TRAUMA FOR EVERYONE

How PTSD Became the Malady of Millions

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Following the attacks on the World Trade Center on September 11, 2001, trauma experts feared that as much as a quarter of the population of New York City needed psychological treatment.[1] In the spirit of emergency aid, counselors offered Critical Incident Stress Debriefing (CISD), a one-session procedure in which those in shock are encouraged to air their emotions and advised of symptoms of Posttraumatic Stress Disorder (PTSD) likely to appear in the future. Evidence from controlled trials, however, suggests that CISD does not promote recovery and sometimes hinders it, presumably by cueing the symptoms of PTSD in the process of warning about them.[2] For some people, the CISD ritual seems only to raise expectations of PTSD which then come to life. Evidently the notion that PTSD lies in wait for those exposed to trauma is now familiar enough that not only therapists but people at large commonly find it intuitive. But how did the entity known as PTSD become so familiar? How did "PTSD" become a household word?

PTSD and Social Injuries

By the early 1970s the American public had lost belief in the Vietnam War. The term "credibility gap" had entered the national lexicon, and with the Watergate affair that gap would soon swallow up the Nixon presidency. Against this backdrop of a severe credibility crisis, the American Psychiatric Association (APA) found itself in the untenable position of lacking both credible definitions of mental disorders and diagnostic criteria that could bring different observers to reliably similar conclusions about particular cases. In an effort to fix the problem, reformers led by Robert Spitzer of the New York State Psychiatric Institute worked out a new taxonomy that abandoned speculation about the origins of disorders—Freudian speculation in particular—and focused instead on the symptoms presented by the patient. (For example, if you had a certain cluster of symptoms including low mood, fatigue, and disturbed sleep, you qualified as depressed regardless of why or how you became depressed.) A man whose strengths matched the challenge of the times, Spitzer is accounted one of the most influential psychiatrists of the twentieth century—some say the most influential of all—on the basis of this revolutionary accomplishment. The new system of classification made its appearance in the third edition (1980) of the APA's *Diagnostic and Statistical Manual*, the now-famous DSM-III.

Spitzer had trained in the psychoanalytic tradition but quit it in favor of more methodical, data-driven forms of investigation. The APA now followed suit, writing Freud out of DSM-III. But while the makers of DSM-III consciously abstained from theorizing

about causes, they did not do so across the board. A conspicuous exception was the new diagnosis of PTSD, of which Spitzer and co-authors later wrote: "Unlike other disorders in the DSM that were agnostic to aetiology [that is, cause], PTSD was defined as a disorder that arose after a specific set of traumatic stressors."[3] While the diagnosis was still being deliberated, the stressors foremost in the minds of many were those associated with the Vietnam War; hence the initially proposed name "post-Vietnam syndrome." To complicate the anomaly of a disorder tied to a cause in a diagnostic system otherwise indifferent to causation, advocates of a post-Vietnam diagnosis took the position that suffering trauma in war is actually normal, and that such trauma becomes a psychiatric disorder only as a result of the dishonesty of the society that refuses to recognize it. In this sense, the social injuries inflicted by one's fellow citizens are as important to the genesis of PTSD as combat per se.[4]

Before the Vietnam War, chronic psychological injuries following combat were presumed to be the result of a preexisting problem or weakness of character. By the time DSM-III was under construction, a sea change in social perception had occurred: "the emphasis had moved from the duties of a citizen to the rights of an individual."[5] The argument that post-Vietnam syndrome reflected not on the soldier but on the society to which he returned was in harmony with this shift, which helps explain how a diagnosis so polemical in origin found its way into a psychiatric taxonomy. Moreover the claim that Vietnam veterans suffered a lack of recognition at the hands of their own society had prima facie plausibility in that DSM-II, introduced in 1968, the year of the Tet Offensive in Vietnam, contained no combat-related diagnosis, not even the Gross Stress Reaction of

DSM-I. According to proponents of such a diagnosis in the 1970s, the Veterans Administration's failure to recognize PTSD "led to a variety of pathogenic consequences."[6]

A right is owed, and the advocates of a post-Vietnam diagnosis further argued that it was owed those who had been "obliged or induced to sacrifice their youths in a dirty and meaningless war."[7] On this showing PTSD arises not from war experience alone but from such experience complicated by the hypocrisy of the society that sent the soldier to war in the first place. While DSM-III makes no mention of any of this, the text of the PTSD criteria published in 1980 (reproduced on the following page) opens the possibility that reentering society could be traumatic in and of itself. If PTSD stems from an event "that would evoke significant symptoms of distress in most people," a returning veteran cursed and jeered in the airport could suffer a PTSD-stressor on the spot, provided only that the act was appalling enough. Whether the framers of the PTSD category had such encounters in mind, and how common they were, are another question.

In addition to being attached to a causal event in an otherwise noncausal diagnostic system, PTSD is surely the only disorder in DSM-III to have been created at the behest of people who suffered from it. Although the text of the PTSD section of DSM-III is mute on the Vietnam War and gives no sign of the story behind its own composition, it's no secret that the demand for the new diagnosis came from disaffected Vietnam veterans working in concert with allies within psychiatry itself, the most prominent of whom was Robert Jay Lifton. The author of powerful studies of Hiroshima survivors and victims of

Diagnostic Criteria for Post-traumatic Stress Disorder
DSM-III (1980)

A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost anyone.

B. Reexperiencing of the trauma as evidenced by at least one of the following:

(1) recurrent and intrusive recollections of the event
(2) recurrent dreams of the event
(3) sudden acting or feeling as if the traumatic event were reoccurring, because of an association with an environmental or ideational stimulus

C. Numbing of responsiveness to or reduced involvement with the external world, beginning some time after the trauma, as shown by at least one of the following:

(1) markedly diminished interest in one or more significant activities
(2) feeling of detachment or estrangement from others
(3) constricted affect

D. At least two of the following symptoms that were not present before the trauma:

(1) hyperalertness or exaggerated startle response
(2) sleep disturbance
(3) guilt about surviving when others have not, or about behavior required for survival
(4) memory impairment or trouble concentrating
(5) avoidance of activities that arouse recollection of the traumatic event
(6) intensification of symptoms by exposure to events that symbolize or resemble the traumatic event

thought reform, Lifton had acquired a familiarity with extremes of suffering—with the very limits of human experience—that gave him unique standing to speak of the savagery of the Vietnam War and its psychological aftermath. The crusading spirit that drove the campaign for a post-Vietnam disorder—the spirit of Lifton's condemnation of an obscene war that led inevitably to the mass murder of civilians at My Lai in 1968—seems foreign to the cautious, data-focused empiricism of the new diagnostic system that won over American psychiatry. Indeed, Lifton ridiculed the psychiatry that defines disorders scientifically, as DSM-III aspired to do, and disliked the term "post-Vietnam syndrome" because of the pretense of scientific objectivity built into the word "syndrome."

Lifton once declared in an interview, "No theory, unless it is probing and one-sided, amounts to anything. The trick is to have one-sidedness in creative tension with a certain amount of balance and fairness. But it has got to be one-sided."[8] In his electioneering on behalf of a psychiatric diagnosis he seems to have gotten the trick down. For his part, Spitzer appears to have had doubts about the PTSD diagnosis, whether because it was lobbied into DSM-III or because it incorporated a repudiated principle of causality. He may also have questioned whether the self-selected band of veterans that Lifton worked with were representative of all Vietnam warriors. In an interview in 1980 he said with respect to PTSD: "Part of the impetus to put this category in *DSM-III* came from groups who had worked with Vietnam veterans. Whether, in fact, the syndrome is more commonly seen in this group is a very controversial issue."[9] While the PTSD diagnosis attests to the power of "strong social concerns" in the making of DSM-III,[10] it comports uneasily with the DSM

system, and one doubts that the implications of mixing psychiatric diagnosis and oppositional polemics were well thought out at the time.

Consider PTSD criterion C, "numbing of responsiveness to or reduced involvement with the external world" as shown by symptoms like a "feeling of detachment or estrangement from others." By the year 1980, who didn't know that American society breeds alienation, which was the going term for estrangement? Any amateur cultural critic could have told the American Psychiatric Association that merely by living in the United States you could meet the "numbing" requirement for PTSD. Indeed, the APA itself proclaimed its "deep concerns" over "the rise of alienation" in a resolution deploring the Vietnam War in 1971.[11] As it happens, the term "numbing" is a virtual allusion to Lifton, who probed the phenomenon of "psychic numbing" in a number of writings, including his 1973 jeremiad against the Vietnam War.

By Lifton's account, soldiers in Vietnam served as their country's scapegoats, perpetrating the crimes their fellow citizens didn't want to stain themselves with or know about. Lifton tells of veterans spat at and reviled as "monsters," "beasts," and "murderers" upon returning to the United States, even though they did exactly what their training, their officers, and—in the final analysis—their society told them to do. A fierce and comprehensive critic of the United States, Lifton contends that the Vietnam War was the product of a culture profoundly addicted to violence, and that in attempting to heal themselves by searching their souls, veterans who met for informal group therapy, or rap sessions, were also working to heal the world around them. If they were haunted by memories of atrocity, the actual sources of their trauma lay not in the jungles of Southeast

Asia—and certainly not in their own dispositions, weaknesses, or personal histories, formerly the presumed origin of war neurosis—but at home, in their own troubled society. The anti-war veterans held "society as a whole" responsible for Vietnam, and when they insisted on telling society the truth about the war and about itself, they were inevitably met with "the rage aimed at rejected prophets." In the end their "painful reenactment of the war had to do with their sense of being . . . left to stew in their own conflicts"[12]—which is to say that their social reception fueled PTSD.

Lifton maintained that the guilt and rage of the veterans he met with were healthy reactions to the depravity of the Vietnam War, not constituents of a clinical syndrome. He did, however, observe telltale symptoms of Vietnam experience—ranging from extreme restlessness and "psychological freezing" to recurrent nightmares and psychosomatic ailments—and campaigned for a diagnosis that would recognize the aftereffects of combat. Delegated by Spitzer in 1975 to deal with veterans also demanding recognition, Nancy Andreasen, a member of the DSM-III Task Force and the eventual author of the PTSD diagnosis (and later the editor-in-chief of the *American Journal of Psychiatry*), saw men who resembled Lifton's scapegoats and reviled truth-tellers, men whose psychological wounds were made worse by injuries inflicted at home. Wrote Andreasen years later, "The Vietnam War was winding down and had been very unpopular. Unfortunately, the general public was not able to distinguish between the war and the people that our country had drafted to fight in it, and so Vietnam veterans quite understandably felt defensive, undervalued, and angry."[13] While this doesn't say straight out that the psychological injuries suffered by the veterans were inflicted by their own society, it does invite the

implication that the original trauma of battle was compounded by social wounds meted out by "the general public."

The rhetorical link between trauma and betrayal by one's own country appeared in a 1971 speech by John Kerry, later senator and secretary of state, then a representative of Vietnam Veterans Against the War, the group that joined forces with Lifton to press for a post-Vietnam diagnosis. Said Kerry in the peroration of his testimony to the Senate Foreign Relations Committee on April 23, "We wish that a merciful God could wipe away our own memories of that service [in Vietnam] as easily as this administration has wiped away their memories of us." Suggested but not quite voiced is the implication that it would be easier for Kerry and others to process their indelible and possibly traumatic war memories if the nation, starting at the top, were more honest about what was being done in Vietnam in its name. While war memories figure purely clinically in the PTSD criteria of DSM-III, they had an explicitly political valence in the thinking of those like Kerry who supplied the driving force for the diagnosis.

How much weight should be given to the argument that social injuries contributed to PTSD? It's possible that less-than-open hostility shown to veterans at home could reactivate the sense of being among hostile civilians that was a requirement for their survival in Vietnam. But the PTSD criteria in DSM-III could also elevate acts of contempt to the status of traumatic stressors in their own right, if only they were sufficiently wounding. Recall that in DSM-III, to qualify for PTSD you had to suffer a stressor "that would evoke significant symptoms of distress in most people." Is there anyone who wouldn't be significantly distressed at being spat on and called a monster, or who wouldn't be haunted

by memories of such an attack? But how often did acts like this take place? Noting that the story of the returned vet spat upon at the airport was "referred to so often by veterans as to become a kind of mythic representation,"[14] Lifton perhaps unwittingly opens the possibility that whatever truth it held was inflated into a legend.

The idea that injuries visited on Vietnam veterans by their own society could somehow complicate the psychological wounds of war did not come only from the Left. Through the cult figure Rambo, the returned Green Beret who wages a one-man guerrilla war against his American persecutors, this idea entered popular culture in the form of another "mythic representation." In the novel from which the figure came, *First Blood* (1972), it's not Rambo's war trauma per se that undoes him but his war trauma inflamed by the everlasting insults and provocations he receives on American soil—in this case in Madison, Kentucky. After being harassed by the local police chief and sentenced to jail time following a kangaroo proceeding, the police attempt to shave him, a pointless ritual of degradation that triggers a flashback and a kind of dissociative state. ("You're not coming near me with that razor," Rambo says, then seizes it and slashes the cop who held it—the first of many killings.) The characterization of Vietnam veterans as "defensive, undervalued, and angry" describes to a T the human stereotype we meet on the first page of *First Blood*. The author, David Morrell, reports that he got the idea for the novel as he came to learn about returned veterans' "problems adjusting to civilian life: nightmares, insomnia, depression, difficulty in relationships, what's now called post-traumatic stress disorder."

If returning vets were seen as beasts and murderers, as Lifton and others allege, Rambo acts out such imagery. But the Rambo story is fiction, at once convention-bound and exaggerated, and before going any further with the theory that the vilification of veterans fueled PTSD, it bears noting that the unpopularity of the Vietnam War did not entail a disdain of those who fought it. One could argue that the war became vastly unpopular when the public came to the sound conclusion that it was a death trap for American soldiers and would remain so as long as the soldiers themselves remained.

If the American public grew disenchanted with the Vietnam War as it became clear that it could not be won, we would expect support for the war to wane steadily over time. And this is exactly what happened. Asked in a Gallup poll in August 1965 whether it was a mistake to send troops to fight in Vietnam, 61 percent of Americans responded No. From then on, the figure sank inexorably, until by May 1971 it reached 28 percent, at which point Gallup stopped asking.[15] (Recall that it was in 1971 that the APA passed a resolution deploring the war and its psychosocial effects.) The numbers tell the tale, and what they say is that is that the longer the war dragged on and the more improbable the prospect or even the concept of victory became, the more Americans regretted sending troops to Vietnam. Overwhelmingly, they did not like the idea of asking young men to lay down their lives in a futile cause. Contrary to the claim that the American public detested Vietnam veterans because they fought a detested war, the public came to regret sending soldiers to die in a misconceived venture. I dwell on this point to bring out a strain of hyperbole in the rhetoric behind the diagnosis that came to be PTSD. Often the very exaggerations of a

narrative contribute to its power, and so it is with the scapegoat narrative that went into the making of the PTSD diagnosis.

Broadening the Diagnosis

Not long before the PTSD diagnosis was drafted, the American Psychiatric Association voted to remove homosexuality from the then-current classification of mental disorders, a change demanded by gay activists and brokered by Spitzer. Thus a precedent was set for revising psychiatric categories in response to intense public pressure. Still, it's one thing to rescind a diagnosis and another to install one. A diagnosis rescinded is off the books while a new diagnosis lives on, open to interpretation and potential expansion. Indeed, once codified in the DSM a diagnosis can spring to life. In an interview a few months before his death, Mandel Cohen, whose operational definitions of disorders made him the mentor of the diagnostic revolution in psychiatry, commented that once the diagnosis of Attention Deficit Disorder (ADD) appeared in DSM-III, it acquired an illusory reality and attracted an inordinate number of cases. "Once you get the initials, the condition solidifies"—a comment that points to the power of disorders, especially those with highly connotative labels, to captivate both the professional and public imagination. PTSD is such a disorder, and about it Cohen was a skeptic:

> There's another disorder DSM-III introduced that's a billion dollar item: post-traumatic disorder, Vietnam Syndrome. I gave a talk at the APA in Canada in which I pointed out that I examined these patients and it seemed to me that they had anxiety neurosis or depression and battle dreams. But battle dreams are normal for a soldier. . . . Sailors dream about sailing, wine-pressers dream about making wine and soldiers dream about fighting. That's all there is to it. Battle dreams have been there since the beginning of time. I think the cases we were seeing were anxiety neurosis, but I feel it was doctors and social workers who put the post-traumatic concept into the heads of these guys.[16]

Cohen was not asked what he thought about the extension of PTSD to the civilian population at large.

PTSD is said to be one of the few psychiatric diagnoses patients actually desire,[17] and over the years since its instatement in DSM-III this diagnosis originally applied to survivors of jungle warfare has risen to popularity among the public at large. As if foretelling the expansion of the category, DSM-III cautions that ordinary misfortunes like business losses or marital conflict are not sufficient to cause PTSD. But no boundary has been able to arrest PTSD's expansion. The text of DSM-III itself introduces a critical ambiguity, declaring prominently that the traumatic stressor will "generally" lie outside the realm of the ordinary. It should be noted, too, that many official symptoms of PTSD, including diminished interest in usual activities, disturbed sleep, faulty concentration, and

guilt, are also official symptoms of Major Depression—like PTSD, a diagnosis that has skyrocketed since its introduction in DSM-III in 1980.

In contrast to a war neurosis, PTSD arises from no defect or disposition of the person who suffers it, which means it doesn't bear the stigma often attached to psychiatric labels. In turn, the absence of stigma contributes to the popularity of the diagnosis. As the author of the original PTSD language wrote thirty years later, the concept of PTSD once on the books was "steadily broadened by clinicians . . . to include milder stressors that were not intended for inclusion," among them "broadly defined and sometimes poorly documented" child abuse. "The diagnosis [of PTSD], assumed to be relatively rare in peacetime, became much more common."[18] Commenting on the same pattern of dilution, Spitzer and co-authors criticize the informal expansion of trauma stressors to include the likes of events seen on television, offensive comments in the workplace, visits to the dentist, and episodes of "embitterment."[19] A trauma therapist reports that she herself suffered trauma when she was pulled over on the highway for driving with expired plates.[20] As in this instance, the word "trauma" is subject to erosion. Ignoring the DSM, my dictionary refers to "the trauma of divorce." In summarizing a line of his research, a well-known psychologist uses the terms "trauma" and "personally upsetting experience" interchangeably.[21] Of course, if upsets qualify as traumas, then all of us without exception will qualify for PTSD.

The inventor of a popular therapy for PTSD, Francine Shapiro, is somewhat more discriminating, citing "the major events needed to diagnose posttraumatic stress disorder, such as major accidents, physical, sexual or emotional abuse, combat, or natural

disasters."[22] Combat appears as one item in an open-ended list of stressors that includes three categories of abuse. With this catalog in hand, Shapiro is able to compute that no less than "three-quarters of the general public will experience an event that could cause a traumatic response sometime in their lifetime"[23]—a figure almost ten times higher than the PTSD rate of American troops exposed to combat in Iraq and Afghanistan, as reported in the *British Medical Journal* in 2008.[24]

What to make of the massive inflation of a diagnosis created to recognize injuries incurred in a guerrilla war fought halfway around the world? Clearly, to universalize the notion of trauma is to violate the intent of the original diagnosis. Still, "emotional abuse"—the wild card on Shapiro's list of stressors—calls to mind the vilification of veterans cited by the movers and makers of the PTSD diagnosis, and by some veterans themselves at the time.

In Lifton's judgment, the hostility directed at returning veterans served to convert normal reactions to war experience, such as guilt and rage, into psychological toxins. The veterans whom Lifton met with spoke of being mistreated or ignored upon their return to the United States, thereby taking us close to the concept of emotional abuse as a cause of PTSD. Emotional abuse leaves you feeling defensive, undervalued, and angry, the words used by Nancy Andreasen, the author of the PTSD diagnosis, to describe the vets who lobbied for psychiatric recognition even as DSM-III was being drafted. While neglect and vilification are not cited in DSM-III as either causes, triggers, or aggravators of PTSD, such social injuries certainly entered into the thinking of those who argued for and devised the diagnosis. A May 1972 op-ed that helped put the term "post-Vietnam syndrome" into

circulation made it clear that veterans suffered not only in Vietnam but at the hands of the society that sent them there; "their gripes encompass society at large," wrote the psychiatrist Chaim Shatan in the *New York Times*. And the Rambo myth, originating in a novel that appeared that same year, reminds us that psychiatrists were by no means the only ones alive to the destructive potential of social injuries.

As Ethan Watters observes in a critique of the foolhardy exportation of DSM diagnoses to other cultures, the impetus behind the PTSD diagnosis came from a social movement.[25] The popular therapy for PTSD cited above became a movement in its own right, taught in training sessions from Japan to South Africa, from Australia to Brazil. True to its origins in a movement, the diagnosis itself has remained in motion despite being officially pinned down to DSM text. Just as the grievances that went into the making of the PTSD diagnosis in the 1970s opened the door to later claims that abuse could cause PTSD, the implication that PTSD arose not from war per se but from the return to a sick society opened lines of argument that were later exploited.

Return means homecoming, and a number of the sources I have cited work in one way or another with the metaphor of *home*. Lifton's jeremiad against the Vietnam War bears the title *Home from the War*. From the first word to the last, the Rambo novel is a tale of chickens coming home to roost. It seems to say, "Don't be too surprised if a Green Beret well trained in jungle warfare were to put his skills to use at home." Nancy Andreasen points out that Vietnam veterans "returned home to find that (unlike previous generations of soldiers) they were not warmly welcomed as heroes, but instead sometimes vilified as social pariahs."[26] (Rambo of course wears the brand of the pariah.) Given such

emphasis on "home" as a place of injury, it was no great distance to the claim that PTSD may arise within the confines of family life; hence the "sometimes poorly documented" claims of PTSD arising from child abuse. Both Lifton and his colleague Chaim Shatan came from the psychoanalytic tradition, whose original object of study was none other than the twisted dynamics of family life. Shatan's op-ed in favor of a "post-Vietnam syndrome" concludes by citing Freud. Thus, in addition to resting on a cause even though DSM-III abstains from causal attributions, the PTSD diagnosis came about in response to a kind of psychoanalytic crusading--despite the fact that DSM-III spelled the end of the Freudian ascendancy in American psychiatry and overthrew the entire psychodynamic model of mental illness.

Claims that a robust majority of the American populace will be exposed to trauma and that ordinary events can cause PTSD imply that society itself—at least American society—may produce traumatic injury. This too harks back to the climate of opinion in which the PTSD diagnosis was born. In the self-help classic *Compassion and Self-Hate*, written by Theodore Rubin (at one time president of the American Institute of Psychoanalysis) and published while the diagnosis that became PTSD was in the discussion stage, the United States is portrayed in terms befitting a concentration camp. "Our culture dictates extreme harshness and punitive measures when violation of any of its dictates and standards are [sic] revealed." "We live in a state of inner terror."[27] Making terror a condition of life, such rhetoric leads straight to the principle that trauma enters our experience not just from without but from within. Not long after PTSD made its appearance in DSM-III, feminist therapists argued that the definition of PTSD needed to be enlarged

beyond extraordinary stressors like combat to encompass “routine or repeated episodes” within the home.[28] It would be hard to argue that such an expansion of the writ of PTSD is not in the spirit of Lifton’s contention that the sources of trauma lie deep in our own midst.

Intended for survivors of extreme ordeals such as combat and confinement in an actual (not virtual) concentration camp, the PTSD diagnosis has been broadened to the point that “nearly everyone in America counts as a trauma survivor today [in 2009], at least according to some surveys.”[29] This much can be said: if there seems to be a popular demand for PTSD, the diagnosis was created in response to the demands of certain veterans and their allies. From the start, PTSD wasn’t just a category but a cause. And if the diagnosis of PTSD seems to lack the reliability for which the DSM-III system was designed, that diagnosis was an outlier from the beginning, its foremost advocates speaking a kind of psycho-historical idiom foreign to the new empiricism, and its criteria emphasizing a causal event (Criteria A and B) even though the new diagnostic system sought to neutralize the issue of causality. Finally, the claim that most Americans will be exposed to trauma revives the narrative that American society causes psychological injury, a source that fed into the original diagnosis. Indeed, if some retrospective reports of childhood abuse prove to be poorly documented, the same is true of stories of the spat-on veterans circulated orally and in the press.[30] In a sense, the PTSD diagnosis continually relives its own history.

Adverse Consequences

According to the inventor of the PTSD therapy known as EMDR (Eye Movement Desensitization and Reprocessing), a traumatic event doesn't have to be in any way out of the ordinary; trauma can and does befall anyone. Noting that everyday experiences "can produce just as many . . . symptoms of PTSD" as acts of violence and sometimes more, Francine Shapiro moralizes as follows:

> This has important implications for all of us. It shows that there is no clear separation between kinds of events, nor is there a clear boundary between symptoms. Similar to those who suffer from PTSD, we all have the experience of feeling anxious, fearful, jumpy or shut off from others, thoughts we can't get out of our heads, guilt, or disturbing dreams.[31]

If we all show symptoms of PTSD and diagnosis rests on the tabulation of symptoms, the inference is unavoidable: all of us are candidates for the PTSD diagnosis. Theories like this have led trenchant investigators to conclude that PTSD has become "a seedbed for outlandish ideas about mental life."[32]

What's wrong with applying that diagnosis to categories of patients far removed from the survivors of jungle warfare or death camps whom the designers actually had in mind? In a critique of diagnostic inflation, the architect of DSM-IV—which broadened the PTSD criteria—cites the use of unnecessary medication and the effects of stigma as costs

of overdiagnosis.[33] Such criticisms fall short. It's the *lack* of stigma attached to PTSD that has made it an attractive label. And a diagnostic label, especially a highly connotative one like "PTSD," is more than a marker or identifier: it also has suggestive power. "Once a person is labeled as ill, he or she is regarded and treated in ways that make recovery more difficult."[34] Many chronic disorders become so through a kind of acquired resistance to amelioration. Whiplash, for example, can become chronic through changes of posture, excessive symptom monitoring, and, above all, a convinced belief that even minor collisions cause lasting injuries—despite causing none in countries where the concept of whiplash is unknown.[35] What of PTSD? It appears that favored treatments hinder recovery, both by making patients more attentive to symptoms (thereby aggravating them) and prompting an obsession with the past to the neglect of the present.[36] But what if someone who wasn't actually scarred by trauma acquires the PTSD label?

Labels not only set patterns of treatment but shape expectations—a mediator of outcomes—and mobilize symptoms. In the case of a number of disputed disorders, the label seems to document the validity of the condition for the patient and inflames symptoms precisely by certifying them as components of a disorder. Of two people with the same set of common symptoms, the one who believes they constitute an actual disorder is likely to experience more distress, quite as if the diagnostic label had an intensifying effect. A records-based study of the outcomes associated with different labels for similar fatigue disorders concluded that as a result of its "suggestion of an untreatable pathological process," the label "ME" (myalgic encephalomyelitis, the accepted term for chronic fatigue syndrome in Britain) "may somehow render the patient less able to combat

their [sic] symptoms and disability than other labels."[37] So charged is the act of labeling a patient that some psychiatrists have been known to apologize for using diagnostic tags at all.[38]

Labels that are contested are that much more highly charged, and patients may cling to them as to a prized possession. Such a label can have an effect of its own, at once validating a disorder and heightening its symptoms. Thus patients self-diagnosed with chronic fatigue—a controversial disorder without biological signs—"may expect, from what they have read, that chronic pain could eventually arise as part of the syndrome"[39]—and arise it does. The field of connotations surrounding the syndrome, condensed in its label, works to amplify distress and render it long-lasting. Such clinical worsening is an example of the reverse placebo, or nocebo, effect, in which expectations of distress produce just that. As in the case of outcomes fueled by what patients may have read, the nocebo effect is often driven by notions in general circulation—in essence, medical folklore. Robert Hahn explains:

> A society's ethnomedicine tells societal members what sicknesses there are, how they are acquired, how manifested, how treated. The nocebo phenomenon suggests that the categories of an ethnomedicine may not only describe conditions of sickness, but may also foster those conditions by establishing expectations that they may occur. Thus, a cultural system commonly thought to serve a healing function may also have a contrary outcome, fostering the same pathologies intended to be healed.[40]

As the spectacular career of diagnoses like Major Depression and ADHD (Attention Deficit/Hyperactivity Disorder) as well as PTSD attests, DSM-III categories have been accepted wholeheartedly into our ethnomedicine.

Because PTSD has come to seem intuitive, a procedure like Critical Incident Stress Debriefing, intended "to serve a healing function," can set up expectations of PTSD which are then realized. The evocative power of the PTSD label is such that inflated diagnoses create the risk of nocebo outcomes, whereby someone suffering normal distress is convinced he or she was really traumatized.[41] A tenable theory for the high number of Vietnam veterans who came to report symptoms of PTSD—almost a million, according to the National Vietnam Veterans Readjustment Study, though only 300,000 had seen combat[42]—is that many bought into the PTSD narrative who hadn't necessarily suffered trauma in the first place. "The PTSD narrative provides an explanatory, and sometimes exculpatory, framework for making sense of one's life. Some cases of apparent PTSD . . . might have arisen from reappraisal of Vietnam experiences as the cause of later difficulties regardless of whether this was true."[43] (Similarly, adults may recall having symptoms of ADHD as children because the ADHD narrative seems to explain their current problems.)[44] PTSD thus takes on a resemblance to a "functional" or medically unexplained disorder in which patients invest not only because it seems to account for their symptoms but because it represents a kind of belief system in and of itself. Among these belief-enlisting but medically enigmatic disorders is a cousin of PTSD, Gulf War syndrome.

Like someone tracing symptoms back to a trauma that may or may not have occurred, people who believe they have suffered a toxic exposure often link their ills to it even if it proves not to have taken place.[45] But in truth, all of us are highly prone to making spurious connections between symptoms and causes. When we seem to improve after taking pills or potions, we impute healing power to these interventions even if they had, in fact, nothing to do with our getting better. Similarly, those who improve after undergoing Critical Incident Stress Debriefing tend to credit the intervention even though they probably would have improved without it.[46] Such habits of attribution are so ingrained that not only patients but doctors have been known to fall into them. As noted in a classic paper of 1974, doctors often construe a patient's improvement after diagnosis as a confirmation of the diagnosis, when the fact is that many patients improve without a diagnosis—indeed, "without any treatment other than contact with their doctor."[47]

The concept of a "cause" of mental disorder in particular is steeped in folklore. In a kind of ethnomedical encyclopedia by Shakespeare's contemporary Robert Burton, dozens of pages are devoted to the causes of melancholy (which we now call depression), most of which would now be deemed outlandish.[48] Until recently, medical history was largely a tale of such misattributions, which isn't to say that the age-old habit of attaching symptoms to theorized causes has at last cleared up. One reason chronic whiplash is so stubborn is that the belief that collisions cause whiplash is itself stubborn. In the case of PTSD, the presumed cause of current symptoms is strong enough to project its power over decades and dramatic enough to figure in narrative. By contrast, our power of recovery

operates subtly, assisted by the most imperceptible of forces—time itself. No wonder it's so often lost in the glare of the PTSD narrative.

It makes sense to speak of a PTSD "narrative" in that PTSD, unlike other DSM disorders, originates in a definite event. One of the most ancient functions of narrative is to tell how something came to be, what caused it. As we learn in a story folded into the *Odyssey*, a boar caused Odysseus's scar. "It is the nature of narrative to explain; it cannot help telling how things are and even why they are that way."[49] But with narrative go problems of belief. If PTSD arises in a trauma that deforms a person's history, in most instances third parties will have no way to know about that trauma and that history except by the report, the narrative, of the person concerned, as unverifiable as it may be; and in a climate where emphasis falls on rights, questioning another's account seems like violating a right. Not the least source of the power of trauma narratives is our feeling that they are not to be doubted, despite everything we may know about the infidelity of memory. Amidst the credibility crisis in which DSM-III itself originated, trauma narratives possessed a credibility few sources could rival. If not for the power of the larger scapegoat narrative that fed into the PTSD diagnosis, the framers and endorsers of DSM-III might not have been willing to make PTSD an exception to their own diagnostic principles. Precisely because it's confounded with narrative, the PTSD diagnosis is both uniquely controversial and shadowed with the possibility of error.

The lore surrounding Eye Movement Desensitization and Reprocessing, a therapy built on an expansive concept of PTSD, suggests one way error can take shape. As explained by EMDR's founder, the trauma that generates PTSD is recorded in memory

exactly as it occurred, held there, and continues to plague us unless and until the memory is retrieved and the trauma discharged, which is where EMDR comes in. EMDR originally involved rapid darting of the eyes under the guidance of a trained therapist. The founder reports that she happened upon the technique one day in 1987 while walking in a park; when her eyes "started moving very rapidly back and forth diagonally in a certain way," nagging thoughts ceased to trouble her.

> I believed I'd stumbled onto the brain's natural healing process. . . . I decided to do a controlled study on my procedure for my dissertation. It seemed the most relevant thing to deal with was old memories. I asked myself who would have the most problems with those issues. The answer seemed clearly to be sexual abuse victims and combat veterans. That brought me to working with people who had the diagnosis of posttraumatic stress disorder (PTSD).[50]

With the theory that "old memories" hold us in their spell, EMDR appeals to two folkloric notions at once: that memory is photographic, and that we become stuck or locked unless oppressive memories are therapeutically processed.

While EMDR presents itself as psychological science and its theory is couched in the jargon of information processing, human memory does not work in the way presumed and required by EMDR. Our memory images are not formed once and for all at the time of the event and do not persist unchanged over the years; in fact, we can be persuaded that we remember things that not only didn't happen but couldn't possibly have happened.[51] As a thoughtful review of the PTSD controversy points out,

> When PTSD was first added to the *DSM-III* in 1980, traumatic memories were considered reasonably faithful recordings of actual events. But as research since then has repeatedly shown, memory is spectacularly unreliable and malleable. We routinely add or subtract people, details, settings and actions to and from our memories. We conflate, invent and edit.[52]

So it is that surveyed Norwegian survivors of the 2004 tsunami in Southeast Asia tended to recall a more life-threatening event after twenty-four months than after six.[53] Contrary to the doctrine of EMDR, then, our memory of trauma is not frozen. Yet if I were to recover an altered memory with the help of EMDR, I could easily be convinced of its truth, owing to the suggestiveness of the healing ritual and the power of the PTSD diagnosis, a diagnosis established by DSM authority and taken to heart by the public at large in a way the framers couldn't have anticipated in the 1970s.

While events themselves don't persist in memory unchanged, stories seem to lend themselves to retention. (From the union of Zeus and Mnemosyne—Memory—came the mothers of storytelling, the Muses.) In a revealing study, subjects who were asked if they were bothered by thoughts of the worst movie they had seen in recent months scored high for symptoms of PTSD—not because they suffered trauma but evidently because they just couldn't get the movie narrative out of their head.[54] Similarly, the sum of the evidence suggests that stories of returned veterans cursed in public places stuck in the nation's consciousness not because these incidents captured American society's attitude toward the vets but because the stories, *as* stories, captivated memory. Such lore goes unmentioned in DSM-III but must have had some influence on a committee whose

members included Lifton and whose chair believed that "the general public was not able to distinguish between the [Vietnam] war and the people that our country had drafted to fight in it."

Paradoxically, the indictment of the general public as an oppressive combination has deep cultural roots and sources. More than a century ago Conrad's *Heart of Darkness* told of a journey into the jungle, the barbarity witnessed there, and the return to a society blind to the atrocities committed in the name of its own ideals. Like someone coming home from a war whose truths cannot be told, our narrator, Marlow, finds himself "resenting the sight of people hurrying through the streets to filch a little money from each other, to devour their infamous cookery, to gulp their unwholesome beer, to dream their insignificant and silly dreams. . . . I daresay I was not very well at that time." The last comment is telling. Despite or because of the terrible knowledge that sets him apart from those around him, Marlow seems to realize that to carry alienation to the point of execrating humanity—spitting in society's face—is to go too far.

Tapping into a source as potent as the anti-society prejudice is a risky business. After all, if PTSD is "associated with poor social and family relationships," as noted in DSM-V (2013), then the weakness, not strength, of social connections is a PTSD risk factor. Contrary to the doctrine that society is hostile to the self, the evidence strongly suggests that social bonds support well-being while frayed bonds threaten it. An impressive review of statistical evidence gathered from several countries two decades ago, concurrently with the National Vietnam Veterans Readjustment Study, found that "more socially isolated or less socially integrated individuals are less healthy, psychologically and physically, and

more likely to die."[55] In light of this striking finding, the figure of Rambo reads not as a romantic hero who visits on American society exactly what it trained him to do but as someone whose complete absence of social ties translates into the absence of a tie to life itself, including his own. The authors of the review in question conclude by noting that "in contrast with the 1950s, adults in the United States in the 1970s were less likely to be married, more likely to be living alone, less likely to belong to voluntary organizations, and less likely to visit informally with others." It was during the social shake-up of the 1970s—a decade in which a "radical presumption of institutional failure" was widely shared[56]—that the PTSD diagnosis was crafted.

With the exception of an ill-advised clause in DSM-IV that would allow someone to be traumatized by watching the evening news (a provision since deleted), the PTSD criteria have not changed much since 1980. But if the DSM language has remained more or less constant even as PTSD "took off like a rocket,"[57] the ascent of the diagnosis must be fueled by something other than the criteria alone**.** The narrative of a trauma-producing society that inspired the original diagnosis has served that function. While inflammatory claims are excluded on principle from a document aspiring to scientific neutrality, the latest edition of the DSM asserts that PTSD rates run much higher in the United States than the rest of the world:

> In the United States, projected lifetime risk for PTSD using DSM-IV criteria at age 75 years is 8.7%. Twelve-month prevalence is about 3.5%. Lower estimates are seen

in Europe and most Asian, African, and Latin American countries, clustering around 0.5%-1.0%.

How are we to account for the gross disparity between PTSD estimates in the United States and elsewhere? Some might say that in regions with low rates PTSD is just waiting to be discovered. But the proposition that what is true, or reportedly true, of the American psyche is true universally does not bear analysis. Just as veterans can be drawn to a trauma narrative that provides a "framework for making sense of one's life," so can many others in a culture where "PTSD" has become a household word. But perhaps it couldn't have become such a familiar presence to begin with—part of our conceptual world, woven into our knowledge and folklore—if not for the notion that trauma is endemic to our way of life.

Notes

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[1] Richard McNally, Richard Bryant, and Anke Ehlers, "Does Early Psychological Intervention Promote Recovery from Posttraumatic Stress?" *Psychological Science in the Public Interest* 4 (2003): 46.

[2] On controlled trials of CISD see Suzanna Rose, Jonathan Bisson, Rachel Churchill, et al., "Psychological Debriefing for Preventing Post Traumatic Stress Disorder (PTSD)," *Cochrane Library* 2009, Issue 1; McNally, Bryant, and Ehlers, "Does Early Psychological Intervention Promote Recovery from Posttraumatic Stress?"; and Scott Lilienfeld, "Psychological Treatments That Cause Harm," *Perspectives on Psychological Science* 2 (2007): 53–70.

[3] Gerald Rosen, Robert Spitzer, and Paul McHugh, "Problems with the Post-Traumatic Stress Disorder Diagnosis and Its Future in DSM-V," *British Journal of Psychiatry* 192 (2008): 3.

[4] Wilbur Scott, "PTSD in DSM-III: A Case in the Politics of Diagnosis and Disease," *Social Problems* 37 (1990): 294–310.

[5] Edgar Jones and Simon Wessely, "A Paradigm Shift in the Conceptualization of Psychological Trauma in the 20th Century," *Journal of Anxiety Disorders* 21 (2007): 165.

[6] Allan Young, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (Princeton: Princeton University Press, 1995), p. 112.

[7] Young, *The Harmony of Illusions*, p. 113.

[8] Cited in Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge, Mass.: Harvard University Press, 2001), p. 361.

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[10] Hannah Decker, *The Making of DSM-III: A Diagnostic Manual's Conquest of American Psychiatry* (Oxford: Oxford University Press, 2013), p. 274.

[11] See *American Journal of Psychiatry* 128:1 (1971): 139.

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[13] Nancy Andreasen, "What Is Post-Traumatic Stress Disorder?", *Dialogues in Clinical Neuroscience* 13 (2011): 242.

[14] Lifton, *Home from the War*, p. 99.

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[18] Nancy Andreasen, "Posttraumatic Stress Disorder: A History and a Critique," *Annals of the New York Academy of Sciences* 1208 (2010): 69–70.

[19] Rosen, Spitzer, and McHugh, "Problems with the Post-Traumatic Stress Disorder Diagnosis and Its Future in DSM-V": 3–4.

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[23] Francine Shapiro and Margot Silk Forrest, *EMDR: The Breakthrough Therapy for Overcoming Anxiety, Stress, and Trauma* (New York: Basic, 2004; orig. pub. 1997), p. 176.

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[26] Andreasen, "Posttraumatic Stress Disorder: Psychology, Biology, and the Manichean Warfare Between False Dichotomies": 964.

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[31] Shapiro, *Getting Past Your Past,* p. 11.

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[46] McNally, Bryant, and Ehlers, "Does Early Psychological Intervention Promote Recovery from Posttraumatic Stress?": 65; Lilienfeld, "Psychological Treatments That Cause Harm": 59.

[47] K. B. Thomas, "Temporarily Dependent Patient in General Practice," *British Medical Journal*, 30 March 1974: 625.

[48] For example, “One Thomas Nickell, born in the city of Brandenburg, 1551, went reeling and staggering all the days of his life, as if he would fall to the ground, because his mother being great with child saw a drunken man reeling in the street.” Robert Burton, *The Anatomy of Melancholy* (New York: New York Review Classics, 2001), I, 215.

[49] Lionel Trilling, *Sincerity and Authenticity* (Cambridge, Mass.: Harvard University Press, 1971), p. 137.

[50] Shapiro, *Getting Past Your Past,* pp. 24-26.

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