

## War stories: Invited commentary on . . . Documented combat exposure of US veterans seeking treatment for combat-related post-traumatic stress disorder<sup>†</sup>

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In 2005 King's College London and the Oral History Society are hosting a conference on the oral history of the Second World War (<http://www.oralhistory.org.uk>). The conference will bring together research that starts with the verbal testimonies of both combatants and civilians involved in the conflict. But note that I write 'starts with' those oral testimonies. I doubt that any of the presenters will argue that these testimonies are the only source of information we have on what happened during the war. All will agree on the importance of listening carefully to the stories told, but also of interpreting, analysing and supplementing them with information from other sources. Many of the papers to be presented also look at how narratives have changed over time. Testimonies of the war from the former East Germany, for example, have changed dramatically since the fall of the Berlin Wall, a process that has happened in all of the countries of the former Soviet bloc, albeit in different ways. War stories change according to who is doing the telling, who is doing the listening, and why the story is being told now.

Most people touched by war will eventually tell their stories, and the Vietnam veteran is no exception. It was the stories that some started telling on their return to the USA that played a vital part in the process that led to the introduction of the new diagnosis of post-traumatic stress disorder (PTSD) into DSM-III (American Psychiatric Association, 1980; Scott, 1993). But how historically accurate were those stories? There have been hints that at least some of these testimonies did not always reflect what happened. There have been documented cases of exaggeration by some Vietnam veterans, and even a few in which military service was fictitious (Sparrow & Pankratz, 1983; Burkett & Whitley, 1998). This is not unique to America or

Vietnam – 13% of referrals of 'combat veterans' to the UK Defence Psychiatric Services Centre likewise made factitious claims of combat exposure or military service (Baggaley, 1998). Both the British and American experiences suggest that claims to have served in Special Forces, with their mystique of being secret supermen, is a particular feature of what Baggaley has labelled 'military Munchausen's'.

Likewise, there was a hint that a more critical approach was needed when dealing with Vietnam veteran testimonies, even in the National Vietnam Veterans Readjustment Study (NVVRS; Kulka *et al*, 1990). The report itself is the source of the much-quoted figure for the prevalence of PTSD in Vietnam veterans, giving a lifetime rate of 30% in male veterans. Yet this figure is twice the number of those in combat roles in Vietnam. Only a handful of the 670 people who have cited the primary report have drawn attention to this discrepancy (Burkett & Whitley, 1998; Marlowe, 2000; McNally, 2003; Satel, 2003). Anthropologist David Marlowe, reflecting on the results of the NVVRS, wrote that these results are

'startling . . . raising many questions about the question of causality . . . leading us to wonder how much we are dealing with the sequelae of post-combat belief, expectation, explanation and attribution rather than the sequelae of combat itself' (Marlowe, 2000).

On the other hand, Richard McNally, a Harvard psychologist whose critical commentaries have challenged many sacred PTSD cows, checked the military records of 30 Vietnam veterans taking part in his research. Evidence of combat exposure was found for nearly all (McNally, 2003). So on the basis of earlier research, we can say that some Vietnam veterans do distort their military records, but we have no idea if this is a significant problem or not.

Psychologist Christopher Frueh has previously reported that there is a systematic bias in the assessment of psychological

outcomes in Vietnam combat veterans due to the overreporting of symptoms of traumatic stress (Frueh *et al*, 2000). Now he and his colleagues have moved on to a different but related issue: how accurate are self-reports of 'exposure', which in this context means war service (Frueh *et al*, 2005, this issue)?

Frueh has taken advantage of the US Freedom of Information Act to obtain the military records of 100 men attending a Veterans Affairs treatment programme for combat-related PTSD. By definition, all claimed to have been exposed to combat during their Vietnam service. In 41% there was documented evidence of combat exposure; a further 20% had served in Vietnam, but it was unclear whether they had seen combat – lacking, for example, the expected award of the Combat Infantry Badge. That left 39% about whom there was considerable doubt that they could ever have been in combat: 32% were in roles that were highly unlikely to have led to combat exposure – we should remember that in any modern army those who do the actual fighting are always the minority; 3% were in the military, but never went to Vietnam; and 2% had never been in the military at all. So if the personnel records were correct, and giving the benefit of the doubt to a further 20%, that leaves 32% who had exaggerated their Vietnam service and 5% who had invented it.

Some will be angry with Frueh and his colleagues for daring to question any traumatic memories; others may feel anger at the spectacle of people manipulating a system to obtain benefits to which they are not entitled. Before this particular battle is joined, we need to take a step back and reflect on not just who is telling their story, but who is listening.

### CHOOSING AN AUDIENCE

Narratives serve many functions, changing according to the audience, and those from Vietnam are no exception. Vietnam veterans tell different stories to each other from the ones they tell to psychiatrists (Young, 1995). The context in which their stories are told has considerable influence on the reporting of symptoms, depending on whether military service is being constructed in a positive or negative light (LaGuardia *et al*, 1983). The antiwar movement provided another, negative,

<sup>†</sup>See pp. 467–472, this issue.

context for the telling of Vietnam war stories. Few of the professionals who had a critical role in the acceptance of PTSD by the American Psychiatric Association made any secret of their antiwar views. Robert Jay Lifton, psychiatrist, humanitarian and historian, is only the best known. Charles Figley, for example, has described how his contributions to the literature were linked to his own antiwar sentiments (Figley, 2002). Mardi Horowitz, who developed the Impact of Events Scale and was another key figure, wrote in a 1975 paper, tellingly called 'A prediction of delayed stress response syndromes in Vietnam veterans' how:

'In 1969, a series of consultations was begun by the authors with staff members at two different [Veterans Affairs] hospitals. . . . According to the staff, stress response syndromes were not spontaneously reported by the population of Vietnam veterans. . . . correspondingly an educational program was begun. . . . As a result of these efforts, new cases of stress response syndromes in Vietnam veterans began to be reported in each subsequent case conference' (Horowitz & Solomon, 1975).

Some of those giving their testimonies must have been aware of the views of their audiences – and they would have been less than human if this had not influenced their own stories. The politics of the antiwar movement had become mixed with the memories of soldiers and their own distress (Fleming, 1985; Scott, 1993).

The Veterans Affairs system also generates its own biases. Historian Ben Shephard has detailed the troubled origins of this system (Shephard, 2000). Its most powerful supporters could not claim that it has been marked by conspicuous therapeutic success in the treatment of Vietnam veterans, even if they would not go as far as others in suggesting it has provided economic disincentives to recovery (Mossman, 1998) or even, as Shephard claims, developed policies that ran counter to the principles of the management of war-related psychiatric injury determined by trial and error during the two World Wars (Shephard, 1999). What is undeniable is that psychologically distressed veterans have many reasons for presenting to the Veterans Affairs system – one of the most common being a desire for the government to acknowledge how they have been affected by their Vietnam service and that the war is to blame for their problems (Sayer *et al.*, 2004). Testimonies given to Veterans Affairs psychiatrists need to be critically interpreted in the light of the context in which they are

given, a conclusion that is not at variance with a recent consensus statement whose authorship included many clinicians with impeccable traumatology credentials (Charney *et al.*, 1998).

### WHEN THE PATIENT REPORTS ATROCITIES

Returning to Frueh *et al.*'s findings, there were few factors that distinguished the Vietnam 'no combat' groups from those with clearly documented combat histories, but one was that the former were more likely to report witnessing or committing battlefield atrocities. Soldiers who deny atrocities that have been committed are nothing new, but reporting atrocities that have not taken place suggests a cultural shift in the history of trauma (Young, 2002). It is also of historical importance. The reporting of atrocities by Vietnam veterans had a central role in the history of PTSD: the disorder assisted veterans to make the public transition from reviled perpetrators to victims. From being accused in the streets of being 'baby killers', gradually sympathies changed, and eventually public opinion came to see the Vietnam veteran as yet another victim of the 'insane war'. The perpetrator was the war itself.

Some atrocity stories are all too true, but others are fantasies, as in the case of a Korean war veteran who made a much-publicised visit to the scene of an atrocity he had committed to beg forgiveness from the descendants of the villagers involved. Only later did it become clear that the war crime to which he had tearfully confessed had not taken place (Barringer, 2000). It is time for a reappraisal of the conclusion of Sarah Haley's seminal paper 'When the patient reports atrocities' (Haley, 1974). When patients do report atrocities, one lesson of Frueh *et al.*'s paper is to check the historical record before jumping to conclusions.

### INTERPRETING SILENCE

Frueh *et al.*'s theme is the exaggeration of war stories by some Vietnam veterans. But soldiers' stories may be unreliable in other ways. There is continuing debate among historians about the conduct and motivation of the *Wehrmacht* on the Eastern Front during the Second World War. The argument is whether soldiers were motivated by National Socialist ideology (Bartov, 1992) or, alternatively, fought the way they did

because of small-group loyalties, leadership, cohesion and professionalism, factors that made the *Wehrmacht* such an efficient fighting organisation (Shils & Janowitz, 1948). More recent scholarship supports a middle position (Browning, 1992; Anderson, 1999), but the argument has taken place partly because of the lack of oral history from the participants. These soldiers' stories are characterised by evasion and amnesia. Once again it is the historian's task to take such testimonies as exist, usually given to war crimes investigators, and subject them to critical scrutiny, a task performed with brilliance by Christopher Browning (Browning, 1992).

Stories told by Soviet soldiers are likewise subject to a different filter of culture, experience and the political environment in which they are told – a culture in which contemporary individual PTSD narratives have no recognition or meaning (Merridale, 2000). Finally, the relative lack of stories until recently from British Far Eastern prisoners of war has yet other reasons – the perceived shame of surrender, the overwhelming nature of their experiences, and the return to a culture that valued reticence and stoicism above emotional expression. In all cases war stories need to be examined for what is said, and what is unsaid.

### DO PSYCHIATRISTS TELL STORIES?

Why have we been so reluctant to examine the stories of Vietnam veterans? There are many reasons. We are ashamed that we 'weren't there', and guilty that these young men confronted danger on our behalf. We are frightened of the reactions that might be provoked if we do anything less than accept these narratives at face value. We have subscribed to our own narrative of trauma, which says that psychiatrists – beginning with Freud – have failed to accept genuine stories of abuse and adversity, turning their backs on victims and denying the reality of child abuse or war, until at last our eyes were opened.

This psychiatric narrative, of our progress from initial denial to contemporary enlightenment, is yet another that cannot withstand close scrutiny (Shephard, 2000; Jones & Wessely, 2005). Psychiatrists have been aware of the psychological cost of war for the past 100 years – the tens of thousands of war pensions paid after the First World War to those with shell shock, neurasthenia, effort syndrome and the like

mean that the psychological costs of war could hardly be denied. Likewise, the drain on manpower caused by psychiatric breakdown was of pressing concern to all the combatant nations during both World Wars, and in the soul-searching that followed. Vietnam and the emergence of PTSD did not signal an acceptance that soldiers broke down in battle for psychological reasons, since that was already well recognised; the coming of PTSD, however, acknowledged a change in our explanations of why this happens (Jones & Wessely, 2005). Prior to the Vietnam conflict, conventional wisdom was that war indisputably created psychological breakdown, but provided this was properly managed using the principles of 'forward psychiatry' (Jones & Wessely, 2003), and provided the condition was neither medicalised, hospitalised nor financially rewarded, then the breakdown would be short-lived (Shephard, 1999). If it was not short-lived, then it was the consequence of mismanagement, poor inheritance and/or disturbed early upbringing, and war was merely the trigger. The authors of DSM-III changed this by stating that the cause of chronic as well as acute breakdown after combat was still the war itself, and that ultimately everyone had a breaking point if subjected to sufficient stress.

## ON TAKING A HISTORY

What conclusions should we draw from Frueh *et al's* paper? They are not arguing that we should discount oral testimonies of war – that would be as naïve and foolish as uncritical acceptance. Nor should we assume that most war stories are at best exaggerated, at worst faked. That would be an example of the kind of sweeping generalisations (such as the ahistorical and unsustainable concept of a 'universal trauma reaction') that I am arguing against. What is needed is more careful local readings of evidence which take into account the specific historical circumstances that have led to this narrative being given at this time and in this place. Hence Frueh *et al's* results cannot be generalised beyond the specific problems of US Vietnam veterans and their difficulties with long-term readjustment. Likewise, the social, financial and political circumstances of these veterans, and their interaction with the Veterans Affairs system in particular and US society in general, does not permit simple extrapolation to other circumstances (Wessely & Jones, 2004).

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We should see war stories for what they are: complex narratives that serve many functions – functions that those of us who have never been to war are not always best placed to interpret. Professional historians treat oral history as the start, not the end, of their search for understanding, looking for other sources, and critically interpreting all evidence in the light of the context in which it is recorded (Evans, 2001). Psychiatrists also talk about taking a history, but it is time we paid more attention to how the professionals approach the task.

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