

## Psychiatry and the 'lessons of Vietnam': what were they, and are they still relevant?

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### ABSTRACT

The Vietnam conflict is conventionally regarded as a watershed in our understanding of the psychological effects of trauma. In particular, it led to the introduction of a new diagnosis in psychiatry, post traumatic stress disorder (PTSD), and also to a new epidemic of disturbed, violent and neglected service personnel. In this paper we reconsider this period, and argue that much of the conventional wisdom about the "lessons of Vietnam" is misplaced. In particular, the stereotype of the traumatised "Vietnam Veteran" owes less to events in theatre, and more to the politics of post Vietnam America. The sequence of events that followed the Vietnam War which determined its psychological consequences should not be generalised to, for example, the war in Iraq.

### INTRODUCTION

'Learning the lessons of Vietnam' is a phrase familiar in military and academic circles to refer to recent American reluctance to engage forces in a long-term counter insurgency war with little prospect of success.<sup>1</sup> Despite this and the firm conviction of several previous administrations that they have learned these lessons, the current situation in Iraq has led to increasing speculation about the prospects of another Vietnam, the implication being that these lessons, whatever they may be, require relearning.

None of this is news to the readers of this journal, but there is another intense, and continuing, debate about the contemporary relevance of the Vietnam conflict that will be less familiar. Vietnam was by common consent a watershed in American military thinking, doctrine and confidence. It also had widespread repercussions for the psychiatric profession in particular, and our general cultural and social attitudes towards the emotional consequences of trauma in general. This is because Vietnam was also the trigger for the emergence of a new psychiatric diagnosis, post-traumatic stress disorder (PTSD), and for a rethink of how we consider the mental health effects of trauma.

Just as debate continues about the military lessons of Vietnam, there is likewise an intense debate in psychiatry about its meaning for mental health professionals. We can agree that the Vietnam conflict was a turning point in our understanding of the links between trauma and mental health. As Ruth Leys puts it: ‘in the United States, concern for the chronic problems of Vietnam veteran, more than any other factor, precipitated today’s consensus about the severity of the effects of external trauma on the human psyche’.<sup>2</sup> Putting aside the questionable use of the phrase consensus, what is not understood is why this was the case, and what other nations and militaries that escaped the direct legacy of the Vietnam War should conclude from America’s experience.

For example, for most of last year the UK Ministry of Defence (MOD) was defending a major class action brought to the Royal Courts of Justice by psychiatrically injured ex-service personnel. One of the claims made by the soldiers (and they were all soldiers) was that the MOD had failed to ‘learn the lessons of Vietnam’. The implication being that had they done so, much of the psychiatric injury amongst service personnel could have been avoided.

When judgement was handed down in May 2003, it was clear that MOD had successfully defended the claims. Mr Justice Owen accepted the argument put forward in court that the MOD could not be condemned for failing to implement the lessons of Vietnam in its psychiatric services, because no one could be sure what those lessons were. The purpose of this paper is to review the psychiatric implications of the Vietnam War for contemporary doctrine and thinking.<sup>3</sup>

## **CHRONOLOGY**

The Vietnam War (1961-75), the longest conflict that America fought, can be divided into three phases in terms of military psychiatry: an advisory period with few combatants and almost no psychiatric casualties; a build-up period with large numbers of combatant troops but low levels of psychiatric casualties; and a withdrawal period in which relatively large numbers of psychiatric casualties took forms other than traditional acute stress reactions.<sup>4</sup>

The Vietnam conflict continues to pose problems for psychiatrists. The reason is that there are almost two entirely different accounts – a ‘game of two halves’ as we might say today. The first story of psychiatry in the war zone, was held to be a success, but the second, the story of what happened when the veterans returned to America, soon appeared to be a resounding failure.

## **IN THEATRE PSYCHIATRY – THE SUCCESS STORY**

The United States entered the Vietnam conflict with a well thought out and coherent doctrine of military psychiatry.<sup>5</sup> Based on experiences dating back to the First World War, overhauled and rethought in the Second, and practised in Korea, the military considered themselves well prepared to deal with psychiatric casualties. Research in the aftermath of the Second World War had quantified the relationship between combat exposure, combat efficiency and psychiatric breakdown.<sup>6</sup> Operational doctrines were altered in consequence, and the doctrine of ‘forward psychiatry’ was widely accepted.<sup>7</sup>

During the initial phases of build-up in Vietnam, the psychiatric program was fully in place, with abundant mental health resources and psychiatrists fairly conversant with the principles of combat psychiatry.

Despite the preparations, the relative lack of acute psychiatric casualties still came as a surprise. The figures show that throughout the entire Vietnam conflict, less than 5% (and nearer to 2%) of casualties in theatre were placed in this category; rates were less than half of those in Korea. Most spectacular was the low rate of identified psychiatric casualties generally and, in particular, the relative absence of the transient anxiety states currently termed combat fatigue or combat reaction. The reasons for this success were usually ascribed by the military psychiatrists themselves to the widespread use of forward psychiatry.<sup>8</sup> Other contemporary accounts pointed to the different and less intense nature of the fighting; far fewer soldiers were involved in combat duties than in Korea, while tours of duty were shorter and links with home improved.

Irrespective of the reasons, at the time Vietnam was considered a psychiatric success. As Albert Glass, the most influential military psychiatrist of the post-1945 period, wrote 'according to authoritative reports, military psychiatry in the Vietnam conflict achieved its most impressive record in conserving the fighting strength'.<sup>9</sup> Psychiatric casualties were 'surprisingly low'. Casualties were, reported another psychiatrist, ten times lower than in the Second World War, and three times lower than in Korea, or lower than 'any recorded in previous conflicts' said a third.<sup>10</sup> Likewise, the implementation of forward psychiatry created the 'impression that psychiatric casualties were rarely produced by the unique nature of combat in Vietnam',<sup>11</sup> whilst 'psychiatric casualties need never again become a major cause of attrition in the United States military in a combat zone'.<sup>12</sup> This was not just the professionals talking. Similar sentiments were expressed in the popular media, and the *New York Times* reported in 1968 that Vietnam veterans were finding jobs faster than ever before.<sup>13</sup> In the UK, one military psychiatrist, reviewing the Vietnam psychiatric experience in the *Journal of the Royal Army Medical Corps*, came to the same optimistic conclusion.<sup>14</sup>

### **VIETNAM: THE VETERANS COME HOME**

As to what happened next, the answers remain both disputed and controversial. Somewhere between 1968 and the mid 1970s the view that Vietnam had been a psychiatric success changed, and changed dramatically. The literature, lay and professional, began to take note of the problems of what appeared to be large numbers of disaffected, demoralised and distressed Vietnam veterans. But precisely how this happened, and what this represented, remains a source of considerable dispute. In essence two positions have developed, which we shall review in turn.

### **VIETNAM: A CONFLICT WITH A UNIQUE CAPACITY TO CAUSE PSYCHIATRIC DISORDER**

One increasingly influential school of thought began to argue that there was something different about Vietnam. The war itself had, by virtue of its particular characteristics, such as the involvement of

civilians as combatants and casualties, a unique propensity to cause psychiatric disorder over and above the normal expected consequences of all warfare. These 'exceptionalists' proposed the uniqueness of the Vietnam conflict, and by inference of the Vietnam veterans, and argued that this uniqueness accounted for the subsequent rise in psychiatric disorder.<sup>15</sup> However, what is intriguing is that some of these arguments seemed to predate, rather than explain, such a rise – what is striking about the early work of key figures such as Marti Horowitz or Charles Figley is how they much they are anticipating a rise in disorders, rather than reflect an established fact, as a quote from a key paper by Horowitz makes clear:

In 1969, a series of consultations was begun by the authors with staff members at two different VA 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.<sup>16</sup>

So the 1970s influential psychiatric figures such as Figley and Lifton began to question the conventional view that Vietnam had been a success from the perspective of the expected numbers of psychiatric disorders.<sup>17</sup> The confident tones of the military psychiatrists from the first years of American involvement also start to change as well in the later years of the conflict, perhaps because they too were turning against the war, or simply reflecting the changing nature of the war, both in its conduct and its increasingly likely outcome.<sup>18</sup>

To substantiate this increasing pessimism came a trickle, and then a flood, of studies, usually small scale and uncontrolled, but reporting the appearance of increasing numbers of servicemen who blamed their symptoms or social maladjustment on their war service. One of the earliest studies of Vietnam veterans was by Charles Figley, a psychiatrist who never made any secret of his honourable anti-war convictions, and grew into a key figure in the anti war and subsequent trauma movements. Figley followed up a random sample about four years after their deployment.<sup>19</sup> The population was selected from veterans receiving educational benefits from the Veteran's Administration (VA) at two college campuses in 1975. All were sent questionnaires<sup>20</sup> and those who responded (the response rate was not given) were divided into two groups: those that had served in Vietnam and those in the forces at the same time but not served in combat. The study therefore relies on retrospective, self-report data by which participants were asked to recall their mental states before military service during military service, one year from discharge and in the present, a methodology that would almost certainly have lead to significant bias. Even then, although the combatants recorded lower questionnaire scores on a mental health measure during military service, these had gradually returned to pre-military levels. Figley observed: 'it is tempting to conclude from the findings that the time-heals-all-wounds thesis is valid after all and, thus, the best treatment for psychological readjustment of veterans is time and patience'.<sup>21</sup>

But it was from such slender beginnings that the concept of the uniquely troubled Vietnam Veteran began to emerge, as these initial studies gave way to larger, but still less than robust, studies. Typical of this next generation of studies is that of Solkoff and colleagues, who compared 50 Vietnam veterans with PTSD with 50 controls who had experienced combat without psychiatric disorder.<sup>22</sup> They found that the PTSD sufferers reported significantly more intense battle experiences, including the deaths of friends. The PTSD subjects perceived their post-discharge and homecoming experiences more negatively than the controls. However, the PTSD veterans, who had been selected from patients at the Buffalo NY Veterans Administration Medical Center do not appear to have been randomly selected, and most of the controls were identified through local Agent Orange screening procedures. As the authors themselves commented such individuals could represent ‘a particularly alienated, angry and discontented group who sought diagnosis and/or treatment’. Assessments of combat experience in these studies were invariably self-reported and retrospective.<sup>23</sup>

Despite the limited nature of the evidence, the existence of any veterans who were alienated, angry or disaffected was considered compelling. These were essentially clinical observations, which by their very nature, cannot be used to generalise to the entirety of the veteran’s experience of Vietnam. Yet that is precisely what occurred.

#### **VIETNAM: THE PROBLEM WAS THE AMERICAN REACTION, NOT THE WAR**

By contrast, other scholars and psychiatrists doubted that that the Vietnam War was truly exceptional, and hence by implication shifted the spotlight to events in the United States to account for what happened after Vietnam.<sup>24</sup> Said one historian, ‘popular culture, without any reference to historical context, began to regard the Vietnam veteran as alone in American history as allegedly being unappreciated, troubled, rejected and blamed for the war’.<sup>25</sup> Dean went on to list the many similarities between Vietnam and previous conflicts involving the American armed forces, most particularly the Civil War, building up a strong case against the exceptionalist position. Vietnam was not the first counter insurgency campaign involving US forces. Even seminal events like the My Lai massacre, which played a significant role in turning the American public against war and in stereotyping the Vietnam veteran was nothing new in the annals of warfare – far worse atrocities had occurred during the Pacific campaign, even if on previous occasions the public either were not, or chose not, to be aware of them.<sup>26</sup> Historians and commentators also were able to show that rather than being the ‘norm’, as the anti-Vietnam campaigners had claimed, such atrocities were very much the exception.<sup>27</sup>

There were many reasons for this change and crisis; for one thing the war was lost. The same measures that were claimed to reduce psychiatric casualties, such as the rotation system and the improved links with home, may have paradoxically increased mental health problems by promoting the so called ‘short-term syndrome’, and showing to the serving soldiers that the American public was turning against the war. In addition, there was indeed an increase in drug use by soldiers in theatre (albeit paralleling a similar increase in society in general); there was a large scale demobilisation linked to a cooling down of the economy, and society itself had undergone profound changes during the

period of the 1960s, much of it inimical to military culture and values. The result was an 'existential malaise... the tenor of the times has had an adverse effect on Vietnam veterans, both in the military and upon entry into civilian life, and for some, readjustment has been difficult and prolonged'.<sup>28</sup> Fleming drew the critical distinction between this and the formal psychiatric disorder that was PTSD, which was far less common.<sup>29</sup> Another noted the deleterious effects on morale and group cohesion of the one year rotation policy, making the insightful comment that 'in a curious reversal of soldierly tradition, Vietnam veterans may have experienced more sustained fellow feeling with their comrades after leaving the war than they ever had while they fought it'.<sup>30</sup>

The returning Vietnam veteran, whether rightly or wrongly, was soon perceived as a social problem. In response to this perceived crisis Congress increased GI benefits, new drug programmes were instituted, the head of the VA was sacked, and efforts were already made to 'welcome home' the allegedly unwelcome Vietnam veteran, who even in 1974 were being described by President Nixon as the 'forgotten heroes'. Nevertheless, already there was an almost unstoppable public perception developing that the government had been wrong to send the soldiers to Vietnam, and then wrong to ignore them on return.

Long before the research reports began to emerge, with their contradictory findings, the media and Hollywood stereotype of the Vietnam veteran as a person who has become traumatized and marginalised by their service, rejected by society, prone to antisocial behaviour including drug taking and violence, and most probably suffering from severe psychopathology, had taken root.

### **VIETNAM: THE EPIDEMIOLOGICAL EVIDENCE**

In an ideal world, epidemiological evidence might have assisted in determining which of the above views was correct. Epidemiology is the study of populations, and its methodologies are such to permit the kind of generalisations and extrapolations that clinical observations and anecdote cannot.

However, one is drawn to analogies with stable doors and horses. By the time it was accepted that large-scale epidemiological studies of the experiences of the Vietnam veterans were necessary, the battle lines had been drawn. Much time had passed, and the issues were already deeply politicised. Perhaps unsurprisingly, the statistical evidence that resulted was murky, and remains insufficient to answer the questions.

On the one hand, well-conducted, follow-up studies on representative samples of veterans remained reassuring. For example, no increase in records of maladjustment was noted between Vietnam and non-Vietnam veterans on their return.<sup>31</sup> In a longitudinal study of all men who had enlisted in the Navy in 1966 (92,000) mental disorders amongst those who had experienced Vietnam combat were surprisingly low, rates that fell even lower during the post-Vietnam period.<sup>32</sup> Instead, it was the non-combatant Vietnam veterans who had the highest hospitalisation rates for stress-related disorders both during and after the Vietnam War.

Probably the best such study, the Center for Disease Control Vietnam Experience Study, found that 'Vietnam Veterans seem to be functioning socially and economically in a manner similar to army veterans who did not serve in Vietnam'.<sup>33</sup> More Vietnam veterans had psychological symptoms, which we have come to expect of all those exposed to war, but 'fewer than 1% met criteria for current drug abuse or dependence'. There were no differences in the numbers in prison. 15% had at some time met the then current criteria for PTSD, but only 2% currently fulfilled criteria. Education, ethnicity and age also were associated with psychological distress. Other studies confirmed that Vietnam veterans had a higher median income relative to their peers.<sup>34</sup> So these studies, all of them large, well conducted and representative, confirmed the general view and conventional wisdom from previous wars that even though many did not emerge unscathed from war, most are still able to resume normal lives.

On the other hand, we have to consider a body of epidemiological evidence that is not so reassuring.<sup>35</sup> Perhaps the most influential study has been the National Vietnam Veterans Readjustment Study (NVVRS), comparable in scale, timing and expense to the CDC study, but with a very different set of findings. The NVVRS was a major, VA-funded investigation into the prevalence of PTSD and other psychological problems encountered in returning to civilian life.<sup>36</sup> Mandated by Congress in 1983, it was conducted with federal input and assistance. The sample of veterans examined in the NVVRS was broader and more inclusive than in earlier studies and hence more representative. Questioning was intensive, indeed some have argued too intensive.

The study showed that the majority of Vietnam veterans had made a successful re-entry into civilian life and experienced few symptoms of PTSD or other re-adjustment problems. Most male Vietnam veterans were found not to differ greatly in their current life adjustment from their non-Vietnam veteran counterparts. Nevertheless, the study found that 15% of male veterans and 8% of female veterans had the symptoms of PTSD. A further 11% of males and 8% of females had clinically significant stress symptoms that adversely affected their lives but do not qualify for the full diagnosis of PTSD. The NVVRS analysis of the lifetime prevalence of PTSD indicated that 31% of male Vietnam veterans (over 960,000 servicemen) and 27% of females (1,900) had PTSD at some time during their lives – a figure some six fold higher than the results from the Center for Disease Control.

The study also demonstrated a strong relationship between PTSD and other post-war adjustment problems. Having PTSD significantly increases the likelihood of having other psychiatric disorders and re-adjustment problems. The estimated lifetime prevalence of alcohol abuse or dependence amongst male Vietnam veterans was 39%, and that for drug abuse was 6%. Male theatre veterans with PTSD were found to be two to six times more likely to abuse alcohol or drugs as those without the disorder. The prevalence of PTSD was correlated with high levels of combat exposure and other war-zone stressors.

Vietnam veterans with post-war psychological problems were found to be more likely to have sought mental health care from the VA than those without such problems. Nevertheless, very substantial proportions of Vietnam veterans with readjustment problems never consulted the VA or anywhere else for their mental problems.

The report's findings tended to encourage the provision of specialist PTSD treatment before these interventions had been fully evaluated. Indeed, the epilogue to the 1990 publication was entitled 'A self-guide for Vietnam veterans' and it gave a detailed list of VA facilities, including specialised in-patient PTSD units and PTSD clinical teams.<sup>37</sup>

This was a landmark study, of immense political importance, and played a major role in the rehabilitation of the Vietnam veteran in the eyes of society, but one not immune to criticism – not least because of the 'remarkable'<sup>38</sup> prevalence of psychiatric disorder reported. Perhaps the most important methodological drawback comes from the way in which combat exposure was assessed. First of all, it was based, as a later authority pointed out, on 'retrospective self reports of events and circumstances that occurred approximately 10 to 20 years prior to data collection'.<sup>39</sup> Military records were available to the researchers, but were not used to validate reports of combat experience. This is a pity, since the finding that nearly one third of Vietnam veterans had ever suffered from PTSD is well above best estimates of numbers exposed to combat. Yet few contemporaries drew attention to this essentially implausible finding, and to this day the NVVRS papers are among the most widely cited papers used by psychiatrists writing on Vietnam in particular, and trauma in general.

We know now that retrospective reports of war experience are coloured by current circumstances and the political and social climate that follows the war. Never was this truer than after Vietnam, and for those reasons it is highly likely that there has been a gradual 'inflation' of traumatic memories to fit with the changing views of the Vietnam War. The influential military anthropologist David Marlowe now sees the results of this study as 'startling... raising many questions about the question of causality', arguing that this and other similar studies 'lead 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'.<sup>40</sup>

### **WHY THEN DID THE STORY CHANGE?**

It is now clear that numerous factors were responsible for the visibility of apparently Vietnam War damaged veterans in the United States during the 1970s and 1980s. Any definitive account (and one yet to be written) must take into account a number of factors - social, economic, military and political.

For example, few can doubt the influence of powerful and charismatic campaigners who believed with conviction that the Vietnam War was immoral. The anti-war movement became a powerful factor in US society. Particularly relevant is the crucial role played by specific psychiatric



campaigners, such as Robert Jay Lifton and Chaim Shatan, who used stories of apparently war damaged veterans as part of the general anti war movement.<sup>41</sup> The rhetoric and passions involved may be glimpsed from one quote from Lifton, arguably the most influential psychiatrist of his generation, who certainly had a ‘tremendous impact on the consciousness of trauma in our era’,<sup>42</sup> and who compared US Army psychiatrists in Vietnam to the Nazi doctors of the concentration camps.

Other reacted equally vehemently against this perceived politicisation of psychiatry. Said one commentator: ‘for some, the politics of the antiwar movement have been perverted and transformed into the politics of illness’.<sup>43</sup> Perverted may be unfair, but views of illness were certainly transformed. Gradually, and almost certainly deliberately, these prominent anti-war campaigners used these case histories as part of the political process (case histories that themselves are now considered to be certainly unrepresentative and possibly of questionable authenticity),<sup>44</sup> and as they did so brought a willing psychiatric establishment with them. By 1972 the American Psychiatric Association stated ‘we find it morally repugnant for any government to exact such heavy costs in human suffering for the sake of abstract concepts of national pride or honour’. Such sentiments, especially from august national bodies, would have been unthinkable only a generation previously. One can see just how far Vietnam had shifted attitudes when one compares that statement with the pronouncements and activities of the same institutions between 1939 and 1945, when they were extremely willing to commit themselves and their expertise unhesitatingly to the war effort.<sup>45</sup>

To this must be added the particular problems of the American medical system, and the fact that for many veterans, especially those from lower socio-economic positions, the only way to access medical care was via the VA system, and for that one needed to have a war-related disorder. The VA benefits system likewise provided an incentive for illness, whilst PTSD, in turn, provided a needed lifeline for the VA system itself. As Paul McHugh, professor of psychiatry at Johns Hopkins Medical School in Baltimore, and an critical commentator on American psychiatry has written: ‘a natural alliance grew up between patients and doctors to certify the existence of the disorder (PTSD): patients received the privileges of the sick, while doctors received steady employment at a time when, with the end of the conflict in South East Asia, hospital beds were emptying’.<sup>46</sup>

The culmination of these endeavours, not least being the ‘concerted and effective effort’<sup>47</sup> of Shatan and Lifton but also the work of Marti Horowitz on stress response syndromes, was the swift introduction of the diagnostic category of PTSD into the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)* in 1980, which, as many have pointed out, owed more to political and social influences, than scientific inquiry.<sup>48</sup> It is striking how nearly all of the studies on the causes, classification and epidemiology of PTSD did not precede its introduction into *DSM-III* as one might expect, but followed it. It is astonishing just how flimsy was the research evidence that led to the introduction of PTSD into the diagnostic canon. Much was made of a small number of studies of psychiatrically disturbed veterans of the Second World War, which whilst certainly showing that amongst the vast numbers of ex-servicemen from the war were some with clear and obvious psychiatric

disorders, but could not prove either the scale of the problem, nor the relationship between war service and current distress. As one commentator observed: ‘the co-evolution of PTSD as a social phenomenon and a psychological speciality focussing on stress is an inescapable fact, and the celebration of mediocre longitudinal studies of stress reactions of World War Two veterans a striking scholarly concomitant’.<sup>49</sup>

That is not to say that PTSD is a socially created illness, but it does contradict the ahistorical view that PTSD represented a further step in the move from ignorance to enlightenment. This Whiggish view of history sits uncomfortably with the facts, in which the creation of the category of PTSD is itself ‘part of American’s efforts to comprehend Vietnam’.<sup>50</sup> As we write, predictions are starting to appear in the popular press that America faces “another Vietnam” in Iraq, and that one consequence may be another epidemic of PTSD. There is a danger that such predictions may become self fulfilling.

## CONCLUSION

It is hard to dissent from the conclusions of Kaylor and colleagues, written in 1987;

Vietnam however was easily America’s most controversial war, and like the war itself, many claims and counter claims have been made regarding the soldiers who fought there. Perhaps paradoxically, the sheer amount of data collected may have helped sustain the controversies. So much has been written about this group of soldiers that it is possible to find data to support almost any position. Consequently, different researchers have come to opposite conclusions regarding the contemporary status of Vietnam veterans.<sup>51</sup>

So were the increased numbers of apparently damaged Vietnam War veterans really the result of unusual battlefield stress? Or do the explanations lie not in the jungles of Vietnam but in the nature of American society and its struggle to come to terms with a war that was lost? Or perhaps it was a self-produced epidemic in which expectations eventually became fulfilled?<sup>52</sup> We cannot provide answers, although it will be clear that we believe that locating the causes in the nature of the war fighting *per se* is the least convincing position.

What one can say with more conviction is that the psychological consequences of the Vietnam conflict are specific to that conflict, and that attempts to apply the ‘lessons of Vietnam’, whatever one may think they were, to other conflicts involving other nations at other times, is a dangerous and possibly misleading enterprise. Generals are justly criticised for ‘fighting the last war, not the present one’, and psychiatrists should beware of the same mistake.

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<sup>1</sup> Brian Holden Reid, 'The Influence of the Vietnam Syndrome on the Writing of Civil War History', *RUSI Journal* 147 (2002), 44-52.

<sup>2</sup> Ruth Leys, *Trauma: A Genealogy* (Chicago: University of Chicago Press, 2000).

<sup>3</sup> Simon Wessely gave expert testimony at the Royal Courts of Justice on behalf of MOD. This paper is based in part on the submission, co-authored by Edgar Jones, made to the court.

<sup>4</sup> F.D. Jones, 'Psychiatric lessons of war', in F.D. Jones et al (eds), *Textbook of Military Medicine, Part I – War Psychiatry* (Washington DC: Office of the Surgeon General, 1995).

<sup>5</sup> No definitive history of military psychiatry has yet been written. R.H. Ahrenfeldt (*Psychiatry in the British Army in the Second World War* London: Routledge & Kegan Paul, 1958) provides a useful 'official' history of the British experiences between 1939 and 1945, whilst ADD Anderson edited a similar volume for the USA: *Neuropsychiatry in World War II* (Washington DC: Department of the Army, 1966). For a definitive narrative and analysis of both World Wars uniting the British and American stories see Ben Shephard, *A War of Nerves, Soldiers and Psychiatrists 1914-1994* (London: Jonathan Cape, 2000). Shephard, however, is less compelling for the modern era, including Vietnam.

<sup>6</sup> See G.W. Beebe and M.E. DeBakey, *Battle casualties: incidence, morality and logistic considerations* (Springfield, Illinois: Charles C Thomas, 1952). For a modern interpretation see E. Jones and S. Wessely, 'Psychiatric battle casualties: an Intra- and Inter-war comparison', *British Journal of Psychiatry* 178 (2001), 242-247, and C. Blood and E. Gauker, 'The relationship between battle intensity and disease rates among Marine Corps infantry units', *Military Medicine* 158 (1993), 340-344.

<sup>7</sup> 'Forward psychiatry' was introduced during the First World War as a reaction to the obvious failures of locating psychiatric services well to the rear and in a medical setting. New doctrine held that if soldiers were treated swiftly, near to the front line, in a military setting, given rest, reassurance and encouragement, and then returned swiftly to their comrades, short-term distress would not give way to long-term disorder. As Jones and I have argued, whether or not this was in fact true cannot be established with any certainty, and nor it is clear whose interests, the soldier or the military, are being served by the system. See E. Jones and S. Wessely, 'Forward psychiatry in the military: its origins and effectiveness', *Journal of Traumatic Stress* 16 (2003), 411-19.

<sup>8</sup> W. Tiffany, 'The mental health of army troops in Vietnam', *American Journal of Psychiatry* 123, (1967), 1585-86.

<sup>9</sup> Albert Glass, 'Mental Health Programs in the Armed Forces', in G. Caplan (ed), *American Handbook of Psychiatry* (New York: Basic Books, 1974), 800-809.

<sup>10</sup> P. Bourne, 'Military psychiatry and the Vietnam experience', *American Journal of Psychiatry* 127 (1970), 481-88; W. Bey, 'Division psychiatry in Vietnam', *American Journal of Psychiatry* 127 (1970), 146-150 and Tiffany, Mental health of army troops. However, these are all studies from the US Army. No figures exist on psychiatric casualties in the Marines, who took part in some high intensity combat, such as the siege of Khe San.

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- <sup>11</sup> Glass, 'Mental health programs'.
- <sup>12</sup> Bourne, 'Military psychiatry'.
- <sup>13</sup> 'Vietnam veterans finds job faster', *New York Times* 3 May 1968, 35.
- <sup>14</sup> R. Belas, 'Combat psychiatry and preventive aspects of mental health', *Journal of the Royal Army Medical Corps* 119 (1973), 1-11.
- <sup>15</sup> A.S. Blank, 'Stresses of war: the example of Viet Nam', in L.B. Goldberger and L. Shlomo (eds), *Handbook of stress: theoretical and clinical aspects* (New York: Free Press, 1982), 631-43.
- <sup>16</sup> M.J. Horowitz and G.F. Solomon, 'A prediction of delayed stress response syndromes in Vietnam veterans', *Journal of Social Issues* 31 (1975), 67-80. We are indebted to Ben Shephard for drawing the importance of this passage to our attention.
- <sup>17</sup> See Charles Figley, 'Psychosocial adjustment among Vietnam Veterans: an overview of the research', in Charles Figley (ed), *Stress Disorders Among Vietnam Veterans* (New York: Brunner/Mazel, 1978), 57-70. For an early example of this, and to see the crisis of confidence of American military psychiatry after Vietnam, see N. Camp, 'The Vietnam War and the ethics of combat psychiatry', *American Journal of Psychiatry* 150 (1993), 1000-10.
- <sup>18</sup> The nature of the war was changing, with drug abuse on the increase, and morale starting to fall. Morale and confidence amongst the psychiatrists was also falling, partly reflecting the situation in theatre, and perhaps also because of the absence of serious leadership amongst the psychiatrists themselves; Vietnam produced no Salmon, Grinker, Spiegel, Hanson or Glass. See J. Renner, 'The changing patterns of psychiatric problems in Vietnam', *Comprehensive Psychiatry* 14 (1973), 169-81; Shephard, *War of Nerves*.
- <sup>19</sup> C.R. Figley, 'Symptoms of delayed combat stress among a college sample of Vietnam veterans', *Military Medicine* 143, 1978, 107-10. See also C.R. Figley, 'Origins of traumatology and prospects for the future, Part 1', *Journal of Traumatic Practice* 1 (2002), 17-32, for a personal account of his own anti-war convictions, in which he wrote that his 1978 book and papers were 'a by product of anti war sentiment and was partly responsible for the US Congress establishing the Vietnam Veterans Readjustment Counselling program' and links this to the introduction of PTSD in 1980.
- <sup>20</sup> Questionnaires are themselves questionable when it comes to making psychiatric diagnoses; studies that rely on questionnaires alone will usually overestimate the true rates of psychiatric disorders compared with those that employ interviews.
- <sup>21</sup> Figley, 'Symptoms of delayed combat stress', xxx.
- <sup>22</sup> N. Solkoff, P. Gray and S. Keill, 'Which Vietnam veterans develop posttraumatic stress disorders?' *Journal of Clinical Psychology* 42 (1986), 687-98.
- <sup>23</sup> Historians need no reminding of the suspect nature of war memories and stories, but psychiatrists apparently do; see the furore caused by B. Burkitt and G. Whitley, *Stolen Valour: How the Vietnam Generation was Robbed of its Heroes and its History* (Dallas: Verity Press, 1998). Recent scrupulous use of military records to demonstrate that the stories of some Vietnam veterans are closer to fantasy than reality may have overstated the case, but we should be aware of just how flexible is memory. There is general tendency for distressed or depressed people to over emphasise negative aspects of their

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history. Such ‘recall bias’, as it is known, is a major and perhaps fatal barrier to assigning cause and effect in retrospective studies that link current disturbance with previous trauma.

<sup>24</sup> R. Fleming, ‘Post Vietnam Syndrome: neurosis or sociosis?’ *Psychiatry* 48 (1985), 122-39, and Allan Young, *The Harmony of Illusions: Inventing Post-traumatic Stress Disorder* (Princeton: Princeton University Press, 1995).

<sup>25</sup> Eric Dean, *Shook Over Hell: Post-Traumatic Stress, Vietnam, and the Civil War* (Cambridge, Massachusetts: Harvard University Press, 1997).

<sup>26</sup> It is, however, true that US atrocities against civilians do not figure highly in accounts of the Pacific War.

<sup>27</sup> What remains unexplained was the apparent willingness of some Vietnam veterans to report such atrocities. In the past, soldiers who have been involved in atrocities rarely admit their involvement publicly; selective amnesia is the norm. Yet some Vietnam veterans appeared keen to report atrocities, including many that we now know were the work of fantasy. Perhaps this was another feature of the way that the traditional perpetrator of violence, the soldier, became via the agency of PTSD transmuted into the victim. See Allan Young, ‘The self-traumatized perpetrator as “transient mental illness”’, *Evolution Psychiatry* 67 (2002), 1-21.

<sup>28</sup> Fleming, ‘Post Vietnam Syndrome’, 122-39.

<sup>29</sup> This distinction is crucial: between the vast majority of combat veterans, who may continue to have troubled memories of war for the rest of their lives but function perfectly well in all spheres of life, and the minority who have psychiatric disorder that impedes social, family and occupational function. Yet it is so often forgotten when we read reports of vast numbers of ‘PTSD’ cases in New York City after 9/11, or indeed in any war torn region. See K. Lee, G. Vaillant, W. Torrey, and G. Elder, ‘A 50-year Prospective Study of the Psychological Sequelae of World War II Combat’, *American Journal of Psychiatry* 152 (1995), 516-22. The small numbers of those who had clear psychiatric disorder after combat remained ill for the rest of their lives, whilst for the vast majority they neither forgot their combat experiences, nor developed war related psychiatric disorder over the next 50 years.

<sup>30</sup> R. Spiller, ‘Isen’s Run: Human Dimensions of War in the 20th century’, *Military Review* 68 (1988), 16-31.

<sup>31</sup> J. Borus, ‘Incidence of maladjustment in Vietnam returnees’, *Archives of General Psychiatry* 30 (1974), 554-57.

<sup>32</sup> A. Hoiberg, ‘Military effectiveness of navy men during and after Vietnam’, *Armed Forces and Society* 6 (1980), 232-46. This study did not incorporate data from out-patient or Veterans Administration hospitals, a methodological weakness.

<sup>33</sup> Center for Disease Control Vietnam Experience Study, ‘Health Status of Vietnam Veterans 1. Psychosocial Characteristics’, *JAMA* 259 (1986), 2701-07.

<sup>34</sup> Dean, *Shook over Hell*.

<sup>35</sup> For example, Card’s study of a high school cohort (J. Card, ‘Epidemiology of PTSD in a national cohort of Vietnam veterans’, *Journal of Clinical Psychology* 43 (1987), 6-17), and most impressively, Jack Goldberg’s twin study (J. Goldberg, ‘A twin study of the effects of the Vietnam War on posttraumatic stress disorder’, *JAMA* 263 (1990), 1227-32), which found that rates of questionnaire

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ascertained PTSD rose from 5 to 17% between the members of the twin pairs discordant for Vietnam service. This is a powerful design since many other factors that influence psychiatric disorder (genetics, environment, family background, socio-economic status and so on) whilst not exact between the pairs, were certainly more similar than in other control groups.

<sup>36</sup> R.A. Kulka, W.E. Schlenger, J.A. Fairbank, R.L. Hough, B.K. Jordan, C.R. Marmar, C.R., et al., *Trauma and the Vietnam War Generation: Report of Findings From the National Vietnam Veterans Readjustment Study* (New York: Brunner/Mazel, 1990).

<sup>37</sup> Paperbound 'Self-guides' were actually in circulation during the 1980s; see Young, *Harmony of Illusion*.

<sup>38</sup> David Marlowe, *Psychological and Psychosocial Consequences of Combat and Deployment* (Santa Monica: Rand Corporation, 2000).

<sup>39</sup> D. King, L. King, D. Gudanowski and D. Vreven, 'Alternative representations of war zone stressors: relationships to posttraumatic stress disorder in male and female Vietnam veterans', *Journal of Abnormal Psychology* 104 (1995), 184-96.

<sup>40</sup> Marlowe, *Psychological and Psychosocial Consequences*.

<sup>41</sup> For an account of the way in which the anti war psychiatrists joined forces with the psychiatric establishment to pave the way for the introduction of the formal diagnosis of PTSD see W.J. Scott, 'PTSD in DSM-III: A case in the politics of diagnosis and disease', *Social Problems* 37 (1990), 294-310; W.J. Scott, 'PTSD and Agent Orange - Implications for a Sociology of Veterans Issues', *Armed Forces & Society* 18 (1992), 592-612; and Young, *Harmony of Illusions* for a very influential and crucial anthropologically orientated account of the origins of PTSD, one of the seminal works that contradict the ahistorical view of PTSD as a timeless entity.

<sup>42</sup> C. Caruth, *Trauma: Explorations in Memory* (Baltimore: Johns Hopkins, 1995).

<sup>43</sup> Fleming, 'Post Vietnam Syndrome', 122-139.

<sup>44</sup> See Borus, 'Incidence of maladjustment in Vietnam returnees', and Marlowe, *Psychological and Psychosocial Consequences*.

<sup>45</sup> See for example the way in which the psychiatric and psychological establishments lent their support, expertise and authority to the flawed psychological screening programme. See E. Jones, K. Hyams and S. Wessely, 'Screening for vulnerability to psychological disorders in the military: a historical analysis', *Journal of Medical Screening* 10 (2003), 40-46.

<sup>46</sup> P. McHugh, 'How psychiatry lost its way', *Commentary* XX (1999), 32-38.

<sup>47</sup> W.J. Scott, 'PTSD and Agent Orange - Implications for a Sociology of Veterans Issues', *Armed Forces & Society* 18 (1992), 592-612.

<sup>48</sup> What was new about PTSD was not the concept that stress could cause psychiatric disorder, as some erroneously believe. The experiences of both World Wars had proved that beyond dispute. But psychiatric thinking during the first half of the twentieth century put the main emphasis for prolonged, as opposed to transient, psychiatric disorder on either biological or genetic factors, if organically inclined, or to early life influences if one was psycho-analytically inclined. Soldiers, it was argued, who gave way under the pressures of combat, should suffer only short-term breakdowns. If they were not, then the prevailing doctrine was that such illnesses would have happened anyway because of either

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heredity or childhood experiences, and combat was merely the trigger. The change that PTSD represented was the concept that long-term, severe psychiatric disorder could be caused by later life trauma such as combat. The truth, as ever, lies somewhere in between. Genetic and childhood factors increase the chances of developing psychiatric disorder when exposed to adversity in adulthood.

<sup>49</sup> J. Modell and T. Haggerty, 'The Social Impact of War', *Annual Review of Sociology* 17 (1991), 205-24.

<sup>50</sup> Ibid.

<sup>51</sup> J. Kaylor, D. King and L. King, 'Psychological effects of military service in Vietnam: a meta analysis', *Psychological Bulletin* 102 (1987), 257-71.

<sup>52</sup> In a study that deserves to be better known (R.L. LaGuardia, G. Smith, R. Francois, and L. Bachman, 'Incidence of delayed stress disorder among Vietnam era veterans: the effect of priming on response set', *American Journal of Orthopsychiatry* 53 (1983), 18-26) showed that the emotional responses of Vietnam veterans to cues about their military service far from fixed and immutable, and depended on the context in which the cues were expressed.