966,[15] and the surveys of illegal drug use in 1967 by RA Roffman and E Sapol,[16] and in 1969 by MD Stanton.[17] Also helpful are publications regarding the theater drug abuse epidemic derived from investigative visits to Vietnam late in the war by senior military psychiatrists—Colonel Stewart L Baker Jr, Medical Corps,[18] Colonel Harry C Holloway, Medical Corps,[19] and Norman Zinberg, MD, a civilian psychiatrist.[20]

Anecdotal accounts published by psychiatrists who served in the war are also a useful source of information.[21] Regrettably, some measure of skew is introduced because, of the 27 psychiatrists who served with the Army and who published accounts, 82% (22) were assigned there during the first half of the war (1965–1968). Also, of 46 publications from the entire group of 24 individuals, half appeared in the *US Army Vietnam Medical Journal*—a nonjuried publication that was circulated primarily in Vietnam and ceased publication in 1970. The few articles by psychiatrists who served during the drawdown phase of the war when psychiatric attrition rates were highest are primarily limited to descriptions of local patterns of drug abuse or drug treatment programs.

Besides being generally spotty, the available research and historical literature specifically lacks validation of the field psychiatric practices and results in Vietnam,[22] especially the adaptation of the classic combat psychiatry "doctrine" (informal) to the irregular, counterinsurgency war that was mostly fought in Vietnam and under increasingly controversial circumstances. This chapter will make additional references to this doctrine, but it can be summarized as the provision of brief, simple, mostly field treatments (eg, safety, rest, and physical replenishment); peer support; sedation, if necessary; and opportunities for emotional catharsis of the soldier's traumatic events—applied as close to the affected soldier's unit as practical and accompanied by expectations that the individual quickly recover, rejoin comrades, and reenter the combat situation.[23,24]

Similar uncertainties surround the use in theater of recently developed pharmacologic agents. Vietnam provided military medicine with its first set of physicians—especially psychiatrists—routinely trained in the use of neuroleptic (antipsychotic), anxiolytic (antianxiety), and tricyclic (antidepressant) medications. The discovery of these medications revolutionized the practice of psychiatry generally; they had considerable promise in the management of combat stress reactions (CSRs) and other conditions in Vietnam. Anecdotal reports indicate that they were commonly prescribed throughout the theater for a full range of symptoms related to combat stress. A limited

survey in 1967 confirmed their high use by Army physicians, including psychiatrists.[25] However, there were no associated clinical or research studies, and, in the aftermath of the war, some have raised questions as to whether prescribing psychoactive medications for combat-exposed soldiers represented unethical medical practice by coercing participation among dissenting soldiers.

It is also critical to try to reconstruct the military psychiatry experience in Vietnam to consider the impact of the reversal in American approval of the war on the clinical decisions of the deployed psychiatrists. Ethical and moral reactions to a war and its politics can influence military psychiatrists regarding the diagnosis and management of their cases (eg, encourage sympathetic overdiagnosis and overevacuation—decisions proven in past wars to prolong morbidity in combat-affected soldiers).[26]

In 1982, in an attempt to fill in this missing information, WRAIR queried all veteran Army psychiatrists who could be located about their professional experiences in the war. Of the estimated 135 psychiatrists who served in Vietnam (133 were men, two were women), 115 were located. Of those, 85 (74%) responded to a structured questionnaire exploring patterns of psychiatric problems encountered, types and effectiveness of clinical approaches, and personal reactions to the associated professional challenges and dilemmas.[2,27] Selected study findings will be summarized later in this chapter.

THE WAR'S RATIONALE AND PROVOCATION

To understand how the US government could reach a point where it would expend American lives and resources to fight a counterinsurgency in Vietnam, one must remember that following the end of World War II (1945), the United States and its allies soon found themselves again in an epic struggle against the menace of totalitarianism—this time, Soviet-sponsored Marxist communism (the "Cold War"). Relations between the two ideological camps were typically strained, and a catastrophic nuclear war seemed frighteningly possible. For example, between 1950 and 1953, the United States waged a costly war in support of South Korea's defense against a communist takeover by North Korea. Even closer to home, in 1961 the United States came perilously close to nuclear war with the former Soviet Union when it was discovered that the communist regime of Fidel Castro in Cuba had permitted the Soviet placement of nuclear missiles on that Caribbean island. The growing perception among Americans was that without vigorous opposition by the United States and its allies, democracy could be obliterated by a cascade of communist revolutions (the "domino theory") throughout the developing nations of the world, such as those in Southeast Asia. Because the United States was a signatory of the 1954 Southeast Asia Treaty Organization (with France, the United Kingdom, Thailand, Pakistan, Australia, New Zealand, and the Philippines),[28] South Vietnam's struggle to defend itself against armed aggression from North Vietnam (in violation of the 1954 Geneva Agreement that brought an end to the First Indochina War)[28] presented a compelling opportunity to draw the line with respect to the perceived threat.

THE SCOPE OF AMERICA'S WAR IN VIETNAM

America's enemies in Southeast Asia were 2-fold: (1) the indigenous Viet Cong guerrilla forces who operated in South Vietnam and who used harassment, terrorism, and sabotage as tactics to destabilize the government of South Vietnam, and (2) their allies—the regular units of North Vietnamese Army, who likewise sought a takeover of South Vietnam.

The pursuit of US military objectives in Vietnam became a huge undertaking. The ground war spanned over 8 years and by the time the remaining military personnel were withdrawn in 1973, 3.4 million American military men and women had served in the theater (typically a single, 1-year assignment), as well as offshore with the US Navy and at US Air Force bases in Thailand and Guam. When it ended, more than 58,000 Americans had died (over 47,000 due to enemy action or missing in action),[29] and more than 300,000 had been wounded.

The majority of those who were sent to Vietnam served in the Army (60%–80%), thus the majority of the casualties also were from the ranks of the Army (over 30,000 killed in action [KIA] and over 200,000 wounded in action [WIA]). Roughly 20% of troops actually served in first echelon combat arms, and the remainder served in combat support and service support roles. For the most part, Reserve and National Guard units were not called up, and the US military, especially the Army, resorted to increased conscription rates to meet its needs. Although only 25% of the total American forces deployed were technically draftees (vs 66% in World War II), many more were "draft-motivated" (ie, they enlisted in anticipation of being

drafted because enlisting improved their chances of obtaining a noncombat assignment[30(p32)]). The average age of the Vietnam War soldier was younger (19 years old) than those who served in World War II (26 years old). They were also better educated than their fathers' generation of soldiers.

The war in Vietnam is classified as a "limited conventional war" because there were units larger than 4,000 soldiers operating in the field. However, it became mostly a counterinsurgency war. The war in Vietnam is also referred to as "low intensity" because of the low ratio of KIA and WIA to the numbers of personnel deployed compared to previous American wars. For example, a comparison of the peak years of US Army WIA rates during Vietnam (1968 = 120/1,000 troops) and Korea (1950 = 460/1,000 troops) suggests a lower combat intensity in Vietnam.[31] This can be misleading because of the smaller proportion of combat personnel compared to those in combat support and service support positions in Vietnam (a "tooth-to-tail" ratio of 1:5) and the availability of improved medical care. According to Ronald Spector, a military historian,

> Men in "maneuver battalions," the units that actually did the fighting, continued to run about the same chance of death or injury as their older relatives who had fought in Korea or in the Pacific [in World War II]. Indeed, during the first half of 1968, the *overall* [author's italics] Vietnam casualty rate exceeded the overall rate for all theatres in World War II, while the casualty rates for Army and Marine maneuver battalions were more than four times as high.[30(p55)]

The data accumulated on the types of wounds sustained in Vietnam are also revealing of the nature of combat there. Many more American casualties were caused by small arms fire or by booby traps and mines than in previous wars, and many fewer were caused by artillery and other explosive projectile fragments.

At home, an estimated quarter of a million Americans lost an immediate family member to the war. South Vietnam's military casualties numbered 220,357, with almost a half million becoming wounded. The United States spent $189 billion prosecuting the war and supporting the South Vietnamese government. In one 12-month period alone—mid-1968 through mid-1969, the peak year of US combat activities—America and its allies had over 1.5 million military personnel deployed (543,000 Americans, 819,200 South Vietnamese, and 231,100 from South Korea, Australia, New Zealand, Thailand, and the Philippines combined); US forces staged 1,100 ground attacks of battalion size or larger (compared to only 126 by the communist forces); and there were 400,000 American air attacks that dropped 1.2 million tons of bombs, costing $14 billion.[32]

AMERICA'S TWO VIETNAM WARS: PRE-TET '68 AND POST-TET '68

The American story of the ground war in Vietnam should be considered as two Vietnam War stories—starkly different, sequential stories that pivot on the events occurring in 1968. Taken together, these two stories portray a dramatic reversal of fortune for the United States, a reversal that powerfully shaped American culture.

The Buildup Phase (1965–1967): Lyndon Johnson's War

Lyndon Johnson was sworn into his first full term as President in January 1965, riding the crest of a national political consensus and overall prosperity. It was only, in the words of *Newsweek*, that "[n]agging little war in Vietnam,"[33(p58)] that cast a shadow on his ambition to create a "Great Society" of social reforms as his legacy. Nonetheless, the administration was determined to pursue those political agendas as well as ensure that South Vietnam did not fall into the communist sphere.

Preceded by over 10 years of US financial assistance and military advisors, US military presence expanded rapidly in South Vietnam after the Marine landing in 1965. By June 1966, American troops numbered 285,000, and another 100,000 would be pouring in by the end of the year. The number of inductions into the US military in 1966 alone was almost 320,000 men, a 250% increase over the previous year.[30]

The US Army, Marine Corps, and, in the Mekong River Delta, Navy units committed in South Vietnam typically found themselves operating in a rugged, tropical environment with formidable impediments to movement over the ground, extraordinary heat and humidity, and monsoonal rains for months at a time. Furthermore, combat operations conducted 10,000 miles from the United States required a very long logistical network. These troops also operated among an indigenous population of an exotic, Asian culture who spoke an exceptionally difficult language for Americans to learn. The local Vietnamese appeared to tolerate the presence of US troops, but it was common for them to be ambivalent about the government of South Vietnam and to harbor Viet Cong guerrillas. The relationships between US forces and the South Vietnamese were generally strained; US troops regarded

them warily at best.[34] US combat units sponsored public relations programs designed to "win the hearts and minds" (ie, recruit the loyalty of villagers by providing for their welfare and security), but these brought only qualified success.

The combat strategy employed by the US Army in the buildup phase in Vietnam was one of attrition (body counts and kill ratios),[35] primarily through search-and-destroy missions initiated from well-defended enclaves. Guerrilla and terrorist operations by Viet Cong forces and periodic attacks by North Vietnamese regular units were the principle tactics of the communist forces. As a consequence, military engagements more often involved clashes between highly mobile, small tactical units as opposed to battles between major military formations. Furthermore, US successes were limited because the Viet Cong guerrillas were elusive, dictated the tempo of the fighting, and too often were content to snipe, set booby traps, and stage ambushes. Their hit-and-run tactics allowed them to fade safely into the jungle or into the local populace if the fight turned against them—tactics ingrained in their culture from centuries of guerrilla warfare against foreign invaders. US forces were more likely to find themselves in conventional war engagements against regular North Vietnamese divisions in the northern provinces. However, even these main force units more often than not staged combat initiatives from behind the safety of the 17th parallel demilitarized zone that separated North Vietnam from South Vietnam, thereby eluding pursuit by US units and their allies. Consequently, most combat activity for US forces involved brief encounters between isolated, small units—a war of no fronts. A Joint Chiefs of Staff study reported that of all the US patrols conducted in 1967 and 1968, less than 1% resulted in contact with the enemy.[35] Still, when there was contact, the fighting was as bloody and intense as any that had occurred during World War II. US forces did periodically stage larger scale operations during this phase of the war, and some elements of these engagements exacted heavy tolls on the enemy.

The US military in the late 1960s enjoyed remarkable technological advantages in Vietnam. Weaponry was a prime example. Whether carried with them into the field, or employed as tactical support from air strikes or artillery, field commanders could bring to bear formidable firepower on the enemy. If the enemy began to outnumber an allied force in an engagement, close support from the air or from artillery quickly reversed the equation. Another element of US technical superiority in Vietnam was that of air mobility—the ubiquitous helicopter. This was unprecedented in US warfare and allowed reconnaissance and ordnance delivery from the air, heliborne movement of troops for tactical advantage, timely evacuation of the wounded, and frequent resupply. In fact, the first full US Army combat division to be sent to Vietnam was the 1st Cavalry Division (Airmobile).

US Army Medical and Psychiatric Support

A third element in the Vietnam theater that greatly enhanced life for the US combat soldier in Vietnam was the outstanding medical support available. From the outset of the war, the US military made every effort to ensure that troops received timely, sophisticated medical attention, including psychiatric care, despite the hostile physical environment and Vietnam's geographical remoteness. The build up of Army medical units was completed in 1968 when 11 evacuation, 5 field, and 7 surgical hospitals were in place. These facilities, plus the 6th Convalescent Center in Cam Ranh Bay, brought the total bed capacity in South Vietnam to 5,283.[31] Most importantly, the new helicopter ambulance capability also permitted rapid evacuation of the wounded to the most appropriate level of medical care. As far as physical casualties, these efforts achieved remarkable success throughout the war. Comparing the ratio of KIA to WIA across wars attests to the superiority of medical care provided in Vietnam (World War II, 1:3.1; Korea, 1:4.1; and Vietnam, 1:5.6).[31]

The Organization and Preparation of Army Psychiatrists for Vietnam

Once the mobilization was under way in 1965, Army psychiatrists and allied mental health personnel were rapidly assigned and widely distributed throughout the theater. This peaked during the 4 full-strength years (1967–1970) when approximately 23 Army psychiatrist positions per year were available. In planning to fight in Vietnam, the Army Medical Department assumed that the greatest psychological threat to the force would be the "breaking point" of soldiers exposed to sustained enemy fire (eg, "combat exhaustion"—now labeled "combat stress reaction"). In anticipating large numbers of these casualties, they not only promulgated the treatment philosophy developed and refined in World War II and Korea (doctrine described earlier),[8] they also established policies and organizational structures[36] borrowed from those earlier engagements—a system that weighted the psychiatric assets in favor of combat units, even though combat-exposed troops would represent less than 20% of the Army deployed in South Vietnam.[30] Military planners were not only confident that this system would promote the conservation of military

strength, they also believed that it would reduce morbidity in affected soldiers. This system centered upon assignment of psychiatrists to either a combat unit, typically as a division psychiatrist, or to a combat service support medical unit, typically a hospital (or specialized psychiatric detachment).

Assignment as a Division Psychiatrist. Throughout the war only the combat divisions (composed of 15,000–20,000 soldiers), that is, their medical battalions, had their own, directly assigned (eg, "organic") psychiatrists (along with allied mental health personnel). The rationale was to embed mental health personnel within combat units to provide psychiatric treatment capability as far forward as could practically be accomplished.[7] It also permitted the psychiatrist to serve as a staff officer of the command of the division and thereby provide timely advice on matters affecting morale and mental health (eg, "command consultation").

Assignment as a Hospital Psychiatrist. Alternatively, psychiatrists (along with allied mental health personnel) were assigned to Army-level hospitals or to the two specialized medical/psychiatric detachments (98th and 935th) in Vietnam. They functioned more often in a clinical role, and their command authority was from higher levels of Army medical command in Vietnam (ultimately the US Army Medical Command, Vietnam, or USAMEDCOMV, as it came to be called). The first priority for these psychiatric elements was to provide inpatient treatment for referrals from the combat divisions or other primary care facilities. In the case of the specialized psychiatric detachments ("KO teams" [the "KO" arbitrarily indicated that these were hospital augmentation detachments]), they offered more extended hospitalized care (up to 30 days) as well as serving as staging centers for out-of-country evacuations for soldiers needing additional care. The mission for hospital psychiatrists and their mental health colleagues also included the provision of outpatient care (eg, the Mental Health Consultation Service) for the soldiers from nondivisional (primarily noncombat) units on a regional basis. However, because these mental health assets were not part of the command structure of these units, mental health "command consultation" was far less predictable than would be the case in the combat divisions.

One psychiatrist slot was allocated to each of the seven full combat divisions deployed in Vietnam, as well as one each to the evacuation and field hospitals. These were filled depending on anticipated need and psychiatrist availability. In addition, throughout most of the war, the two Army neuropsychiatric specialty centers were operational and each was to be staffed with three psychiatrists. Furthermore, each year of the war a senior psychiatrist was to serve in a staff position with US Army Vietnam Headquarters as the Neuropsychiatric Consultant to the Commanding General, United States Army Republic of Vietnam (CG/USARV) Surgeon. The central task of the Consultant was to direct the coordination of psychiatric facilities and program planning, which required extensive travel throughout Vietnam to visit psychiatrists and programs, to provide clinical leadership, and to serve as consultant to senior military leaders about psychiatric issues.

The training and indoctrination provided for physicians, including psychiatrists, who would be assigned in Vietnam also centered on the limits of soldiers in combat, the causes of breakdown under sustained fire (social, physical, and emotional), and the prevention or management of large numbers of combat-generated psychiatric casualties as were encountered in the wars preceding Vietnam. This was the case in the Army's two psychiatric residency-training programs (Walter Reed General Hospital, Washington, DC, and Letterman General Hospital, San Francisco, California) where the principles of prevention and treatment of combat breakdown were emphasized in the curricula. It was also the case regarding newly commissioned, civilian-trained psychiatrists who would be assigned in Vietnam. They received their primary orientation to military psychiatry at the Army's Medical Field Service School, which was located at Fort Sam Houston in San Antonio, Texas. This preparation included only a few hours of didactic instruction in military psychiatry, and this was primarily regarding the pathogenesis, symptoms, and management of combat exhaustion[37] and the organization of psychiatric services within the combat division.[38]

The Relative Infrequency of Classic Combat Exhaustion Casualties in Vietnam

In time it became evident that the large numbers of combat exhaustion casualties that were predicted and planned for in Vietnam never materialized. The only overview of the psychiatric problems in the Vietnam War, published by Jones and Johnson, did not report theater-wide incidence statistics for combat exhaustion specifically,[7] although they were apparently collected by USAMEDCOMV.[9] Although these authors attested to the fact that the incidence throughout the war was "extremely low,"[7(p53)] Jones and Johnson added some confusion by referring to all hospitalized psychiatric patients in Vietnam as "combat psychiatric casualties." They also acknowledged that disagreements as to diagnostic criteria produced major problems in collecting and comparing incidence statistics for combat exhaustion in Vietnam, or even between wars. Boman,

an Australian psychiatrist, provided corroboration in his postwar analysis of military psychiatry practices in Vietnam. He illustrated significant diagnostic confusion in the literature, and he posited that US military psychiatrists systematically, if inadvertently, mislabeled combat-generated psychological problems as character disorders, resulting in inappropriate administrative or disciplinary dispositions as well as spuriously lowering apparent incidence rates.[39] Finally, the only official summary of US Army medical experience in Vietnam (covering the war up through May 1970, two thirds into the war), which was authored by Major General Spurgeon Neel, does not mention combat exhaustion or any other forms of combat-generated psycholopathology.[31]

Also hampering the collection of data regarding combat exhaustion casualties in Vietnam was the fact that, by definition, it is a reversible, stress-generated, psychosomatic regression that, when treated early and effectively, typically remits within a couple of days. As a consequence, many cases would have been treated at lower echelons of medical care and thus not be included in hospitalization rates.[40,41]

Approximations of CSR incidence measures in Vietnam came in the form of comparisons of the number of hospitalized CSR cases with those for other psychiatric conditions. The overview by Colbach and Parrish of US Army mental health activities in Vietnam through the first two thirds of the war reported 7% of all psychiatric admissions were diagnosed as CSR, but unfortunately they did not include data sources.[6] A smaller window, but one with more specific data, is provided by Major Peter Bourne, Medical Corps, Chief, Neuropsychiatry, WRAIR Medical Research Team in Vietnam (1965–1966). While comparing US Army psychiatric hospitalization rates in Vietnam with those of the Army of the Republic of Vietnam during the first 6 months of 1966, Bourne found 6% of US Army psychiatric admissions were diagnosed as combat exhaustion.[9] Captain HSR Byrdy, Medical Corps, division psychiatrist (1965–1966) with the 1st Cavalry Division (Airmobile) reported a true CSR rate for his division of 1.6/1,000 troops per year; however, he also comments, "What gets referred [to the division psychiatrist] depends on the tactical situation of the unit [and] one is hard-pressed to know what a real incidence is."[41(p50)] Still, these figures are consistent with an unusually low incidence, at least for the first half to two thirds of the war. In addition, in a postwar survey of psychiatrists who served with the Army in Vietnam, 32% reported that they had only rare exposure to combat-induced psychiatric casualties.[27]

All this is not to say that the specialized treatment of combat exhaustion was not an important challenge in Vietnam; just that it was never at the level (numbers) that had been anticipated, and that in time it was greatly overshadowed by other unanticipated psychiatric conditions and behavior problems.

Morale in the Buildup Phase: Consensus at Home and Esprit in Vietnam

During the war's first 3 years, opposition at home was only gradually building, whereas draft call-ups quickly gathered momentum to meet the huge personnel needs in Southeast Asia. Because reserve units and the National Guard were, for all practical purposes, exempted from deployment in Vietnam throughout the war, the ground forces were composed of a mix of career soldiers, draftees, and volunteers (including many draft-motivated volunteers). Although the combat could at times be very intense during these initial years, and the cities and countryside were not secure, morale and sense of purpose remained high among the troops fighting in Vietnam. Furthermore, attrition due to psychiatric or behavioral problems was exceptionally low compared to previous conflicts. This was somewhat surprising considering the psychologically depleting nature of the remote, exotic, hostile, tropical setting and the enemy's guerrilla tactics and resolute tenacity.[42]

Throughout the war, soldiers fighting in Vietnam encountered certain novel features that distinguished the theater from those of previous wars and invariably affected morale. For example, the battlefield ecology was powerfully affected by the helicopter mobility of US ground forces; the enemy's elusiveness but lack of a capacity to deliver sustained, precision-guided indirect fire (as with artillery and combat aircraft); and, especially, the overall US strategy of fighting a war of attrition as opposed to one for territorial control. The psychosocial complexion of the "rear" was unique. US troops typically staged combat activities from geographically isolated, fixed, relatively secure enclaves that were easily resupplied by helicopter. The high ratio of combat support and service support troops to combat troops (5:1) was also unusual compared to earlier wars.

Efforts to understand soldier stress and resilience in Vietnam also have to take into account the influence of the draft (stress inducing) as well as the effect of the military's replacement policy of individualized, 1-year tours. The 1-year tour was intended to be stress reducing because these soldiers would perceive their obligation and risk as limited.[9,31] However, over time the resultant churning and ultimate depletion of experienced military personnel in the theater (including officers and noncommissioned officers [NCOs]) also

had a hugely negative effect on commitment and cohesion, and consequently morale.[29,30]

Still, according to General Westmoreland, Commander, US Military Assistance Command, Vietnam (COMUSMACV), the troops operating in Vietnam during the buildup years were "the toughest, best trained, most dedicated American servicemen in history."[43(p34)] More specific to the Army in Vietnam, Retired Brigadier General SLA Marshall, combat veteran of World War I and front-line observer in World War II and Korea, commented after his extended visit in 1966:

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

The observations and interpretations by military sociologist Charles Moskos from his time in Vietnam as a war correspondent between 1965 and 1967 are especially useful in understanding the morale, stress, and psychosocial adaptations of the soldiers serving in those initial years. Moskos reported high morale and combat motivation despite the rigors of the counterinsurgency warfare and the extremely inhospitable setting. He believed this arose out of the linkage between the soldiers' individual self-concern (heightened because of the 1-year, individual rotation system) and devotion to the other soldiers in the immediate combat group (eg, instrumental interdependencies motivated by the functional goal of survival). He also observed their shared belief in an exaggerated masculine ethic as well as a "latent ideology" of devotion to US ideals, which stemmed from their conviction regarding the supremacy of the US way of life. Furthermore, the soldiers he studied were notably apolitical and antagonistic toward peace demonstrators ("privileged anarchists") at home.[44]

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

> They are not only unconcerned about the political and strategic aspects of the war; they are also disinterested in the outcome of any battle that is not in their own immediate vicinity. . . . [The soldier] retains certain deep allegiances and beliefs in an . . . amorphous positive entity, "Americanism," which allow him to justify his being sent to Vietnam.[9(p44)]

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

Buildup Phase Psychiatric Overview

Correlating with the observations of high esprit and commitment, troop attrition due to psychiatric or behavioral dysfunction was exceptionally low as well during those first few years. The proportion of medevacs out of Vietnam for psychiatric reasons (3%–4%) compared quite favorably with that for the Korean conflict (6%) and for World War II (23%).[23] Rates for deviant behaviors for the same period were also low (eg, the annual stockade confinement rate was 1.15/1,000, compared to the expected overseas rate of 2.2).[4] Some senior Army psychiatric observers attributed this to an array of operational and preventive factors that appeared to protect the soldiers from psychiatric and behavioral difficulties: (*a*) technological superiority and the professionalism of the troops; (*b*) fixed, 1-year assignments; (*c*) high-quality leadership; and (*d*) adequate supplies, equipment, and support—especially medical support.[7,23,45,46] Others also credited the application of the aforementioned doctrine of combat psychiatry.[47,48]

Although alcohol use and abuse was predictably a common stress outlet for these soldiers,[7] military leaders and the psychiatric contingent were primarily concerned with the use of illegal drugs by troops, especially the locally grown marijuana, which was readily available and highly potent. In their survey regarding drug use patterns of 584 lower ranking enlisted soldiers departing Vietnam in 1967, Roffman and Sapol reported that of the 32% who acknowledged ever smoking marijuana, 61% began in Vietnam and one quarter were considered heavy users (greater than 20 times during their 1-year tour in Vietnam). The authors concluded that the extent of marijuana use in Vietnam was very similar to that among civilian peers.[16] Furthermore, in the opinion of Bourne, marijuana use created almost no psychiatric problems.[9] Use of opiates was also reported in Vietnam, but it was not as pure as that sold after 1970 and was not used by soldiers in sufficient numbers to constitute a serious problem for command.[17]

One psychological phenomenon that did attract a fair amount of attention from military psychiatrists was the phasic nature of moods and attitudes affecting soldiers during the course of their 12-month tour of duty in Vietnam: (*a*) "immersion shock" and fearfulness; (*b*) then mastery and reduced preoccupation with home, but with some depression, resignation,

and flight into a "hedonistic psuedocommunity"; (*c*) followed by growing combat apprehension and a "short-timers syndrome."[7,49,50] The latter refers to a low-grade form of disability often exhibited in combat soldiers who were within 4 to 6 weeks of their date of expected return from overseas (DEROS). Symptoms consisted of reduced combat tolerance and efficiency; increasing fear about being killed or wounded; and sullen, irritable, or withdrawn behavior. This had also been noted among troops serving in the Korean War after fixed, individualized tours were first introduced there in mid-1951.[51]

Overall, the incidence of psychiatric and behavioral difficulties among the deployed Army troops in Vietnam in these initial years was held to levels no greater than if they were still stateside. Satisfaction was expressed that adequate psychiatric resources had been deployed from the start in contrast to previous wars.[3,8] To that effect, Bourne confidently, if prematurely, declared the end of the military-medical problem of combat psychiatric casualties: "The Vietnam experience has shown that we have now successfully identified most of the major correlates of psychiatric attrition in the combat zone."[47(p487)]

Buildup Phase Psychiatrist Reports

The morale and confidence of the deployed Army psychiatrists during these early years also appeared to be high. This is suggested both in the large numbers who were inspired to publish professional accounts and the role satisfaction that these reports reveal. Taken together, these psychiatrists reflect optimism and tout the effectiveness of the traditional doctrine of combat psychiatry in Vietnam, the utilization of newly developed pharmacologic agents (anxiolytics and neuroleptics), and the extension of principles of social psychiatry to military leaders (command consultation). Simply scanning selected titles provides an impression as to the predominant psychiatric challenges faced through these early years in the war (Exhibit 2-1).

More specific to the growing antiwar sentiment in the United States, two Army psychiatrists who served in the buildup phase and published accounts, Captain AS Blank Jr and Captain HS Bloch, commented specifically that they did not believe the growing opposition to the war was significantly affecting their patients. Blank, who served early in this phase (1965–1966), commented,

> Do the ambiguities of the war seem to be a problem for the soldiers? The answer is very simply, "No." I did not see a single patient in whom I felt that any kind of conflict about the war on any level was primary in precipitating his visits to me.[41(p58)]

Bloch, who served 2 years later (1967–1968) in the same area as Blank, asserted that in his experience, soldiers who struggled with concerns regarding the morality of the conflict typically were driven by pre-Vietnam psychological conflicts.[40] Nonetheless, considering what followed, it is apparent that time was running out on positive morale in Vietnam.

The Transition From Buildup to Drawdown (1968–1969)

1968 Surprise "Tet" Offensives and Perceptions of a Lost War

The year 1968 was the bloodiest year in Vietnam for US forces (16,592 KIA), and events both at home and in Southeast Asia served as the tipping point in US sentiment for pursuing military objectives there. During the month of May alone, 2,000 Americans were killed—the highest monthly death toll of the war.[52] June 13th marked the day that Americans had been fighting in Vietnam longer than any prior war. However, the greatest negative effect arose from the enemy's "Tet" offensives.

On the morning of January 31st, communist guerillas broke the Tet (or Lunar New Year) truce and launched coordinated attacks on cities and towns throughout South Vietnam. Although they were ultimately extremely costly to the communist forces and achieved little militarily, their political yield was enormous. Many held the US media accountable for misinterpreting these events as signaling a US defeat and provoking a reversal in public and political support for war.[53] Nonetheless, these attacks, as well as the month-long, bloody battle to retake Hue and the prolonged siege of the Marine base of Khe Sanh, created the indelible perception in the United States that the war could not be won. The enemy appeared to defy the Johnson administration's assurances of imminent defeat, and nowhere in the country seemed secure despite great expenditures of lives and money. As a consequence, calls for the war to end became urgent and trumped most other considerations.

On March 31, 1968, President Johnson announced that he would halt the bombing over North Vietnam as a prelude to peace negotiations. He also declared that he would not seek reelection in service of that end. Ten days later he announced that General Creighton Abrams would relieve General William Westmoreland, the original commander, United States Military Assistance Command, Vietnam (USMACV). Still, it wasn't until a year later, mid-1969, that the first Army units pulled out of South Vietnam. America had begun to disengage, yet the fighting continued amid tortuous peace negotiations, continued assignment

EXHIBIT 2-1

SELECTED PUBLICATIONS BY BUILDUP-PHASE ARMY PSYCHIATRISTS (INCLUDING RESEARCH REPORTS)

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

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

of replacement troops (albeit in decreasing numbers after mid-1969), and a progressively confrontational antiwar/antimilitary faction stateside. The war took on characteristics of a tedious, agonizing stalemate, and the lack of tangible measures of progress contributed to the widespread feelings of futility and frustration about the war.

Emerging Demoralization and Dissent

The contentious and protracted counterinsurgency war soon started to have corrosive effects on successive cohorts of replacements sent to fight there. Budding demoralization and dissent during these pivotal years began to reveal itself especially in racial incidents and widening drug use (particularly marijuana, but also commercially marketed stimulants and barbiturates) by soldiers. Law enforcement figures demonstrated an increase of over 260% in the number of soldiers involved with possession or use of marijuana during 1968 as compared to the previous year.[30] Also, excessive combat aggression (atrocities) seemed to become more prevalent.[54–57] According to Ronald Spector, who served as a Marine field historian in Vietnam (1968–1969),

> as the war ground on through its third and fourth year, the prestige of performing a mission well proved increasingly inadequate to men who more and more could see no larger purpose in that mission, and no end to the incessant patrols, sweeps, and ambushes which appeared to result only in more danger, discomfort, and casualties.[30(p61)]

Spector also noted that the evolving stalemate in Vietnam came to resemble the bloody trench warfare of World War I, a battle in which both sides grossly underestimated the other.[30(p314)]

Journalist Donald Kirk reported from the field in 1969 that

> [t]he attitudes of GIs [slang for "government issue"] did not turn seriously until Fall of 1968 when President Johnson stopped the bombing of North Vietnam and agreed to enter into peace talks . . . .The change in [soldier] attitudes was so sudden . . . [as compared to earlier] they by and large applauded the [antiwar] demonstrators . . . the senselessness of the struggle.[58(p61)]

Correspondent JP Sterba provides observations on the shifting demographics and particularly the attitudes of the soldiers who went to fight in Vietnam in 1969. He demonstrated how the rapidly unfolding political events in the United States caused the romance and idealism of the early war to be replaced by a "hated, dreary struggle" in which the soldier's overriding preoccupation was that of self-protection:

> These were the grunts of the class of 1968—they had come out of that America some of their commanders had seen only from the windows of the Pentagon. They were the graduates of an American nightmare in 1968 that stemmed mostly from the war they had now come to fight—the year of riots and dissention, of assassinations and Chicago, the year America's ulcer burst.[59(p447)]

Transition Phase Psychiatric Overview

The official summary of US Army medical experience in Vietnam through May 1970 made note of rising annual incidence rates for psychiatric conditions beginning in 1969 (from 13.3/1,000 for 1968, to 25.1/1,000 through first quarter of 1970). It also underscored that this increase did not covary with the dropping rates for WIA, the traditional measure of combat intensity—a correlation that had been true in previous wars.[31] The principle author of this report, Major General Spurgeon Neel, attributed this uncharacteristic rise in psychiatric disorders to dissenting soldier subgroups who were motivated by racial, political, or drug culture priorities, and to the widening use of illegal drugs by soldiers in Vietnam. However, because this review only encompassed the first two thirds of the war and was not published until 1973, after the troops were withdrawn, it failed to illuminate the fuller, more ominous picture in a timely fashion.

Published more contemporarily in 1970, the Army Psychiatry Consultant to the Surgeon General, Colonel Matthew Parrish, and the Assistant Consultant, Major Edward Colbach, both of whom had served in Vietnam, did broadcast their concern about the rise in the psychiatric casualty rate in Vietnam up through mid-1970. In their opinion this was a consequence of the increase in racial tensions and the general decrement in perception of military purpose within the soldier. They correctly predicted that the intent to disengage from Vietnam would likely produce accelerating psychiatric problems among those newly assigned there.[6] However, despite this warning, there were no structural changes in the organization of mental health assets in Vietnam nor modifications in the selection, preparation, or deployment of mental health personnel sent as replacements to the theater.

MD Stanton[17] reported sizable increases in the use of most drugs from a survey of drug use patterns among soldiers entering or departing Vietnam in late 1969, which he compared with results from the 1967 survey by Roffman and Sapol. Stanton speculated, however, that marijuana and some other drugs might actually

allow certain types of individuals to function under the stresses of a combat environment and separation from home.

As far as comparisons with the US Marines fighting in Vietnam, Lieutenant Commander JA Renner Jr, a Navy psychiatrist who served in the Vietnam theater in 1969, noted a similar rise regarding disciplinary problems, including racial disturbances, attacks on superiors, drug abuse, and the number of men diagnosed with character disorders ("hidden casualties"). He expressed his concern that military psychiatrists were premature in touting the low rate for psychiatric difficulties in the war.[60] (He did not publish until 1973, after the Marines had left Vietnam.)

Transition Phase Psychiatrist Reports

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

The Drawdown Phase (1969–1972): Richard Nixon's War

The second half of the war took on a starkly different character from the first half. By January 1969, when President Nixon succeeded President Johnson, the United States had been at war in Vietnam for 4 years. Nixon promised "peace with honor," negotiations with the enemy, and a gradual withdrawal of troops, while confronting extreme impatience and often violent protest in America.[61] With the change of command in Vietnam, the military strategy of attrition shifted to a defensive one that sought area security and "Vietnamization" of the fighting. Enemy offensive activity also slackened. Overall US troop strength in Vietnam peaked at 543,400 in mid-1969 and declined through the next 3 years until all combat forces were

EXHIBIT 2-2

SELECTED PUBLICATIONS BY TRANSITION-PHASE ARMY PSYCHIATRISTS (INCLUDING RESEARCH REPORTS)

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

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

withdrawn. US operations of battalion size or larger slowly began to decline beginning in mid-1968.[62] Still, despite the reduction of combat operations and the peace negotiations, which proceeded erratically, US service personnel continued to die there (15,316 from 1969–1972).

In 1969, the US public was horrified to learn that in 1968 several hundred Vietnamese civilians of the hamlet of My Lai had been massacred by a US Army unit.[63] Although there had been previous reports of atrocities by US troops, this incident seemed to verify the public's worst fears about the war being senseless and destructive.

"America's war" had become prolonged, stalemated, and costly; the sense of national purpose and resolve was dropping fast. Furthermore, the abandonment of hopes for military victory in Vietnam had a powerfully negative effect on the country, the institution of the US Army,[64–66] and especially those whose fate it would be to serve during the drawdown in Vietnam and who would be required to fight battles of disengagement amid pressures from home to oppose the war and the military.[62] Simultaneously waging war and pursuing a peace with the enemy undermined the commitment of these soldiers compared to those deployed in the first few years of the war. This commitment was replaced with alienation, disaffection, and sagging morale. In retrospect, gradually rising rates for psychiatric conditions and behavior problems during 1968 and 1969 signaled a brewing discontent and dissent within the ground forces deployed on a massive scale.

Cultural Polarization in America and the Vietnam War

To fully understand the psychosocial forces affecting the soldiers sent to Vietnam, one must appreciate the powerful and often clashing cultural crosscurrents in the United States that surrounded them in the late 1960s and early 1970s. This history must be viewed against the backdrop not only of the nation's post–World-War-II experience and subsequent Cold War tensions between the United States and the former Soviet Union, but also of the advent of television coverage of the war, the assassination of President John Kennedy in 1963, and the coming of age of the post–World-War-II "baby boom" generation.

The years surrounding the Vietnam War (1965–1975) represented an excruciatingly volatile period in American life. Intense and often militant challenges to government institutions, especially the military and the war in Vietnam, were increasingly made by: (*a*) a progressively disapproving American public, (*b*) the rising civil rights and black pride movements, and (*c*) the emerging New Left and a dissenting youth counterculture (the "generation gap"). They, in turn, were opposed by an equally fervent and reactive conservative sector. The prolonged, costly war in Vietnam served as a rallying point, both pro and con, for their passions and ambitions. These three movements, fostered by an expanding drug culture, variously fed and were fed by a widening crisis within the military overall (unprecedented demoralization and alienation), and in Vietnam especially. As they synergistically intersected, they generated a groundswell of opposition to military service among draft-eligible men.

Public Opposition to the War and Political Activism. Over the course of the war larger and louder antiwar protest rallies, marches, and demonstrations took place in the United States, with some reaching the level of riots. The new television coverage of the war brought the costs and the political turmoil in Vietnam straight into the living rooms of US citizens and most likely accelerated the public's perception that the war's justification was questionable, despite reassurances from both the Johnson and Nixon administrations.

The steadily growing public disapproval of the war in Vietnam can be traced through a series of nationwide Gallup opinion polls conducted during the war years in which respondents were asked: "In view of the developments since we entered the fighting in Vietnam, do you think the US made a mistake sending troops to fight in Vietnam?" In 1965, only 25% thought US military involvement was a mistake (vs 60% who said "No"), but by 1971 these factions had almost completely reversed (60% saying "yes," it was a mistake, and only 30% disagreeing).[67]

Following the insertion of ground troops in March 1965, the growing personnel requirements in Vietnam resulted in dramatically accelerated draft calls. For example, total inductions in 1965 were about 120,000; those for 1966 and 1967 were two-and-a-half times the 1965 figure. As opposition to the war mounted, the draft became the epicenter of the antiwar protest until the military switched to an all-volunteer force in 1973.[30] With each passing year, as the need for more troops became evident, additional criteria for draft exemption were removed to increase the pool of eligible draftees. In 1968, in an effort to blunt the public's growing concern for unevenness and inconsistency in the Selective Service System, the draft was modified to a lottery system, based on birthdays. On December 1, 1969, the first drawing was held. Men then knew the likelihood of being drafted based on where their birthdays fell; however, for those selected and sent to Vietnam under this new, random system, their sense of injustice was compounded.[68] Ultimately 4 million young men were exempted by high lottery numbers;

more than 200,000 young men were accused of draft offenses.[68]

The Counterculture and Youth/Student Opposition to the Vietnam War. Opposition to US involvement in Vietnam began slowly in 1964 on various college campuses as part of a more general rising spirit of student activism. In addition to various liberal causes, "free speech," "free love," "peace," and "do your own thing" were also popular. The means employed to indicate opposition included political advocacy, civil disobedience, "sit-ins," "teach-ins," and generally nonviolent resistance to the status quo.

A succession of tremendous shocks ushered in a more fervent antiestablishment spirit: the assassination of President Kennedy in the autumn of 1963; the first ghetto uprisings in the summer of 1964; the escalation of the war in Vietnam beginning in 1965 and the impact of the draft; the 1968 assassinations of presidential candidate Robert Kennedy and civil rights leader Reverend Martin Luther King; and, also in 1968, the enemy's surprise Tet offensives and other seeming military setbacks in Vietnam. The result was widespread impatience with the prospects for orderly change through more peaceful, passive means, and deep cynicism and mistrust of American institutions and "anyone over 30." The "Woodstock generation," named after the huge rock festival held in upstate New York in August 1969, and it's "summer of peace and love" were quickly fading memories as the movement took on a more radical perspective and accepted a more open, and at times violent, revolutionary approach.

As one measure, surveys of student attitudes in 1969 revealed that although only 2% of college youth were highly visible activists, roughly 40% of their peers held similar views ("protest prone"), signifying a true generation gap. Among this larger group, approximately half endorsed the belief that the United States was a sick society and acknowledged a loss of faith in democratic institutions. Two thirds endorsed civil disobedience to promote their causes, especially antiwar protests and draft resistance.[69]

Emergent Black Pride Movement and Racial Tensions. In 1948, President Harry Truman put forth an executive order directing the nation's military services to eliminate all vestiges of racial segregation. Since then, many positive gains made in the status of black Americans can be directly attributed to the men and women who served in the military. However, the burgeoning civil rights movement in the 1960s heightened black soldiers' awareness of disparities (with accusations of discrimination) in positions and roles for blacks in the military, especially among the younger soldiers and particularly regarding combat exposure and risk.[62,70]

For instance, during the initial years in Vietnam, questions were raised as to whether blacks represented an unfair proportion of the combat casualties. In fact, for the period 1965 to 1966 in each of the deployed combat divisions, the proportion of deaths of African-Americans exceeded the proportion of African-American soldiers in the division. However, closer analysis revealed that, overall, blacks did not serve in Vietnam out of proportion to their numbers in the general population; and rather than racially-driven policies, various other social and cultural factors (eg, levels of education and socioeconomic status) served to select African-Americans for greater risk in Vietnam.[30] Still, beginning in 1967, the military began to reduce the numbers of black soldiers assigned to infantry, armor, and cavalry units in Vietnam, and by mid-1969 the percentage of black casualties was close to the percentage of blacks serving in Vietnam.[70]

Racial tensions in America became explosive following the assassination of Reverend Martin Luther King in April 1968. Racial protests and riots erupted at numerous US military installations worldwide, including in Vietnam. The most notorious in Vietnam was in August 1968, when black confinees seized the Long Binh stockade and held it for almost a month. These sentiments coincided with the rapid evolution of a more radical "black power" faction, which advocated a black pride revolution and rejected assimilation in American culture as a central goal for African-Americans. Career military blacks were often caught between their loyalty to the military and the attitudes of the younger, black enlisted soldiers who were restive and expected solidarity from them regarding questions of discrimination. As the war wound on, younger blacks increasingly opposed sacrifices and risks in what they perceived as a racially inspired war (eg, against other people of color).[71,72] They dismissed it as a "white man's war" and asserted their intention to return home to take up the fight against repression and racism in America.[73]

Soldier Resistance and the "GI" Underground Movement. As opposition to the war mounted, public attitudes in the United States toward returning veterans reversed from acceptance to scorn. This left those who chose, or were directed, to serve in Vietnam as replacements conflicted as to what represented patriotic, morally justifiable behavior, as well as less certain regarding the inherent risks and hardships they faced there. Johnston and Bachman[74] compared results of surveys of draft-eligible men conducted in spring 1969 and again in summer 1970, regarding their plans and attitudes toward military service. In that short span of time the majority shifted from identifying with US political and military policies in Vietnam to feeling

alienated from the greater society, the government, and US involvement there.[74] The roughly 4-fold Army-wide increase in rates for absent without leave (AWOL) and desertion during the period from 1964 to 1974 provides a measure of the growing opposition to serving over the course of the war.[75]

Organized dissent within the military did not emerge until 1967 and disappeared in 1973 once combat units were out of Vietnam. It apparently was slow in its development because its inspiration required the angst of returning veterans to be combined with draftee resistance. In time, a vicious cycle developed in which returning veterans publicly repudiated their Vietnam service record, including joining war protest organizations such as Vietnam Veterans Against the War, which in turn encouraged prospective Vietnam soldiers to oppose service there. In the United States this essentially first-term enlistee and draftee antiwar resistance movement was especially promulgated through "alternative culture" GI coffee houses, underground newspapers (estimated to exist on 300 posts and bases),[51(p234)] antiwar protest petitions, and support from civilian antiwar groups.

As it turned out, most soldiers in Vietnam were not true antiwar protestors and, overall, the GI resistance movement had only limited success.[76] Still, although the antiwar movement within the Vietnam-era military failed to reach revolutionary proportions for several reasons, especially the lack of sympathetic civilians in Vietnam, its emergence was unique in US history and some believed it accelerated withdrawal from the war.[51] Others argued that it emboldened the enemy and thus dragged out the peace negotiations and prolonged the war. Nonetheless, military and government officials were quite concerned about its effects.

The Spreading Drug Culture and Its Effects on Soldiers Sent to Vietnam. The incidence of illegal drug use among teens and young adults in the United States, especially psychedelics and marijuana, rose rapidly in the 1960s in tandem with the emerging dissidence of this group. Various studies were conducted during the Vietnam era comparing drug use among soldiers with their civilian peers. For example, a nationwide study of psychoactive drug use by young men at the close of the Vietnam War indicated that the peak of the drug epidemic was 1969 to 1973, and that veterans, regardless of where they served, showed no higher rates than nonveterans.[77] Regarding measures among the military in the United States, a survey of drug use at a stateside military installation in 1970, 1971, and 1972 showed the percentage of respondents reporting premilitary drug use increased as did the amount of use and the number of current users.[78] A study of pattterns of drug use among 5,482 active duty enlisted men assigned to 56 separate Army units in the United States between January 1969 and April 1969 found one quarter of subjects acknowledged past use of marijuana, amphetamines, lysergic acid diethylamide (LSD), or heroin.[79] Two years later a similar survey of 19,948 new military inductees between January 1971 and June 1971 found that almost one third acknowledged civilian drug use.[80]

Among soldiers sent to Vietnam, Sapol and Roffman surveyed 584 enlisted soldiers departing Vietnam in 1967 (31.7% reported use of marijuana at least once) and concluded that the rates were comparable with those reported in published studies among university students.[81] In a survey of soldiers entering or departing Vietnam 2 years later, Stanton found a sizable increase in the reported use of marijuana among those leaving Vietnam (28.9% vs 50.1% respectively compared to the 1967 survey). Most of this was accounted for by the increase reported by soldiers entering Vietnam. However, Stanton did find a shift toward heavier use among his sample of departing enlisted soldiers (29.6% compared to the 7.4% from the earlier study). Nonetheless, his impression was that the rise in casual marijuana use in Vietnam mostly mirrored rising use patterns among civilian peers.[82]

Regarding heroin use, a 1972 heroin use survey comparing 1,007 noncombat Army soldiers in Vietnam simultaneously with 856 counterparts assigned to a stateside post found that 13.5% of Vietnam soldiers and 14.5% of those stateside reported previous use of heroin. The authors compared their findings with published surveys, concluding that a heroin epidemic occurred in Vietnam earlier in the 1970s, but that any conclusion that "such an epidemic '[w]as unique' . . . and 'infected' many average US soldiers appears inaccurate and misleading."[83] Taken together, these studies strongly verify that younger enlisted soldiers, not surprisingly, brought into the service and into Vietnam their drug use habits from civilian life.

Disputes About the Ethics of Combat Psychiatry

The shifting social and political zeitgeist in the latter half of the war—particularly the accelerating antiwar and antimilitary sentiment—began to affect psychiatrists and psychiatry, and provoked concerns about cooperating with the military. Debates—typically quite passionate—that questioned the ethics of psychiatrists who performed draft evaluations[84–88] or served with the military, especially in Vietnam[39,89–93] appeared in the professional literature beginning in 1970. Denunciation of military psychiatry came both from psychiatrists and other physicians who had served in Vietnam, as well as from those who had not.[26]

Mental health organizations also sought to take official positions on the war. Even if not specifically questioning the ethics of their colleagues in uniform, they nevertheless questioned the morality of the US military and government. In March 1971, 67% of members responding to a poll of the American Psychiatric Association voted that the United States should terminate all military activity in Vietnam.[94] In July 1972, the American Psychological Association joined seven other mental health associations in attacking the US role in the war. Their public statement included, "we find it morally repugnant for any government to exact such heavy costs in human suffering for the sake of abstract conceptions of national pride or honor."[95] Defense of professional support for the US forces was published by several psychiatrists, most of whom had served in Vietnam.[5,6,96–99]

Mounting Biopsychosocial Stressors in the Combat Theater Ecology

In the second half of the war, even though more troops were leaving than were sent as replacements, hostilities and dangers continued. The successive cohorts of replacement soldiers in Vietnam were deeply affected by the moral crisis at home, which included increasingly radical US politics, especially regarding the war, and a rapidly expanding drug culture. Furthermore, the annualized troop rotation schedules, rapid and wholesale transportation of soldiers and media representatives, and modern technology all promoted the accelerated infusion of a growing antiwar, antimilitary sentiment into the ranks of the military there. Unrelenting public opposition to the war may have accelerated the US pullout, but the process demoralized those who were sent there during the drawdown years. Understandably, many soldiers interpreted antiwar sentiment as criticism of them personally—not the war more generally. The uncertain combat results in the theater and vacillating—at times contradictory—government policies and military strategies regarding prosecuting the war and pursuing the peace were also demoralizing.

This demoralization and alienation of soldiers in the Vietnam theater often took the form of psychiatric and behavioral problems, especially drug abuse, racial incidents, and misconduct, and presented problems for the Army and Army psychiatrists on an unprecedented scale. These were even more of a problem among soldiers in the "rear," but even within combat units, troops covertly, and at times overtly, challenged authority (eg, combat refusal incidents, "search and avoid" missions, excess combat aggression). Matters became even more serious after a Vietnamese-based heroin market began to flourish in the spring of 1970 and large numbers of US soldiers became users. It took 9 months to institute an effective urine drug screening system that would permit the military to comprehend and react to this insidious and widespread problem of self-inflicted soldier dissent and disability. Equally disturbing to the Army in Vietnam were the incidents of soldiers attacking their superiors, typically with explosives ("fragging"—named after the fragmentation grenade). Like the widening use of heroin by soldiers, such attacks became increasingly common in the drawdown phase of the war.[62,100] Although there are no official figures, data presented by Gabriel and Savage identified a total of 1,016 incidents (for all branches) for the years 1969 through 1972 (eg, "actual assaults" combined with incidents where "intent to kill, do bodily harm, or to intimidate" was suspected).[65] Whereas assassination of officers and NCOs had been seen in earlier wars to a limited degree, typically under combat circumstances, the Vietnam theater is distinct in that not only was the prevalence of such incidents exceptionally high, but these attacks occurred more often in rear areas with the tacit approval of peers.[101]

Thus, despite the reduction in combat levels, Army leadership and the medical/psychiatric contingent in Vietnam became increasingly consumed with problems associated with the wholesale demoralization and alienation of soldiers—symptoms of a seriously compromised Army that were competing for attention with the challenge of preparing the South Vietnamese military to take over from the United States and its allies. Furthermore, by now the deployed psychiatrists were surrounded by a professional literature that was mostly critical of the military psychiatric structures and doctrine that were applied in Vietnam.[26]

An especially thorough historical series on the Vietnam War by the Boston Publishing Company included vivid descriptions of the various expressions of the contempt for the war and the South Vietnamese shared by US military forces in the last years of the war:

> The daily round of random death and incapacitation from mines and booby traps, combined with short-timers fever and skepticism about the worth of "search and clear" steadily lowered American morale.[62(p97)]

The authors give ample witness to the pervasive demoralization in the theater and the brittle nature of race relations, primarily within noncombat units. They also document the associated weakening of the military legal system. According to these authors, combat refusals, drug problems, and racial strife often proved impossible to resolve in the last years in Viet-

nam. While punishments tended to be increasingly lenient, commanders openly acknowledged that rather than hunt the enemy or carry out a tactical mission, they considered their primary responsibility to be to return their men safely home. "It sometimes seemed to be little more than a ragtag band of men wearing bandannas, peace symbols, and floppy bush hats, with little or no fight left in it."[43(p16)]

Similarly, Balkin's historical review of the severe breakdown in morale and effectiveness of the US military in Southeast Asia during this phase of the war provided thoroughly referenced data indicating an unprecedented increase in rates of combat refusals, combat atrocities, heroin use, assassinations (or threats) of military leaders, racial conflicts, desertion and AWOL, and the emergence of the GI antiwar movement.[51] It also underscored the corrosive effects on morale and cohesion consequent to pervasive careerism among military leaders ("ticket punching," an emphasis similarly brought to bear by Gabriel and Savage[65]).

Kirk, a journalist reporting from the last years of the war, noted that,

> [i]t is, in reality, a desultory kind of struggle, punctuated by occasional explosions and tragedy, for the last Americans in combat in Vietnam. It is a limbo between victory and defeat, a period of lull before the North Vietnamese again seriously challenge allied control over the coastal plain, as they did for the last time in the Tet, May and September offensives of 1968. For the average "grunt," or infantryman, the war is not so much a test of strength under pressure, as it often was a few years ago, as a daily hassle to avoid patrols, avoid the enemy, avoid contact—to keep out of trouble and not be the last American killed in Vietnam.[58(p65)]

More ominous is the investigative report by Linden, another journalist, about his visit in 1971. Linden covered much of the same ground as those mentioned above, but he provided case examples and other observations. These included corroboration from Captain Robert Landeen, an Army psychiatrist assigned to the 101st Airborne Division. Linden dynamically depicted the circumstances and meanings that combined to produce a class war between leaders and subordinates in Vietnam, often with fragging as its final result. He described how fraggings and other threats of violence were commonly used as a means of controlling officers and NCOs: "[fragging in Vietnam became] prevalent, passionless, and apparently unprovoked, representing the grisly game of psychological warfare that GIs use."[100(p12)]

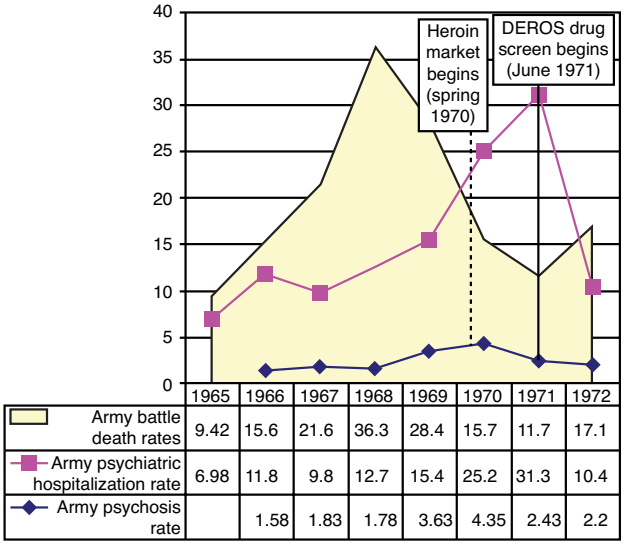
Not surprisingly, the Army's pernicious morale and discipline problems were mirrored on a comparable scale among the Marines fighting in Vietnam. The official review of US Marine activities late in the war acknowledged rampant combat atrocities, "friendly fire" accidents, combat refusals, racial strife, drug abuse, fraggings, and dissent.[102] William Corson, a retired Marine lieutenant colonel (expert on revolution and counterinsurgency warfare, and a veteran of World War II, Korea, and Vietnam), blamed the military's demobilization problems in late Vietnam (drug use, dissent, and racial incidents) on both America's failure in Vietnam and to an "erosion of moral principle within the military."[103(p100)] He referred to the rise in fragging incidents as a new service-wide form of psychological warfare and an aspect of institutionalized mutinous behaviors (along with sabotage, evasion of leadership responsibilities, and internecine conflict). According to Corson, "[a]s with fragging, the potential for a mutinous refusal to carry out an order is so widespread [in Vietnam] that routine actions are being avoided by those in charge."[103(p99)]

Drawdown Phase Psychiatric Overview

Traditional Military Psychiatry Indices. The summary of Army neuropsychiatry in the Vietnam War provided by Jones and Johnson illustrated a dramatic rise in the standard indices of psychiatric attrition during the last few years of the war.[7] As noted previously, the inpatient hospitalization rate had hovered around 12–14/1,000 soldiers per year through the first 3 years of the war[7–9]—favorable compared to figures for Korea (73/1,000) and World War II (28–101/1,000).[11] However, the rate started to rise in 1968, doubled by April 1970, and doubled again by July 1971, reaching an annualized rate of 40/1,000. From there it dropped rapidly until the remaining troops were pulled out in March 1973, apparently primarily because the Army relaxed its medevac policies (in Vietnam only) for drug-dependent soldiers, which ordinarily would have excluded them[104] (Figure 2-1).

Especially dramatic is the skyrocketing out-of-country psychiatric evacuation rate, which had remained below 4–5/1,000 troops per year throughout the war until 1971. By July 1971, it had risen to 42.3, and by the following year, July 1972, the rate had climbed to 129.8. In other words, at that point in the war, *one out of every eight soldiers* was being medically evacuated from Vietnam for psychiatric reasons (primarily for heroin dependency).

As a corollary, the percentage of neuropsychiatric evacuations among all medevacs from Vietnam also accelerated. It had remained below 5% but rose to 30% in late 1971, and by late 1972 it was at 61%. By 1971,



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

Figure 2-1. US Army Vietnam rates per 1,000 troops for battle deaths,[1] psychiatric hospitalization,[2] and psychosis.[3]
[1]US Army Adjutant General, Casualty Services Division (DAAG-PEC). Active duty Army personnel battle casualties and nonbattle deaths Vietnam, 1961–1979, Office of The Adjutant General counts. February 3, 1981.
[2]Datel WE. *A Summary of Source Data in Military Psychiatric Epidemiology*. Alexandria, Va: Defense Documentation Center; 1976. Document ADA 021-265.
[3]Jones FD, Johnson AW, Jr. Medical and psychiatric treatment policy and practice in Vietnam. *J Social Issues*; 1975;31(4):49-65.
DEROS: date of expected return overseas

more soldiers were being evacuated from Vietnam for drug use than for war wounds.[82] However, taken alone this could overstate the case for spiraling neuropsychiatric rates because the WIA rate was declining simultaneously.

It is of special note that the doubling rate for psychosis in 1969 and 1970 in Vietnam (see Figure 2-1) from its rather historically predictable 2/1,000 troops per year presented a paradox for Army psychiatry. Because it coincided with an Army-wide rise in the psychosis rate, it was initially explained by Jones and Johnson as secondary to the influence of illegal drugs in confusing the diagnosis.[7] Subsequently, Jones noted that the psychosis rate reverted back to its historical levels only in the Vietnam theater and only after the Army allowed drug-dependent soldiers to utilize medevac channels.[105] He speculated that the rising rates also reflected the tendency for Army psychiatrists and other physicians in Vietnam to mislabel soldiers "who did not belong overseas" as psychotic (eg, insinuating the physicians' intent to manipulate the system).[105]

Behavior Problems and Misconduct. In themselves, these traditional measures of psychiatric morbidity are startling. Equally disturbing, however, during the drawdown years in Vietnam the Army also saw a concomitant rise in behavioral problems as measured by rates for: (*a*) judicial and nonjudicial (Article 15) disciplinary actions,[106] (*b*) noncombat fatalities,[107] (*c*) combat refusals,[62] (*d*) corruption and profiteering,[30,51] (*e*) racial incidents,[30,51] (*f*) convictions for the specific crime of "fragging,"[108,109] and, especially, (g) use of illegal drugs. Army mental health personnel often became involved with these types of problems and sought to apply traditional means and models but with uncertain results.

Heroin Epidemic. As already suggested, the exponential increase in heroin use by lower ranking soldiers from 1970 on—a problem that overlaps the realms of psychiatry and military leadership (discipline and morale)—greatly confounded the psychiatric picture in Vietnam in the latter third of the war. Jones and Johnson substantiate that the rapidly rising, late-war psychiatric admissions/evacuations were primarily for narcotic use once urine drug screening technology became available in June 1971. This greatly increased military detection capability, increased the jeopardy for drug-using soldiers, and consequently affected prevalence measures. DoD statistics estimate 60% of soldiers in Vietnam late in the war were using marijuana, and 25% to 30% were using heroin.[62] Robins' follow-up study of Vietnam veterans' drug use in 1972 found that 44% of the general sample reported having tried some narcotic while in Vietnam (compared to 7% who acknowledged using heroin before assignment there).[110] Even more ominous, deaths (confirmed by autopsy) attributed to drug abuse rose to a peak of 15 for the month of November 1970 before starting to slowly recede.[111]

Stanton's review of the most credible drug use prevalence studies conducted through the course of the war underscores that although the rise in drug use in Vietnam between 1966 and 1970 is best explained with the rise in pre-Vietnam use, the meteoric rise in heroin use beginning in 1970 is not. Instead, the rise coincides with the deteriorating social and political features in the United States and the sudden availability of very inexpensive, almost pure heroin in Vietnam.[82] Because the heroin was so cheap, pure, and accessible, soldiers in Vietnam most commonly mixed it with tobacco and smoked it in ordinary-looking cigarettes. Some soldiers preferred to snort heroin (insufflation), and a minority injected it intravenously.

Some insight into the world of the heroin-using soldier in Vietnam comes from the sociological studies of Ingraham.[112] He interviewed opiate-positive

soldiers recently returned from Vietnam in late 1971 and presented findings regarding drug-use patterns. He noted the fraternal social network described by his respondents (that existed within the larger but basically approving body of soldiers) and the various status distinctions that existed within this "head" society. The soldiers rationalized heroin use as a necessary adaptation to the unique stressors in Vietnam (not typically combat stress), considered their use to be minor because they had not injected drugs, and denied any need for further treatment. Most contended that they were able to maintain their habits without loss of function. The jargon of these soldiers exalted the enlisted "heads" and denigrated the "lifers/juicers" (NCOs and officers). For Ingraham, heroin use was not especially representative of a political ideology (antiwar), but instead it reinforced the appreciation of an extended network of associates with whom a member could express antimilitary sentiments accompanied with an intense sense of acceptance and belonging.[112]

The "Amnesty Program." As noted in Neel's report, *Army Medical Support in Vietnam*, "Growing awareness of the nature and extent of the drug problem in Vietnam led to a search for a flexible, non-punitive response."[31(p48)] Ultimately, the "Amnesty Program," an adaptation of Army Regulation 600-32 (*Drug Rehabilitation/Amnesty Program*), became US Army Vietnam (USARV) policy.[113] This policy outlined procedures and conditions regarding a one-time-only "amnesty," as well as stipulated the elements that should comprise a unit's rehabilitation program ("for restorable drug abusers, when appropriate, and consistent with the sensitivity of the mission"). Efforts at implementation saw major commands hastily improvise treatment/rehabilitation programs and facilities that utilized resources at hand and reflected a diversity of approaches for soldiers voluntarily seeking drug abstinence. In time, however, it became evident these were mostly failed efforts. The only variable that predicted successful heroin abstinence was the soldier nearing his DEROS.[20,114,115] Consequently, the military was forced to resort to a law enforcement approach wherein units were subjected to unannounced urine screening. Soldiers found to have morphine breakdown products in their urine were quarantined in detoxification centers and, when medically cleared, returned as medevac patients to one of 34 Army hospitals in the United States for further evaluation and treatment. As of September 21, 1971, 92,096 soldiers had been screened and 5.2% (4,788) had tested positive.[18] However, these numbers must considerably underrepresent actual prevalence in Vietnam because soldiers preparing to leave were highly motivated to discontinue their heroin use in order not to delay their departure.

Effects of the Heroin Problem in the Theater and Postdeployment. The most serious concern arising from the heroin problem was the effect of soldier drug use on military preparedness and effectiveness. According to Spector, few if any soldiers used drugs in combat, although some believed that after a battle it helped calm them down.[30] From another approach, Holloway and his research colleagues concluded that drug abuse among US military forces represented a "significant threat to combat readiness."[116]

On the plus side, the great apprehension of government and military leaders that the military would release large numbers of addicted Vietnam returnees onto the streets of the United States proved baseless. Not only did a controlled research study of withdrawal patterns of heroin-dependent soldiers conducted in Vietnam demonstrate a surprisingly mild physiological withdrawal despite high levels of heroin tolerance,[12] other studies in the United States revealed that these soldiers generally did not return to heroin use.[117] From Stanton's postwar perspective, given the remission rate of 95% for heroin-using soldiers once they returned stateside and the lack of data indicating that heroin use degraded individual or group performance in Vietnam, the question can be raised as to whether heroin use there really was more deleterious than the alcohol use of previous wars.[82] In support of that perspective, Zinberg recalled from his 1971 inspection visit in Vietnam a military judge telling him that 80% of his heroin use cases received top efficiency ratings from their commanding officers.[20]

Drawdown Phase Psychiatrist Reports

As in the tranisition phase, few Army psychiatrists deployed during the drawdown phase of the war published accounts of their experiences. Those who did publish wrote about the epidemic of soldier heroin use and implied that their efforts to respond to this and related problems of soldier demoralization and dissent through traditional psychiatric models mostly failed (Exhibit 2-3).

Two accounts from this period seem especially illuminating. Major R Ratner served with the 935th Medical (psychiatric) Detachment on the Long Binh post near Saigon (August 1970–August 1971) and later documented his experience there ("Drugs and Despair in Vietnam"), which mostly addressed the challenge of the heroin epidemic.[118] Ratner conveyed a dark picture of military life in Vietnam at that time. He considered his caseload to be only a fraction of the estimated 30% of all younger, lower-ranking soldiers who used heroin regularly; and that they in turn only partially reflected

EXHIBIT 2-3

SELECTED PUBLICATIONS BY DRAWDOWN-PHASE ARMY PSYCHIATRISTS (INCLUDING RESEARCH REPORTS)

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

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

the pervasive demoralization within the larger military population in Vietnam. Although alluding to likely individual premorbidity factors in the drug-dependent soldier, Ratner credited more their universal despair, which he attributed to a combination of societal factors (eg, America's motivation for waging war in Southeast Asia represented a displacement of its internal "racial hostilities") and an "inhumane" Army. Furthermore, he acknowledged the sense of clinical impotence he shared with his colleagues ("there seems to be no place for a psychiatrist to begin") and appeared to echo the cynicism of his soldier-patients.[118]

Equally troubling is the publication of Lieutenant Commander HW Fisher, a Navy psychiatrist who served with the 1st Marine Division during the same year as Ratner, only far to the north near Da Nang. According to Fisher, of 1,000 consecutive referrals, he diagnosed 960 Marines as personality disorders, usually antisocial.[119] Furthermore, although he differs from Ratner in attributing their military dysfunction to predisposition (eg, he labels them with personality disorder diagnoses), Fisher especially faulted their officers and NCOs for encouraging indiscipline. He felt that this occurred through vacillations in enforcing regulations and argued that these problems were exacerbated by expectations that psychiatry provide medical evacuation out of Vietnam or recommend administrative separation from the service in lieu of punishment, thus serving as encouragement of the deviant Marine's rebellion.[119]

Taken together, the record from this phase suggests the morale of some of these psychiatrists suffered a serious decrement parallel to that of the typical soldier of that period. More importantly, it also indicates that the psychiatric contingent, like the military leadership in Vietnam, was wholly unprepared to contend with the extensive proportion of US troops who would in time oppose serving under the post-Tet (1968) circumstances through antimilitary behaviors and psychological disability.

POSTWAR FEATURES

Vietnam Veterans and the High Prevalence of Readjustment Problems

A comprehensive review of postdeployment adjustment and psychiatric morbidity is outside the scope of this chapter. However, the data indicate that many who served in Vietnam subsequently experienced serious and sustained readjustment problems, including frank posttraumatic stress disorder (PTSD). Some suggest that the prevalence of debilitating psychological and social problems among Vietnam veterans greatly exceeds that for earlier US wars. Additionally, when

postdeployment adjustment difficulties are included with psychological problems that arose in the theater, the psychosocial cost for the Vietnam War appears unprecedented.

However, estimates as to the prevalence of sustained postwar adjustment and psychiatric problems for Vietnam veterans seem to vary as widely as the political reactions to the war itself.[22,120–125] Furthermore, comparisons of the psychosocial effect of combat service across US wars is especially difficult because measures are inconsistent. Somewhat reassuring, a 1980 Harris Poll of Vietnam veterans commissioned by the then Veterans Administration found 91% reporting they were glad they had served their country, 74% said they enjoyed their time in the service, and nearly two thirds said they would go to Vietnam again, even knowing how the war would end.[29]

Nonetheless, rising professional concern for the psychological injury of veterans secondary to service in Vietnam brought about a revolutionary change in the taxonomy of psychiatric disorders in civilian medicine. In the decade that followed the war, the *International Classification of Disease,* 9th edition, *Clinical Modification* (ICD-9-CM),[126] and the *Diagnostic and Statistical Manual of Mental Disorders,* 3rd edition (DSM-III),[127] both contained the new category "Post-Traumatic Stress Disorder or PTSD," which had been originally called "post-Vietnam syndrome." The inclusion of PTSD in DSM-III reflected the political efforts of the Vietnam veterans who were seeking greater recognition, as well as the efforts of Americans with residual antiwar sentiment and psychiatrists who believed that DSM-II had neglected the ordeal of combat veterans.[128] In that DSM-III includes combat as an etiological factor for PTSD, it suggests that overwhelming combat stress and civilian catastrophes are identical—a proposition that seems arguable.

The most definitive findings regarding PTSD prevalence and incidence following the Vietnam War come from the government-sponsored National Vietnam Veterans Readjustment Study (NVVRS). At the time of the study (mid-1980s), approximately 30% of male and 27% of female study participants had evidenced PTSD at some point since serving in Vietnam, and for many PTSD had become persistent and incapacitating (15% and 9% of study participants respectively).[129]

However, divergence from the emphasis in the original PTSD model (the traumatic event is singularly explanatory) has occurred. Over the years since the war, disputes have arisen as to the relative weight to give various etiologic influences (eg, predisposition and personality, traumatic extent of combat theater circumstance, and post-Vietnam experience). These disputes have complicated the diagnosis and treatment of PTSD and related adjustment difficulties. Many behavioral science observers have commented on the considerable potential for postwar adjustment difficulties to be powerfully affected by psychological and social dynamics that are not the direct consequence of combat zone "trauma."[39,123,130–132] According to Arthur S Blank Jr, a former Army psychiatrist who was assigned in Vietnam and who subsequently served for many years as National Director for the Department of Veterans Affairs Readjustment Counseling Centers,

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

Following the cessation of hostilities in Southeast Asia, the ethical challenges to military psychiatry, which were voiced during the war, shifted to retrospectively critical conclusions regarding negative long-term consequences of field psychiatric practices in Vietnam (the aforementioned doctrine). The perspective seems to be that the implementation of these practices may have been in the service of collective goals (eg, military objectives), but in the process it ignored the needs of the soldier and fostered the development of PTSD.[39,134–136] Offsetting opinion came from Blank, who noted that acute CSRs usually do not meet the criteria for PTSD and do not generally evolve into diagnosable PTSD later.[137] It also came from Jones, who argued vigorously that postwar sympathies for maligned Vietnam veterans may have led psychiatrists without military experience to misunderstand the unique aspects of a soldier's state when psychological defenses become overwhelmed in combat. As a consequence they fail to appreciate the characteristically fluid and reversible nature of the resultant acute stress disorder and the increased risk for psychiatric morbidity (including PTSD) if treatments do not promote symptom suppression and rapid return to military function and comrades.[138]

Survey of Veteran Army Psychiatrists Who Served in Vietnam

As mentioned earlier, in 1982 WRAIR queried veteran Army psychiatrists who served in Vietnam about their experiences in the war.[2,27] Of the estimated 135 who served in Vietnam, 115 were located, and of those, 74% (85) completed a structured questionnaire exploring patterns of psychiatric problems encountered, types and effectiveness of clinical approaches, and personal reactions to the associated professional challenges and dilemmas. Study respondents were evenly distributed over the years of deployment in Vietnam so that the gleaned information can be considered representative. Also, in the theater, 21% (18) served exclusively in combat units (roughly one third of the slots each year), 49% (42) served exclusively in combat service support medical units (eg, with hospitals or the psychiatric specialty teams), and 25% (21) spent some time assigned to each. The remaining four served exclusively as the theater "Neuropsychiatric Consultant" to the CG/USARV Surgeon. The following summarizes the most salient findings from the study:

- *Unprecedented levels of predeployment professional training*. The degree of formal psychiatric training shared by these psychiatrists was unprecedented in contrast to World War I and World War II, as was the proportion of deployed psychiatrists who received residency training in Army programs (one third).[139]
- *As theater problems progressively increased, predeployment military experience among replacement psychiatrists decreased.* Although the psychiatrists who served in Vietnam averaged little postprofessional training experience in the military, greater numbers of civilian-trained psychiatrists with no practical military background, as well as an increasing proportion of military-trained psychiatrists with no field experience, were sent during the second half of the war. In the first half of the war these two groups constituted only one quarter of the assigned psychiatrist strength. In the second half they represented three quarters. This decline in practical experience, which characterized successive groups of psychiatrists sent to Vietnam, was mirrored in an equally salient reduction in relevant background experience, though not rank, of the Vietnam theater Neuropsychiatric Consultant to the CG/USARV Surgeon.
- *Psychosocial disorders progressively outweighed combat-generated ones.* Regarding the distribution of patients by standard psychiatric diagnoses, these veteran psychiatrists reported over one half of their clinical efforts were devoted to personality disorders, adjustment reactions, or substance abuse syndromes. Furthermore, 32% (24) of the study participants reported that they had only rare exposure to combat-induced psychiatric casualties during their tours. Similarly, the mean percentage of clinical caseload devoted to "combat reactions" for all psychiatrists in the study was only 12.6%. These findings appear to validate that Vietnam was a "low-intensity" war,[31] at least by the measure of its potential to psychologically overwhelm soldiers committed to combat. Furthermore, the burden of treating various psychosocial problems rose dramatically as the war passed the halfway mark. In comparing ratings of 16 behavioral problems by the study participants from the first half of the war with those of the second half, the exponential rise in the heroin problem was distinguishable from the steady, although not insignificant, problems associated with the use of other drugs such as alcohol and marijuana. This finding held true when comparing psychiatrists who served only with combat units with those who served only in hospital assignments. Also, like the jump in problems associated with heroin use in the latter third of the war, the study psychiatrists overall reported a significant rise in their involvement in group racial conflicts and with individuals responsible for violent incidents.
- *Psychoactive medications were extensively prescribed, but risks and benefits were not monitored.* The descriptive and quantitative data from the 48% (41) of the study psychiatrists who acknowledged some exposure to combat reaction cases indicate that they extensively used and highly valued these medications (neuroleptics and anxiolytics) in the treatment and management of soldiers suffering from a wide variety of combat-generated symptoms. (The Army psychiatrists in Vietnam, however, had little or no way to measure the subsequent effects of such medications on the combat effectiveness, or vulnerability, of solders who were returned to duty following such treatment, or regarding their long-term effects including postwar adjustment.)

- *Many Vietnam psychiatrists still felt embittered, especially those who served in the latter half of the war.* A large proportion of the study psychiatrists emphasized, often eloquently, that they still felt quite strongly—typically negatively—about the war and their role in it. This was primarily the case among those who served in the second half of the war. These psychiatrists' responses indicate that in many respects they felt overwhelmed when trying to treat soldiers (and advise commanders) affected by a raging drug epidemic, eruptions of racial animosities, and outbreaks of violence, while using staffing and policies instead designed to manage large numbers of combat-generated casualties. Compared to their counterparts in the first half of the war, these psychiatrists tended to be more vocal, more divided (according to training differences), and, in some cases, quite defensive. The psychiatrists of this latter period also appeared more likely to perceive inequities and to be critical of their preparation and utilization by the Army.[2,27]

LINGERING QUESTIONS AND CONSIDERATIONS

This review indicates that during the drawdown years in Vietnam (1969–1973), Army psychiatrists faced a different and more challenging scenario than that encountered by those who preceded them—one that suggests a dangerous erosion of Army morale and discipline and an associated epidemic of psychiatric conditions and misconduct. It also raises important questions that might have been more easily answered at the conclusion of hostilities if a thorough and systematic study of the psychiatric and behavioral crisis there had been conducted—questions for which the answers may be critical in preparing for a similar military engagement in America's future.

Should more have been done by military and medical/psychiatric leaders to preserve the mental health, psychosocial resiliency, and, by implication, the combat readiness of the replacement soldiers sent to fight in Vietnam? Did the military leadership and the psychiatric component in Vietnam ignore the mounting evidence and warnings by senior medical and psychiatric observers[6,31] and fail to adjust psychiatric perspectives or modify the preparation, deployment, and organization of psychiatric assets in order to meet these challenges? By way of response, the following considerations are offered despite the late date and incomplete information.

The Larger Army During the War

Although the troops in Vietnam were more demonstrative, clearly the long and controversial war took a massive toll on the morale and mental health of the US Army generally.[64–66,140] The troops in Vietnam were resonant with the restive, antiestablishment sentiments of their military peers outside the theater. More specific to mental health, epidemiological data provided by Datel regarding the larger US Army indicate that by mid-1973:

- the worldwide incidence of neuropsychiatric disease among Army personnel rose to near the peak level seen during the Korean War;
- the psychosis rate for the worldwide active duty Army had never been higher;
- character and behavior disorder diagnoses also peaked; and
- the proportion of Army hospital beds in the United States occupied for all psychiatric causes was greater than it had ever been,[25] including during the so-called "psychiatric disaster period"[10] of World War II.

The Soldiers Who Served in Vietnam

The reduction in combat activities and the perception of demobilization surely explains some of the rise in psychiatric conditions and behavioral problems from 1969 on. These kinds of problems were predictable based on data from World War II and Korea, where large numbers of soldiers were stationed far from home, living in confined and isolated groups, and serving primarily in service and support roles.[141,142] Similar problems have been associated with constabulary forces and those in the process of demobilization in an overseas setting who resent being asked to sustain further sacrifices beyond the conclusion of hostilities.[104,143] Even a dramatic increase in the use of narcotics by US soldiers was seen at the close of the Korean War, which was also attributed to service in the Asian theater.[144] Should all of these problems be lumped under a concept like a collective "short-timer's syndrome" (ie, impatient to complete their assignment and return to their stateside lives)? In the case of the skyrocketing evacuation rates in Vietnam for soldiers with opium breakdown products detected in their urine, Jones referred to these casualties as "evacuation syndromes" (eg, efforts by soldiers to manipulate the system to get relief from foreign deployment and,

perhaps, combat risks).[105]

However, beyond these familiar stressors, the troops in the latter part of the war in Vietnam also exhibited intense opposition to military authority—an attitude that coincided with the virulent antiwar and antimilitary feelings of those at home. Should it be concluded that the pervasive psychiatric and behavioral problems in these individuals were primarily expressions of an embittered aggregate of soldiers who resented being asked to make sacrifices to salvage America's lost cause there while surrounded by the moral outrage and blame of the US public? Some consider these soldier behaviors to have collectively represented a "macromutiny."[145] But was Vietnam so sociopolitically unique that the US experience there can be discounted as unlikely to repeat? Or does a closer look need to be taken at what happened there? What can it teach about the limitations of human nature, including among the civilian population at home, under these specific conditions of war and deployment, especially from the standpoint of the social psychology of military groups?

The Army Psychiatric Component in Vietnam

Certainly the overall record of psychiatric care provided through the course of the war in Vietnam was laudatory. But the traditional psychiatric models for the management and treatment of this avalanche of demoralization and alienation seem to have mostly been ineffective by the end of the war. It does appear that military psychiatry failed to extrapolate from drawdown and demobilization problems seen in earlier wars. A failure to anticipate the growing demoralization and dissent in Vietnam secondary to public repudiation of the war resulted in a failure to modify the system of mental health resources and the selection and preparation of replacement psychiatrists.

A Social Stress and "Disease" Model

On the other hand, perhaps these problems were insoluble on any terms pertaining to clinical psychiatry. First, the overlap between matters bearing on morale and mental health ultimately became quite entangled as the war progressed, and yet those primarily responsible for the former (military commanders) and those responsible for the latter (military mental health personnel) did not typically maintain a running dialogue, especially in instances of divergent command structures, which was most usually the case. Second, considering the exceptionally high prevalence of problems that arose among previously functional soldiers, the pathogenesis is more suggestive of a social–psychiatric disorder of the collective (eg, Goffman's pathogenic "total institution,"[146] Fleming's "sociosis,"[131] or Rose's "macromutiny"[145]), as opposed to one primarily centered on the individual soldier. In this regard, it should be noted that the psychiatric training of the times, including in the Army settings (and despite intents otherwise[23]) did not emphasize social pathology and interventions (including at the macro level) nor provide sufficient practical training.

In other words, in that these problems were epidemic in the Vietnam theater and were not, for the most part, combat-related, a social stress model seems especially warranted because these seem to represent failures of adaptation at the group level. They evidently arose from complex interactions combining personal circumstance with powerful biological (often including drug-induced), psychological, and social stressors (in Vietnam as well as from home)—stressors that became progressively onerous for sequential cohorts of replacement soldiers as the war wound to its bitter conclusion.

Veteran Postwar Adjustment Problems

As noted earlier, the important subject of the adjustment problems of veterans after the war is beyond the scope of this chapter, but it should be mentioned that the clash of values affecting soldiers in Vietnam also invariably complicated the reintegration of returning soldiers. For many, it may have contributed to chronic psychiatric conditions and serious adjustment difficulties because some symptom formation may have served to obtain, through the "sick role,"[147] an honorable adaptation to impossibly contradictory public (moral) pressures (eg, "damned for going, blamed for losing"). Furthermore, in most cases the symptoms and difficulties of these veterans remained unaddressed because of the unavailability of the PTSD diagnosis prior to 1980. Following the promulgation of the PTSD diagnosis through the publication of DSM-III, the problems and conditions of this group of veterans began to be more systematically addressed by the Department of Veterans Affairs, which began the gradual implementation of the Vet Centers—a nationwide system of community-based, war veteran counseling centers[133] (totaling 260 centers by 2009). More information on the Vet Centers is available at their Web site: http://www.vetcenter.va.gov.

Final Considerations

In his book, *Psychiatry in a Troubled World*,[148] Dr William C Menninger, the Army Surgeon General's chief psychiatrist through most of World War II, described

military psychiatry as a "dirty job," one in which the psychiatrist helps a normal individual adjust to the abnormal situation of combat. He was primarily referring to the moral weight inherent in expecting soldiers to return to combat duty and additional risks following the brief, simple measures associated with the classic combat psychiatry treatment regimen (the doctrine mentioned earlier). Following military psychiatry's experience in Vietnam, it can surely be acknowledged that it is a "messy job" as well. As such, attention can be drawn to the multivariate social and environmental stressors that can also serve to corrupt soldier morale, commitment, and discipline, as well as mental health, under certain adverse combat theater circumstances, and psychiatry's limited capabilities for making this bearable for them.

SUMMARY

The commitment of US forces in Southeast Asia resulted in 7 exhausting years of combat activities. Ultimately, however, despite their material and technological inferiority, the enemy's resolve and resilience outlasted the tolerance of the US public, and US involvement ended following mounting protest in the United States, withdrawal of US military forces and civilian advisors in 1973, and, finally, the defeat and surrender of the Saigon government to North Vietnam in April 1975—little more than 2 years after the negotiated truce in January 1973. More specific to military psychiatry, these remarkable events and circumstances—and the attendant social and political convulsion in America—adversely affected the mental health and psychological resilience of a large proportion of the military service members assigned in Vietnam, and the task for military psychiatrists there broadened and became more complex.

Even if widely scattered, the various publications from psychiatrists and other professionals who served in Vietnam, visited the theater, or were in a position to review the circumstances there, do comprise a partial historical record. These reports and the WRAIR survey of veteran Army psychiatrists suggest a number of characteristics regarding the psychiatric challenge in Vietnam, some of which appear to be unique compared to the wars that preceded it. They also provoke additional important questions.

In the beginning, when US ground troops were first committed and throughout the buildup phase (1965–1967), adequate psychiatric resources were deployed with the combat forces, and psychiatric and behavioral problems were manageable. Rates of psychiatric evacuations from Vietnam were exceptionally low, as were rates for disciplinary problems. Morale and commitment of Army troops, including psychiatrists, proved to be high. Of special note is that newly developed psychoactive medications, especially neuroleptics and anxiolytics, were enthusiastically used throughout the theater by psychiatrists and other medical officers, but their use and effects were never studied.

The US public's attitude toward the war reversed dramatically following the enemy's bold surprise attacks in 1968. These events heralded the withdrawal of US forces and demobilization from the war. Despite this, there continued the assignment of replacement soldiers (in decreasing numbers), including psychiatrists; killing and wounding of more US service members; and passionate antiwar, antimilitary sentiment within US society. These years also saw the beginning of a surge in psychiatric admissions and behavioral problems throughout the Army—and especially in Vietnam.

Over time, the reality in Vietnam proved to be far different than expected. The combat exhaustion casualties that were predicted never materialized and the replacement Army psychiatrists and allied personnel who served in Vietnam from 1969 on found themselves in a radically different war (and with a radically different Army) than was faced by those who served in previous wars (with their emphasis on psychiatric attrition among soldiers worn down by sustained combat) or those who preceded them in Vietnam. Furthermore, psychiatrists with appreciably less military experience, including those in leadership positions, were sent even as the problems in the theater were multiplying. Not only were they challenged with unprecedented levels of psychiatric and behavior problems, it was unprecedented for these rates to rise while the United States was reducing its military and political presence in South Vietnam, US forces were gradually turning the fighting over to the Army of the Republic of South Vietnam, and US casualty rates were declining.

What military psychiatry ultimately encountered in large numbers were young troops with severe demoralization, a progressive reluctance to soldier, antagonism—sometimes violent—toward military authority, and a variety of psychiatric conditions and behavioral disorders. Theater psychiatric hospitalization statistics indicate a 4-fold increase compared to the early war years. Related, and even more remarkable, was the common and casual use of heroin by a large proportion of US troops, although most were not addicted. At its worst point, one out of every eight enlisted soldiers was medically evacuated from Vietnam because of narcotic use.

These accelerating psychiatric conditions and behavior problems, which coincided with America's repudiation of the war and the counterculture passions of their civilian peers, were certainly consequential to serving in the combat theater, but in most cases they had little or no direct connection to combat activity. It appears that many soldiers more or less disabled (or demobilized) themselves through mental disorders, drug use, and other symptoms and forms of misconduct.

Regarding the response of the deployed mental health elements, because the rising theater and deployment demoralization and alienation-driven problems arose far more predictably among noncombat troops, the center of effort shifted to hospital-based mental health assets and gradually overtaxed the psychiatric and related medical resources. These problems mostly failed to yield to conventional psychiatric approaches, and increasingly drastic administrative and law enforcement measures were required. The late-war psychiatrists complained about being unprepared and may have become uncertain of their goals and structures. They may have also shared, to some degree, the demoralization and antimilitary passions of the soldiers with whom they served. Combat readiness went thankfully untested by the enemy. Nonetheless, it is striking that there were no structural changes in the organization of mental health assets in Vietnam or modifications in the selection, preparation, or deployment of mental health personnel sent as replacements to the theater.

With the advantage of the relative objectivity offered by the passage of time, it can now be acknowledged that the models for understanding and anticipating casualties both from combat stress and from deployment stress are considerably more complex than was understood before—or even during—the Vietnam War. The earlier model was derived from observations of troops fighting in sustained, intense combat environments, and it primarily weighed combat stress against resiliency of the individual soldier (although the buffering effects of allegiance to combat buddies and other factors were considered to be vital). But in an extended, "low-intensity," counterinsurgency conflict the model must be broadened to also take into account other critical, compounding, and often indirect influences of the combat theater. A list centered around "soldier variables" might include the usual ones, that is, (*a*) the nature and setting of the fighting; (*b*) training and expertise; (*c*) physical condition; (*d*) background and personality; (*e*) social circumstance (within the small combat unit as well as the soldier's network of family and friends); (*f*) confidence in military leaders and equipment; and (*g*) commitment to the military goals. It might also, and surely not least, include the necessity to ensure that soldiers believe the country requires, as well as values, the inherent risks and sacrifices they undertake.

Retrospective suggestions generated out of the Vietnam War especially include the need for the military to develop a multivariate concept of combat "theater" breakdown (as opposed to combat breakdown) that considers both the symptomatic soldier and the dysfunction arising in groups of soldiers, and to employ an epidemiological approach for early recognition of deteriorating psychosocial and psychiatric circumstances. For example, in Vietnam a psychiatric field research team could have been created for the sole purpose of collecting, analyzing, and disseminating information regarding a wide array of often initially innocuous indices of flagging morale (eg, rising malaria rates among soldiers subverting malaria prophylaxis as a means of avoiding service). This information could have then served for clinicians and commanders as a timely map of the psychosocial "terrain" of stressors, morale, performance, and symptom patterns of the troops, which would have permitted the development of early intervention measures. Such an epidemiologic approach could have been combined with systematic debriefing of returning psychiatrists to redirect some of the attention of replacement psychiatrists from a combat stress model toward a social stress model of psychiatric dysfunction.

Other structural adaptations as the war in Vietnam lengthened might have included: (*a*) extending the tours of each of the theater Neuropsychiatry Consultants (as well as tours of other psychiatrists in leadership positions) to provide needed continuity; (*b*) increasing the level of seniority of the replacement military psychiatrists as the pool of experienced civilian psychiatrists unavoidably decreased; and (*c*) linking numbers of deployed psychiatrists to epidemiologically documented need, rather than to overall troop strength. Finally, a policy could have been established, presuming it met overall mobilization needs, requiring that each recently graduated psychiatrist serve some time with a stateside military unit before departing for Vietnam.

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