LETTERS TO THE EDITOR

The Army Psychiatrist—An Adjunct to the System of Social Control

SIR: Dr. Bloch's account of Army psychiatry in Viet Nam ("Army Clinical Psychiatry in the Combat Zone—1967-1968," September 1969 issue of the *Journal*) is sadly reminiscent of the propaganda to which I was exposed during my tour (between 1965 and 1967) in Japan where I was chief of an Army neuropsychiatric service devoted to treatment of Viet Nam casualties. I believe such a paper perpetuates the fiction, long nurtured by professional military psychiatrists, that the day-to-day practice of Army psychiatry is in fact dedicated to patients who have "run into some difficulty in interpersonal relationships in their units . . . ." The author's "typical" case examples, so often ending happily with a man "ready" or even "eager" to return to duty, distort his statistical accumulations to create what seems to me an Alice-in-Wonderland picture, lending a specious scientific vindication to the entire undertaking.

It was my experience that the "typical" Army psychiatric patient is most unlikely to arrive at a clinical setting such as that depicted by Dr. Bloch. I am referring to the man who presents with symptoms directly reflecting his confrontation with the tragic absurdity of risking his life or of killing other human beings in this meaningless military exercise and whose entire being is devoted to extricating himself from the situation. Of course his style of coping varies, but it seldom engenders symptoms of psychotic quality or of neurosis in a classic descriptive sense.

Such a patient falls subject to the rigid and archaic military nosology to which Dr. Bloch alludes only in passing. The soldier who wants to get out of this war acquires the label "character and behavior disorder"—by far the most common military diagnosis (one which psychiatrists are constantly urged to make) and a quasi-medical pejorative lacking the official status of disease. It is forbidden to refer to these men as "patients." Orally and in administrative documents they are "individuals."

These nondiseases merit nontreatment. Every effort is made to exclude such men from psychiatric channels; those hospitalized on Dr. Bloch's service were surely a minority. Recipients of the character disorder diagnosis are returned forthwith to the coercive province of command. Their subsequent handling ranges on a continuum from ridicule and threat to court-martial. The benign administrative discharge from service suggested by the author is an outcome of relative rarity. Suicide gestures, for example, are routinely dealt with by placing the offender under guard, pending his assurance that he will not repeat the act.

By excluding from treatment, in a manner that would be reprehensible in civilian practice, the majority of patients who come to him, the psychiatrist becomes an adjunct to the system of social control. By acting to "conserve the fighting strength" in this war of boundless immorality, he partakes of the passive complicity that is the mark of guilt in our time. I find it incongruous that Dr. Bloch's paper should appear in the month following the *Journal* issue with the special section on ethics. Whatever else Army psychiatry may be, I see neither moral nor scientific justification for the dignity of its definition as clinical psychiatry.

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Dr. Bloch Replies

SIR: Dr. Maier's concern about the relationship of psychiatry to the war and to prospective patients is apparent. Unfortunately, even praiseworthy sentiments do not justify specious reasoning in professional matters. I will reply to the essential elements of his letter.

1. Dr. Maier comments that the most frequent psychiatric casualties were not described in my article. This is correct to the extent that the cases reported were typical of disabled hospitalized patients who constituted about ten percent of all patients seen. However, Dr. Maier's underlying contention is that the typical psychiatric casualty is not a man who is willing to return to duty but is one who "wants to get out of this war" for moral reasons. This is inaccurate based on psychodynamic data (intrapsychic and interpersonal).

Letters to the Editor are welcomed and will be published, if found suitable, as space permits. Please submit two copies (typewritten, double spaced), the length, if possible, not to exceed 500 words. Letters will be subject to the usual editing.