
Military Psychology: A Half Century Ago

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Has military psychology changed in the past fifty years? Five decades ago, the Vietnam War ended but not on good terms. The military draft terminated, and the all-volunteer Army encountered difficulty recruiting qualified volunteers. The post-Vietnam military was too large and needed shrinking. Today our nation is stepping away from decades of war in the Middle East. Only a quarter of America's citizens of military age are mentally or physically fit to serve in the armed forces. Americans do not view the military as a favored vocational choice. Maintaining a military force of competent men and women is difficult, indeed.

In the 1970s, the military experienced downsizing turmoil after a prolonged war. Today, it is both downsizing and refocusing. Afghanistan was a counterinsurgency war, but now the military is shifting toward near-peer competition. Our military is preparing for space supremacy and perhaps expanded warfare on the seas or in the air (neither were issues in Afghanistan or Vietnam). Yet, only the naïve do not expect military budget cuts in the future.

As a military clinician in the 1970s, I saw dozens of Army Vietnam repatriated prisoners of war (RPOW). For us, returning successfully to freedom and family were our biggest concerns. Most RPOWS accomplished the transition very well. Tours in Vietnam were a single one-year assignment. During the Middle East wars over the past thirty years, multiple combat tours for career, Reserve, and National Guard troops were common. These numerous overseas tours caused separation from family and friends, resulting in mental health issues.

Post-traumatic stress disorder (PTSD) was not a concern I saw with active-duty Vietnam veterans. Suicide among active-duty military was a rare occurrence in the 1970s. Military psychologists today face these concerns daily. Suicide among active-duty military people is the highest it has ever been. Studies indicate that the problem is a complex mental health issue where soldiers endure social separation, despair, and enduring severe psychological anguish. Death is seen as the only way out. Sexual assaults were a major concern fifty years ago and remain a problem today.

As I read back issues of the Division 19 journal, *Military Psychology*, and the third edition of *Military Psychology: Clinical and Operational Applications* by Carrie Kennedy and Eric Zillmer, I understand what concerns and problems today's military psychologists face. In my book, *The Making of an Army Psychologist*, I describe my leaving the Army in 1969, attending graduate school, and becoming an Army psychologist. This book is my story of what I did and how I did it half a century ago as a

military psychologist. For eight years I served in two Army medical centers, one hospital, and a mental health clinic, and as the Psychology Consultant for the Army command managing medical facilities and personnel in the continental United States (CONUS), Alaska, Hawaii, and the Canal Zone. Before becoming an Army psychologist, I served as an enlisted Marine and Army officer for 15 years, serving three separate combat tours. I retired in October 1981 with almost 25 years of service in the Marines and Army.

Psychology in the 1970s

In the 1960s and 1970s, the field of psychology underwent a vast transformation. Psychologists were moving out of typical medical practices seeing patients in their office. Instead, they utilized their skills of understanding how humans behave in different situations in a variety of non-clinical areas. Psychologists found that their theoretical expertise became particularly useful in a variety of endeavors such as sports, industry, management, aviation, law enforcement, legal consultation, organizations, and leadership. This movement in civilian psychology was mirrored in the military.

During these times, psychology education was also undergoing considerable conversions. Until the late 1960s, PhD programs in psychology focused on research, rather than clinical skills. During the 1970s, practical experiences (like attorneys, dentists, and physicians) were demanded so clinical training was added to research education. Some schools created a new degree, emphasizing practical studies, called the Doctor of Psychology degree. Schools of education were granting EdD degrees in counseling and school psychology. The American Psychological Association (APA) required students seeking an APA-approved doctoral degree to serve a one-year internship in a clinic or hospital.

Throughout my book reference is made to both clinical and counseling psychologists. From a practical point of view, they are similar, and their job functions are identical. From an academic stance, clinical education stresses theoretical orientation while counseling emphasizes humanistic approaches. Clinical psychology is taught by Psychology Departments while counseling psych is taught by Schools of Education. My PhD was in Counseling Psychology with a minor in clinical psychology.

Additionally, clinical and counseling psychology practice was moving into new territories, using behavioral science education and skills as consultants to improve performance by collaborating with professionals outside the traditional medical model. Clinical psychologists also desired more freedom to practice independently, not un-

der the control of a psychiatrist. The focus was directed on having clinicians certified and licensed to practice their profession, independently, without supervision. Requirements were strengthened to regulate the profession the same as physicians, lawyers, and dentists.

Military Psychology in the 1970s

Military psychology in the 1970s was similar yet distinct from clinical practice in the civilian world. Military clinicians provided the same services as their non-military counterparts. Educational backgrounds were similar. Practicums and internships were in both civilian facilities and the military. Military and civilian clinical psychology practices were similar.

So, what was the difference? What set military psychologists apart from their civilian counterparts? Two distinct differences: the populations served and the environments each practiced in. Civilian clinical psychologists worked in a variety of organizations from private practices to medical facilities to state and non-military federal organizations. Military psychologists worked within the structured armed forces framework. Most were stationed at military medical facilities. Some served as a member of various military units such as Army combat divisions or Air Force and Navy major commands.

Rules and regulations required these psychologists to be part of the military. This meant wearing uniforms and training to be an officer. It required an understanding of other assigned duties expected as part of the military unit they belonged to. A benefit to a military patient or client is they would be able to receive whatever help was necessary and available, regardless of cost. Most often, civilian psychology practices were controlled by either insurance or budget limitations regarding what services could be provided.

The Army in the early 1970s was undergoing challenging times. America's involvement in the Vietnam War terminated in 1973. The draft ended; the Army became an all-volunteer force. It had to attract and retain qualified men and women. Additionally, its size for supporting fighting in Vietnam was far larger than necessary for peacetime missions. Add to these arduous tasks the homecoming of several hundred U.S. military men, incarcerated for years as prisoners of war by the North Vietnamese and their communist allies. Their evaluations and safe return after captivity was supported by Congress as another responsibility of the military.

The Army faced demanding undertakings. Often requiring the assistance of behavioral scientists to smooth the transition from a bloated conscript organization into a leaner fighting force comprised entirely of volunteers. Supporting the adjustment of repatriated POWs from prisons to freedom would also fall to military psychologists, psychiatrists, social workers, and other mental health professionals. The return of the repatriated POWs required long-term physical and psychological evaluations, rehabilitation, and probable modifications for combat training.

Another challenge both military and civilian behavioral scientists addressed was PTSD, a mental condition caused by experiencing or seeing a traumatic event such as war and combat or other non-war emotionally disturbing event or situation. The media (and anti-war professionals) predicted that most Vietnam veterans would suffer some degree of post-service adjustment problems. This myth was debunked by American repatriated POWs and a congressionally mandated psychological study of veterans in the 1980s (the National Vietnam Veterans Readjustment Study).

Behavioral scientists in the 1970s were embracing a concept known as Organizational Development (OD). In the Army, this was Organizational Effectiveness (OE), a science-based effort designed to evaluate the effectiveness of an organization and then create programs to enhance performance from the bottom up. The Army had OE enthusiasts such as General Bernard Rogers and other flag officers. It also had detractors, senior officers, and NCOs who believed that command is only a one-way street, from the top on down. Army OE staff members were assigned to Army posts and combat divisions to assist commanders more effectively deal with command and organizational issues.

For all branches of the post-Vietnam War military, these ordeals would require the services of people trained in the behavioral sciences such as psychology and social work. To accommodate this need, the Army created a program to procure these people. The Army sought former combat officers who were entering doctoral programs in the behavioral sciences. The program brought them back on active duty allowing them to complete their doctoral education receiving full pay and benefits. For psychologists this typically involved three years of education followed by a year's internship at an Army medical center, culminating with a PhD and assignment as a clinical psychologist in the Army. This program proved successful with several graduates remaining in the Army until retiring.

For me, as a disgruntled Army infantry major and a veteran of two Vietnam combat tours, I left the Army and earned a master's degree in psychology. After working for a year as a psychologist, I was admitted into the Counseling Psychology doctoral program at the University of Utah. I applied and upon being accepted into the Army psychology graduate program, returned to active duty as a major.

As an interesting aside. Before I applied to the Army graduate program, I contacted the appropriate offices in both the Air Force and the Navy, seeking the possibility of transferring from the Army Reserve to active duty in their service as a psychologist. The Air Force said upon obtaining my PhD, they would bring me on active duty as a second lieutenant. The Navy was kinder, replying after receiving my PhD, they would bring me on active duty as a lieutenant senior grade (O-3). As an Army O-4, neither appealed to me. Ironically, in 1959, as a 21-year-old Marine Corps corporal, the Air Force offered to send me to OCS and commission me as a second lieutenant. I said no, I returned to college and entered Army ROTC.

I left the Army in 1969 because of what I perceived as poor senior leadership. I realized that with the ending of the Vietnam War and the draft, the Army would have to change. Returning to the Army as a psychologist would offer me the opportunity to work within the system to institute change. During my time as an Army psychologist, I advanced from being a student, to a clinician, to quickly becoming a very senior psychologist, involved in a variety of military evaluation programs and ways to establish change.

Military Psychology Today

As I read and discuss military psychology today, I note (and with pride because of what I advocated in the 1970s) that aspects of the profession that were not found in the military fifty years ago are now common. Take one, for example, the title of aeromedical psychologist, awarded to Defense Department (DOD) military psychologists upon successfully completing a three-week course training aviation psychologist at the Fort Rucker, Alabama, U.S. Army Aviation Center of Excellence.

In the early-1970s, every aviation psychologist I knew was a researcher, studying the interaction between pilots and cockpits. By the mid-1970s, a group of clinical psychologists (most were military psychologists, like me) who either were previously military pilots or now civilian pilots, began to discuss how and why pilots made correct or incorrect decisions while flying. We would meet annually at the American Psychological Association Conference and discuss what we were doing. Our expertise in both aviation and the study of human behavior suggested that we could be of value to pilots regarding aviation decision-making and safety. My background as a clinical psychologist, and a civilian pilot with 180 hours as a crew member during combat flights in Vietnam where I received a Purple Heart and Air Medal allowed me to experience most challenges a military pilot may be exposed to. Thus, another field of aviation psychologists was born.

Another example of advances in military psychology replicated by our civilian brothers and sisters is the training of psychologists in pharmacology to prescribe psychotropic medication. As an Army Psychology Consultant, I pushed for the Army to train selected clinicians in the use of psychotropic medications. During my tenure (1975-1981) this was considered but not instituted until the 1990s. As the military realized uniformed psychiatrists were becoming fewer, the concept of training clinical psychologists to prescribe medications was reconsidered.

By 1984 APA began lobbying for legislative approval for psychologists to be trained to prescribe medications. In 1988 DOD approved the Psychopharmacology Demonstration Project (PDP) which began at Walter Reed Army Medical Center in 1991. This program graduated ten military psychologists until Congress defunded the program in 1998. The reason was no more prescribing military psychologists were needed. An after-action report found the program was successful and the graduates were seen as valued and added immensely to providing exceptional

medical treatment to the military. Several states have followed by approving similar educational programs to certify prescribing psychologists.

A major problem in the 1970s was getting uniformed clinicians out of hospitals and medical units and into an embedded environment, where the combat troops lived and worked. Seeing patients in a clinic was familiar and comfortable. Seeing commanders and leaders where they worked placed the psychologist in an unaccustomed situation. What I strongly advocated, command consultation was difficult for many psychologists and therefore avoided. As a former combat infantry soldier, I thoroughly enjoyed returning to the environment I was comfortable in. I encouraged clinicians to spend more time with the troops to understand what they did and the challenges they faced. Unfortunately, this was an uphill battle during my career as an Army psychologist.

Chapter 10 of *Military Psychology: Clinical and Operational Applications* was authored by a joint team of psychologists from across the military services. In this chapter, the authors describe Embedded and Expeditionary Mental Health—a concept which I called command consultation. They refer to it as an emerging field, yet my colleagues and I practiced it fifty years ago. Most military psychologists back then preferred their clinics and medical facilities. Apparently, that problem remains today.

In the early 1970s, physicians did not have to be licensed in a state to practice medicine in the military. Neither did psychologists. But competency had to be certified to practice in the Army. My PhD was from the University of Utah in an APA-approved program that required a year's internship in a clinical setting. I completed my internship at the Veterans Administration Hospital in Salt Lake City. Then I completed a one-year post-doctoral fellowship in Community Psychology at the Army's William Beaumont Medical Center. As I moved from clinical assignments one first requirement was to present my credentials to a board at the Army medical facility where I would practice. This board would then approve my ability to provide clinical services. State licensure was not a requirement. Today it is. Another advancement for military psychologists.

Military psychologists currently serve in a variety of non-clinical settings such as special operations, SERE, national security, teaching, and DOD. When I began my doctoral training in psychology, most Army clinicians served in medical facilities or troop medical units. But a decade later we found several of us in a variety of non-clinical assignments. For example, I was a psychologist on the staff of a major Army command, Colonel Bob Nichols was on the faculty of the Army War College, and Lieutenant Colonel Dick Hartzell, after serving as the OTSG Psychology Consultant was assigned to another government agency. Another Army psychologist was on the selection staff for the newly formed special operations counterterrorist Delta Force. Major (promotable) Howard Prince, 1962 graduate of the U.S. Military Academy and Vietnam infantry commander, was assigned to West

Point as a counselor. In 1978 he was selected as the head of the newly created Department of Behavioral Sciences and Leadership becoming the Army's youngest full colonel. He retired from that position as a brigadier general. When West Point admitted women in 1976, a female counselor was requested. I was able to recruit a new PhD graduate from Texas A & M, Teresa Rhone, commissioned as a captain, to fill that slot. In the 1970s and 80s, clinical psychologists began finding career-fulfilling jobs outside the traditional medical model. What was unusual in the 1970s, is now common for military psychologists.

Civilian military psychologists were seldom seen. In the Army, as the CONUS Psychology Consultant, I was the career advisor for all Army civil service psychologists who worked in Army medical facilities in the U.S. Few saw themselves as military psychologists, just civilian professionals working for the Army. Civilian research psychologists employed by the Army were not part of those I advised. Yet several Division 19 members in the 1970s were civilians who worked in VA facilities, military research facilities, or DOD medical schools. It ap-

pears today, there are many more civilian psychologists throughout military facilities, both medical and on senior headquarters staffs.

Final Reflections

Has military psychology changed in the past fifty years? Comparing the current profession of military psychology with a half-century ago, the differences are small. What we advocated and initiated in the 1970s is normal today. The primary mission of providing behavioral health care for the personnel of our armed forces remains unchanged. What has altered are treatment modalities and the variety of assignment opportunities available to military psychologists. I consider what I did fifty years ago with the opportunities today. It seems a military psychologist today has a vast array of career options available in medical facilities, staff assignments, schools, and working directly with troops in their environs.

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