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14. ABSTRACT

Vietnam was America's most protracted and divisive war in modern times, however, evidently the US Army did not retain psychiatric records and related materials that would serve as a data base for analysis and formulation of "lessons learned" regarding the dynamics of psychiatric attrition or prevention in the theater. Yet Vietnam introduced a rich variety of unique or changing circumstances altering both the ecology of the battlefield and the rear, as well as provided a new technology for treatment of psychiatric disorders, i.e., relatively non-sedating psychotropic drugs. This report provides an alternative rationale, survey instrument, and methodology for ascertaining a comprehensive description of the dominant patterns of psychiatric and psychosocial breakdown among U.S. Army troops in Vietnam and the forms of intervention provided through the accumulation of survey data from Army psychiatrists who served there.

15. SUBJECT TERMS

military psychiatry, combat psychiatry, Vietnam

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PATTERNS OF PSYCHIATRIC NEED AND INTERVENTION AMONG U.S. ARMY TROOPS OF THE VIETNAM CONFLICT

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RESEARCH PROTOCOL

1. Project Title: Patterns of Psychiatric Need & Intervention among U.S. Army Troops of the Vietnam Conflict

2. Principal Investigator: Norman M. Camp, COL, MC

3. Time Required to Complete: October-December 1982

4. Introduction:

A. Medical Application. A comprehensive description of the dominant patterns of psychiatric and psychosocial breakdown and the types of intervention provided as recalled by the physicians serving as psychiatrists for the Army during the Vietnam conflict will provide important new information toward understanding variables contributing to or mitigating against psychological breakdown in combat and in such a combat theatre as Vietnam. Of particular value in this study will be the accumulation of physician experience regarding the perceived indications and contraindications for use of psychotropic medications in that combat setting, since anxiolytic and neuroleptic medicines were not available in previous American wars. Analysis of such prescribing practices and results could be critical for designing a psychiatric treatment doctrine for the battlefield of the future.

B. Objective. To utilize the recollections of all physicians who served as psychiatrists for the Army in the Vietnam conflict to construct a descriptive history of the dominant patterns of perceived psychiatric need, practices and results. More specifically, this survey is designed to inquire regarding: the relative prevalence of all psychiatric, psychosomatic and behavioral conditions of the Army troops in Vietnam that served to erode force readiness; psychiatric intervention efforts designed to treat or counteract such conditions along with the degree of success obtained; and the subjective reactions of the psychiatrists to service in Vietnam, operational doctrine and the ethical dilemmas inherent in combat psychiatric practice there. Ultimately this material can be correlated with more objective data regarding order of battle and battle intensity, or other information regarding situational variations that may emerge from historical recounts not yet available. This line of inquiry is an attempt to assess the dynamics of psychiatric practice, nosology, diagnosis, and treatment in the context of a limited war.

C. Background for the Study. In contrast to WWI, WWII, and the Korean Conflict, sufficient archival material does not currently exist that could serve as a data base for analysis and formulation of “lessons learned” regarding the dynamics of psychiatric attrition or prevention in Vietnam. As America’s most protracted and divisive war in modern times, and as a limited war with an ambiguous conclusion, it served to introduce a rich variety of unique or changing circumstances altering both the ecology of the battlefield and the rear, as

well as introducing new technology for treatment of psychiatric disorders (i.e., anxiolytic and neuroleptic psychoactive medications). Psychiatric observers of the first half of the war reflect a confidence in the doctrine of psychiatric treatment and prevention implemented in Vietnam, based on the unprecedented low levels of psychiatric attrition.[1 2, 3] Those and others serving in Vietnam during the buildup half of the war described the morale and commitment of troops as high, speculating on a list of operational factors serving to protect the soldiers from combat breakdown such as confidence in weapons, professionalism of troops, fixed one year assignment schedules, high caliber of leadership and adequacy of supplies, equipment, and support, especially medical support.[4 5 6] A summary of Army medical experience in Vietnam 1965-1970, however, highlighted an increase in psychiatric admissions beginning Army-wide in 1968 with the rate in Vietnam increasing more precipitously than elsewhere.[7] The Psychiatric Consultant to the Surgeon General's office associated this rise with an increase in racial disharmony and a general decrement in perception of military purpose within the soldier and speculated that the intent to disengage from Vietnam may result in a new phase of psychiatric attrition.[8] This prophecy proved to be accurate. Renner, a psychiatrist with the USMC in 1969, a mid-point in the war, noted "a marked increase in disciplinary problems", "an alarming increase in drug abuse", "atrocities, episodes of racial conflict", and "increasing number of attacks made by enlisted men on officers and senior enlisted men".[9] His conclusion was that despite the reports of fewer psychiatric casualties, it was clear that there had only been a change in the nature of symptoms. Although at that time he perceived a "morale problem", be believed that "the average soldier, despite complaints about his duties and possible reservations about involvement in Vietnam, seems to adapt to the situation."

The demobilization half of the Vietnam conflict, from 1970 through 1975, is recognized as having an accelerating deterioration of troop morale causing a serious degree of force degradation. Dramatic increases in overall inpatient and outpatient psychiatric rates;[10] specific diagnoses of narcotic abuse;[11] judicial and non-judicial (Article 15) disciplinary actions,[12] and convictions for the specific crime of "fragging"[13] (use of explosives in assaults on superior officers) as well as racial incidents[14] make this point convincingly.

Camp, reporting from his vantage point with the Army's northern psychiatric specialty treatment detachment in 1971, during the period of peak incidence of these psychiatric and behavioral disorders, described the summation of circumstantial stressors and resultant psychosocial phenomena peculiar to the demobilization phase of the war, and questioned the effectiveness of the psychiatric treatment doctrine and structure as practiced under those circumstances.[15]

Regarding use of psychoactive medications for the purpose of treatment and prevention of combat breakdown, little exists in the open literature to document use during the Vietnam conflict. Field reports seem to fall into categories of vague[16 17 18] general, [20 21 22] or anecdotal, [23 24] and the implication seems to be that psychoactive medications were liberally and casually used by psychiatrists and battalion surgeons for a wide variety of conditions that included anxiety, agitation, and mental disorganization, psychosis, and fatigue. Bourne in summing the psychiatric experiences in Vietnam during the buildup period and phase of most intense combat stated that these medications had a "relatively slight impact" in prevention and treatment of psychiatric conditions.[25] Datel and Johnson, however, in an unpublished

survey of 116 psychiatrists and general medical officers in 1967 found that the annual psychotropic drug prescription rate was 7.4 percent per year.[26] The most frequently treated condition was "anxiety", treated with anxiolytic medicines. Combat fatigue, although undefined, was primarily treated with neuroleptic medication. Eighty-five percent of neuroleptic prescriptions written by primary care physicians were for one day only and 36 percent of those written by psychiatrists were prescribed on a "take as needed" basis. These investigators conclude their principal finding as "across condition and across drug, then, the prescribing physicians were of the opinion that psychotropic drug treatment was by and large quite influential in reducing the problems presented." Johnson, senior psychiatrist in Vietnam in 1967, summing the preventive psychiatry results in Vietnam during the buildup period stated: "It may very well be that the use of tranquilizing medications is one of the most important factors in keeping the psychiatric rates in Vietnam at a low level." He adds, however, that in his survey of prescription patterns that psychoactive drugs were prescribed frequently "for apparently emotional conditions even when this was not immediately obvious to the patient or the physician."[27]

Clearly, the diversity of psychiatric practices spanning the wide variations in time and circumstance in Vietnam warrant further research and description.

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5. Plan: A recent search has yielded a more or less complete listing of 120 names and addresses of physicians who served as psychiatrists with the U.S. Army in Vietnam. Each will be contacted and invited to cooperate with the study. Those who agree to participate will be given a survey instrument developed by the investigator. This instrument consists of questions designed to inquire about direct professional experiences, supervisory and consultative experiences and observations, professional opinions and subjective reactions.

The mode of analysis of the resultant information would be descriptive, designed to lay out the dominant patterns as described by the participants. A more fine grained analysis is precluded by the length of time that has elapsed between actual practice and present estimates.

6. Personnel: This study is designed to utilize the principal investigator and one technician. It is expected that the initial survey will require a month to tally responses and another to evaluate the data. An additional month will be required for final write up.

Camp:

Preliminary findings from this research can be found in:

Camp, N.M., Carney, C.M. (1987). U.S. Army psychiatry in Vietnam: Preliminary findings of a survey I. Background and Method. Bulletin of the Menninger Clinic, 51, 6-18, and Camp, N.M., Carney, C.M. (1987). U.S. Army psychiatry in Vietnam: Preliminary findings of a survey II. Results and Discussion. Bulletin of the Menninger Clinic, 51, 19-37.

Definitive findings can be found in:

Camp, N.M. Army Psychiatry in Vietnam. Washington, DC: Department of the Army, Office of The Surgeon General, Borden Institute (in production).
[http://www.bordeninstitute.army.mil/]

DEPARTMENT OF THE ARMY

WALTER REED ARMY INSTITUTE OF RESEARCH
WALTER REED ARMY MEDICAL CENTER
WASHINGTON, D.C. 20012

SGRD-UWI-A

Dear Dr.

The psychiatric heritage from the Vietnam conflict remains ambiguous, painful, and unresolved for many. It has led some to question the mode and patterns of treatment used within the framework of military psychiatry and others to defend them. It was furthermore cross-cut by the introduction into combat psychiatry of psychotropic medications never before used in such a circumstance.

The Department of Military Psychiatry, Walter Reed Army Institute of Research, is attempting to complete the description of psychiatry as practiced in Vietnam by seeking information from each physician who served in Vietnam as a psychiatrist, or as a physician with psychiatric training before or after service there. We have, therefore, sent you this questionnaire with the hope that information you can provide will assist in designing modifications in the form and function of military psychiatry in the future.

There were relatively few psychiatrists who actually served in Vietnam, and furthermore, there was great variability in the situation and time period in which each served. Consequently, a sample survey will not suffice and we feel that it is only through the cooperation of every Vietnam psychiatrist that we can approach an accurate and useful reconstruction of the realities of Vietnam. We earnestly hope and anticipate that you will take this opportunity to reflect upon your Vietnam experiences and share your perceptions and reactions with us.

This survey form may appear to be quite lengthy. It has been designed so that only relevant portions will require your attention. We acknowledge that the situation in Vietnam was complex and no set of standardized questions could either plumb or do justice to your experiences. Please feel free to expand on this instrument to describe situations or activities that you think are important to recount. In considering your responses to the survey questions, take care to isolate your Vietnam experience from other military medical experience you might have had, or the published accounts of others.

Although we cannot reimburse you for the time and effort required to complete this survey, we will share with each respondent who desires it, a summary report of the research. We would appreciate it if you could return the survey within 30 days. Because of the occasional unpredictability of mail service, we will contact those from whom we have not heard after 30 days. If at that time the survey has not been completed we will inquire if there are questions or assistance needed for its completion. Please call me collect at (202) 427-5312/5360 if you have any questions or would further like to discuss your Vietnam service.

Thank you!

NORMAN M. CAMP, COL, MC
Research Psychiatrist

PATTERNS OF PSYCHIATRIC NEED AND INTERVENTION AMONG US ARMY TROOPS OF THE VIETNAM CONFLICT

WALTER REED ARMY INSTITUTE OF RESEARCH

[WRAIR CREST]

VOLUNTEER AGREEMENT

Having full capacity to consent, I hereby volunteer to participate in a research study entitled, "Patterns of Psychiatric Need and Intervention among US Army Troops of the Vietnam Conflict" which is being carried out by the Department of Military Psychiatry, Walter Reed Army Institute of Research.

My voluntary participation is limited to the completion of a survey questionnaire and returning it to the research team.

I understand that I may withdraw at any time during the course of this study; I can revoke my consent without prejudice by writing to the research team and requesting that any materials pertaining to me be withdrawn from the study. I understand that the questionnaire I complete will be held as confidential and that access to it will only be granted to members of the research team.

_____ _____
Signature Date

_____
(Please Print Your Name)

PRIVACY ACT STATEMENT

AUTHORITY:

Section 3101 of Title.44, U.S. Code; Sections 1071-1087 of Title 10, U.S. Code; and Executive Order 9397.

PRINCIPAL PURPOSE(S):

The purpose for requesting information is to provide the various types of data needed to satisfy the scientific objectives of the study.

ROUTINE USES:

This information may be used to provide full documentation of investigative studies; conduct further research; teach and compile statistical data. Even though permitted by law, whenever possible, this personal data will not be released without your consent. Material from this study will not be published with names, or described in such a way that an individual can be identified without permission of that individual.

MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION:

The disclosure of requested information is voluntary. If the information is not furnished, and/or not available from other sources, your voluntary participation in this investigational study maybe precluded.

A copy of the Volunteer Agreement, together with a copy of this form, may be retained permanently by the investigator and by the U.S. Government as evidence of this notification. I have received or have declined to accept a copy of the Volunteer Agreement and a copy of this form which I may keep.

_____ _____

Signature Date

WALTER REED ARMY INSTITUTE OF RESEARCH VIETNAM PSYCHIATRIST SURVEY
Principal Investigator: Norman M. Camp, COL, MC

PLEASE MAKE LIBERAL USE OF MARGINAL NOTATIONS TO REFINE RESPONSES INCLUDING NA = NOT APPLICABLE; DK = DON'T KNOW OR RECALL

NAME:

I - PROFESSIONAL EXPERIENCE

Psychiatric training before serving in Vietnam?

Locations	Dates
_____	_____
_____	_____
_____	_____

Number of years of active duty military experience before serving in Vietnam (to the nearest half year)?
_____

Number of years of active duty experience as military psychiatrist before serving in Vietnam (to the nearest half year)? _____

Number of years of active duty military experience after last service in Vietnam _____

Dates of service in Vietnam? _____ to_____
Month/year Month/year

Preparation for service in Vietnam:

a. Attended officer basic courses at Medical Field Service School at Ft. Sam Houston, Texas? (Circle) Yes/No
If yes, please circle the number which represents the value to you that this course represented?
Very useful - 5 4 3 2 1 - Not useful

b. Psychiatry residency training was in part directed to considerations of the special milieu of a combat theater?
(Circle) Yes/No
Specifics?_____

c. Any additional specialized training in Military Psychiatry?
(Circle) Yes/No
Specifics? _____

d. Literature references you found useful in preparing for service in Vietnam?
_____
_____

e. Did you retain a personal journal, statistics, or write up your Vietnam experience?
_____
_____

UNITS TO WHICH YOU WERE ASSIGNED IN VIETNAM:

Dates	Unit Names & No (include both unit parent unit)	Type Unit (i.e. combat, support, service)	Your Title &/or job
Unit A___to _____	_____	_____	_____
Unit B___to _____	_____	_____	_____
Unit C___to_____	_____	_____	_____

(Henceforth some questions will refer to your unit assignment by the letters A, B, C).

Did you enter Vietnam with the unit to which you were assigned in the states? (Circle) Yes/No

Were you assigned as a replacement to any unit that had arrived previously in Vietnam as a group? (Circle) Yes/No
Which Unit? (A, B, or C)_____

Was there a period of overlap with you predecessor in the units to which you were assigned?
Unit A_____ (Time) overlap
Unit B_____ (Time) overlap
Unit C_____ (Time) overlap

Comment generally (circle number) on adequacy of professional facilities and supplies, by military standards, in each unit to which you were assigned (medicines, beds, transportation, communication, etc.)

Unit A Very adequate - 1 2 3 4 5 - Very inadequate
Unit B Very adequate - 1 2 3 4 5 - Very inadequate
Unit C Very adequate - 1 2 3 4 5 - Very inadequate

Likewise comment on adequacy of psychiatric treatment capability in regards to numbers and expertise of staff.
Unit A Very adequate - 1 2 3 4 5 - Very inadequate
Unit B Very adequate - 1 2 3 4 5 - Very inadequate
Unit C Very adequate - 1 2 3 4 5 - Very inadequate

If you were assigned to provide psychiatric services, comment generally (circle number) on the degree to which this job was facilitated or obstructed by assignment of additional duties (ie other medical/administrative tasks).

Unit A Very Facilitated - 1 2 3 4 5 - Very Obstructed
Unit B Very Facilitated - 1 2 3 4 5 - Very Obstructed
Unit C Very Facilitated - 1 2 3 4 5 - Very Obstructed

DUTIES AND TIME ALLOCATION:
Indicate generally the % of your time spent in each category in each unit
(Please have each column add to 100%)

AS PSYCHIATRIST	UNIT A	UNIT B	UNIT C
a. Patient evaluations: (Include symptomatic, command referred and forensic cases, plus attendant work)	_____	_____	_____
b. Direct treatment of patients:	_____	_____	_____
c. Supervisory: (as of general medical officers, Psychiatric techs, and other psychiatrists, etc.)	_____	_____	_____
d. Program consultation: (as with commanders or unit staff)	_____	_____	_____
AS GENERAL PHYSICIAN (As treatment of casualties Sick call, Medcap mission, etc.)	_____	_____	_____
AS OFFICER (Administrative or staff duties)	_____	_____	_____
OTHER (Please explain)	_____	_____	_____
Total	100%	100%	100%

DIAGNOSTIC DISTRIBUTION:
Estimate the percentages of the patients that you evaluated of treated during your Vietnam service that fell within each of these major ICD-9-CM categories (percentages need not add to 100% because some categories are omitted)

a) ORGANIC PSYCHOTIC CONDITIONS:
(Include alcoholic psychoses, DTs, drug psychoses) _____%

b) SCHIZOPHRENIC PSYCHOSES:
(excludes brief psychoses of a hysterical or reactive nature) _____%

c) AFFECTIVE PSYCHOSES:
(includes "Endogenous Depression") _____%

d) NEUROTIC DISORDER:
(includes neurotic depression and hypochondriasis) _____%

e) PERSONALITY DISORDERS:
(i.e. "deeply ingrained maladaptive patterns of behavior) _____%

f) ALCOHOL DEPENDENCE SYNDROME:
("characterized by behavioral and other responses on a periodic basis; tolerance may or may not be present." _____%

g) DRUG DEPENDENCE SYMDROME:
(similar definition) _____%

h) COMBAT REACTION: Appendix A, opposite page:
(all types requiring psychiatric attention) _____%

i) NO DISEASE FOUND: _____%

j) OTHER:
(Please Specify) _____%

	Appendix A: SPECTRUM OF COMBAT REACTION			
	COMBAT REACTION: APPREHENSION "NORMAL FEAR"	**COMBAT REACTION: INCIPIENT DISORGANIZATION/ DYSFUNTION**	**COMBAT REACTION: PARTIAL DISORGANIZATION/ DYSFUNTION**	**COMBAT REACTION: COMPLETE DISORGANIZATION/ DYSFUNTION**
SOCIAL AND BEHAVIORAL	Appropriate Effective Close with comrades Share fears with comrades	Add: Irritability	Seclusiveness & Moroseness Over-dependent Decline responsibility Reduced initiative Impulsive Decreased interest in: combat, food, letters, etc. Alarms unit	Unstable and erratic Reckless or overcautious Savagely irritable Unreasonable and defiant Sobbing & screaming Passive & helpless
EMOTIONAL AND COGNITIVE	Increased vigilance Worried of: 1. Death or mutilation 2. Incapacitation by fear 3. Losing caste with group thru fear	Add: Startle reaction	Mild disorientation Reduce judgment Psychomotor retardation Affect blunting Depressive rumination re: 1-Survival 2-Combat failure 3-Aggression in combat	Confused Disorganized
SOMATIC	Tense Autonomic arousal (gastrointestinal irritability, etc.) Disturbed sleep (sleepwalking etc.) Psychosomatic complaints	Add: Significant insomnia Exhaustion	Add: Severe diarrhea and vomiting Somatic preoccupations	Stammering and incoherent Tremulous and uncoordinated Mute and staring Conversion symptoms (deaf, blind, amnesia, paralyzed, convulsive)

II - TREATMENT OF COMBAT RECTIONS (See Appendix A)

PRIMARY INTERVENTION CARE – IT IS THE CARE OF FRESH CASUALTIES, REGARDLESS OF LOCATION. THIS CARE WAS COMMONLY APPLIED BY MEDICS, PSYCHIATRIC/SOCIAL WORK TECHNICIANS (91G), OR GENERAL MEDICAL OFFICERS AT THE BATTALION AID STATION LEVEL. THE FOLLOWING QUESTIONS REFER TO SUCH CAUALTIES. STRIKE THROUGH ANY OF THE FOLLOWING QUESTIONS THAT YOU FEEL YOU CANNOT ANSWER.

1. In any of your assignments did you provide primary intervention care or supervise same for fresh combat psychiatric casualties?

   Very frequent - 1 2 3 4 5 - Very seldom

   IF YOU CIRCLED #5 – VERY SELDOM, SKIP THIS SECTION, PROCEED TO PAGE 8 "SECONDARY INTERVENTION CARE"

2. To your knowledge how frequently were soldiers seeking or brought for case as fresh psychiatric casualties successfully treated and returned to combat duty without resorting to direct intervention care, or treatment lasting longer than 24-48 hours? (circle number)

   Very frequent - 1 2 3 4 5 - Very seldom

3. Referring to the list of psychoactive meds marked PRIMARY INTERVENTION MEDS, which were commonly prescribed by yourself or other medical personnel for any symptoms of these 4 phases of reaction to combat stress in fresh casualties? Note drug and route with a check in any of columns 1-4 that apply (or preferably indicate dosage range or schedule.)

4. In column 5 marked RETURNED TO DUTY, note with a check (or preferably with a dosage range of schedule) maintenance medications that were routinely prescribed by yourself of other medical personnel for combat reaction cases who were returning to the combat environment after receiving primary intervention care, in order to assist them with control over such symptoms.

5. In column 5 marked EFFECTIVENESS, note whether in your estimation meds prescribed in the RETURNED TO DUTY column resulted in generally in increased combat effectiveness, decreased combat effectiveness or no observable difference by marking +, - , or 0 respectively (i.e. alertness, competence, clarity, of thought , rapport with comrades, as compared to peers.)

6. How commonly were soldiers returned for additional medical care for recurrence of such symptoms after being returned to duty following primary intervention care?

   Very frequent - 1 2 3 4 5 - Very seldom

7. If you have first hand experience at a FIRST ECHELON CARE FACILITY such as a Battalion Aid Station, how frequently were patients kept for treatment over 48 hours?

   Very frequent - 1 2 3 4 5 - Very seldom

PRIMARY INTERVENTION MEDS (Treatment: onset of symptoms thru 48 hours)

	Phase of Combat Reaction (CR)					
	APPRENENSION (1)	CR INCIPIENT (2)	CR PARTIAL (3)	CR COMPLETE (4)	RETURN TO DUTY (5)	COMBAT EFFECTIVENESS
"MAJOR TRANQ"						
Thorazine Oral						
IV/IM						
Mellaril						
Stelazine						
Prolixin Oral						
IV/IM						
"MINOR TRANQ"						
Equanl/Miltown						
Libruim Oral						
IV/IM						
Valium Oral						
IV/IM						
Vistaril (Atarax) Oral						
IV/IM						
ANTIDEPRESSANT						
Tofranil Oral						
IV/IM						
Desipramine						
Aventyl						
STIMULANTS						
Dexadrine						
Dexamyl						
Ritalin						
SEDATIVE/HYPNOTIC						
Phenobarb Oral						
IV/IM						
Seconal						
Amytal Oral						
IV/IM						
Nembutal Oral						
IV/IM						
Doriden						
Chloralhydrate						
OTHER						
Compazine Oral						
IV/IM						
Spansule						

SECONDARY INTERVENTION CARE – ESSENTIAL FEATURE IS THAT PATIENT RECEIVED THIS CARE USUALLY AFTER AT LEAST 24-48 HOURS HAD ELASPED AND PERHAPS PREVIOUS TREATMENT HAD BEEN TRIED ELSEWHERE. THIS SECONDARY CARE WAS MOST COMMONLY APPLIED BY PHYSICIANS WITH PSYCHIATRIC TRAINING OR EXPERIENCE OR BY OTHERS UNDER THEIR DIRECT SUPERVISION AT THE DIVISION LEVEL. THESE QUESTIONS REFER TO SUCH CASES. STRIKE THROUGH ANY OF THE FOLLOWING QUESTIONS THAT YOU FEEL YOU CANNOT ANSWER.

1. In any of your assignments, did you provide secondary intervention care, or supervise same, for combat psychiatric casualties (i.e. after 24-48 hours following onset of symptoms, but before 5 days had elapsed)

   Very frequent - 1 2 3 4 5 - Very seldom

2. How frequently were those referred for secondary intervention care for combat related psychiatric symptoms successfully treated and returned to combat duty within the 2-5 days usually allotted at this level?

   Very frequent - 1 2 3 4 5 - Very seldom

3. Referring to the list of medications marked SECONDARY INTERVENTION MEDS, which were commonly prescribed by treatment staff for any symptoms of these 4 phases of reaction to combat stress in such patients? Note drug and route with a check (or preferably indicate dosage range or schedule) in the first four columns where appropriate.

4. In column 5 marked RETURN TO DUTY, note with a check (or preferably a dosage range or schedule) those maintenance medications which routinely were prescribed for the soldier who completed such treatment within the 2-5 days allotted, and was returning to combat duty.

5. In column 6 marked EFFECTIVENESS, note whether in your estimation those meds prescribed for such cases in the RETURN TO DUTY column resulted generally in increased combat effectiveness, decreased combat effectiveness or no observable difference by marking +, - , or 0 respectively (i.e. alertness, competence, clarity of thought, rapport with comrades, as compared to peers)

6. How frequently did soldiers return to any medical facility for recurrence of symptoms following return to duty from secondary intervention care?

   Very frequent - 1 2 3 4 5 - Very seldom

7. If you have experience at a division or other 2nd echelon level facility, how frequently were fresh psychiatric casualties treated there? (i.e. bypassing Aid Station)

   Very frequent - 1 2 3 4 5 - Very seldom

8. Likewise how often were psychiatric combat casualties kept for treatment over 5 days after onset of symptoms?

   Very frequent - 1 2 3 4 5 - Very seldom

SECONDARY INTERVENTION MEDS (Treatment: after 2 days thru 5 days)

	Phase of Combat Reaction (CR)					
	APPRENENSION (1)	**CR INCIPIENT (2)**	**CR PARTIAL (3)**	**CR COMPLETE (4)**	**RETURN TO DUTY (5)**	**COMBAT EFFECTIVENESS**
"MAJOR TRANQ"						
Thorazine Oral						
IV/IM						
Mellaril						
Stelazine						
Prolixin Oral						
IV/IM						
"MINOR TRANQ"						
Equanl/Miltown						
Libruim Oral						
IV/IM						
Valium Oral						
IV/IM						
Vistaril (Atarax) Oral						
IV/IM						
ANTIDEPRESSANT						
Tofranil Oral						
IV/IM						
Desipramine						
Aventyl						
STIMULANTS						
Dexadrine						
Dexamyl						
Ritalin						
SEDATIVE/HYPNOTIC						
Phenobarb Oral						
IV/IM						
Seconal						
Amytal Oral						
IV/IM						
Nembutal Oral						
IV/IM						
Doriden						
Chloralhydrate						
OTHER						
Compazine Oral						
IV/IM						
Spansule						

TERTIARY INTERVENTION CARE - ESSENTIAL FEATURE IS THAT PATIENT RECEIVED THIS CARE AFTER 5 DAYS HAD ELAPSED AND PROBABLY PREVIOUS TREATMENT EFFORTS HAD BEEN TRIED. THIS TERTIARY CARE WAS MOST COMMONLY APPLIED BY PSYCHIATRISITS ANDALLIED PROFESSIONALS AT THE K.O. DETACHMENT OR EVAC HOSPITAL LEVEL. THESE QUESTIONS REFER TO SUCH CASES. STRIKE THROUGH ANY OF THE FOLLOWING QUESTIONS THAT YOU FEEL YOU CANNOT ANSWER.

1. In any of your assignments did you provide tertiary intervention care, or supervise same, for combat psychiatric casualties 5 or more days after the onset of symptoms?

   Very frequent - 1 2 3 4 5 - Very seldom

IF YOU CIRCLED #5 – VERY SELDOM, SKIP THIS SECTION AND PROCEED TO PAGE 12: "TREATMENT ELEMENTS FOR COMBAT REACTION"

2. How frequently were those patients referred for tertiary intervention care for combat related psychiatric symptoms successfully treated and returned to combat duty?

   Very frequent - 1 2 3 4 5 - Very seldom

3. Referring to the list of medications marked TERTIARY INTERVENTION MEDS, which were commonly prescribed by treatment staff for any persisting symptoms of the 4 phases of reaction to combat stress? Note drug and route with a check, (or preferably indicate dosage range and schedule) on the first 4 columns where appropriate.

4. In column 5 marked RETURN TO DUTY, note with a check (or preferably a dosage range or schedule) those maintenance medications which routinely were prescribed for the soldier who completed treatment and was returning to combat duty.

5. In column 6 marked EFFECTIVENESS, note whether meds prescribed in the RETURN TO DUTY column resulted generally in increased combat effectiveness, decreased combat effectiveness, or no observable difference by marking +, - , or 0 respectively (i.e. alertness, competence, clarity of thought, rapport with comrades as compared to peers.)

6. How commonly did soldiers return to any medical facility for recurrence of symptoms following return to duty after tertiary intervention care?

   Very frequent - 1 2 3 4 5 - Very seldom

7. If you were assigned to a K.O. team or evac hospital, how often were psychiatric combat casualties referred for care as fresh casualties, (i.e. skipping conventional 1st and 2nd echelon treatment facilities)?

   Very frequent - 1 2 3 4 5 - Very seldom

8. Likewise how often were psychiatric casualties transferred for care after treatment of 24-48 hours at a battalion aid station or equivalent 1st echelon treatment facility, but bypassing any 2nd echelon treatment facility, such as at division level?

   Very frequent - 1 2 3 4 5 - Very seldom

TERTIARY INTERVENTION MEDS (Treatment: after 5 days)

	Phase of Combat Reaction					
	APPRENENSION (1)	**CR INCIPIENT (2)**	**CR PARTIAL (3)**	**CR COMPLETE (4)**	**RETURN TO DUTY (5)**	**COMBAT EFFECTIVENESS**
"MAJOR TRANQ"						
Thorazine Oral						
IV/IM						
Mellaril						
Stelazine						
Prolixin Oral						
IV/IM						
"MINOR TRANQ"						
Equanl/Miltown						
Libruim Oral						
IV/IM						
Valium Oral						
IV/IM						
Vistaril (Atarax) Oral						
IV/IM						
ANTIDEPRESSANT						
Tofranil Oral						
IV/IM						
Desipramine						
Aventyl						
STIMULANTS						
Dexadrine						
Dexamyl						
Ritalin						
SEDATIVE/HYPNOTIC						
Phenobarb Oral						
IV/IM						
Seconal						
Amytal Oral						
IV/IM						
Nembutal Oral						
IV/IM						
Doriden						
Chloralhydrate						
OTHER						
Compazine Oral						
IV/IM						
Spansule						

TREATMENT ELEMENTS FOR COMBAT REACTION:

The following 3 questions concern your perceptions of the effectiveness of treatment elements directed at any of the symptoms of COMBAT REACTION. (See Appendix A), as applied at each phase of intervention. Again note that the emphasis is on the length of time since onset of symptoms, rather than the location (echelon) of the treatment facility. Please estimate by circling one of the numbers 1-5, the relative importance of each category of care as implemented with combat related patients in any intervention level that you had experience. IF YOU HAD ONLY RARE PROFESSIONAL CONTACT WITH TROOPS EXPOSED TO COMBAT STRESS, SKIP TO PAGE 20, SECTION IV, "MORALE IN GENERAL"

1= OFTEN USEFUL 5= SELDOM USEFUL	PRIMARY CARE: ONSET TO 48 HOURS	SECONDARY CARE: AFTER 2 DAYS THRU 5 DAYS	TERTIARY CARE: AFTER 5 DAYS
Recuperative: (examine and treat wounds, disease, or disability; food, hydration, sleep, rest, recreation)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Medication: (Anxiolytic, neuroleptic, stimulant, antidepressant)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Social: (ward milieu, partial military environment, staff expectancy of return to duty, maintenance of ties to unit, contact with home)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Interpersonal-direct treatment: (catharsis, counseling, therapy, group therapy, narcosynthesis)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Environment-protective: (assist return to non-combat position, assist reassignment to less stressful unit, evac out of area of risk or out of country)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Regarding types of direct interpersonal therapy, please similarly note from 1-5 the relative usefulness of each in cases of combat reaction. If any type was tried and perceived as contraindicated circle "C". If any type was not tried or outcome not observed circle "U".

1 = OFTEN USEFUL; 5 = SELDOM USEFULL
C = CONTRAINDICTED
U = UNKNOWN

	PRIMARY CARE: ONSET TO 48 HOURS	SECONDARY CARE: AFTER 2 DAYS THRU 5 DAYS	TERTIARY CARE: AFTER 5 DAYS
Catharsis/Abreaction: (implies that therapist mostly listened and offered empathy and support)	C 1 2 3 4 5 U	C 1 2 3 4 5 U	C 1 2 3 4 5 U
Counseling: (Above plus reassurance, encouragement, information, inspiration, and exhortation)	C 1 2 3 4 5 U	C 1 2 3 4 5 U	C 1 2 3 4 5 U
Psychotherapy: (some of above, but with emphasis on interpretation of defenses, drives, or conflict)	C 1 2 3 4 5 U	C 1 2 3 4 5 U	C 1 2 3 4 5 U
Group therapy:	C 1 2 3 4 5 U	C 1 2 3 4 5 U	C 1 2 3 4 5 U
Narcosynthesis: (use of short acting barbiturate to facilitate recall, abreaction, and reintegration)	C 1 2 3 4 5 U	C 1 2 3 4 5 U	C 1 2 3 4 5 U
Hypnosis: (similar but without use of psychoactive medication)	C 1 2 3 4 5 U	C 1 2 3 4 5 U	C 1 2 3 4 5 U

STAFF EFFECTIVENESS:

Of the possible types of staff engaged in providing direct interpersonal treatment for soldiers with symptoms of combat reaction in any setting, rate them as to which commonly provided such care, and as to which generally were effective in assisting the soldier to recovery.

1 = OFTEN USED/ OFTEN EFFECTIVE
5 = SELDOM USED/ SELDOM EFFECTIVE

	USE	**EFFECTIVENESS**
LINE MEDIC (91B, C)	1 2 3 4 5	1 2 3 4 5
PSYCHOLOGY/SOCIAL WORK TECH (91G)	1 2 3 4 5	1 2 3 4 5
INPATIENT PSYCH CORPSMAN (91F)	1 2 3 4 5	1 2 3 4 5
GENERAL MEDICAL OFFICER	1 2 3 4 5	1 2 3 4 5
NURSE	1 2 3 4 5	1 2 3 4 5
SOCIAL WORK OFFICER	1 2 3 4 5	1 2 3 4 5
PSYCHIATRIST	1 2 3 4 5	1 2 3 4 5
PSYCHOLOGIST	1 2 3 4 5	1 2 3 4 5
LEADER (Officer, NCO, Squad Leader)	1 2 3 4 5	1 2 3 4 5
BUDDY	1 2 3 4 5	1 2 3 4 5
OTHER (SPECIFY)		
_____	1 2 3 4 5	1 2 3 4 5
_____	1 2 3 4 5	1 2 3 4 5

SPECIAL SYMPTOMS AMONG COMBAT EXPOSED TROOPS:

Note by circling the appropriate number the relative prevalence of the following symptoms or "syndromes", and indicate any medications you found useful in treating these conditions. All the following conditions presume the absence of a primary physical cause. Limit responses to combat troops.

	RELATIVE PREVALENCE	USEFUL MEDS
1.	sleepwalking or talking very common 1 2 3 4 5 very uncommon	_____
2.	nocturnal enuresis very common 1 2 3 4 5 very uncommon	_____
3.	persistent anxiety dreams very common 1 2 3 4 5 very uncommon	_____
4.	falling asleep on guard very common 1 2 3 4 5 very uncommon	_____
5.	insomnia very common 1 2 3 4 5 very uncommon	_____
6.	"short–timers" syndrome very common 1 2 3 4 5 very uncommon	_____
7.	"narcolepsy"-like complaints very common 1 2 3 4 5 very uncommon	_____
8.	threatened assaultive behavior very common 1 2 3 4 5 very uncommon	_____
9.	"seizures" very common 1 2 3 4 5 very uncommon	_____
10.	musculoskeletal type complaints very common 1 2 3 4 5 very uncommon	_____
11.	amnesia very common 1 2 3 4 5 very uncommon	_____
12.	blurred vision very common 1 2 3 4 5 very uncommon	_____
13.	stuttering very common 1 2 3 4 5 very uncommon	_____
14.	exaggerated or persistent startle reaction very common 1 2 3 4 5 very uncommon	_____
15.	persistent nausea, vomiting, diarrhea, etc. very common 1 2 3 4 5 very uncommon	_____
16.	"tension" headaches very common 1 2 3 4 5 very uncommon	_____
17.	"hysterical" hearing loss, aphonia, etc. very common 1 2 3 4 5 very uncommon	_____

III - PATHOGENESIS OF COMBAT BREAKDOWN

In an attempt to organize factors contributing to psychiatric breakdown in combat (that is combat ineffectiveness whether in the form of psychiatric symptoms or through the multitude or disabling behaviors noted in past wars to be the consequence of being psychologically and physically overwhelmed by the stress of battle), the following questions about your observations and opinions are divided into individual factors and group factors. Please limit your responses to your actual experience and observations while in Vietnam.

INDIVIDUAL FACTORS: (Assume average expectable small combat unit cohesiveness and commitment) indicate for each potential stress factor its etiological relevance in producing a combat reaction.

STRESS FACTOR	ETIOLOGICAL RELEVANCE
1. Intensity - combat stress as measured in life threatening quality of the individual's circumstance	HI 1 2 3 4 5 LO
2. Magnitude - combat stress as measures by intensity times duration of life threatening nature if individual's circumstance, i.e., the factor of physical & psychological exhaustion is additive	HI 1 2 3 4 5 LO
3. Noxious Events - psychologically loaded events peculiar to the individual (i.e. buddy lost, squad decimated, guilt about combat aggression or inactivity, helplessness under fire, newness to combat etc.)	HI 1 2 3 4 5 LO
4. Pre-combat Vulnerability - individual personality features or neurotic traits leading to adaptive failure or incapacitating conflict.	HI 1 2 3 4 5 LO
5. Life Changes - conscious or unconscious concerns over events related to home (threatened divorce, new baby, illness), or events affecting the individual apart from the combat circumstance	HI 1 2 3 4 5 LO
6. Limited Bonding - marginal acceptance by combat unit due to limited intellect or social skill, atypical background, or newness to the group	HI 1 2 3 4 5 LO
7. If you were to choose, which one of the above list do you consider the principal etiological factor for the individual (make checkmark)?	HI 1 2 3 4 5 LO
8. Are there other individual factors not mentioned above, that you found to be important (please describe)?	

GROUP FACTORS: Following is a list of factors reported to have lowered combat unit cohesion and commitment to the military objectives in some units in Vietnam. From your experience, in those instances in which you perceived such a situational factor to be operating, please assign numerical value to the degree to which you perceived that factor to be degrading combat motivation. Please confine your responses to combat troops. If a factor was not operating in any of the combat troops to which you were exposed please strike thru that question.

SITUATIONAL FACTORS	DEGRADING EFFECT
1. The use of indices of enemy attrition (such as body count) to measure progress rather than terrain objectives.	HI 1 2 3 4 5 LO
2. Soldiers may have been pessimistic regarding the likelihood of strategic success (i.e. war outcome).	HI 1 2 3 4 5 LO
3. Soldiers may have been pessimistic regarding the likelihood of tactical success (i.e. local military).	HI 1 2 3 4 5 LO
4. Soldiers may have been pessimistic regarding the timeliness and effectiveness of medical care in combat circumstances.	HI 1 2 3 4 5 LO
5. Soldiers may have been pessimistic regarding the suitability of their individual weapons, equipment, and tactics to the unique terrain and climate, and the tactics of the enemy.	HI 1 2 3 4 5 LO
6. Soldiers may have felt that their leaders were either not competent, not committed, or not ethical in the planning and executing of combat operations.	HI 1 2 3 4 5 LO
7. Officers were often rotated from field to staff positions (or vice versa) such that a soldier's relationship with his leader lasted at most only six months.	HI 1 2 3 4 5 LO
8. A depleted physical state of unit members may have occurred because of recurrent and arduous patrols, combat activity, guard duty, etc.	HI 1 2 3 4 5 LO
9. Social cohesion may have been limited resulting in rivalrous subgroups along racial, ethnic, or status lines.	HI 1 2 3 4 5 LO
10. The majority of a unit's members may have persistently perceived themselves as antagonistic to the espoused military objective.	HI 1 2 3 4 5 LO

SITUATIONAL FACTORS	DEGRADING EFFECT
11. The majority of a unit's members may have perceived themselves to be alien to the military milieu and antagonistic to its values.	HI 1 2 3 4 5 LO
12. The majority of the a unit's members may have disavowed any feeling of patriotic pride in America and perceived their countrymen as hopelessly divided on issues of national purpose in Vietnam.	HI 1 2 3 4 5 LO
13. The majority of a unit's members may have adopted a passive personal credo, declining to behave in ways that could be conceived of as aggressive.	HI 1 2 3 4 5 LO
14. Soldiers were obligated only to a one year assignment in Vietnam thereby limiting their perception of obligation and commitment to a one year portion of the total war effort.	HI 1 2 3 4 5 LO
15. Soldiers entered and departed on different timetables because of the individual rotation policy thereby limiting to some extent interpersonal bonding and commitment.	HI 1 2 3 4 5 LO
16. The physical health of many soldiers may have been seriously compromised because of regular and excessive use of alcohol, heroin, or other substances.	HI 1 2 3 4 5 LO
17. The average age of soldiers fighting in Vietnam was appreciably younger than in previous wars. Some have labeled it our first "teen war".	HI 1 2 3 4 5 LO
18. There may have been sizable and persistent racial tension within units.	HI 1 2 3 4 5 LO
19. Climate, terrain, and other elements of physical circumstances were most inhospitable for conducting combat operations.	HI 1 2 3 4 5 LO
20. Combat in Vietnam tended to be brief, intermittent, intense, and fluid.	HI 1 2 3 4 5 LO
21. Soldiers may have complained of repetitive and meaningless tactical assignments. (i.e. were asked to retake the same military objective).	HI 1 2 3 4 5 LO

SITUATIONAL FACTORS	DEGRADING EFFECT
22. Combat was rarely conducted in conventional set piece battles with clearly delineated lines of engagement in which allied forces fought with an identifiable enemy, but instead consisted of fragmented combat with an enemy who blended with civilians and took his toll with surprise attacks by his initiative with unconventional weapons and tactics.	HI 1 2 3 4 5 LO
23. Some soldiers became intoxicated with drugs or alcohol before going on patrol or engaging in combat activity.	HI 1 2 3 4 5 LO
24. A "soldier-leader" may have been killed or seriously wounded leaving a squad or other small unit feeling leaderless.	HI 1 2 3 4 5 LO
25. Whether or not the actual numbers of killed or wounded sustained in an action was high, a unit's members may have perceived themselves as having been "licked" and thus suffered a significant blow to previous group feelings of invulnerability.	HI 1 2 3 4 5 LO
26. A serious tactical error by leadership elements may have resulted in a severe loss of confidence by the unit's members in the wisdom of those making such critical decisions.	HI 1 2 3 4 5 LO
27. Unit identity may have been seriously eroded by the knowledge that some members had committed atrocities or unnecessary violence while in combat.	HI 1 2 3 4 5 LO
28. A seemingly critical number of unit's members may have been lost thru death or wounding such that the remaining group members were doubtful about the security offered to them from the effectiveness of that diminished and altered group.	HI 1 2 3 4 5 LO

IV - MORALE IN GENERAL

Estimate the morale of all the troops in your catchment area. (Circle number/s)

Unit A Very high – 1 2 3 4 5 – Very low
Unit B Very high – 1 2 3 4 5 – Very low
Unit C Very high – 1 2 3 4 5 – Very low

Estimate the morale among combat troops.

Unit A Very high – 1 2 3 4 5 – Very low
Unit B Very high – 1 2 3 4 5 – Very low
Unit C Very high – 1 2 3 4 5 – Very low

Estimate the morale among support troops.

Unit A Very high – 1 2 3 4 5 – Very low
Unit B Very high – 1 2 3 4 5 – Very low
Unit C Very high – 1 2 3 4 5 – Very low

Estimate the morale among medical personnel.

Unit A Very high – 1 2 3 4 5 – Very low
Unit B Very high – 1 2 3 4 5 – Very low
Unit C Very high – 1 2 3 4 5 – Very low

The following list of observations and speculations have been suggested as serving to lower morale of troops in Vietnam at various times or in various locations. Please circle the number indicating the degree to which you believe the average soldier's morale was negatively affected by each factor during your tour. If in any instance you believe there was a reverse correlation, i.e. the factor was the result if low morale rather than the cause, circle the whole answer set for that factor, but also circle the number indication the degree of correlation you perceived.

SITUATIONAL FACTORS	DEMORALIZING EFFECT
1. A prominent source of dissention within the Army in Vietnam was an extension and amplification of American class polarity with consequent reciprocal animosities (i.e. upper-classes and privileged in positions of greater relative authority, safety, or comfort vs. under classes with greater risks and hardships).	HI 1 2 3 4 5 LO
2. A prominent source of dissention within the Army in Vietnam was an extension and amplification of American racial polarity with consequent reciprocal animosities (i.e. whites generally in positions of greater relative authority, safety, or comforts vs. non-whites with greater risks and hardships).	HI 1 2 3 4 5 LO

SITUATIONAL FACTORS	DEMORALIZING EFFECT
3. A prominent source of dissention within the Army in Vietnam was an extension and amplification of stateside American "generational gap" polarization with consequent reciprocal animosities (i.e. older individuals in positions of greater relative authority, safety, or comfort vs. younger individuals with greater risks and hardships.	HI 1 2 3 4 5 LO
4. A prominent source of dissention within the Army in Vietnam was an extension and amplification of stateside American polarity regarding traditional values with consequent reciprocal animosities (i.e. younger individuals rejected conformist values and identity of older individuals instead demanding humanistic ideals and values vs. older individuals condemning youths as amoral "hippies").	HI 1 2 3 4 5 LO
5. A prominent source of dissention within the Army in Vietnam was an extension and amplification of stateside American polarity regarding traditional institutions with consequent animosities between those groups representing the values of the military and generally believing in authoritarianism and conservatism vs. those groups representing anti-establishment sentiments and believing in rule by consensus and "do your own thing."	HI 1 2 3 4 5 LO
6. A prominent source of dissention within the Army in Vietnam was an extension and amplification of stateside American polarity around national purpose in the war, with those in authority generally taking a more pro-war stance vs. lower ranking individuals representing an antiwar stance.	HI 1 2 3 4 5 LO
7. Doubt and ambiguity of purpose generated by media presentations emphasizing the destructive consequences of U.S. military operations	HI 1 2 3 4 5 LO
8. The severity of living and working conditions	HI 1 2 3 4 5 LO
9. Influence of ungrateful or exploitative Vietnamese.	HI 1 2 3 4 5 LO
10. Vagueness of military objective and lack of apparent success.	HI 1 2 3 4 5 LO

SITUATIONAL FACTORS	DEMORALIZING EFFECT
11. Combat operations in an alien culture and setting	HI 1 2 3 4 5 LO
12. Chronic insecurity of feeling vulnerable to surprise attack by unconventional means	HI 1 2 3 4 5 LO
13. Individualized and random rotations thru Vietnam resulting in diminished interpersonal bonding	HI 1 2 3 4 5 LO
14. Individualized and random rotations thru Vietnam resulting in loss of sense of military purpose within the individual	HI 1 2 3 4 5 LO
15. Frequent rotations of officers from staff to command jobs or vice versa	HI 1 2 3 4 5 LO
16. Perceived inequality of hardship and risk (i.e. support troops or those stationed in rear areas were generally better off in regard to living conditions, etc)	HI 1 2 3 4 5 LO
17. Officers or NCOs perceived as uncommitted to the welfare of their men, incompetent, or unethical	HI 1 2 3 4 5 LO
18. Enforcement of rules and regulations perceived as more appropriate for a stateside garrison post	HI 1 2 3 4 5 LO
19. Alcohol too available thus serving as an irresistible temptation to certain especially vital and vulnerable leadership groups	HI 1 2 3 4 5 LO
20. Marijuana too available serving to reduce some groups of soldier's commitment to the mission of the military	HI 1 2 3 4 5 LO

SITUATIONAL FACTORS	DEMORALIZING EFFECT
21. Heroin and other dangerous drugs too available, serving to reduce some groups of soldier's commitment to the mission of the military	HI 1 2 3 4 5 LO
22. For most soldiers, Vietnam beyond the perimeter of their own compound was "off limits" and transportation to other U.S. military facilities was severely limited such that the soldiers led an extremely isolated and confined existence.	HI 1 2 3 4 5 LO
23. Soldier's perceptions that they were assigned to meaningless or redundant jobs, thus feeling non-productive and "bored"	HI 1 2 3 4 5 LO
24. Age appropriate opportunities for recreation were limited.	HI 1 2 3 4 5 LO
25. The 12 month isolation from home and family with only limited opportunities for contact left soldiers feeling lonely, frustrated and bored.	HI 1 2 3 4 5 LO
26. The ease with which one could have periodic contact with home (cassette tapes, phone calls, stateside leave) forced soldiers to deal more directly with sentiments from home, especially disapproval of war activity.	HI 1 2 3 4 5 LO
27. The war in Vietnam was believed by many soldiers to be immoral and exploitative.	HI 1 2 3 4 5 LO
28. The popular media often portrayed Vietnam soldiers as destructive and murderous villains.	HI 1 2 3 4 5 LO
29. Insufficient enforcement of rules and regulations necessary for the generation of good unit discipline	HI 1 2 3 4 5 LO

V - BEHAVIORAL PROBLEMS

The following list of behaviors or symptoms at times came to the attention of psychiatrists in Vietnam. Please denote the degree of relative prevalence and the degree of your involvement with each of the conditions (circle number). Include instances if the behavior was a serious threat as well as if it was consummated.

1 = VERY COMMOM
5 = VERY UNCOMMON

	You noted prevalence among troops	You were involved in eval and dx	You were involved in treatment
Antisocial behaviors: Non-violent (theft, corruption, etc)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Antisocial behaviors: Violent (Violence to other GIs, etc)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Anti-military behaviors: Non-violent (Insubordination, combat refusal)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Anti-military behaviors: Violent (Attack NCO, fragging, etc)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Open racial group conflict	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Excessive use of alcohol	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Use of Binoctal or other Barbiturate	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Use of Heroin thru smoking	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Use of Heroin thru IV or inhalation	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Other drug use: LSD, amphetamines, other. Be specific	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Disregard for hygiene (antimalarial, footcare, VD, etc.)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Characterologic maladaptation (AWOL, suicide gesture, etc.)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Indiv. Combat avoidance behaviors (malingering, self-inflicted wounds)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Excessive combat aggression (toward civilians, prisoners, souvenirs of dead)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Group combat refusals	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Antiwar demonstrations or tensions	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

VI - PREVENTIVE PSYCHIATRY

Preventive psychiatry in the military usually takes the form of command (program) consultation. The success of such may vary depending on factors both within the consultant and within the consultee. Structural definitions also affect the process in some instances. Please answer the questions that apply to your circumstance and experience in Vietnam.

1. Estimate the relative frequency with which you or your staff provided consultation to small unit command cadre (i.e. company level or below, or its equivalent)
   Very frequent - 1 2 3 4 5 - Very seldom

2. Estimate the relative frequency with which you feel it was successful (i.e. perceived some reduction in anticipated psychiatric casualties) at this level of intervention.
   Very frequent - 1 2 3 4 5 - Very seldom

3. Estimate the relative frequency with which you or your staff offered or provided consultation at battalion command staff level or it equivalent.
   Very frequent - 1 2 3 4 5 - Very seldom

4. Estimate the relative frequency with which you feel it was successful (i.e. perceived some reduction in anticipated psychiatric casualties) at this level of intervention.
   Very frequent - 1 2 3 4 5 - Very seldom

5. Estimate the relative frequency with which you or your staff offered or provided consultation at brigade command staff level or its equivalent, or higher.
   Very frequent - 1 2 3 4 5 - Very seldom

6. Estimate the relative frequency with which you feel it was successful (i.e. perceived some reduction in anticipated psychiatric casualties) at this level of intervention.
   Very frequent - 1 2 3 4 5 - Very seldom

In the instances when you perceived community psychiatric efforts to be probably <u>not useful</u> please note the degree of your agreement/disagreement with the following statement as to your perceptions of why such intervention was not successful.

   a. Consultee military leaders were generally uninterested in behavioral science opinion, regardless of the source.
      Strongly agree - 1 2 3 4 5 - Strongly disagree

   b. Consultee military leaders were generally not receptive because they feared the consultant would highlight and broadcast the deficiencies within the unit and that would reflect badly on them and their career.
      Strongly agree - 1 2 3 4 5 - Strongly disagree

   c. Psychiatric opinion generally had limited usefulness under such circumstances.
      Strongly agree - 1 2 3 4 5 - Strongly disagree

d. Lack of training in community psychiatry or military psychiatry left some in a position to be only marginally useful.
Strongly agree - 1 2 3 4 5 - Strongly disagree

e. Consultee military leaders were uncommitted to the men and their problems.
Strongly agree - 1 2 3 4 5 - Strongly disagree

f. Consultee military leaders tended to deny most of the problems within their units.
Strongly agree - 1 2 3 4 5 - Strongly disagree

g. Lack of familiarity or identification with the military culture kept some from being sufficiently accepted and trusted by those leaders.
Strongly agree - 1 2 3 4 5 - Strongly disagree

h. Consultee military leaders were generally not receptive to inquiry and advice from someone outside the chain of command for their unit.
Strongly agree - 1 2 3 4 5 - Strongly disagree

i. Other? (please explain)

VII. SUBSTANCE ABUSE

Identify how the substances apply to the following list of statements regarding use patterns & effects. Please limit answers to information gained either from your direct observations in Vietnam, or self-reports by users. If with any question you feel you have no observation from which to respond, strike thru its number. If regarding a particular substance within a question you feel you have no response, strike thru that substance name.

1. It was a common source of personal intoxication during off-duty time.
   Alcohol strongly agree 1 2 3 4 5 strongly disagree
   Marijuana strongly agree 1 2 3 4 5 strongly disagree
   Narcotic strongly agree 1 2 3 4 5 strongly disagree

2. It was generally used in a peer group communal fashion on a periodic and unscheduled (that is spontaneous) basis.
   Alcohol strongly agree 1 2 3 4 5 strongly disagree
   Marijuana strongly agree 1 2 3 4 5 strongly disagree
   Narcotic strongly agree 1 2 3 4 5 strongly disagree

3. Regular use did not generally lead to individual ineffectiveness.
   Alcohol strongly agree 1 2 3 4 5 strongly disagree
   Marijuana strongly agree 1 2 3 4 5 strongly disagree
   Narcotic strongly agree 1 2 3 4 5 strongly disagree

4. Users tended to leave anonymous provocative evidence of its use for unit leaders so as to express anti-military sentiment.
   Alcohol strongly agree 1 2 3 4 5 strongly disagree
   Marijuana strongly agree 1 2 3 4 5 strongly disagree
   Narcotic strongly agree 1 2 3 4 5 strongly disagree

5. It was used by some before entering battle to gain control of fear and anxiety.
   - Alcohol strongly agree 1 2 3 4 5 strongly disagree
   - Marijuana strongly agree 1 2 3 4 5 strongly disagree
   - Narcotic strongly agree 1 2 3 4 5 strongly disagree

6. It was used by some during combat to gain control of fear and anxiety.
   - Alcohol strongly agree 1 2 3 4 5 strongly disagree
   - Marijuana strongly agree 1 2 3 4 5 strongly disagree
   - Narcotic strongly agree 1 2 3 4 5 strongly disagree

7. It was used by some immediately post-combat to calm down.
   - Alcohol strongly agree 1 2 3 4 5 strongly disagree
   - Marijuana strongly agree 1 2 3 4 5 strongly disagree
   - Narcotic strongly agree 1 2 3 4 5 strongly disagree

8. It was a serious if not common source of individual dysfunction due to toxic psychosis, psychological deterioration, or spiraling addiction or dependence.
   - Alcohol strongly agree 1 2 3 4 5 strongly disagree
   - Marijuana strongly agree 1 2 3 4 5 strongly disagree
   - Narcotic strongly agree 1 2 3 4 5 strongly disagree

9. It generally served as a constructive form of self-medication furthering adaptation under difficult and stressful circumstance.
   - Alcohol strongly agree 1 2 3 4 5 strongly disagree
   - Marijuana strongly agree 1 2 3 4 5 strongly disagree
   - Narcotic strongly agree 1 2 3 4 5 strongly disagree

10. The military in Vietnam overreacted to the problem.
    - Alcohol strongly agree 1 2 3 4 5 strongly disagree
    - Marijuana strongly agree 1 2 3 4 5 strongly disagree
    - Narcotic strongly agree 1 2 3 4 5 strongly disagree

11. Physicians/ psychiatrists should have been in charge of treatment-management programs for all identified abusers in Vietnam.
    - Alcohol strongly agree 1 2 3 4 5 strongly disagree
    - Marijuana strongly agree 1 2 3 4 5 strongly disagree
    - Narcotic strongly agree 1 2 3 4 5 strongly disagree

12. It was commonly utilized by non-combat personnel while on duty.
    - Alcohol strongly agree 1 2 3 4 5 strongly disagree
    - Marijuana strongly agree 1 2 3 4 5 strongly disagree
    - Narcotic strongly agree 1 2 3 4 5 strongly disagree

13. Please use additional space to note other behaviors commonly associated with the above 3 substances, or behaviors associated with use of other psychoactive substance.

VIII - SUBJECTIVE VIEWS OF VIETNAM PSYCHIARY

Please note your level of agreement/disagreement with the following set of statements. Strike through any question that you believe does not apply to you. LIMIT YOUR RESPONSES TO REACTIONS EXPERIENCED BEFORE OR DURING VIETNAM SERVICE.

1. I reacted to notification of my assignment to Vietnam with aversion.
   Strongly agree 1 2 3 4 5 Strongly disagree

2. I reacted to notification of my assignment to Vietnam with eagerness.
   Strongly agree 1 2 3 4 5 Strongly disagree

3. I reacted to notification of my assignment to Vietnam with ambivalence.
   Strongly agree 1 2 3 4 5 Strongly disagree

4. In anticipating my assignment to Vietnam I perceived the American involvement there to be counterproductive and destructive.
   Strongly agree 1 2 3 4 5 Strongly disagree

5. In anticipating my assignment to Vietnam I perceived the American involvement there to be immoral.
   Strongly agree 1 2 3 4 5 Strongly disagree

6. In anticipating my assignment to Vietnam I perceived the American involvement there to be justified.
   Strongly agree 1 2 3 4 5 Strongly disagree

7. Among other reactions I had to notification of my assignment to Vietnam, I perceived acceptance of that assignment to be a consequence of my sense of duty and obligation to my country.
   Strongly agree 1 2 3 4 5 Strongly disagree

8. I experienced significant frustration when practicing psychiatry in Vietnam because of the oft encountered dispositional dilemma between considering the needs of the group (i.e. "conserve the fighting strength" via return to duty) and the apparent needs of the individual (i.e. wanting to not be returned to a noxious environment).
   Strongly agree 1 2 3 4 5 Strongly disagree

9. I experienced significant frustration when practicing psychiatry in Vietnam because I was reluctant to serve as an agent in the process of social control of the soldier by forcing him to return to duty and to conformity.
   Strongly agree 1 2 3 4 5 Strongly disagree

10. While serving in Vietnam I was troubled by the fact that I perceived much <u>professional</u> condemnation of physician/psychiatrists who cooperated with that military endeavor.
    Strongly agree 1 2 3 4 5 Strongly disagree

11. While serving in Vietnam I was troubled be the fact that I perceived much <u>social</u> condemnation of those cooperating with that military endeavor.
    Strongly agree 1 2 3 4 5 Strongly disagree

12. I experienced periodic frustration in practicing psychiatry in Vietnam when I felt I could not do justice to the emotional treatment needs of my patients because I was serving as a "double agent", i.e. expected to represent the needs of the system while inviting the soldier to believe I was representing his needs.
    Strongly agree 1 2 3 4 5 Strongly disagree

13. I experienced significant frustration in practicing psychiatry fro Army in Vietnam because I perceived that the espoused doctrine of combat psychiatry (Immediacy, Expectancy, and Proximity) may lead to an individual returning to a psychologically damaging (and possibly life threatening) stress inadequately treated and still quite vulnerable.
    Strongly agree 1 2 3 4 5 Strongly disagree

14. I experienced periodic frustration when practicing psychiatry in Vietnam because I knew that in the Military, psychiatrists do not possess complete confidentiality for their patients.
    Strongly agree 1 2 3 4 5 Strongly disagree

15. I experienced periodic frustration when practicing psychiatry in Vietnam because I had a real position in the social system of my patient (i.e. had a rank and accompanying authority) so that I could not assume a position of neutrality and maximally assist him (i.e. be "trusted" by him)
    Strongly agree 1 2 3 4 5 Strongly disagree

16. I experienced periodic frustration when practicing psychiatry in Vietnam because in instances when the most appropriate diagnosis for an individual was one of a character/behavior disorder, my hands became tied dispositionally since further action regarding such a case was an administrative decision, subject to the whims of command.
    Strongly agree 1 2 3 4 5 Strongly disagree

17. I experienced periodic frustration when practicing psychiatry in Vietnam because certain cased I believed needed further evacuation were none-the-less returned to duty thru decisions at other levels in the chain of evacuation by professionals who were unsympathetic to the treatment needs of the patient.
    Strongly agree 1 2 3 4 5 Strongly disagree

18. I experienced periodic frustration when practicing psychiatry in Vietnam because I occasionally found myself in a dilemma with a patient who alluded to atrocities or other crimes that he may have committed or others he knew may have committed, and my not being certain whether to report such information, or to remain silent.
    Strongly agree 1 2 3 4 5 Strongly disagree

19. I experienced periodic frustration when practicing psychiatry in Vietnam because I occasionally was pressured through command channels to act in ways contrary to my best clinical judgment (i.e. evac when not justified, or return to duty when not appropriate).
    Strongly agree 1 2 3 4 5 Strongly disagree

20. I experienced periodic frustration when practicing psychiatry in Vietnam because certain diagnostic and dispositional decisions I might make had deleterious long-range effects on the patient inherent in the type of discharge ultimately granted by the service (i.e. likely negative social and vocational consequences.)
    Strongly agree 1 2 3 4 5 Strongly disagree

21. I experienced periodic frustration when practicing psychiatry in Vietnam because many of the most needy individuals, i.e. officers and senior non-commissioned officers, rarely underwent psychiatric treatment because of their fear of the negative consequences for their career.
    Strongly agree 1 2 3 4 5 Strongly disagree

22. I found guidance from and input to the Vietnam theatre psychiatric consultant timely and beneficial.
    Strongly agree 1 2 3 4 5 Strongly disagree

23. I found my psychiatric experience in Vietnam periodically frustrating because of the high level of clinical need, versus the low level of clinical capability.
    Strongly agree 1 2 3 4 5 Strongly disagree

24. I found my psychiatric experience in Vietnam periodically frustrating because of unrealistic expectations from both the individual clients and the organizational clients (i.e. expecting magical solutions)
    Strongly agree 1 2 3 4 5 Strongly disagree

25. I believe that greater numbers of military-trained psychiatrists should have served in that combat theatre (during my tour).
    Strongly agree 1 2 3 4 5 Strongly disagree

26. I perceived that the military in Vietnam paid insufficient attention to the human considerations necessary for fielding an army under such circumstances.
    Strongly agree 1 2 3 4 5 Strongly disagree

27. I perceived that para-professional medical staff such as 91G social work/psychology specialists had too much authority and responsibility for making psychiatric diagnostic and dispositional decisions.
    Strongly agree 1 2 3 4 5 Strongly disagree

28. I perceived that the non-psychiatric general medical officers had too much authority and responsibility for making psychiatric decisions.
    Strongly agree 1 2 3 4 5 Strongly disagree

29. In spite of the arduous circumstances and numerous frustrations of my tour in Vietnam it was a constructive experience from which I learned a great deal.
    Strongly agree 1 2 3 4 5 Strongly disagree

30. I suffered little ethical dilemma in Vietnam because I perceived that providing medical/psychiatric service to the troops was a neutral activity (i.e. humanitarian regardless of circumstance)

Strongly agree 1 2 3 4 5 Strongly disagree

31. I experienced ethical conflict in Vietnam due to my concern that effectively restoring an individual to function risks propelling him back to a psychologically or physically damaging situation.

Strongly agree 1 2 3 4 5 Strongly disagree

32. Knowing now what you know, what would you have done better to prepare for Vietnam service?

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33. Suggestions and recommendations (please elaborate.)

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