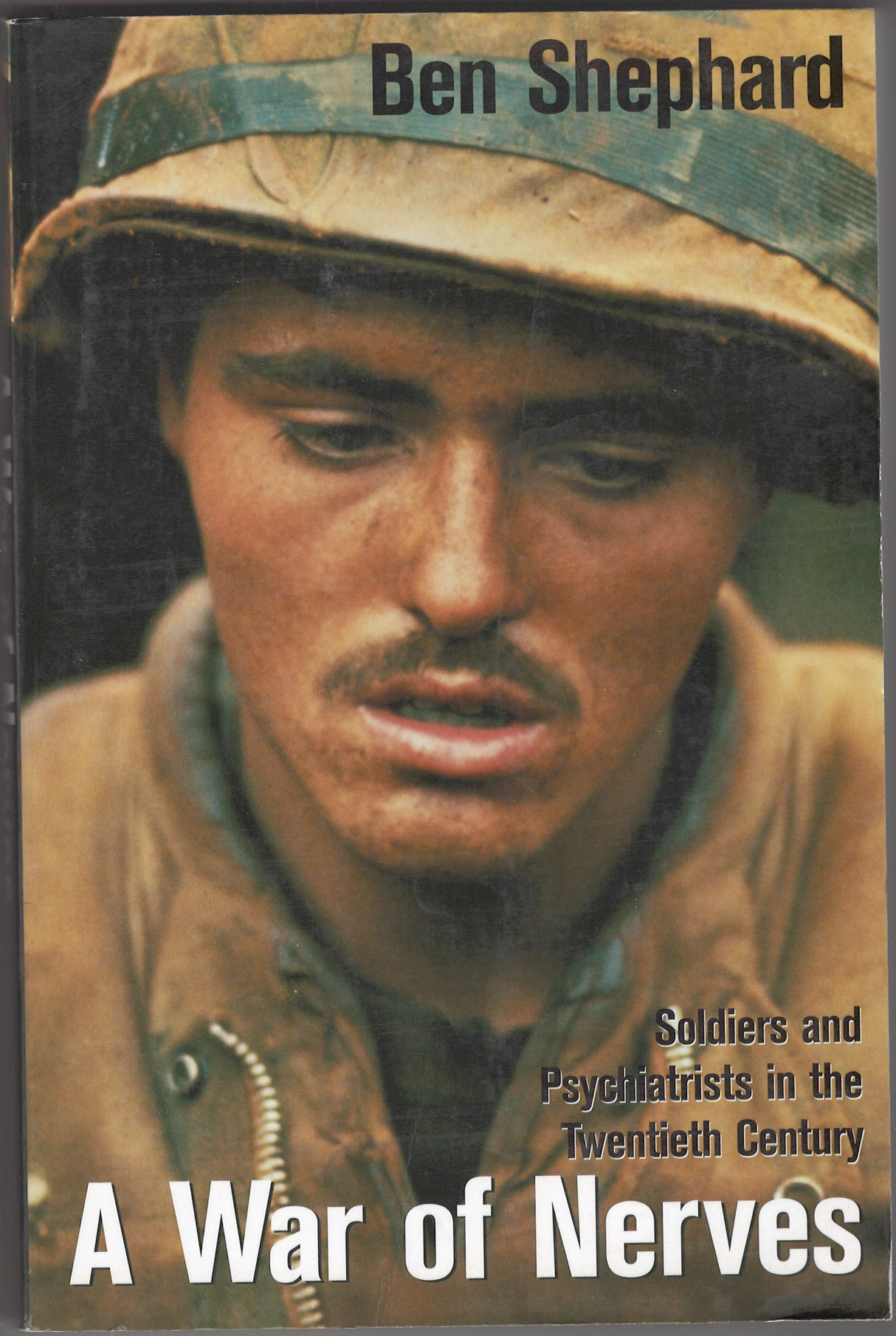
Ben Shephard
Soldiers and Psychiatrists in the Twentieth Century
A War of Nerves

24

FROM POST-VIETNAM SYNDROME TO POST-TRAUMATIC STRESS DISORDER

There is no trauma field without advocacy.
Dr Arthur S. Blank, Jr.[1]

More than any other war in the twentieth century, Vietnam redefined the social role of psychiatry and society's perception of mental health. Five years after the fall of Saigon, a new psychiatric term was devised, tailored to the needs of veterans. Psychiatric counselling was made available on an unparalleled scale, paid for by the United States government. Even more significantly, Vietnam helped to create a new 'consciousness of trauma' in Western society.

Some see this train of events as a triumph, a 'self-help success story', in which 'informed public opinion prevailed' and a group of victims fought for their rights. To others, it is a tragedy, a disastrous incursion of politics into medicine, the hi-jacking of traditional values by a small minority of activists, the elevation of the pathological into the mainstream.[2]

It is certainly a complex tale, into which many social, political and medical strands were woven; a story which cannot be understood without some sense of the fevered, divided mood of the United States in the early 1970s. Four main elements contributed: the acrid political aftermath of a lost war; the politics of veterans' affairs; a revolution in American psychiatry; and the legacy of the Nazi Holocaust.

The story begins in the late 1960s – when a small group in New York formed an organisation called Vietnam Veterans Against the War. Its membership remained tiny but, because they were all veterans, VVAW had a status denied to more powerful anti-war groups. After news of a massacre by American troops at the village of My Lai appeared in the press late in 1969, VVAW began to use the issue of atrocities to undermine support for the war and held a widely-publicised series of hearings into the behaviour of American forces in Vietnam at which many soldiers testified to having witnessed or committed atrocities.[3]

VVAW also organised 'rap groups' – meetings at which members talked together about their own experiences during the war and their feelings about

them. These rough stabs at psychotherapy brought them into contact with the psychiatric community. In 1970, a New York analyst called Chaim Shatan was approached at a university mass meeting on 'My Lai and Kent State' by a number of veterans who told him they were 'hurting'. They either didn't want to go to the Veterans' Administration for help or they were 'ineligible'. Shatan and another prominent analyst and opponent of the war, Robert Jay Lifton of Yale, agreed to work with the groups, helping them to organise their sessions: 'They said shrinks could join provided that we joined as peers. They knew more about the war than we did, and we knew more about what makes people tick.'[4]

At one rap session Shatan attended, the men sat 'on packing cases, filing cabinets and radiators in a ramshackle downtown office building' in Manhattan. The group that day included Bob, a former Marine still seized by 'unpredictable episodes of disorientation and panic' in public places; Phil, avoiding enemy snipers six years after leaving Vietnam; Bob, a former helicopter doorgunner, only able to forget his 'pleasure in killing [his] first 16-year-old Commie for Christ' by hurtling along freeways at night on his bike; and Don, who had watched his friend die for four days in Vietnam and was ashamed of being alive when his buddy was dead.[5]

The veterans' groups also organised workshops on the themes which obsessed them, 'The John Wayne image', 'When Do we stop being Vets?' and, inevitably, 'Women and Sex'. Hallowed institutions like the Marine Corps were also questioned. Earlier generations had joined the Marines in a spirit of 'blazing patriotism' and endured the sadistic abuse of its drill instructors as a necessary price for the glory of Tarawa; every boy in America had wanted to be like John Wayne in *The Sands of Iwo Jima*. Now it was said that Marine Corps basic training – during which recruits were routinely taunted by a litany of 'You dirty faggot' and 'Can't hack it, little girl?' – produced a degraded masculinity. Recruits were whipped up into a state of quasi-sexual excitement, which had traditionally found an outlet in the short, climactic battles that won the Corps its honours. But in Vietnam there were no pitched battles, no great release of aggression and energy, just a year of tense, inconclusive, unresolved patrolling, during which the enemy was seldom seen, let alone vanquished. The ordinary Marine, whipped up to pitch of sexual frenzy, never 'got his gun off'. Consequently, many men sought an outlet in atrocities and in brutal, sadistic sex with Vietnamese women.[6]

One member of the early rap groups remembers that they helped him to understand why he felt as he did. 'We had these shrinks but we weren't really in therapy,' Jack Smith, a former Marine, said in 1988. 'We were trying to understand what we were feeling about the war . . . it was a safe place to talk . . .We weren't thinking of ourselves as victims, but rather thinking, "How are we going to get our act together so we're not undone by our feelings about what's going on, and how are we going to convey what's going on to the general public?"' 'The vets who came to the early rap groups,' Arthur Egendorf recalled, 'brought with them, as an overwhelming residue from the war, a deep demoralization and loss of trust in their leaders, in the cause, and in the person they were before going in.' 'When I went to Vietnam,' said one, 'I believed both

in Jesus Christ and John Wayne. After Vietnam, both went down the tubes. It didn't mean nothing.' The poet Robert Bly later wrote that 'when the Vietnam veteran arrived home, he found a large hole in himself where his values were.'[7]

One way for members of VVAW to rediscover a sense of values was through political activism. The high point of the movement, for many, was a demonstration in Washington in April 1971 when veterans staged a 'medal turn in' ceremony. Jack Smith found it 'probably the most powerful moment of my life'. It was 'enormously cathartic,' another veteran agreed: '[For] all of us who did [it], it was as if we had a device for throwing our sins away.' But, with the scaling down of the American presence in Vietnam – the last soldier came home in 1973 – political opposition to the war became muted and Vietnam Veterans Against the War 'splintered into warring regional and ideological factions.'[8]

However, from these beginnings emerged a more broadly-based movement, the National Veterans Resource Project, bringing together veterans, psychiatrists and members of religious groups, which aimed to get the needs of Vietnam veterans across to the public, politicians and psychiatrists. For, increasingly, it came to be felt that the war had left a psychological aftermath on all who fought in it; that there was a 'Post-Vietnam Syndrome'.

* * *

The aftermath of Vietnam first really claimed public attention on 30 April 1971, the day that Sergeant Johnson was shot.

In Vietnam, Sergeant Dwight Johnson had won the Medal of Honour, the United States' highest decoration for valour, for single-handedly knocking out twenty enemy soldiers during a raid on his position. He had then served with distinction for another two years, but on returning home, found difficulty in readjusting to civilian life. He became convinced that the Army exploited and black soldiers and made no effort to help them afterwards; Army psychiatrists did not change this view. His frustrations grew until he decided to deploy in his rundown Chicago neighbourhood the skills he had shown in Vietnam. He was robbing a liquor store when he was killed.[9]

The fact that a heavily decorated soldier could behave in this way shocked public opinion and put veterans' issues on the map. A year later, the *New York Times* carried an article by Dr Shatan on the 'Post-Vietnam Syndrome', a term veterans detested and psychiatrists were uneasy with, yet whose 'evocative quality' and 'availability as catchall' made it 'widely used by almost everyone'. According to Shatan, Post-Vietnam Syndrome often set in nine to thirty months after the return from Asia. Men would notice, often for the first time, 'growing apathy, cynicism, alienation, depression, mistrust and expectation of betrayal, as well as an inability to concentrate, insomnia, nightmares, restlessness, uprootedness, and impatience with almost any job or course of study.' They were suffering, he said, from 'delayed massive trauma', guilt feelings and self-punishment, the feeling of being scapegoated, rage, psychic numbing and alienation from their feelings – in short, from 'impacted grief'.

The so-called Post-Vietnam Syndrome confronts us with the unconsummated grief of soldiers – impacted grief, in which an encapsulated, never-ending past deprives the present of meaning. Their sorrow is unspent, the grief of their wounds is untold, their guilt is unexpiated. Much of what passes for cynicism is really the veterans' numbed apathy from a surfeit of bereavement and death.[10]

This was powerful and eloquent, but also vague and hyperbolic. Army psychiatrists hit back, accusing Shatan and Lifton of making politically-motivated generalisations from a tiny sample. Just because the small group of anti-war veterans they had worked with had these problems didn't mean *all* Vietnam veterans were similarly maladjusted. This was a telling point; but, in making it, the military doctors relied on data derived from small samples of Vietnam veterans still in the Army, in garrisons in the United States; no follow-ups had been done on veterans back in civilian life. The Army's studies tended to show that *all* soldiers were miserable and taking drugs, whether they had been in Vietnam or not. The more intelligent Army psychiatrists were also aware that much more should have been done to ease the process of readjustment to civilian life by providing 'reorientation programs' to soldiers while they were still in the Army. The contrast between the imaginative, confident leadership shown by Menninger in 1945 and the feeble buck-passing thirty years later pained them.[11]

The truth – which, in a less charged atmosphere, would have been acknowledged – was that many Vietnamese veterans *were* having troubles readjusting to civilian life, as all returning veterans do, both practical and emotional problems. Like earlier generations, they had built up unrealistic fantasies about their home lives, received 'Dear John' letters, developed 'passive-dependent' needs of the kind described by Roy Grinker in the 1940s, and were having to adapt to changes in their absence. But there were also elements about Vietnam that aggravated the usual difficulties. For all the technological wizardry of the war, no thought seems to have gone into understanding the basic dynamics of 're-entry'. Soldiers usually returned home from Asia abruptly, by aeroplane, and as individuals (where their World War Two equivalents had sailed slowly home with other members of their units). They were not welcomed as heroes; indeed the opposition to the war meant that some were reviled:

> The day I arrived home a woman of my own age walked up to me with several of her friends, while I was waiting for a bus, at the Newark New Jersey Airport and asked me if I had been in Vietnam. When I responded that this was my first day home she spat in my face and the group let loose with a barrage of insults. I don't think that she knew then that her spit would forever stain my face. It is not possible to wipe that spittle clean. It is on my face today.[12]

Not only were there 'no victory parades', there were fewer jobs: the great post-war economic boom was over and full employment a thing of the past, especially in the sectors of society from which many veterans came. The therapeutic power of work was not automatically available, as it had been in 1945. Relations between the sexes, too, were changing. The arrival of feminism and the

unpopularity of the war left middle-class women reluctant to provide mothering they had so readily given in the 1940s; the warm, supportive, fem embrace was no longer as easily available.

All these issues, though, were poisoned by political divisions. The Ni administration was trying to end the war while pursuing and harassing domestic opponents, including Shatan and Lifton, whose links to Vietn Veterans Against the War led to their mail being tampered with. In August 19 following the publication of the *Pentagon Papers*, the President himself authori a break-in at the offices of Dr Daniel Ellsberg's psychiatrist; eleven months la on 17 June 1972, the five 'Watergate' burglars were arrested. In this climate polarisation, it was probably inevitable that battle lines should be drawn, w one side denying that the war had had any effects at all and the other overstat its consequences.[13]

The mood of those times has been evoked by one of the moving spirits in veterans' movement. 'In the mid-1970s,' the psychologist Charles R. Figley written, 'the mental health professions barely recognized the plight of emotionally disabled Vietnam veteran.' There was a division between hawks a doves. 'Hawkish' psychiatrists maintained that the psychiatrists' dictionary mental disorders did not recognise combat fatigue or any other stress disor originating from a catastrophic event. Whereas, continues Figley, 'Perhaps w some overreaction, "dovish" psychiatrists and other practitioners believed t emotional disorders among returning veterans could reach epidemic proportio The post-Vietnam syndrome became a frightening buzz word among clinici and journalists, but in fact was a thinly veiled position of opposition to the w stop the war or more young killers will be released to terrorize the population

The 'doves' were influenced, too, by the growing psychiatric literature on t terrible episodes in the recent past, the Holocaust and Hiroshima.

Nowadays, we routinely talk about 'the Holocaust'. There are Holoca Museums around the world, Holocaust days, and – it must be said – somethi of an Holocaust industry. Yet little of this existed in 1970. Similarly, t emotional after-effects of the Nazis' Final Solution on those of its victims w survived took time to reveal themselves. Immediately after the war, everyone h wanted to forget, to get on with building new lives. A few doctors a psychoanalysts had lingered on what the camps had revealed about hum behaviour, but most people wanted to move on.[15]

In the late 1950s, however, two things happened. Doctors in Scandina began to study the Holocaust survivor population there – which was sm enough to trace and monitor – and found that many of its members were havi problems. Secondly, the issue of compensation arose. The West Germ government offered reparations to camp victims, but only if a causal link cou be established between their current ill-health and the traumatic experiences th had undergone. A number of German 'experts' then testified in the Germ courts that it was 'common knowledge that all psychic traumata, of whatev

degree or duration, lose their effects when the psychologically traumatizing event ceases to operate'. One German psychiatrist even stated that a man who had spent most of his early childhood hiding in a cellar, being stifled or even choked into silence in case he revealed his parents' hiding place, could not have been damaged because 'he was quite young at the time of the war and would have forgotten it all.'[16]

The gauntlet was thus thrown down – to all psychiatrists outside Germany, but doubly to Jewish psychoanalysts – to prove that the effects of that experience *were* prolonged. Whereas most medical work on veterans had hitherto been carried out by doctors institutionally inclined to minimise the effects of trauma, now it was being done by doctors inclined – for understandable and laudable reasons – to stress them, to get justice for their patients. Holocaust survivors were examined by doctors all over the United States. In 1961, after seeing some 800 people, Dr William Niederland, an analyst in New York City, coined the phrase 'survivor syndrome'.[17]

Massive psychic trauma, said Niederland, caused 'irreversible changes' in the personality. Death camp survivors, who had been 'selected' to live by the SS and seen others (including, often, their own families) selected to die, were crippled by 'survivor guilt'. They were prematurely aged, often confusing the present with the past. Having learned to function in a world without morality and humanity, they now found it difficult to relate to ordinary people, to have ordinary feelings. They suffered from depression, anxiety, and nightmares.[18]

Some have since argued that Niederland and his colleagues exaggerated and overgeneralised. The distinguished Israeli psychiatrist, Shamai Davidson, for example, believed that 'the somewhat stereotyped diagnostic construct' of the survivor syndrome was both too sweeping and too pessimistic, that Holocaust survivors *could* be helped considerably by sympathetic therapy. Besides, he pointed out, the vast majority of the large survivor population in Israel had not become psychiatric patients. Davidson thought the blanket label 'survivor syndrome' had, by 'focusing solely on the pathological consequences of trauma,' 'obscured the remarkable potential for new adaptation, recovery and reintegration throughout the life span.' It also lumped everyone together:

> Each survivor is unique in the individual nature and meaning of his experiences and responses to these experiences . . . this uniqueness may be obscured by the shared events and common behaviour patterns. Experiencing similar events in the same situation often had entirely different meanings for different survivors.[19]

The cases seen by Dr Niederland in New York were also, by their very nature, 'self-reporting': people claiming compensation.

The point, however, is not whether the concept of survivor syndrome was right or wrong, helpful or unhelpful, in the lives of Holocaust survivors; rather that in the late 1960s the post-Holocaust literature had a considerable influence on psychiatrists working with Vietnam veterans. It created a new professional model: the psychiatrist as patients' advocate, helping a group of wronged victims to win

reparation. It also popularised the idea of a general, loosely-defined 'syndrom among a group of patients, made the idea of *delayed* emotional after-effects trauma respectable and put guilt, especially *survivor guilt*, on the agenda. Th the balance was shifted between trauma and victim, putting much grea emphasis on victimhood than on endurance.

To the lay mind it may seem perverse, even obscene, to equate the experien of those who were victims of terror – at Auschwitz, say – with that of perpetrat of it – for example at My Lai. Was not the Holocaust experience unique in effects on the personality, not least because of the removal of all social suppor Niederland himself was ambivalent on this point. Chaim Shatan, though, w very struck by the resemblance between the emotional after-effects of extensi Vietnam combat experience, the 'homecoming syndromes' of prisoners of w and the 'survivor syndromes' of living concentration camp inmates. In 1972, invited Niederland to give a workshop presentation on 'The Guilt and Grief Vietnam veterans and Concentration Camp Survivors' and the shadow of t Holocaust was seldom absent from his work.[20]

For Robert Lifton, however, Hiroshima was 'the main encounter'. His work wi survivors of the atom bomb, described in his 1968 book *Death in Life*, left him wi a vision of modern history as 'immersion in death'. He felt that American vetera who opposed the Vietnam War made up, together with Holocaust survivo Hiroshima victims and some of the scientists responsible for the Hiroshima weapo 'a special contemporary group of "prophetic survivors" whose "inspiration" deriv not from the Divinity, but from the holocausts they survived . . . who have manag to emerge from their holocaust with special regenerative insight.'[21]

A powerful and persuasive writer and an important figure in America intellectual life, Lifton was also in a self-promoting tradition (to which Benjam Spock and Bruno Bettelheim also belonged). He brought a grandiose, rhetoric quality to everything. 'No theory, unless it is probing and one-sided,' he once to an interviewer, 'amounts to anything. The trick is to have one-sidedness creative tension with a certain amount of balance and fairness. But it has got be one-sided.' The overstatements of the Vietnam era came easily to Lifton.[22]

If some of the 'doves' saw Vietnam veterans through distorting lenses, th 'hawks', too, had baggage of their own. This was especially true of the 'iro triangle' in Washington that controlled the powerful ex-service lobby: th Veterans' Administration, the traditional veterans' organisations (like th Veterans of Foreign Wars) and the Congressional committees concerned wit veterans' affairs. By the 1970s, the Veterans' Administration had become a va federal bureaucracy, the single most important health care provider in th country, run by and for the 'class of '46'; its primary purpose to provide fr medical care to 12 million veterans of the Second World War (one of its hospita was said to be 'essentially . . . a place for World War Two guys to die fro alcoholism'). Any attempt to remodel this system and to redirect its benefi towards Vietnam veterans would inevitably arouse resistance from the politicall

very powerful veterans' organisations, worried that their main constituency, the World War vintage, would lose out.[23]

There were several further complications. Many Vietnam veterans viewed the VA with suspicion as another bureaucratic arm of the government they loathed; yet, if they needed help, they could only get it for free through the VA. The VA's leadership saw that it needed to become more user-friendly to the Vietnam generation but was constrained by politics, some veterans' opposition to the war having aroused the wrath of President Nixon and his circle.[24]

In this divided national mood, readjustment after Vietnam inevitably became a highly political issue. The 'doves' argued that the 'post-Vietnam syndrome' was made worse because veterans rejected authority and mistrusted institutions and therefore only went to the VA when they were desperate. Then, it was suggested, the VA doctors frequently failed to understand that the symptoms these men complained of – aggression, combat flashbacks – were caused by stressful war experiences. As a result, the VA doctors were misdiagnosing them as schizophrenics and giving them massive doses of anti-psychotic drugs. What was needed, therefore, was a way of providing psychotherapy or 'readjustment counselling' for these veterans.[25]

The 'hawks', on the other hand, denied there was such a problem. They accused Shatan, Lifton and their allies of feeding public hysteria with overstated claims – for example about the numbers of veterans to have committed suicide – and saw no reason to make further resources available. If Vietnam veterans had problems, they were the problems of American society at large. This view prevailed in Congress throughout the 1970s.[26]

Gradually, however, ways of breaking the deadlock, and of bridging the gulf of suspicion between the veterans and the VA, began to emerge. In 1974, staff at the VA hospital in Brentwood, California, began offering Vietnam veterans treatment at 'storefront' out-patient clinics in the community; they brought in a maverick Vietnam veteran, Shad Meshad, to run it. The success of this 'Outreach' model formed the basis for several bills that were introduced into Congress throughout the 1970s and defeated thanks to the opposition of the traditional veterans groups and their political allies. In 1979, however, nearly ten years after most veterans had returned, both Houses of Congress voted for a general Outreach programme. The bill's passage, the historian Wilbur Scott has written, was 'due not to widespread public support but to a handful of Vietnam veterans who had by that time either been elected to Congress or had risen to influential positions in the VA and traditional veterans' lobbies.'[27]

By that time, however, the veterans' advocates were fighting another campaign, to persuade the American Psychiatric Association to create a new terminology reflecting the veterans' psychiatric problems. For, by 1974 it had become clear that, on top of everything else, American psychiatry was undergoing a revolution.

* * *

There is a recurring tension in medicine between the general and the particular,

between the illness and the patient, especially in psychiatry, which concerns itself with the human spirit rather than the body. How can human souls, each separately formed, the product of a complex interaction between personality and environment, be lumped together in categories? Yet as soon as medicine is practised on any scale and taught in medical schools, once public money is spent standardisation becomes inevitable, and with it, quantification. In modern society, many forces outside medicine pull in this direction: as governments have acquired bureaucrats, so their hunger for statistics, and skill in manipulating them, has grown. It was the Bureau of Census that in 1880 first persuaded America's mental hospitals to put their patients into different categories. More recently, the advent of computing has given further impetus to quantifiers and further removed many doctors from their patients.[28]

The greatest classifier of mental disorders was the German physician Emil Kraepelin, a sinister figure to historians of racist ideas, yet a colossus within his own profession, the man whose 'nosology' – or system of classification – created modern psychiatry. 'The Kraepelinian classification of the psychoses,' a recent work states, 'governs twentieth century psychiatric thinking.' Yet even Kraepelin has had to be adapted over the years, for, as Edward Shorter says, 'a naming system incorporates the dominant philosophy of the day'.[29]

For example, the labelling system American psychiatrists were supposed to use during the Second World War derived from experience in large mental institutions; for much of the time, it simply didn't describe the mental disorders of soldiers on the battlefield. As a result, it was largely ignored and numerous fresh terms invented instead. In 1952, the American Psychiatric Association attempted to resolve the ensuing shambles by publishing a standardised system of classification, *The Diagnostic and Statistical Manual of Mental Disorders*, generally known as *DSM-I*[30]

Both *DSM-I* and its 1968 successor *DSM-II* reflected the dominance which psychoanalysis then enjoyed in American psychiatry. By the 1970s, however, the pendulum was swinging the other way, with the Freudians now in retreat as a 'biological' counter-revolution swept through psychiatry. This was set off by a new wave of pharmacological breakthroughs. Chlorpromazine (or largactil), 'the drug that changed the face of psychiatry', was first used by a French naval surgeon in 1951 as a pre-anaesthetic sedative and then quickly taken up by Parisian psychiatrists. By May, 1953, 'the atmosphere of the disturbed wards of mental hospitals in Paris was transformed: straitjackets . . . were things of the past'. Later that year, a psychiatrist in French Canada reported on 'the remarkable effects' of the drug in calming 'restless, excited, overactive patients without oversedating them to the level where they could not function'. A successful drug trial at the Maclean Hospital, Boston was followed by energetic selling by the Smith, Kline company – a brash newcomer to the field. Many state hospitals were soon persuaded of the drug's merits, especially in saving them money. Chlorpromazine was presented 'as the first drug in psychiatry to abolish the symptoms of psychosis though not necessarily to cure the underlying brain disorder'. In Edward Shorter's judgement, it 'initiated a revolution in

psychiatry, comparable to the introduction of penicillin in general medicine.'[31]

Chlorpromazine, which worked best on schizophrenics, was quickly adopted by psychiatry. By contrast, the effects on manic patients of the natural substance, lithium, though first observed by the Australian John Cade in 1949, were not generally appreciated in the United States until the 1970s. By then, a third major disorder, depression, had also been tamed, by the 'tricyclic' anti-depressant, imipramine, developed by the Swiss Geigy company. From quite early on, it was apparent that these miraculous new drugs had side-effects. But for psychiatrists who had spent centuries grappling with psychoses, the new treatments were indeed marvellous, making it 'relatively easy to remove symptoms'. They also made it possible to clear the asylums. In 1955, there were some 559,000 patients in state and county mental hospitals in the United States. By 1970 the figure had fallen to 338,000, by 1988 to 107,000.[32]

Most of the running in this swing back towards 'biological' psychiatry was made by the drug companies: theory trailed some way behind clinical practice. Nonetheless, there was a group of psychiatrists at Washington University, St Louis, interested in the chemistry of the brain and in devising standard procedures and criteria for doctors to follow when diagnosing patients. Just as in economic theory the free market group in Chicago associated with Milton Friedman suddenly went from being wacky, marginal irritants to the ruling Keynesian orthodoxy to being the dominant school themselves, so, in psychiatry, the St Louis group went from being obscure provincial mavericks to the new masters of the universe.[33]

The swing towards biological psychiatry was one factor behind mounting pressure in the early 1970s for a further revision of the classification system, the *DSM*. Another was that newly assertive gay groups were unhappy that homosexuality was still listed as a psychiatric disorder; a third, that insurance companies wanted the vague parameters of Freudian psychoanalysis replaced by a much more tightly defined system of classification based on symptoms, rather than presumed underlying causes. Drug-based treatments were creating a more biological climate. The American Psychiatric Association decided to go with the flow; it entrusted the revision of *DSM* to a 'task force' dominated by 'biological' psychiatrists. This group did its best to produce a 'scientific' document, with elaborate field trials to establish the effectiveness of each diagnosis, but in practice was open to lobbying and pressure.

As has been said, all naming systems embody the values and experiences of their time. *DSM-I*, written in 1952 in the aftermath of war, contained a category known as 'gross stress reaction', a reaction thought to occur even in emotionally sound soldiers on the battlefield, which then usually went away and which was quite different from a neurosis or a psychosis. *DSM-I* made no reference to delayed after-effects. By the time that system was revised in 1968, however, few psychiatrists with first-hand experience of warfare were still around and, as a result, the new system of classification, *DSM-II*, no longer had a specific listing for psychiatric disorders produced by battle. It was suggested instead that the symptoms associated with 'gross stress reaction' should now be classified under

the catchall term 'adjustment reaction to adult life'.[34]

The result was that by the 1970s, as Wilbur Scott has written, 'mental healt professionals across the country . . . assessed Vietnam veterans using a diagnosti nomenclature that contained no specific entries for war-related trauma. I hospitals, insurance companies and the courts, the *DSM-II* nomenclature wa important because it provided the official diagnoses for categorising sicknesses. I was also the biggest barrier to getting appropriate help from the Veteran Administration. For that reason, the psychiatrists agitating for proper help fo veterans believed it was vital to make sure that the new nomenclature, *DSM-II* currently in the works, *did* acknowledge the role of war-related stress. Yet in Jun 1974 Robert Lifton, Chaim Shatan and their allies heard that it was not planne to 'reinstate stress reactions associated with combat'. The group appointed by th American Psychiatric Association to produce *DSM-III* – mostly, as we have seen apostles of the new 'biological' psychiatry – did not feel 'a separate classificatio was necessary in diagnosing the problems of Vietnam veterans'. Lifton, Shata and their allies were not put off, however. In a two-pronged offensive, they too their message to the American media and public and, at the same time, lobbie and organised within the psychiatric profession.[35]

In 1974 radio station WBAI in New York City was persuaded to stage an all-da marathon broadcast on Vietnam veterans. Listeners from all over New Englan called in with comments and questions and the station's lobby was invaded b veterans. The broadcast had a huge impact and won awards.[36]

Ever since the early 1970s there had been press stories about the problems o Vietnam veterans – their drug addiction, high crime rate, homelessnes propensity to violence and suicide. Whereas, after World War Two, 'the symbo of the vet was GI Joe, the lovable, typical young American, the veteran who cam home from Vietnam was perceived as something sinister, disturbin frightening'. Now this was redoubled. 'Vietnam Veterans called Time Bomb went a *Baltimore Sun* headline in January 1975. Four months later, th prominent *New York Times* columnist Tom Wicker told the story of a Vietna veteran who slept with a gun under his pillow and had shot his wife during nightmare, 'only one example,' wrote Wicker, 'of the serious but largel unnoticed problem of "post-Vietnam syndrome", or PVS, the label by which th extraordinary psychological difficulties of hundreds of thousands of Vietna veterans have come to be identified.' Wicker quoted statistics from *Penthou* magazine showing that 38% of those who were married before they went t Vietnam had separated or got divorced within six months of their return, tha 500,000 veterans had attempted suicide since leaving the service and that som 175,000 had 'probably' used heroin since returning to civilian life.[37]

The media image of the Vietnam veteran as a 'trip-wire killer' reached i apotheosis in the hands of Hollywood. In Martin Scorsese's *Taxi Driver* (1976 Robert de Niro is unable to distinguish between the New York present and th 'Nam' past and kills accordingly; in *Rambo: First Blood* (1982) Sylvester Stallon

is driven by isolation and frustration to turn hunter. 'Hollywood finally caught up with the image of dysfunctional vet created first by the antiwar movement and veterans' advocates and added its own mythic twist: Vietnam vet as dysfunctional superman.'[38]

The media, then, was fertile ground for those wishing to highlight the plight of the Vietnam veterans. But how bad *was* the problem? Even among those committed to the veterans' cause, estimates of the size of the problem varied sharply. Chaim Shatan argued in 1974 that there were probably one to one and a half million men suffering from 'post-combat syndrome'. In 1978, John Wilson put the number of 'veterans suffering from adjustment problems' at 250,000 whereas, four years later Arthur Egendorf (using looser criteria) made it over two million, a figure almost ten times as great. Another article in 1982 declared that 500,000–700,000 veterans were 'in need of emotional help at the present time'.[39]

Yet a *Los Angeles Times* survey of veterans in 1975 concluded that, overall, 'there is ample evidence to suggest that the vast majority of Vietnam veterans have melted back into society as successfully as any soldier from any war.' Vietnam veterans were joining the traditional veterans' organisations, using the GI Bill for education in greater numbers than any previous generation and successfully getting off heroin. Only 2% of Vietnam veterans used narcotics in civilian life. The LA *Times* quoted a VA psychiatrist: 'Our society was scared by the image of the Vietnam veteran coming home and shooting up the community, of being a junkie. It was a distorted image that the veteran is still paying for.' There was, he believed, 'no evidence that Vietnam has produced a disproportionate share of people who are maladjusted to society and no evidence that the primary contributor to that maladjustment was military service.'[40]

Why then did the negative stereotype persist? Eric Dean has argued that although, objectively, the difficulties of the Vietnam veteran were over by the late 1970s, there was at that time a renewed emphasis on the uniqueness and difficulties of the Vietnam veteran, focusing especially on 'delayed stress syndrome', Agent Orange, and a supposedly high suicide rate in veterans.[41]

For Shafton, Lifton and their allies, mobilising the media was important in helping to create a climate of emotional pressure. But skilful lobbying of fellow psychiatrists had the more immediate effect. The psychiatrists working with veterans managed to shake off the impression of being a special interest group by creating a wider category of trauma and shrewdly presenting their case in a way designed to appeal to the new psychiatry.

The contact between the psychiatrists working with Vietnam veterans and doctors working with concentration camp victims led Shatan, Lifton and their associates 'to think of the diagnostic category as a more generalised phenomenon of which post-combat disorder was but a single example'. Then they started to review the literature of catastrophes in general, and to make contact with fellow doctors who had worked with victims of civilian disasters, including burns victims.

Lifton and Shatan were both outside the psychiatric mainstream – psychoanalysts in New York – but they used allies within the profession to put their case

in a series of presentations at conferences and meetings with the sub-comm looking into Reactive Disorders in *DSM-III*. They also adapted themselves t new mindset, with its emphasis on hard quantifiable data, and by 1976 had on some 700 cases, mainly Vietnam veterans. While they failed to convinc researchers at St Louis, who continued to argue that 'the standard diagn categories of depression, schizophrenia and alcoholism adequately covered veterans' symptoms, they did eventually persuade the drafters of *DSM-III* of case. Shatan and Lifton wanted a category called 'catastrophic stress diso divided into acute, chronic and delayed manifestations. They also 'argued the only significant predisposition for catastrophic stress disorders was traumatic event itself, and stated that the symptoms' course and treatn differed by the cause and onset of the disorder.'[42]

An important role in getting the concept of post-trauma stress accepted by psychiatric world was played by the San Francisco psychiatrist, Marc Horowitz. A tireless builder of intellectual structures, Horowitz was thorou steeped in the literature of civilian and military trauma and the discours modern psychology. He had also made a close study of the responses of pati to trauma and systematised their course. In his book *Stress Response Syndr* (1976), Horowitz drew on the writings of Freud, Janet, Kardiner, Grinker Spiegel and on Erich Lindemann's work with the Cocoanut Grove fire victim provide a coherent framework within which to understand the patter responses to trauma. Although called, with a nod towards modern experime psychology, an information-processing model, it dealt in fact more with processing of emotion. Everything was factored into Horowitz's equatio except experience with military cases and an awareness of the role of so culture. The building bricks of his model were intellectual, not practical. In battle between the consulting room and the laboratory, the field hospital and study, the intellectuals had triumphed.[42]

Opinion is divided as to whether Horowitz really came up with something n or just dressed up old ideas in new garb. But in his hands, Shatan's vague emotive 'post-Vietnam syndrome' acquired real intellectual authority. A bri was forged between 'war neurosis' and the victims of civilian trauma that never really existed before. Mardi Horowitz, along with Shatan and Lift helped to create a new, unitary kind of 'trauma'.[43]

What finally emerged from the APA's committee in 1980 was the term Po Traumatic Stress Disorder. According to Wilbur Scott, 'PTSD is in *DSM* because a core of psychiatrists and veterans worked consciously and deliberat for years to put it there. They ultimately succeeded because they were be organized, more politically active and enjoyed more lucky breaks than th opposition.'[44]

In 1981 the psychologist Charles Figley looked back over the battles of the 197 'Since those days,' he wrote, 'there have been dramatic and precedent-setti changes that have depoliticised the debate over the mental health of Vietn

vets. Powerful and prestigious bodies have deliberated the issues and concluded that as a group the VN combat vet is neither a walking time bomb nor an invincible robot; that the vast majority of the survivors of the war are leading productive lives and are more emotionally stable than the general population. However, the catastrophic stress of combat leaves its marks on the psyche that require both time and confrontation to erase; and a small but significant minority of combat veterans are suffering from the frightening and debilitating aftershock of VN and should be helped. They are getting that help now.'

One reason for Figley's optimism was the new public mood of acceptance, symbolised by 'Vietnam Veterans Week' in 1979, when President Carter told a gathering of some 200 of them in the White House that 'the nation ha[d] not done enough to respect, to honour, to recognise and to reward their special heroism'. The unveiling of the Vietnam Wall in Washington and the 'surge of patriotic feeling' generated by the Iran Hostage Crisis in 1981 all seemed to set the seal on the process of healing. 'The Strangers,' Figley wrote, 'have been welcomed home'.[45] On 10 November 1982 the Vietnam Wall in Washington was dedicated.

25

'WHEN THE PATIENT REPORTS ATROCITIES . . .'

Is there a danger that the increasingly standard perception that we live in a 'sick soc also carries with it the idea that nothing is anyone's fault any longer?

H. Stuart Hughes, 19

In September 1969, soon after taking her master's degree, Sarah Haley repor for her first job – as a psychiatric social worker at the Boston branch of Veterans' Administration. She was the daughter of a World War Two veteran, alcoholic who had, a friend wrote, 'not only caused her pain, but taught he great deal about the relationship between the VA and war veterans'. B although brought up on soldiers' tales, she had not served in the military or Vietnam.[2]

On her first day at work, she interviewed a new patient, very anxious a agitated, who told her that his company had killed women and children a village called My Lai. He had not fired any shots himself, but had been threaten by the other soldiers. He thought they were now coming to kill him.

At this stage, Sarah Haley was unaware of the story then beginning to break the media. On 16 March 1968, a company of the Americal Division had kill more than 400 women, children and old men at My Lai; but the story had be hushed up by the Army until a soldier-photographer sold pictures to the press his return to the United States. She accepted the veteran's account at face val but found that her colleagues were unmoved by it, insisting that the patient w 'obviously delusional, obviously in full-blown psychosis'.

I argued [she recalled in 1988] that there were no other signs of this if one took his sto seriously. I was laughed out of the room. I was told that it was my first day and just didn understand how things worked . . . I was aghast. These professionals denying the reali of combat! This clouded their clinical judgment. They were calling reality insanity! I kne from my father's stories that [this man was] not crazy. That encounter became typical.

This was to be the first of many variations on the same tale. By 1974 Haley ha