

Chapter 8

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INTRODUCTION

Psychiatrists who serve in the military function in the ethical shadow of an enormous and strict hierarchy, the central organizing principle of which is the subordination of individual values to those of the organization—presumably for the benefit of society.

There have been various attempts to examine and reconcile potential loyalty conflicts for the military psychiatrist, which may be similar to those faced by psychiatrists who work for other organizations. However, little specific attention has been paid to the exquisite and absolute contradiction of values that may affect military psychiatrists when they serve in a combat theater. As came to light during the Vietnam conflict, whereas combat psychiatrists' clinical decisions can have far-reaching consequences, they may face organizational expectations, codified in the military treatment doctrine, that they function in ways which are perceived, at least by others, if not by themselves, as violating the most basic ethical tenets of psychiatry serving the welfare of the individual. To understand how this value clash can arise, one must understand certain fundamental distinctions between psychiatric reactions to combat and similar civilian casualties.

The treatment of combat psychiatry casualties differs from the treatment of similar casualties in civilian settings because the soldier-patient faces not only the extraordinarily stressful combat but also the arousal of his own moral conflict.^{1,2} Even if the soldier is reluctant, he has a duty on recovering to risk further sacrifices, perhaps to the point of giving his life. The military psychiatrist is similarly in a unique position. Also a soldier and also subject to the authority and hierarchical values of the military, the psychiatrist is obligated to aid his patient in fulfilling this duty—even if the psychiatrist is reluctant. More specifically, because the combat psychiatrist's foremost military responsibility is that of stemming the flow of individuals who manifest a psychological incapacity or reluctance to soldier,³ he may be obligated to deny a psychologically traumatized soldier's expectation of medical exemption from further exposure to combat (or from a court martial) to conform to the military's expectation that the soldier be returned to that environment if he can function, regardless of whether he has persisting psychiatric symptoms or is opposed to returning.⁴

Before the Vietnam era, the potential for conflict between military and civilian value systems when psychiatrists in military service treated combat casualties was rarely mentioned in the psychiatric literature;⁵ however, it was often implied.⁶⁻⁸ For example, Peterson and Chambers⁶ acknowledge the discomfort their colleagues experienced in satisfying military priorities during the Korean conflict:

It is easy to evacuate a soldier from combat and difficult to do the reverse. It is easier to say, "this man should never have been drafted," than to help him adjust to his duties. It is easier to send a frightened young soldier, who reminds one of one's self or one's own son, to the rear than to return him to combat duty. . . . One's own feelings of guilt over returning another to combat duty, make it difficult for the psychiatrist to function effectively and without anxiety.^{6(p253)}

Nevertheless, in World War I, World War II, and the Korean conflict, thousands of psychiatrists, typically mobilized civilians, performed their professional duties with a sustained allegiance to the military objectives and accepted that their clinical goals, techniques, and values would be altered by expediency associated with fighting those wars.^{9,10} Important in this regard is the huge impact of World War II on the course of American psychiatry. At one point (June 1944), 26% of the members of the American Psychiatric Association (APA) were in military uniform.¹¹ Following the war, many who had served became the leaders of American psychiatry.¹⁰ In their experience, the combat psychiatry doctrine—a treatment regimen that utilizes basic physical and psychologically supportive treatments, deemphasizes patienthood, and encourages rapid resumption of duty function—seemed validated through its effectiveness in treating large numbers of soldiers, and their influence on psychiatric thinking in America was revolutionary.¹² The development of civilian applications of social and behavioral therapeutic strategies^{13,14} and the modalities of brief psychotherapy¹⁵ and crisis psychotherapy¹⁰ were natural extensions of the doctrine.

The implementation of the traditional combat psychiatry doctrine in the Vietnam conflict, however, came to be severely criticized, primarily on ethical grounds. As will be described, the new opponents of military psychiatry, including some who

served as psychiatrists in Vietnam, argued that the doctrine's treatment goals and methods violated psychiatry's humanitarian principles by neglecting the needs of the soldier in order to wage an unjust

war. After the United States withdrew its forces from Southeast Asia, however, these issues were mostly forgotten¹⁰ as were many related societal controversies associated with the conflict.

TRADITIONAL VIEWS OF COMBAT PSYCHIATRY

When Fear Overshadows Combat Motivation

A review of selected aspects of combat psychiatry is pertinent to understanding its potential value conflicts. It has only been within the era of the modern battlefield, essentially beginning with World War I, that acute, disabling psychiatric reactions to the stress of combat have arisen in numbers sufficient to constitute a military medical problem.¹⁶⁻¹⁸ Throughout the 20th century, weapons have become increasingly destructive and their delivery systems more precise; consequently the stress levels sustained by troops, as measured by the proportion of nonfatal combat casualties that are psychiatric, have risen proportionally. Furthermore, because disabling psychological and behavioral reactions to the stress of modern combat have at times arisen in sufficient numbers to alter the course of military engagements, the U.S. military has come to value highly the services of its psychiatrists and allied medical department personnel.

Clinical Presentations of Combat Stress Reactions

The psychiatric symptoms associated with combat stress may range in severity from hyperalertness, irritability, difficulty concentrating, and insomnia, to gross and disabling disturbances in affect, thinking, and behavior.¹⁹ Collectively, they have been labeled with uniquely military names such as shell-shock, war neurosis, and combat fatigue (or exhaustion).²⁰ More lately they have been referred to as battle stress (or shock) casualties and combat stress reactions.

Behavior disturbances as a reaction to combat stress include such obviously avoidant behaviors as combat refusal, malingering, self-inflicted wounds, and desertion, as well as less direct ones such as alcohol and drug misuse; neglect of healthcare, weapons, or equipment; indiscipline; short-timers syndrome; and combat atrocities.^{21,22} Of special importance to military objectives, both psychiatric and behavioral reactions can spread by suggestion and reach epidemic proportions (eg, as with the

incidents of group gas hysteria in World War I²³ and the heroin problem in the latter years in Vietnam²⁴). Consequently, soldiers with combat stress reactions may jeopardize other soldiers, reduce a unit's combat effectiveness, and affect the outcome of a combat situation. Although suggesting there is more homogeneity than experience dictates, for discussion purposes, the collection of combat-generated conditions will be referred to generally as combat stress reactions.

Diagnosis and Pathogenesis

The clinical presentations of combat stress reaction cases have at times conformed to various specific *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., revised, DSM III-R)²⁵ diagnostic categories.¹⁰ However, presenting symptoms tend to be diffuse and variable with particular patterns influenced by the combat situation and "ecology."²⁶ In fact, because of their typically protean nature and apparent reversibility when managed according to the doctrine,¹⁹ military psychiatrists have concluded that the combat stress reaction is essentially the battlefield equivalent of the acute reaction²⁷ or catastrophic reaction²⁸ to stress. The soldier with a combat stress reaction is considered to have suffered a reversible, if profound, regression as a consequence of having had his psychological defenses, as well as his combat motivation,⁶ overwhelmed by the rigors, dangers, losses, and horrors of the combat situation.²⁹ Although combat stress reactions do not meet the criteria for post-traumatic stress disorder (PTSD) and do not generally evolve into diagnosable PTSD,³⁰ without effective treatment, chronic debilitating forms will develop.²⁸

From World War I, when combat stress reactions were determined to be psychiatric rather than neurologic disorders, it was concluded that they were caused by the combination of combat intensity or duration and individual predisposition⁷ (often with insinuations of cowardice⁸). More recently, this etiologic dialectic, often referred to as "every man has his breaking point," has been expanded to encompass a more complex biopsychosocial model.³¹⁻³³

Such a model suggests that a variety of individual and social risk factors can interact with a variety of combat stresses to undermine a soldier's combat adaptation. The preventive activities of military psychiatrists have typically utilized their understanding of these factors to influence military policies and planning regarding screening, indoctrination and training, physical conditioning, morale and leadership, social supports, and combat conditions and tactics.^{22,34,35} Personality factors are posited to have relatively less etiologic importance in combat stress reactions^{36,37} but to be of increasing importance in cases arising in low-intensity combat³⁸ as well as influence recovery.³⁹ However, as Erikson's³¹ analysis of a specimen combat stress reaction case from World War II suggests, a theory of intrapsychic conflict may be especially useful in explaining breakdown and recovery at the level of the individual soldier.

In conclusion, combat stress reactions are considered by military psychiatry to represent a normal reaction to an abnormal circumstance at least in their acute stages. Although not the primary etiology, the combat stress reaction commonly expresses the soldier's "refusal to fight"^{40(p11)} and thus represents a situation in which his fear overshadows his combat motivation.⁴¹

The Use of Psychoactive Drugs

Through the ages, the extreme physical and emotional demands of combat naturally led warring states to experiment with various psychoactive substances to limit excitement and fear and reduce exhaustion and dysfunction among its warriors.¹⁶ In the American wars before the Vietnam conflict, the use of medications in the treatment of psychiatric casualties was generally limited to sedatives, primarily barbiturates.⁴² The addition of recently discovered neuroleptics and anxiolytics in the Vietnam theater represented a powerful new tool to the armamentarium of combat psychiatrists. The numerous reports from those serving in South Vietnam⁴³⁻⁴⁶ and the prescription prevalence study conducted there by Datel and Johnson⁴⁷ indicate the widespread, enthusiastic use by military psychiatrists and other military physicians of these newer psychoactive medications in the treatment of combat-related psychiatric symptoms. However, the effects of these drugs on soldiers and their combat performance have never been studied. Current doctrine discourages the use of all but the short-acting sedatives and anxiolytics,²² and those

are to be used only when reassurance, strong suggestion, and behavioral methods have been tried without sufficient effect. However, psychiatric and medical units in a combat theater are still equipped with a wide range of psychoactive medicines.

The Critical Nature of Expectancy

The goal of traditional U.S. Army combat psychiatrists has been to fulfill the U.S. Army Medical Department's mission of contributing to the achievement of the combat objective (the motto of the U.S. Army Medical Corps is "To Conserve Fighting Strength"⁴⁸). Over the course of World War I, World War II, and the Korean conflict, combat psychiatrists empirically derived a set of clinical principles that appeared to restore quickly the affected soldier's critical physical and psychological functions so that he could return to his military unit and comrades and resume the fight.¹⁸ These principles have become condensed in the mnemonic PIES: proximity, immediacy, expectancy, and simplicity.¹³ These principles refer to elementary physical (ie, rest, replenishment, and psychoactive medication in selected instances) and psychosocial treatments (ie, assisted anamnesis, reassurance, and encouragement) that are applied as rapidly as possible and as close to the soldier's unit and the fighting as the tactical and clinical situations permit.

Especially central to this review are the ethical implications surrounding expectancy. *Expectancy* refers to an overarching clinical attitude that has been recognized since World War I to be essential in restoring soldiers and returning them to duty.⁷ The treatment team's collective attitude of expectancy shapes the various physical, psychological, and environmental interventions to bolster the patient's self-confidence as a soldier and discourage self-protective feelings and invalidism (eg, to reduce the secondary gain wish for medical exemption from further combat).^{6,8} As will be illustrated in a later section of this chapter, the soldier is managed more as a soldier and less as a patient. While hospitalized, he is regarded as if his symptoms represent simply a temporary, normal reaction to stress and fatigue. He is encouraged to believe that after a brief period of rest and recuperation and with the psychiatric team's assistance in ventilating his traumatic combat experience, he can and will recover quickly, rejoin his comrades, resume his military job, and regain his self-respect. Shaw describes this exhortative approach:

Reinforcement is given to the soldier's softly heard voice of conscience, which urges him to stay with his buddies, not to be a coward, and to fulfill his soldierly duty. Encouragement is given to patriotic motivation, pride in the self and the unit, and to all aspects of one's determination to go through with one's commitment.^{32(p131)}

Current U.S. Army doctrine⁴⁹⁻⁵⁴ divides the dysfunctional combat stress behaviors into battle fatigue and misconduct stress behavior. Battle fatigue covers all subtypes and syndromes that are treated according to PIES¹³ and the four Rs: reassure, rest, replenish, and restore confidence. Misconduct stress

behavior refers to conditions that are judged to be willful violations of unit regulations, the Uniformed Code of Military Justice, or the law of land warfare and are presumed to respond better to disciplinary action.

The doctrine recognizes that there may be gray areas at the minor end of the misconduct spectrum where command can choose to treat the misbehaving soldier for battle fatigue and return him to duty. However, it states unequivocally that "once serious misconduct has occurred, it must be punished to prevent further erosion of discipline. Combat stress, even with heroic combat performance, cannot justify criminal misconduct."^{53(¶2-9d)}

VIETNAM PSYCHIATRY: FROM CONFIDENCE TO DISMAY

Unanticipated Challenges in Vietnam

Over the 8 years of conflict in Southeast Asia (1965 to 1973), an estimated 135 U.S. Army psychiatrists, as well as smaller numbers of U.S. Navy and U.S. Air Force psychiatrists, were sent to provide care for the almost 3 million American men and women who served there. During the first few years following the insertion of American ground forces into South Vietnam, troop morale remained high, and few Americans opposed the conflict. Rates for psychiatric admissions and evacuations remained well below those seen in earlier wars.⁵⁵ Psychiatric observers remarked on the apparent effectiveness of the combat psychiatry doctrine^{56,57} and the value of newly discovered neuroleptic and anxiolytic drugs in the treatment of a broad range of psychiatric symptoms among combat-exposed troops.^{43,46,47,58}

Then, from 1968 until all U.S. troops were withdrawn in 1973, antiwar and antimilitary sentiment accelerated in the United States and among U.S. troops in Vietnam. Collectively, the spectacular increase in the Vietnam theater rates of disciplinary actions and of psychiatric disorders, including heroin dependency,⁵⁹ indicated that a very large proportion of U.S. troops were unable or unwilling to accept the risks of combat, acknowledge military authority, or tolerate the hardships of an assignment in Vietnam. The resultant challenge to the assigned military psychiatrists was unprecedented.⁶⁰

Shifting Professional Attitudes Toward the Conflict

As increasing numbers of Americans denounced the conflict in Southeast Asia, military psychiatry

and its doctrine came under attack.⁶¹ Criticism came both from psychiatrists and other physicians who had served in Vietnam as well as from those who had not served there. Lifton,⁶² a psychiatrist with experience with military populations, veterans, and survivors of extreme military and civilian stress, is a prominent example of the latter. In his opinion, the military psychiatrists in Vietnam were "technicist" professionals who had colluded with an "absurd and evil organization."^{62(p808)} Later, he equated them with German physicians who worked for the Nazis in their death camps.⁶³

Spragg⁶⁴ and Boman,²¹ two Australian military psychiatrists, drew on their experiences with Australian troops who fought in Vietnam and were also very critical of the U.S. combat psychiatry doctrine. Boman referred to the published accounts by American military psychiatrists as "hair raising reading."^{21(p111)}

Mental health organizations also reacted strongly to the conflict's increasing unpopularity. In March 1971, 67% of APA members responding to a poll indicated that they wanted the U.S. government to terminate all military activity in Vietnam.⁶⁵ This poll was followed by APA Board of Trustees' passing of official resolutions that condemned the conflict and argued for an American withdrawal.⁶⁶ In July 1972, the American Psychological Association joined seven other mental health associations in the following public statement, "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."^{67(p1)} In raising questions about the morality of the U.S. military intervention in Vietnam, these organizations increased the ethical dilemmas for psychiatrists, psy-

chologists, and social workers in uniform, yet they neglected to provide their colleagues with the guidance for addressing these dilemmas.

The debate between psychiatrists Bloch and Maier illustrates the shift in professional attitudes from the more sanguine early conflict period to the late conflict enmity. In 1969, Bloch⁴³ wrote an article describing the psychiatric goals and methods used at the 935th U.S. Army Medical (Psychiatric) Detachment in 1967 to 1968 in Vietnam. A civilian-trained psychiatrist in uniform, Bloch confidently explained how his team adapted the U.S. Army's traditional doctrine for the treatment of combat casualties to fit the unique features of the low-intensity, counter-insurgency combat theater of Vietnam. He also highlighted the value of previously unavailable psychoactive medications, primarily chlorpromazine, in the treatment of seriously combat-disabled soldiers.

Maier, a psychiatrist who treated psychiatric casualties from Vietnam while he served with the U.S. Army in Japan in 1965 to 1967, reacted in a letter to the editor⁶⁸ that was intensely critical of the ethics and practices of military psychiatrists in Vietnam. He concluded, "By acting to 'conserve the fighting strength' in this war of boundless immorality, [the military psychiatrist] partakes of the passive complicity that is the mark of guilt in our time. . . . Whatever else Army psychiatry may be, I see neither moral nor scientific justification for the dignity of its definition as clinical psychiatry."^{68(p1039)}

Bloch⁶⁹ replied that in his experience in Vietnam, soldiers who struggled with concerns regarding the morality of the conflict typically were driven by pre-Vietnam psychological conflicts. He also defended the goals and methods of military psychiatry in Vietnam, "If reality is that America's youth are now fighting, then they deserve the best psychiatric care that can be afforded them. Such care neither oversimplifies issues nor encumbers and compromises the evaluation or treatment setting by intrusion of the psychiatrists' moral judgments and emotions."^{69(p1040)}

Livingston, a West Point graduate who volunteered to serve in Vietnam, was not a psychiatrist at the time he served as a medical officer there in 1968. However, his account^{70,71} of the moral outrage he developed from serving in the conflict (" . . . one of the most antilife enterprises of our time"^{70(p272)}) is noteworthy because of his specific condemnation of the combat psychiatry doctrine. He remarked:

I was confronted with several cases of 'combat neurosis' who told me that they saw nothing in what

they were doing that justified the risks they were being asked to take. In effect, they had seen enough of death to know that they preferred life.

What was I to do with deviant behavior like that? They were given a brief respite and returned to their units; the fighting strength was conserved. How many were later killed I do not know, nor do I wish to.^{70(pp268-269)}

Compared with the more confident accounts by psychiatrists who served in the first half of the conflict,^{43,46,58,72-74} ones who went during the second half, such as Camp (as quoted in Ingraham and Manning),¹⁸ Char,⁷⁵ Colbach,⁴⁵ Fisher,⁷⁶ Joseph,⁷⁷ and Ratner,⁷⁸ exhibited more frustration and cynicism. Collectively, they give the impression that conventional military psychiatric structures and doctrine were inadequate to address the burgeoning psychiatric and behavioral problems of the later years of the Vietnam conflict.

The anguish described by Colbach, also a civilian-trained psychiatrist, suggests the moral uncertainty of those who served in the second half of the conflict. Shortly after Colbach's service in Vietnam (1968 to 1969), Colbach and Parrish published an overview of U.S. Army mental health activities since the conflict began that included a justification for the combat psychiatry doctrine there: "If one soldier is relieved of this duty, another will have to replace him. And the soldier replaced by another will have to live a long time with the realization that he was so 'sick,' so weak, that someone else had to take over for him when the chips were really down."^{79(p341)}

Fifteen years later, Colbach⁴⁵ wrote a personally and professionally wrenching retrospection on his role and activities in Vietnam, which evidently haunted him long after his return. Throughout his narrative, there are expressions of conflict and regret. For example, he believed that his anger at being sent to Vietnam interfered with his empathy for his soldier-patients: ". . . in many ways I was a failure in actually reaching out to those fellows and touching them and alleviating their suffering"^{45(p265)} Like Bloch, Colbach was resigned to being the "guardian of reality."^{45(p265)} However, this position seemed to give him little relief from his role-linked guilt: "I tried to help my patients learn that lesson [that all of life is a struggle], not to quit but to go on. Probably a few of them did learn that, if they survived."^{45(p265)}

Ultimately, Colbach found an ethical position he hoped would bring him peace of mind: "Whether

the Vietnam conflict fits these criteria [of a just war] or not is really beyond me to say. I did accept it as a just war when I agreed to serve in it. . . . I then had to accept that my obligation to my individual patient was far superseded by my obligation to the military and, eventually, to my country."^{45(p265)}

A Survey of Psychiatrists Who Served in Vietnam

The results of a 1983 survey by Camp and Carney^{80,81} of 115 psychiatrists (of an estimated total of 135) who served with the U.S. Army in Vietnam appear to verify that Colbach's struggle was not unique. When respondents were asked to include personal reactions to the professional challenges they faced there, a large proportion, especially among those who served in the second half of the conflict, emphasized that they still felt quite strongly—typically, embittered—about the conflict and their role in it. For example, one psychiatrist noted, "I have yet to find the peace of mind that would allow [me] to watch any of the Vietnam conflict movies, or talk about the war without threat of loss of control."^{81(p28)} Many indicated that they had felt overwhelmed, betrayed, and blamed—overwhelmed by a raging drug epidemic, eruptions of racial animosities, and outbreaks of violence; betrayed by the army because of their poor preparation and support in the theater; and blamed by their stateside colleagues and countrymen for doing the job they were required to do.

The following quotes (collected during Camp and Carney's research^{80,81} but not previously published), all from individuals who received their psychiatric training in civilian programs and who served in the second half of the conflict, illustrate the confusion that many acknowledged:

I soon adapted by realizing I could only be of use by cooperating with the military in most ways. To have tried to be another Ghandi would have been pointless and would have deprived those few I could help with my expertise.

As my year in Vietnam passed my ethical dilemma increased some, but I was hired by the Army, not the specific patient. The second fact was that I knew if I wanted to try to do something for a specific person, I knew someone else would have to come to Vietnam to take his place.

. . . I accepted my assignment as an obligation despite my conviction as early as 1964 that our involvement was stupid, would fail, would be a disastrous waste of wealth, power, and lives, and

was unjustified politically, historically, and morally. . . . I did not feel strong ethical conflict over my role in the Army in Vietnam. . . . The therapeutic technique of psychiatry is inimical to the military cast of mind and would probably undermine morale and exacerbate disciplinary problems with many soldiers.

On the other hand, some study participants denied feeling ethical strain in Vietnam, while others indicated that they intentionally shielded patients. For example, a psychiatrist who served with one of the specialized psychiatric units responded, "What [ethical] dilemma—I evac'd them all to Japan!"

Role Dilemmas for All Psychiatrists During the Conflict

A number of Vietnam-era authors explored the functional and ethical dilemmas inherent in military psychiatry that are indirectly linked to the combat theater role.⁸²⁻⁹⁰ Many suggested that psychiatrists serving in the military had invariably abandoned or corrupted their medical ethics. For example, Daniels referred to the military psychiatrist as a "captive professional."^{84(p255)} Friedman saw him as ". . . the overseer of a system of social control which is distinctly nonmedical in its character."^{87(p122)} Locke⁸⁸ contended that psychiatrists who serve with the military are systematically persuaded to dehumanize the soldier, prosecute the war, and betray their individualist values. Barr and Zunin⁸⁶ took the criticism of military psychiatrists a step farther and recommended that their designation be changed from medical officer to "psychiatric military officer" in order to warn drafted psychiatrists and soldiers of the replacement of their medical ethics by those of the institution.

Concern for these ethical dilemmas was not confined to the psychiatrists serving with the military services during the Vietnam conflict. A number of civilian psychiatrists indicated that they were deeply troubled by conducting evaluations of young draft-eligible men with symptoms that apparently arose in response to the threat of being drafted.⁹¹⁻⁹⁷ Several were overtly suspicious of the allegiances of military psychiatrists. For example, Kirshner⁹⁶ suggested that military psychiatrists were antitherapeutic when they evaluated and treated dissenting soldiers because of countertransference obstacles based on the psychiatrist's unresolved identity issues. Ollendorff and Adams defined the military-oriented "establishment" psychiatrist as one who is corrupt and who "declares as fit everybody who is not dead."^{95(p89)}

In Support of Military Psychiatry

There were a few publications in the latter half of the conflict and afterward that sought to justify the role, doctrine, and methods used by military psychiatrists in Vietnam. Generally, these publications were by career military psychiatrists, such as Arthur,¹⁰ Brown,⁶¹ Gibbs,⁹⁸ Hays,⁹⁹ Parrish,¹⁰⁰ and Johnson,¹⁰¹ and were more restrained than those of critics.

One exception is found in the review by Bey and Chapman;⁴¹ Bey is a civilian-trained psychiatrist who served with a combat division in Vietnam (1969 to 1970). They unapologetically argue that the "vast differences" between military and civilian psychiatry are necessary to support wartime mobilization, and the military psychiatrist's first priority must be the predominance of collective goals and values over those of the individual.

Lingering Criticism of the Treatment Doctrine Since Vietnam

As the numbers of veterans reporting post-Vietnam psychiatric symptoms and adjustment

difficulties grew in the years following the cessation of hostilities in Southeast Asia, criticism of the doctrine of combat psychiatry resurfaced in the form of speculations that it had generated these delayed casualties for the sake of questionable military goals.^{62,102-105} For example, Abse comments:

Such [PTSD] patients in my experience have not received early effective treatment with emphasis on cathartic psychotherapy. On the contrary, they received, while in Vietnam, treatment which emphasized massive psychotropic medication, followed by crowding out with sundry recreational activities any focus on their essentially traumatic and pathogenic experiences. Such temporary suppressive treatment invited the reinforcement of dissociation though it may have worked for the while, while the soldier was in active service overseas.^{103(p20)}

However, no correlation has been found between proximate combat-generated psychiatric difficulties in Vietnam and psychiatric problems in readjustment to stateside life.¹⁰⁶

ETHICAL DILEMMAS IN THE TREATMENT OF COMBAT STRESS REACTIONS

The Military Psychiatrist as a "Double Agent"

Before an attempt to analyze the ethical conflicts associated with the treatment of combat reaction cases can be made, the military psychiatrist's "double agent" status must be underscored.¹⁰⁷ For physicians, being a double agent refers to professional situations that involve responsibilities to a patient that may contradict fiduciary ones (a contractual arrangement based on trust). More specific to the military psychiatrist, the double agent conflict follows from the fact that because they work for the military, their professional responsibilities typically include both patient-centered, therapeutic decisions and organization-centered, administrative decisions.¹⁰⁸ Furthermore, because there is considerable professional disagreement about mental health norms,¹⁰⁹ balancing loyalties can become more difficult for psychiatrists than for other types of military physicians. In addition to being affected by the values of the military organization, their clinical decisions may also reflect their personal ideology,^{85,90} training, and experience,⁸¹ as well as changing social contexts.⁴⁵

Effective Treatment May Not Be Ethical Treatment

In November, 1967, Specialist 4th Class (Sp4) Frank Gentili (case material disguised), a 20-year-old infantryman who had been assigned in Vietnam for 5 months, was transported by helicopter to a U.S. Army evacuation hospital along with other combat casualties. On his arrival, he was observed to be mute, grunting incomprehensibly, and posturing. He was quite disorganized and could not communicate with his examiners. He was easily startled by noises and walked with a slow, shuffling gait. When he sat in a chair, he rocked with his eyes closed and occasionally mumbled "Mama." The results of his physical examination were otherwise normal.

On the psychiatric unit, Sp4 Gentili was given a shower, reassurance, and was "put to sleep" with chlorpromazine (dose not available). When he awoke 18 hours later he seemed alert, coherent, and rational. He was issued a fresh uniform and received instructions about the quasi-military ward routine. The staff told him that he was recovering from overexposure to combat and that he could expect to be returned to his military unit soon. In the group

therapy meeting, Sp4 Gentili emotionally told how he had been serving as a fire team leader when six of his friends were killed and mutilated by enemy fire and described how he had become agitated and began screaming while loading their bodies into a helicopter. He talked of his revulsion at the killing and his regret that he had "gone to pieces." He felt torn because he always sought to be "good" and wanted to be a good soldier, but that it just was not his "make-up" to kill. He declared that he could not return to the field. The record notes that the psychiatric staff responded to Sp4 Gentili's feelings "with reality-testing and ego support of his duty and mission." That night he was informed that he would be returning to his unit the following day, and he was again given chlorpromazine.

Because of his rapid improvement and lack of a past psychiatric history, Sp4 Gentili was discharged back to his unit with the diagnosis of "combat exhaustion." It was also recommended that he be reexamined by his division psychiatrist if his symptoms recurred.

Except for the addition of chlorpromazine, this soldier would have been managed similarly by military psychiatrists during the latter phases of World War I, in World War II, or in the Korean conflict, and probably with the same rapid return to duty.⁴³ In those wars, the military doctrine's effectiveness in fulfilling its treatment goal was unambiguous.¹⁸ However, just as legality is not a sure test of morality, neither is treatment effectiveness. The challenges to the military treatment doctrine from the Vietnam conflict era raised questions centered around how loyal military psychiatrists were to the welfare of their soldier-patients in the process. Using the case of Sp4 Gentili, a closer look at the criticisms, such as that of Livingston,⁷⁰ suggests two confounded questions: (1) Was his treatment and disposition by military psychiatrists unethical because it primarily served, as some believed, the prosecution of an immoral war? (2) Was his treatment and disposition unethical because it served military expediency at the expense of his interests or welfare?

The answer to the first question is logically straightforward. Any professional activity by military psychiatrists that contributes to an immoral or unjust war would be immoral and unethical. However, in reality such a judgment on the morality of a war remains inconclusive with respect to Vietnam.¹¹⁰ Many share the view that the Vietnam conflict was categorically immoral.^{2,111} In addition, specific com-

bat activities, such as atrocities, may be readily distinguishable as immoral. Others would justify the U.S. intervention in Vietnam on the basis of the principles of international law established after World War II by the military tribunal at Nuremberg.¹¹² Furthermore, a link between particular immoral combat activities and the specific clinical activities of military psychiatrists may be very difficult to establish.

The Challenge of Distinguishing Harm and Benefit

The second and more general question regarding the psychiatrist's obligation to the soldier is also complicated and has implications for the use of the military treatment doctrine in any war. Because of his double agent position, the combat psychiatrist faces an array of competing values and influences and, therefore, is responsible for the effects of his treatments in terms of the balance of harm and benefit.¹¹³

The Question of Harm to the Soldier

Is it likely that Sp4 Gentili was harmed by the combat psychiatry treatment approach because it put him in unreasonable jeopardy in subsequent combat? If he was only partially treated, or if he was still under the sedating effect of chlorpromazine, or because of his already demonstrated susceptibility, his vulnerability in combat may have been greatly increased.¹¹⁴

As was mentioned previously, the question of the effects of the neuroleptic and anxiolytic drugs on the performance (or vulnerability) of combat soldiers who served in Vietnam has not been studied. A study by Palinkas and Coben¹¹⁵ did, however, suggest that, at least for some diagnostic groups, returning soldiers to combat exposure after psychiatric hospitalization may have increased their risks. According to these authors' review of the records for all U.S. Marines deployed in Vietnam throughout the conflict (N = 78,756), psychiatric hospitalization was significantly associated with an increased risk of becoming subsequently wounded among those diagnosed with social maladjustment, psychosomatic conditions, "nervous and debility [sic]," transient situational disturbance, and acute situational maladjustment. However, the 243 Marines listed specifically as having combat fatigue were not shown to be at greater risk.

The Question of Benefit to the Soldier

Is it likely that Sp4 Gentili benefitted by being treated according to the combat psychiatry doctrine? Psychiatric morbidity in prior wars was greatly reduced among soldiers affected with combat stress reaction who were treated and managed according to the traditional doctrine⁵⁷ because it apparently (1) reinforced the soldiers psychological defenses against subsequent breakdown in combat and (2) opposed the fixation of his symptoms into a “self-protective disabling neurotic compromise.”^{7(p731)} It was the impression of the earlier military psychiatrists that through suppressive and repressive clinical means, they could strengthen the affected combat soldier’s investment in his combat comrades, leaders, and objectives, as well as reinforce his confidence in his own capabilities, thereby reestablishing his primary psychological resistance against further combat-induced disorganization:

[To adapt to combat the soldier must] fuse his personal identity with the new group identity, to form deep emotional relationships with his buddies and with his leader, in sharing boredom, hardship, sacrifice and danger with them, and whether by compromise or illusion, to become oriented with them toward the destructive goals which he understands to be necessary for the common good.^{19(p365)}

Deeper, longer, or more complicated treatments, and especially those occurring far from the soldier’s original unit and in more comfortable surroundings, were found as far back as World War I to favor the development of chronic psychiatric disability.¹¹⁶ Glass commented on the disadvantage of using uncovering therapies:

Indeed, any therapy, including usual interview methods, that sought to uncover basic emotional conflicts or attempted to relate current behavior and symptoms with past personality patterns seemingly provided patients with logical reasons for their combat failure. The insights obtained by even such mild depth therapy readily convinced the patient, and often his therapist, that the limit of combat endurance had been reached as proved by vulnerable personality traits.^{7(p727)}

The Question of Coercive Treatment and Its Benefit to Society

Was Sp4 Gentili’s treatment unethical because his combat stress reaction represented the combat

refusal of a dissident or because it is normal not to want to return? By labeling him with the exclusively military diagnosis combat exhaustion, disregarding his opposition to further combat, and imposing the military doctrine’s treatment regimen, were his military psychiatrists blaming the victim?⁸⁴ Some writers have even referred to the soldier’s new willingness to enter combat after such coercive treatment as an iatrogenic psychosis.^{1,62}

The matter of informed consent or refusal is especially critical when psychiatrists are representing the interests of other parties in addition to those of their patients.¹¹⁷ In Sp4 Gentili’s presenting condition of near catatonia, he was not competent to understand an adequate consent process and there can be little doubt about the rightfulness of treating him as the military psychiatrists deemed necessary. However, on the following day, his regression and decompensation had largely resolved, and the situation became quite different. He was treated with more chlorpromazine and behavioral strategies, including exhortation of the duty side of his conflict to sway him from his expressed (at least initially) opposition to killing, and he was rapidly returned to more combat duty. No matter what efforts the treatment team might have expended to obtain Sp4 Gentili’s consent, the existence of a powerful negative incentive, that is, the threat of a court martial, eliminated the possibility of informed consent or refusal. Because these clinical techniques were imposed on an individual who was sufficiently competent and rational to cooperate with a consent process, Sp4 Gentili’s treatment was technically coercive by definition and violated a “moral rule” (against causing pain and depriving freedom).¹¹³

There may, however, be overriding moral justification for coercive treatment when it is felt to serve the best interests of the patient (so called paternalistic treatment¹¹³), but in civilian settings, the paternalism exception to the moral rule does not apply to rational, competent adults. However, because the rights of those in active military service have historically been abridged by law, these boundaries are less certain.² In fact, there are numerous military regulations and policies that shape the practice of psychiatry to represent the preeminence of institutional goals and values over those of the individual.^{41,118} Besides the absence of a right to informed consent or refusal with regard to hospitalization or psychiatric treatment, there are also limitations in the service member’s rights to privileged communication²² and to psychiatric due process.¹¹⁹

There also may be overriding moral justification for coercive treatment when the treatment is deemed necessary for the welfare of others (so called utilitarian value). Was there sufficient benefit to society to justify treating Sp4 Gentili according to the combat psychiatry doctrine? That is, in overriding his autonomous choice and quickly returning him to fight again in spite of some additional risk to him, was his treatment team serving a superseding value representing the welfare of the American people? As a soldier, was he obligated to unconditionally sacrifice his self-interest for the common good?

Some individuals would argue that a treatment approach that justifies the sacrifice of the interests of the individual soldier in the service of society may simply coincide with the military's value of teamwork and combat efficiency in some situa-

tions. The military's values can diverge from those of society, as many believe was the case in Vietnam. In practice, it is unrealistic to believe that the combat psychiatrist can distinguish at any given time whether the military treatment doctrine serves essential public welfare or only conforms to military objectives, political goals, or a war's popularity. Furthermore, this uncertainty may compound the already difficult task of determining clinically whether a soldier who is opposed to returning to combat is suffering from a mental disorder or expressing a rational refusal.¹⁰⁹ Brill's comment from World War II illustrates the influence of the seeming utilitarian values on clinical judgment: "It was difficult to define exactly how much of such patients' ineffectiveness was due to illness and how much to lack of desire to do their part."^{120(p242)}

DISCUSSION

The Ethical Foundation of Traditional Military Psychiatry

How can we understand the emergence of such strenuous opposition to the combat psychiatry doctrine in Vietnam and the subsequent weakening of the professional credibility of military psychiatry during the Vietnam conflict era? Evidently, under the conditions of more "popular" wars—World War I, World War II, and the Korean conflict—psychiatrists serving in the military apparently experienced little ethical strain, even though they required reorientation from civilian values.⁸ The traditional military treatment doctrine rested on a foundation of mutually reinforcing ethical positions that seemed sufficiently humanitarian to provide military psychiatrists with the moral context for their clinical interventions. These earlier combat psychiatrists believed that not only were they conforming to the expectations and values of the military, but even more important, there was congruence between what was perceived to be best for the soldier and best for society. It was felt that the doctrine not only contributed to America's defense but also represented the most effective, scientifically based regimen for protecting soldiers from further combat traumatization and from chronic psychiatric disability. Thus, it seemed apparent that the psychiatrist who failed to understand both sides of the soldier's struggle to overcome his fear and his own moral dilemma could overly empathize with the soldier's self-protective tendencies and

"overdiagnose" and "overevacuate" such soldiers, inadvertently increase psychiatric morbidity, and risk negatively affecting the military situation.⁴

Furthermore, these early psychiatrists had confidence in the morality of their treatment goals and methods because of supportive positions taken by organized psychiatry.⁹ They believed that their professional activities were consistent with the ethical principles of their profession.

Psychiatry's Ethical Ambiguity Concerning Vietnam

The Vietnam conflict provides a vastly different picture. Evidently, the alignment of justifying moral principles for combat psychiatry's doctrine that had held throughout the earlier wars was precariously balanced. As the conflict in Vietnam dragged on and the numbers of casualties reached an intolerable level for the American public, doubts arose about what constituted the ethical practice of military psychiatry. Such doubts also coincided with the rising social consciousness in the late 1960s and early 1970s and the increased proportion of civilian-trained psychiatrists assigned to the military in Vietnam.⁸¹ Many military psychiatrists who served in the second half of the Vietnam conflict felt inclined to identify with the dissent of the vast numbers of soldiers who were—for the first time in the modern history of American warfare—themselves opposed to the nation's political and military objectives. These replacement psychiatrists became con-

cerned that the military treatment doctrine was not humanitarian and might only serve authoritarian and political ends (ie, violating *primum non nocere*). They questioned the treatment regimen that would induce soldiers to believe that further exposure to combat was in their best interests and evidently worried that they could “expect” soldiers to risk their lives or their mental stability without moral justification.

In spite of their attempts to find the balance between harm and benefit, military psychiatrists in Vietnam functioned in the dark. Although they knew of the successful implementation of the military treatment doctrine in past wars, they had no reliable information about whether their patients might face unacceptable risks because of its use in Vietnam. Nor could they comprehend whether the doctrine truly served public welfare. Even if the conflict met the standard for a just war by international law, its morality for the psychiatrist in Vietnam, just as for the soldier or citizen, may have been far more subjectively determined.²

The Military Psychiatrist as Scapegoat

The ethical burden for Vietnam’s combat psychiatrists was magnified because they struggled with these issues alone. Psychiatry failed to recognize their dilemma, provide them with ethical sanctions, or monitor the institutional regulations, policies, and treatment doctrine that affected the practice of military psychiatry. Furthermore, the tendency for critics such as Lifton⁶² to equate the questions

about the institutional abuse of psychiatry with those regarding the conduct of the individual psychiatrist greatly added to the combat psychiatrists’ role confusion. A more realistic consideration would acknowledge the impossible contradiction of military and professional obligations under those circumstances. In the words of Boman, “The role of the military psychiatrist in a conflict like Vietnam encompasses so many ambiguities and moral dilemmas that one would not be surprised at his lapsing into almost a state of frozen ambivalence”^{21(p124)} London^{121(pp249–250)} went further by challenging the new “moralistic ‘right think’” of those who would fault military psychiatrists for not actively opposing the military in Vietnam, “. . . it is unseemly, if not immoral, to retrospectively condemn the doctors of last decade’s war for doing what then looked like their duty. . . .”^{121(p250)}

Section three of the APA’s principles of medical ethics with annotations especially applicable to psychiatry¹¹⁷ speaks of the psychiatrist’s obligation to provide the best possible care within the constraints of the system while striving to change those conditions that are not in the best interests of the patient. However, it is unclear what could have been done differently by military psychiatrists during the Vietnam era. Opposition to military regulations and policies by individual professionals appears self-defeating if one considers the examples of social worker Meshad,¹²² general medical officer Livingston,⁷¹ psychiatrist Locke,⁸⁸ and the well-publicized court martial in 1967 of dermatologist H. Levy, as commented on by Veatch.¹²³

CONCLUSION

Although this chapter seeks to understand the negative impact of the Vietnam conflict on the psychiatrists who served there and the degradation of the prestige of military psychiatry, perhaps it contributes little more than to express lamentations following a failed war. If the United States had achieved its military and political goals in Southeast Asia, would concerns about a doctrine that urges soldiers to return to the fight be taken seriously? It certainly seems self-evident that as the country loses its will to make sacrifices for the sake of fighting a war, soldiers will quickly become demoralized, and the psychiatrists sent to support them will struggle as well.

Still, it has been amply documented how the Vietnam conflict’s unpopularity and the collective

sense of its wrongfulness affected America’s combatants; however, far too little has been said regarding the impact of these aspects on healthcare providers such as psychiatrists and allied medical personnel. This chapter’s inclusion of the personal reactions from the Vietnam era—testimony that is typically absent from the analyses of moral philosophers and bioethicists—seeks to recognize the agony of the psychiatrists (and others) who wrestled with the Vietnam conflict’s moral and ethical questions.

The moral dilemma for combat psychiatrists in Vietnam was no greater than that for the soldier or military leaders. Furthermore, their service there was clearly less physically hazardous. Nevertheless, might psychiatry and the nation owe some

measure of gratitude and acknowledgment to these men and women in consideration of their impossible task and the personal sacrifices they sustained in performing the duties that their country asked of them?

Regarding the more general questions surrounding the implementation of the traditional combat psychiatry treatment doctrine, in the more than two decades since American troops were withdrawn from Vietnam, there has been regrettably little interest in resolving challenges that arose during the conflict regarding its ethical justification. In the wars before Vietnam, this doctrine had proved to be highly effective for treating individuals with combat stress reactions and returning them to duty. Furthermore, it was uncontroversial and later successfully adapted for use with civilian populations. As this review of the doctrine's rationale and ethical quandaries suggests, combat psychiatrists are influenced by powerful, potentially competing value systems but cannot always appreciate some of the

most important factors that affect the balance of harm and benefit associated with their treatment decisions.

Surely, it can be said that psychiatry as a profession buried its bitter Vietnam memories after the conflict and that they have yet to be assimilated. Yet critical moral and ethical questions regarding the loyalties of combat psychiatrists remain. Rather than replacing the wrenching memories of the Vietnam conflict and the associated decadent and divisive epoch with amnesia, psychiatry and its military representatives should seek consensus regarding the unique collection of ethical dilemmas that can surround the delivery of psychiatric care under combat conditions. More specifically, future research and study should be devoted to the establishment of fundamental ethical standards and formalized professional guidelines for the treatment of military casualties. Otherwise, there remains, as there was during the Vietnam conflict, a greater burden of conscience borne by each psychiatrist who serves.

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