PTSD vs Post-Vietnam Syndrome

In a determined effort to write the influence of Freud out of the third edition of the Diagnostic and Statistical Manual of Mental Disorders, the framers not only deleted the class of disorders designated Neuroses in DSM-II but made the text "atheoretical with regard to etiology," in the words of its Introduction. That is, in contrast to the Freudian practice of tracing the patient's troubles to some putative source in his or her past, DSM-III refrains on principle from speculating about causes. The informing philosophy is one of empiricism, with diagnosis hinging on observed symptoms, whatever might lie behind them. This policy of suspending the question of causation has exceptions, however.[1]

Among the diagnoses introduced in DSM-III was Posttraumatic Stress Disorder, soon to be known familiarly as PTSD. By definition, a posttraumatic reaction occurs not only after but because of a suffered trauma. How, then, did a disorder unusual in its dependence on causality find its way into DSM-III? Nancy Andreasen, who oversaw the drafting of its definition and criteria, answered as follows:

[1] "The approach taken in DSM-III is atheoretical with regard to etiology or pathophysiological process *except for those disorders for which this is well established* and therefore included in the definition of the disorder" (DSM-III, p. 7; my emphasis).

The Vietnam War was winding down and had been very unpopular. Unfortunately, the general public was not able to distinguish 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. A small but militant subgroup of Vietnam veterans clamored for the introduction of a diagnosis that would recognize the potential consequences of experiencing the stress of combat, and that might perhaps provide disability and treatment benefits for the psychiatric disorder that combat stress induced. Bob Spitzer, the Task Force chair, asked me to deal with the problem. . . . He did not know that I was actually already an expert on the topic of stress-induced neuropsychiatric disorders. I began my psychiatric career by studying physical and mental consequences of one of the most horrible stresses that human beings can experience: severe burn injuries. Within this model of stress, I had already examined brain abnormalities using electroencephalography, the pattern of acute and chronic symptoms, the long-term outcome and its predictors, and the role of coping mechanisms. . . . The answer to the veterans' request was obvious to me: there is a well-established syndrome, defined by a set of physiological (autonomic) and cognitive and emotional symptoms, that occurs after exposure to severe physical and emotional stress.[2]

[2] Nancy Andreasen, "What is Post-Traumatic Stress Disorder?" *Dialogues in Clinical Neuroscience* 13 (2011): 242; runs 240-43.

Thus, while the disaffected veterans argued for a Vietnam diagnosis, Andreasen believed that combat can be subsumed under the more general category of extreme stress. It appears that she sympathized with the veterans' militancy—a spirit of fervor boiling with grievance and accusation—but not to the point of sacrificing the objectivity that ought to govern an official manual of mental disorders. Neither does she note that she and the psychiatrists allied with the veterans held discordant conceptions of trauma itself.

Two Conceptions of Trauma

As documented by Wilbur Scott in his account of the intensive lobbying that went into the making of the diagnosis of PTSD,[3] the prime movers were two New York psychiatrists, Robert Jay Lifton and Chaim Shatan, working with a group of veterans opposed to the Vietnam War. The absence of a diagnosis of combat stress from the second edition of DSM—published in 1968, in the middle of the war—cried out to be corrected. However, in the eyes of Lifton, Shatan and their allies, established concepts of battlefield trauma did not apply in a war without battlefields and without meaning to which young men were sent by a dishonest society. In the end, while Lifton and Shatan succeeded in getting a trauma diagnosis into DSM-III, it made no mention of the unique form of trauma of concern to them, one bound up with service in a dirty war. The framers of

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

the new category could not be expected to inscribe such animus into the text of DSM-III, whatever their private opinions.

While Andreasen questions the representativeness of the anti-war veterans with whom Shatan and Lifton worked,[4] for the two psychiatrists it was these soldiers and no others who spoke the truth about the Vietnam War. Like a living synecdoche, they were the part that stands for the whole. Hence Shatan's claim in an op-ed in the New York Times on May 6, 1972 that the anti-war veteran suffers a severe disturbance to which all who served in Vietnam are subject. Titled "Post-Vietnam Syndrome," it lists a number of the symptoms that would be codified eight years later as those of PTSD, in particular flashbacks, guilt and severe numbing. Additional symptoms are murderous rage; dehumanization; a bitter sense of betrayal; alienation from others; and loss of the ability to love and trust.

The latter symptoms of Post-Vietnam Syndrome are linked much too closely and specifically to the Vietnam War itself to pertain to the general category of extreme stress. What is more, Shatan's op-ed radiates an ideological fervor which, if adopted by the framers of the new diagnosis, would have the effect of politicizing the criteria of a mental disorder. Even while making clinical observations Shatan comprehensively denounces the Vietnam War, the military and American society in the name of the anti-war veterans, citing the brutalization of the troops, their just resentment at being "deceived," their cold reception at the hands of the society that sent them to Southeast Asia, and—not least—"inadequate V. A. treatment and paltry G.I. benefits." It is possible that the hope of

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[4] Cf. John Talbot, "An In-Depth Look at DSM-III: An Interview with Robert Spitzer," *Hospital and Community Psychiatry* 31 (1980): 32; runs 25-32.

redressing this poor recompense moved many in the American Psychiatric Association to take the unusual step of introducing into DSM-III a diagnosis with such a charged and complex history.

As envisioned by Shatan, the GI in Vietnam is a Rambo-like figure with two enemies: his enemy in arms and his own masters, who use him as a "scapegoat" and leave him feeling "duped." Immersed in danger and unable to trust, he stands exposed to trauma from all directions. Just as the war in Vietnam itself represents an "atrocity-producing situation" according to Lifton,[5] so it represents a trauma-producing situation for Shatan. In the DSM text this all-encompassing concept of trauma gives way to a much more determinate one.

The entry on Post-traumatic Stress Disorder in DSM-III opens as follows:

> The essential feature is the development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of usual human experience.

By tying trauma to a specific event, the DSM text rules out the speculation that gave etiological theorizing a bad name with many in the APA. Post-traumatic stress is necessarily caused, but its cause is sufficiently clear (despite the temporal distance) to pass muster in a manual otherwise wary of the concept of causality. By the same token, if

[5] Robert Jay Lifton, *Home From the War—Vietnam Veterans: Neither Victims nor Executioners* (New York: Simon and Schuster, 1992; orig. pub. 1973), e.g. p. 41.

it becomes necessary to verify self-reported PTSD, an incident or episode dramatic enough to stand out as its cause ought to be documentable. Investigators who later checked self-reports of PTSD against military records and press coverage could have said that they were acting in the spirit of the original DSM text.[6] In effect, they made sure PTSD met the first requisite of the diagnosis, that of causality. Hence Criterion A:

> Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone.

According to Shatan, however, it was the exact opposite of a definitive exposure that left soldiers in Vietnam with severe emotional wounds. "The injury is not so much the outgrowth of one or two traumatic incidents, but rather of a cumulative, chronic, recurring pattern of exposure—little by little—to unrecognized, depreciated, or unpublicized risk and peril."[7] In direct contrast to the "recognizable stressor" of DSM-III, stressors are now imperceptible and go "unrecognized." In effect, the cause of Post-Vietnam Syndrome is Vietnam itself. Significantly, not one of the examples of the syndrome in Shatan's op-ed refers to any single trigger or cause. For example: "The most poignant feature [of Post-

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[6] Bruce Dohrenwend, J. Blake Turner, Nicholas Turse et al., "The Psychological Risks of Vietnam for U. S. Veterans: A Revisit with New Data and Methods," *Science* 313 (2006): 979-82. Revisited was the National Vietnam Veterans Readjustment Study, commissioned by Congress in 1983.

[7] Chaim Shatan, "The Grief of Soldiers: Vietnam Combat Veterans' Self-Help Movement," American Journal of Orthopsychiatry 43 (1973): 645; runs 640-53.

Vietnam Syndrome] is an agonizing doubt about their continued ability to love others, and to accept affection. One veteran said: 'You paid a high price for trusting other people in the Nam. Every time you acted human, you got screwed.'" Where is the stressor responsible for the withdrawal from others that characterizes Post-Vietnam Syndrome? Instead of a specific causal event, there is a pattern of events, with acts of trust (in whom?) producing pain "every time."

In the case of combat trauma as well, the stressor is not a single incident or episode but an entire history. "Steve stiffened, looked around fearfully, and thought, 'These people all look alike. How do I know who's friend and who's enemy?' Then he shook himself, remembering, 'They are all your friends. This is Times Square, U. S. A.' Eighteen months after a nonpsychiatric discharge following four years Marine combat duty in 'the Nam,' Steve still suffers unpredictable episodes of terror and disorientation." No causal event stands out. Indeed, it seems to be the omnipresence of danger in Vietnam that leaves Steve so unnerved that he eventually experiences a flashback in Times Square. Note too that unlike prior forms of combat stress, the stress suffered by those like Steve comes about not just because they confront danger without signs of danger, but because they must habituate themselves to killing civilians.

The Vietnam War, without which no one would have campaigned for the creation of a new diagnosis in the first place, is not named in the DSM-III entry on PTSD. Evidently the framers did not want to tie PTSD to a topical context. The nonspecific etiology of Post-Vietnam Syndrome disappears as well. While some argue that the "recognizable stressor"

criterion mistakenly allows for the distress of a divorce or bereavement,[8] its immediate effect was to rein in the open-endedness of the concept of trauma employed in arguments like Shatan and Lifton's. Confronting hidden threats as well as civilians and superiors who cannot be trusted, the GI in Vietnam finds himself engulfed in what Shatan calls "conditions of universal terror." The entire country becomes a trauma zone.[9] Critics (including Spitzer) who later traced the laxity of the concept of PTSD to the text of DSM-III[10] may not have perceived that it implicitly disallows this expansive—and highly polemical—conception of trauma itself.

It was right to do so. If Vietnam is a trauma zone—if the threat of trauma lies not so much in any single incident or episode as in the waging of a war without lines, honor or meaning—then every American soldier caught up in the war is a trauma victim in waiting. But if that is so, then every American soldier is also a potential perpetrator of atrocities—because, according to the same line of argument, trauma generates atrocity. As Lifton

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[8] Robert Spitzer, Michael First and Jerome Wakefield, "Saving PTSD from Itself in DSM-V," *Journal of Anxiety Disorders* 21 (2007): 243; runs 233-41. See however DSM-III, p. 236: "The stressor producing this syndrome would evoke significant symptoms of distress in most people, and is generally outside the range of such common experiences as simple bereavement, chronic illness, business losses, or marital conflict."

[9] A question to be asked is: "Did Marine cooks, truck drivers, and clerk-typists really experience the same trauma as Marine riflemen heavily engaging the best the North Vietnamese had to throw at them?" B. G. Burkett and Glenna Whitley, *Stolen Valor: How the Vietnam Generation Was Robbed of Its Heroes and Its History* (Dallas: Verity Press, 1998), p. 229.

[10] Gerald Rosen, Robert Spitzer and Paul McHugh, "Problems with the Posttraumatic Stress Disorder Diagnosis and its Future in DSM-V," *British Journal of Psychiatry* 192 (2008): 3-4.

contends in *Home from the War,* the very same guilt, rage and numbing identified by Shatan as "themes" of Post-Vietnam Syndrome led straight to the My Lai massacre.[11] Shatan's op-ed itself, while focusing on the GI's sense of betrayal, cites the outpouring of "violent impulses against indiscriminate targets." Thus, before Post-Vietnam Syndrome comes a real-time syndrome in which the same psychology produces not flashbacks and alienation but murder, even mass murder. Wrote Shatan elsewhere, "It is hard to speak of the moral corruption, the habituation to evil . . . that gradually accustom and numb young men [in Vietnam] to torture, atrocity, massacre, and, finally, perhaps even genocide."[12] How could Andreasen and others have been expected to predicate a disorder on such crimes? On the other hand, how were they to believe that the United States engaged in genocide—the murder of a people—in Vietnam?[13]

In 1976, while the new trauma diagnosis was in the draft stage, Alan Stone, the President of the American Psychiatric Association, observed that only recently "social

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[11] "Many forms of desensitization and rage contributed to My Lai" (p. 42). "One must make it up to the man killed, do something that gives significance to his death, in order to justify one's survival and avoid the experience of overwhelming death guilt" (p. 46).

[12] Shatan, "The Grief of Soldiers": 651.

[13] The exodus of boat people from Vietnam even while the new trauma diagnosis was under discussion might have given pause to any who believed that American intervention in Vietnam was an unmitigated evil. For a clear-eyed history of mass murders committed by the Communists in Vietnam, see Stephane Courtois, Nicolas Werth, Jean-Louis Panné, Andrzej Paczkowski, Karel Bartosek, Jean-Louis Margolin, *The Black Book of Communism: Crimes, Terror, Repression* (Cambridge, MA: Harvard University Press, 1999), pp. 565f. In the city of Hue alone in 1968, "at least 3000 people were massacred" by the Communists, a figure "far higher than in the massacres carried out by Americans" (p. 572). In all, the authors estimate that Communists are responsible for *one million deaths* in Vietnam alone: p. 4.

psychiatry and social activism, carrying psychiatrists on a mission to change the world . . . brought the profession to the edge of extinction."[14] If the framers of PTSD had adopted the adversarial rhetoric of Lifton and Shatan, they would have thrown their weight behind this self-destructive process. They did no such thing. So it is that while PTSD preserves a number of the symptoms of Post-Vietnam Syndrome—most notably, perhaps, flashbacks and numbing—it does away with their original framework, makes no mention of Vietnam, and instates a clear line of causality in place of the atmospheric concept of trauma advanced by Shatan and Lifton.

Historical Shift

But there are other ways of changing the world than prosecuting it. A case can be made that DSM-III itself changed the world by linking PTSD to a specific cause, thus voiding all questions about the character of the survivor. Prior to DSM-III, a lingering reaction to combat stress was deemed a "traumatic neurosis," and as such cast a shadow over the affected person. The abolition of war neurosis in favor of a new condition known as PTSD went along with the eviction of neurosis in general from DSM-III, and served to clear the survivor of the ad hominem implications that clung to the notion of neurosis as such. Precisely because PTSD is caused by a shocking event, its occurrence cannot be attributed to the person in question.

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[14] "Stone Sees Psychiatry Advancing Despite Criticism," *Psychiatric News*, June 3, 1977, p. 24.

In the words of Edgar Jones and Simon Wessely, "From being the responsibility of the subject, traumatic illness became an external imposition and possibly a universal response to a terrifying and unexpected event [with the advent of PTSD]. This shift from predisposition to the characteristics of the event itself reduced guilt and blame."[15] The cardinal criterion of PTSD—the specific stressor—emphatically marked this shift of focus from the person to the event that overtook him. No amount of psychological theorizing can accomplish this change of perspective, because all of it is taken up with the analysis of the person, and a traumatic event does not reflect the person on whom it falls.

A much abbreviated version of a paper that appeared the following year in the *American Journal of Orthopsychiatry*, Shatan's op-ed on Post-Vietnam Syndrome nevertheless finds the space to sketch Freud's theory of grief, suggesting that it is the veteran's inability to "consummate" or discharge grief that holds him captive to the past. A throwback to the venerable theory that illness results from pent-up, repressed or undischarged fluids or matter, the passage illustrates the mystique of psychoanalysis—the same mystique that got in the way of the framing of sound diagnoses, according to Andreasen.[16] At the moment Spitzer asked Andreasen to review the issue of war trauma, when psychoanalysts were fast losing their dominance within the APA, what was needed was not a means of unknotting the subject's psyche but a means of severing the knot of

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[15] Edgar Jones and Simon Wessely, "A Paradigm Shift in the Conceptualization of Psychological Trauma in the 20th Century," *Journal of Anxiety Disorders* 21 (2007): 164; runs 164-75.

[16] Nancy Andreasen, "DSM and the Death of Phenomenology in America: An Example of Unintended Consequences," *Schizophrenia Bulletin* 33 (2007): 108-12.

psychology itself. This the entry on PTSD did by attributing the disorder to a specific event, leaving the character of the affected person out of consideration, retiring the concept of a war neurosis, preserving a few features of Post-Vietnam Syndrome while omitting the mentality that binds them, and not once referring by name to a war portrayed by critics as a great source of emotional injury.

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