# THE MEDICAL DISCOURSE ON MILITARY PSCYIATRY AND THE PSYCHOLOGICAL TRAUMA OF WAR: WORLD WAR I TO DSM-III

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ABSTRACT

RACHEL LEVANDOSKI: The Medical Discourse on Military Psychiatry and the Psychological Trauma of War: World War I to DSM-III
(Under the Direction of Dr. Wayne Lee)

Using the professional journals of the mental health community this thesis discusses how the discourse on psychological trauma and the trauma of war developed within the psychiatric profession during the twentieth century. During WWI military psychiatrists attempted to master the dual responsibilities of treating and preventing war neuroses. Then, during and after WWII, the professional discourse acquired greater nuance when the mental health community sought to understand the chronic nature of some trauma-related neurotic conditions. The thesis concludes with the public and professional debates on the psychological trauma of war during and after the Vietnam War, which culminated in 1980 with the acceptance of Post-Traumatic Stress Disorder (PTSD) by the mental health community as an official diagnostic category. Whereas some scholars argue that PTSD was a social construction of the post-Vietnam era, this thesis demonstrates that the theoretical foundations of the diagnosis developed long before American involvement in Vietnam.

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*"Military psychiatry is to psychiatry as military music is to music."*

-Dr. Chaim Shatan, 1996

## Introduction

**"He had needed to believe that just one person cared…"**

At the close of the 1960s Sarah Haley, a psychiatric social worker, had just begun a new job at the Veterans Administration Outpatient Clinic. One day a young veteran entered her small office, sat down, and began to sob uncontrollably. Slowly the man began to tell his story. Twenty-two years old and "intense, intelligent, and handsome" he had enlisted in the Marines after his older brother was killed Vietnam. He recounted to Haley that during his own tour in Southeast Asia he "'refused to think of the Vietnamese as people,' killed prisoners after entreating them to surrender, and killed civilians on little or no provocation." Towards the end of his deployment the guilt of his actions began to weigh on him until one day he refused an order by his commanding officer to execute a number of Vietcong prisoners with whom he had formed a friendship over the course of the week he had been responsible for guarding them. Instead he stood by and watched with horror as his fellow soldiers gunned down the unarmed men. He returned the United States, entered but then left college, became addicted to drugs in an effort to escape his memories and tried to kill himself. With tears in his eyes he whispered to Haley "'No one can forgive me - I don't deserve to live… I - we should be shot.'" The conclusion of the veteran's story left Haley

"numbed and frightened" and uncertain of how to respond. She encouraged the young man to talk about his experiences and over the next few months he visited with Haley sporadically at the VA clinic. Unfortunately the treatment was unsuccessful and the veteran was hospitalized after attempting to kill himself while on LSD. After his hospitalization he maintained only minimal contact with Haley until one year later he returned to the clinic in order to find help for a friend and fellow veteran in whom he saw symptoms similar to his own. In the course of their conversation Haley found out that the young man whose psychological suffering had rendered him nearly nonfunctioning a near or so ago, was now working a part time job and attending college. When she asked him what happened to bring about such a change he responded that "he had needed to believe that just one person cared, that one person could be trusted to know what he had done and not reject him."[1]

Since the First World War the medical and psychiatric profession has mobilized to treat the psychological trauma suffered by participants of war. Initially the military and the mental health profession considered military psychiatry to have two important roles in a war setting. The first was to treat soldiers who suffered a mental breakdown as a result of combat and when possible, return them to their units as quickly as possible. The second and equally important - and infinitely more difficult - job of the psychiatric profession was to aid the military in preventing combat related mental trauma. Through intense study, first-hand experience, and trial and error mental health professionals learned over the course of the twentieth century effective ways to treat and sometimes prevent severe traumatic breakdown.

[1] Sarah A. Haley, "When the Patient Reports Atrocities: Specific Treatment Considerations of the Vietnam Veteran," *Archive of General Psychiatry* 30 (February, 1974): 191-196. This is a frequently cited incident found also in: Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge: Harvard University Press, 2001); Gerald Nicosia, *Home to War: A History of the Vietnam Veterans' Movement* ( New York: Crown Publishers, 200); and Jerry Lembcke, "The 'Right Stuff' Gone Wrong: Vietnam Veterans and the Social Construction of Post-Traumatic Stress Disorder," *Critical Sociology* 24 (1998).

It is possible that truly promising psychiatric research was truncated, however, because interest in combat psychiatry tended to evaporate within a year or two of a war's conclusion. With the cessation of combat it was believed there could be no more combat related breakdown and therefore, psychiatrists could no longer identify patients to study. This often resulted in an interesting, though inefficient, process of professional rediscovery once the next war started and the services of military psychiatrists were needed again. Ben Shephard aptly characterized this pattern as "[war neuroses] is first denied, then exaggerated, then understood, and finally, forgotten."[2] Despite this phenomenon the field of military psychiatry advanced and overall, achieved consistent success in its two war time functions. With each military conflict doctors and therapists applied new techniques, tweaked their methods, and over time managed to limit the number of psychiatric casualties during a war.

Early on, however, a handful of psychiatrists and researchers questioned whether the responsibility of the psychiatric profession to combat veterans really ended when the guns were silenced or if in fact, the psychological trauma of war could continue long after the veteran exited a combat situation. This question stimulated a modicum of professional debate after WWI and then again after WWII. Each time the deliberation slowly faded away only to begin again in a limited fashion with the conclusion of the next war, much in the same cyclical manner as the rest of the field of combat psychiatry. As a result, by the 1960s there was still no consensus amongst mental health professionals as to whether or not the trauma of war was a lasting condition, let alone what measures were needed to treat any potential sufferers.

[2] Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge: Harvard University Press, 2001), xxii.

America's entrance into the Vietnam War once again mobilized the practitioners of combat psychiatry. At the same time the psychiatric profession continued to reevaluate some of its foundational beliefs about the origins of some mental illnesses, a process begun during the 1950s. New theories were suggested about the effect of psychological trauma on the long term mental health of an individual, with some hypothesizing that conditions such as war neuroses could have lifelong, debilitating effects on veterans. The impact of these discussions was most felt by the military and civilian psychiatrists responsible for treating the returning Vietnam veterans. These professionals in turn contributed their first hand experiences to a growing psychiatric discourse on trauma and the mind. The interaction of Sarah Haley and the traumatized Marine veteran is emblematic of similar contacts between mental health professionals and Vietnam veterans that took place all across the county in the late 1960s and throughout the 1970s. The relationships that formed as a result of these many interactions played a significant role in shaping the professional discussion on combat trauma as it unfolded in the wake of the Vietnam War.

What mental health professionals and combat veterans lacked during this period was official recognition by either the government or the medical community of the potential for a chronic mental illness to be triggered by a traumatic experience. As a result treatment options were limited, and the Veteran's Administration was uncertain how to proceed when confronted by an increasing number of Vietnam veterans claiming to suffer from persistent psychiatric wounds. Some mental health professionals had earlier considered such a diagnosis based upon their experiences during and after previous wars. However, a persistent belief amongst the majority of psychiatrists that combat related mental illness was a result of either cowardice or a preexisting psychiatric condition prevented any such

conclusion from being reached. This tenet of psychiatry was challenged in the wake of the Second World War, but a new consensus on trauma related mental illness had yet to be reached by the time the veterans of the Vietnam war began to seek help.

Conditions were ripe for change during the late 1960s and throughout the 1970s. The insertion of Vietnam veterans into the psychiatric discourse and the politicization of many psychiatrists in the 1960s and 1970s managed to bring the discourse on combat trauma to a national stage. The result of their efforts was official recognition of what is now called Post-Traumatic Stress Disorder (PTSD) and the eventual acknowledgement by medical practitioners and government officials of the continued need to support war veterans.

Americans have created a national memory of the Vietnam War based upon a synthesis of multiple discourses. Politicians, veterans, scholars, and popular culture have all contributed language and experiences to the master narrative of this conflict. Within the myriad of discussions on the Vietnam War exists the discourse on Post-Traumatic Stress Disorder and the effect of combat on the psyche of soldiers and civilians. Like the collective memory of the Vietnam War, our understanding of the psychological trauma of war is also the result of a synthesis of many discourses. One such discourse can be found in the evolution of understanding amongst mental health professionals about the effects of trauma on the human mind. The development of this one discourse demonstrates how the many discussions - both professional and public - about not only combat trauma but all aspects of the Vietnam War had the potential to influence and shape one another. Ultimately these interactions formed the larger framework for a national memory of the Vietnam War.

Using books, newspapers, and professional journals this paper discusses how a fledgling discourse on combat trauma developed within the psychiatric profession at the

beginning of the twentieth century as military psychiatrists attempted to master the dual responsibilities of treating and preventing war neuroses. It describes how the discourse acquired greater nuance during and after the Second World War when mental health professionals sought to understand the chronic nature of many veterans' neurotic conditions. It was during this period that post-traumatic manifestations of combat neuroses began to gain legitimacy in the psychiatric community. The paper ends by discussing how the professional discourse on combat trauma moved from the background at the beginning of the Vietnam War to the forefront of both the popular and the professional discussions on Vietnam veterans as the war drew to a close in the mid-1970s. The Vietnam veterans added their own voices to the professional debate on the short-term and long-term psychological effects of war, helping to shape the discourse that finally culminated in 1980 with the acceptance of PTSD as a diagnostic category by mental health professionals.

## Historiography

Military medicine has struggled to keep pace with the ever increasing gamut of ways devised to injure the human body. The combat medicine of 1917 was very different from the combat medicine of 1970 simply because of the nature of warfare. Doctors in each conflict encountered injuries they never anticipated. One constant was - and continues to be - psychological breakdown amongst a war's participants and a medical professional serving in a warzone could expect to come in contact with such a casualty at some time during the conflict. In the past century a soldier had a greater likelihood of becoming a psychiatric casualty than of being killed by enemy fire. Mental health professionals now recognize that

with few exceptions every soldier has the potential to experience some form of psychological trauma during war. [3]

The pervasiveness of combat-related mental illness underscores how important it is for scholars to understand these conditions if they wish to comprehend the human experience during war. There is a growing discourse on war-related psychological illness developing both inside and outside of the medical profession. This is a complex topic and the historiography has developed along many different paths. The following section highlights some of the directions this discussion has taken and provides examples of the scholarship shaping the conversation.

The scholarly discussion on the trauma of war has focused on the development of the field of combat psychiatry. Researchers are apt to describe changes in practice and definition over time rather than the potential causes for those changes and their consequences for military and medical history. One such work is *From Shell Shock to Combat Stress: A Comparative History of Military Psychiatry* (1997), an excellent summary by Dutch historian Hans Binneveld of military psychiatry from as early as the Thirty Years War of the seventeenth century through American involvement in Vietnam. Also notable are the works of social scientist and military historian Richard A. Gabriel: *No More Heroes: Madness & Psychiatry in War* (1987) and *The Painful Field: The Psychiatric Dimension of Modern War* (1988). In each of these works Gabriel traces the history of combat psychiatry in the American and the Soviet militaries in addition to offering commentary on the future of military psychiatry in modern war.

[3] Richard A. Gabriel, *The Painful Field: The Psychiatric Dimension of Modern War* (New York: Greenwood Press, 1988), 30.

There are, however, some scholars who have historicized the field of combat psychiatry beyond simply a discussion of change over time. Their work, which explores the influence of social and cultural trends on the mental health profession, serves to both elucidate and complicate our understanding of how medical professionals conceptualize the trauma of war. David H. Marlowe, working with RAND's Center for Military Health Policy Research and the Forces and Resources Policy Center of RAND's National Defense Research Institute, produced a monograph entitled *Psychological and Psychosocial Consequences of Combat and Deployment: With Special Emphasis on the Gulf War* (2001) that includes a concise history of the understanding of psychological trauma in war beginning as early as the wars fought in Classical Greece and ending with the United States' first intervention into the Gulf. Marlowe sought to uncover the reason for the wide variety of symptoms reported by Gulf War veterans long after the conclusion of U.S. involvement in the region. He argues that the trauma created by the high-stress environment of combat or simply by being in a theater of war could lead to both immediate and long-term physical and psychological consequences, a theory he correctly identifies as an outgrowth of previous conclusions drawn from the Vietnam War. Marlowe complicates this premise by further hypothesizing that it is too simple to consider stress the sole catalyst for the undiagnosed illnesses of Gulf War veterans. Medical professionals, scholars, and military officials must also take into account social and cultural inducements such as the media, the Internet, support groups, and people in positions of authority. Marlowe argues that all of these factors could shape a veteran's perception of his or her illness and only a better understanding of how the symptoms of combat stress have presented themselves in past wars could enable clinicians

and academics to determine what may be a common psychological reaction to combat and what is unique to Gulf War veterans.

Ben Shephard also draws on over one hundred years of military psychiatry in order to make larger claims about the mental health profession, its often complex role within a large, modern military, and the ability of popular culture to shape the field and its members. In *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (2000) Shephard argues that a persistent dialogue existed within the field of military psychiatry, characterized by opposing opinions on the responsibility mental health professionals had to their soldier patients. On one side were the "realists" who believed their function was to preserve the fighting strength of the military and therefore, treat mentally ill soldiers and, when at all possible, return them to their units. The "realists" were opposed by psychiatrists and psychologists whom Shephard refers to as "dramatists" or those men and women more inclined to study and treat their military patients and less concerned with military policy. According to Shephard the existence of these two philosophies of treatment resulted in a tension that permeated and shaped the field of military psychiatry throughout the twentieth century, ultimately coming to a head in the post-Vietnam years. In the wake of the social turmoil created by the Vietnam War the "realist" tradition of military psychiatry was discredited because of its tacit support of U.S. military policy, thus leaving the "dramatists" - "full of complex emotions about Vietnam and the atrocities committed there" - to shape the discipline. The result, according to Shephard, "has been to standardise [sic] a model of post-traumatic illness derived from one of the most ill-conceived, morally confused and disastrous conflicts ever waged - Vietnam" which leads him to conclude that "much of the work of

psychiatrists is, in reality, marginal to the military effort and serves more as a receptacle, a sponge for absorbing public concern about war." [4]

Ethnographer Allan Young also develops an argument around the notion that social factors influence how mental health professionals understand and treat combat related trauma. His book, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (1995) uses historical examples as well as information gathered during Young's two years (1986-1988) spent observing the medical staff of the National Center for the Treatment of Post-Traumatic Stress. Based upon this research Young argues conclude that the "generally accepted picture of PTSD… is mistaken" and the public and as well as medical professionals need to understand that PTSD is "a historical product" created by "the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilized these efforts and resources."[5] Young firmly believes that PTSD and the suffering associated with it was real, however, as an ethnographer he questions the ways in which the popular understanding of PTSD initially developed and then continued to be cultivated. Ultimately this led him to wonder whether or not that understanding influenced the way in which PTSD was diagnosed.

A social-constructionist view of PTSD can also be found in Jerry Lembcke's article "The 'Right Stuff' Gone Wrong: Vietnam Veterans and the Social Construction of Post-Traumatic Stress Disorder" published in *Critical Sociology* in 1998. Lembcke's article locates the origins of PTSD at the intersection of the political and cultural debates on the Vietnam War in the late 1970s. He argues "we need to understand PTSD as much as a

[4] Shephard, xxii - xxiii

[5] Allan Young, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (Princeton: Princeton University Press, 1995), 5.

cultural and political category as a mental health category and that the content of PTSD - alienation, survivor guilt, and flashbacks - were derived from popular culture."[6] Like Young, Lembcke considers PTSD to be as much a constructed condition as it was a real illness suffered by many veterans. This article, while important for its insights into the discourses that influenced the mental health community during the 1970s, largely ignores the research conducted by psychiatric professionals on chronic war neuroses before the Vietnam War. Instead it seems to imply that psychiatrists considered protracted combat trauma for the first time once they read about it in the New York Times. As this will demonstrate, the medical discourse on combat trauma certainly was shaped by social forces, however, the foundations of the professional understanding of traumatic neuroses were in place long before the Vietnam War.

Historical work on the psychological trauma of war is complex and includes work on subjects related to but separate from a history of combat psychiatry. A wide and varying group of professionals including historians, sociologists, members of the armed forces, and mental health experts continue to seek a better understanding of how the human mind withstands and then processes the trauma of war. This includes recent research which has addressed the impact of war on civilian populations. However, the majority of the scholarly discourse has focused on the mental health of a war's various military participants during and after the conclusion of a battle. In this historical discussion scholars have cast the soldier as both the victim and the perpetrator of the violence that may have resulted in a traumatic reaction. The most recent scholarship has explored the latter hypothesis, resulting in a growing body of work on the psychology of killing.

[6] Jerry Lembcke, "The 'Right Stuff' Gone Wrong: Vietnam Veterans and the Social Construction of Post-Traumatic Stress Disorder," *Critical Sociology* 24 (1998): 38.

A notable example of this scholarship is *On Killing: The Psychological Cost of Learning to Kill in War and Society* (1995) by psychologist and United States Army Lieutenant Colonel Dave Grossman, a work which the author characterizes as "an attempt to bring the objective light of scientific scrutiny into the process of killing."[7] Grossman applies statistical data gathered by S.L.A Marshall in the wake of WWII to careful analyses of other historical battles in an effort to understand how soldiers reacted in combat. This analysis and his training as a psychologist led Grossman to conclude that many soldiers were resistant to killing, with some - if not many - refusing to fire their weapon against an enemy. Modern armies have worked to counter this instinctual response through intense reconditioning measures, often during basic training, and the nurturing of an environment in which killing is acceptable. Grossman identifies these dual attempts by the military to overcome the soldier's aversion to killing, in addition to a lack of public support for the soldier's actions, as possibly contributing to the rise in post-traumatic mental illness after the Vietnam War.

Historian Joanna Bourke also addresses the psychology of killing during war with her work *An Intimate History of Killing: Face to Face Killing in Twentieth Century Warfare* (1999), though her very different conclusion from Grossman signifies just how convoluted and difficult it is to study this particular aspect of warfare. Bourke provocatively attempts to "put killing back into military history,"[8] seeking to understand how combatants experienced the act of killing within the process of mechanized warfare. After careful study of soldiers' accounts gathered from World War I, World War II and the Vietnam War, Bourke concludes that combatants forced to kill an enemy soldier often did so with intense, contradictory

[7] Dave Grossman, *On Killing: The Psychological Cost of Learning to Kill in War and Society* (New York: Little, Brown and Co., 1995), xxviii.

[8] Joanna Bourke, *An Intimate History of Killing: Face to Face Killing in Twentieth Century Warfare* (New York: Basic Books, 1999), xiv.

emotions of both horror and pleasure. Bourke does not cite Grossman in her work so it is unclear whether or not she disagrees with his argument of the soldier's aversion to killing. However, her conclusion that many combatants actually enjoyed killing and this conclusion's dramatic contradiction to Grossman's belief that many soldiers actively avoided killing in battle certainly indicates the complex and varying nature behind the psychology of killing, as well as the need for further research on this topic.

For reasons grounded in history and popular culture, psychological trauma caused by war is most often associated with the American intervention in Vietnam and the hundreds of thousands of veterans this involvement produced. It is entirely possible that, in the future, discussions about combat-related mental distress will center on the new veterans of the wars in Iraq and Afghanistan. These conversations may someday eclipse those of the Vietnam War and might serve to eliminate the stigma that currently surrounds this earlier generation of young men and women. As it stands now, however, much of the scholarly discourse on war-related psychological trauma remains focused on the Vietnam War and its veterans.

Many scholars have already discussed the way in which the psychological trauma of war shaped the experiences of Vietnam veterans and to some extent, the national memory of the conflict. Indeed, PTSD is now a ubiquitous topic when it comes to a study of the Vietnam War.[9] An historian attempting to write about the veterans of this conflict is almost obligated to address PTSD because it has become an integral part of the master narrative of the war in Vietnam. One of the earliest - and perhaps most influential - works to highlight

[9] By 1988 the body of work related to psychological trauma and the Vietnam War had grown so large that an annotated bibliography was published in an attempt to catalogue all of the past and present research on this topic. The result was a book of about 302 pages and 851 separate references. Norman M. Camp, Robert H. Stretch, and William C. Marshall, *Stress, Strain, and Vietnam: An Annotated Bibliography of Two Decades of Psychiatric and Social Science Literature Reflecting the Effect of the War on the American Soldier* (New York: Greenwood Press, 1988).

the mental trauma suffered by Vietnam veterans was *Long Time Passing: Vietnam and the Haunted Generation* (1984) by journalist Myra MacPherson. Based upon hundreds of interviews conducted by the author, this book is best remembered for helping to break the national silence on American involvement in Vietnam. It was important to the larger discussion on psychological trauma, however, because it demonstrated the depth and scope of emotional suffering many veterans still endured a decade after the war's conclusion. The precedent set by MacPherson indicated to researchers that future work on Vietnam veterans would require a discussion of the psychological trauma caused by that war.

It would not be prudent to try and list all of the books on the Vietnam War and its participants which discuss PTSD or other forms of combat related mental illness. There are, however, a few works worth mentioning because of the unique manner in which the authors chose to frame their discussion of Vietnam veterans and PTSD. For example, Julia Bleakney discusses the manifestation of physical and psychological trauma in the memoirs of Vietnam veterans through the veterans' use of what she calls "body memory." She argues in *Revisiting Vietnam: Memoirs, Memorials, Museums* (2006) that veteran memoirists "write bodies into their texts using metaphors of the physical" in order to explain their traumatic experiences and express anti-war sentiments. The psychological trauma of war was so difficult for veterans to express that they appropriated language of the body and created metaphors in the hopes of conveying their suffering. [10]

Historians Jonathan Shay and Eric Dean have also added complexity to our understanding of the relationship between the Vietnam veteran and PTSD. Each author utilized the current discourse on the Vietnam War and combat trauma as a lens through

[10] Julia Bleakney, *Revisiting Vietnam: Memoirs, Memorials, Museums* (New York: Routledge, 2006), 37-70.

which to discuss manifestations of the condition in much earlier wars. Dean's *Shook Over Hell: Post-Traumatic Stress, Vietnam, and the Civil War* (1997) draws connections between the experience of Vietnam veterans with participants of the Civil War while Shay's *Achilles in Vietnam: Combat Trauma and the Undoing of Character* (1994) identifies indicators of PTSD in the characters of Homer's *The Illiad*.[11] Allan Young takes issue with research such as this, believing that it is not possible to project PTSD, a condition he considers to be an historical construction, on past conflicts. He does not advocate for an absence of psychological trauma in previous wars, he argues instead that an application of a modern understanding of the illness onto historical examples ignores how the definition of PTSD was shaped by the context in which it was ultimately identified.

Wilbur J. Scott's *The Politics of Readjustment: Vietnam Veterans Since the War* (1993) and Gerald Nicosia's *Home to War: A History of the Vietnam Veteran's Movement* (2001) highlight the politicization of PTSD by Vietnam veterans searching for a way to both protest the war and bring national attention to the social marginalization of the war's participants.[12] *Stolen Valor: How the Vietnam Generation Was Robbed of Its Heroes and Its History* (1998) by researcher and Vietnam veteran B. G. Burkett also discusses the politicization of PTSD, however, this work posits an alternate argument. Burkett suggests that both veterans and non-veterans created a false notion of pervasive mental illness in Vietnam veterans in the years after the war, culminating in official recognition of PTSD by the Veteran's Administration and mental health professionals in 1980. The result, according

[11] Eric T. Dean, *Shook Over Hell: Post-Traumatic Stress, Vietnam, and the Civil War* (Cambridge: Harvard University Press, 1997). Jonathan Shay, *Achilles in Vietnam: Combat Trauma and the Undoing of Character* (New York : Simon & Schuster, 1995).

[12] Wilbur J. Scott, *The Politics of Readjustment: Vietnam Veterans Since the War* (New York: Aldine De Gruyter, 1993). Gerald Nicosia, *Home to War: A History of the Vietnam Veteran's Movement* (New York: Crown Publishers, 2001).

to Burkett, are false claims of PTSD in an effort by healthy veterans to gain disability support from the government, but worse yet, an inaccurate national perception of all Vietnam veterans as psychologically traumatized. Burkett contends that this perception remains prevalent even now.[13]

All of the works mentioned here demonstrate the potential for researchers to deepen their understanding of war, and the experiences of its participants, through further research on the psychological trauma of combat. This could be especially true of their understanding of the Vietnam War because of the conflict's perceived association with combat-related mental illness, a relationship which many scholars identify as crucial to shaping the popular memory of this conflict. A better understanding of how the medical discourse on combat trauma developed before, during, and after American involvement in Vietnam will bring awareness to one of the many complex discussions which ultimately merged to form the national memory of the Vietnam War.

[13] B.G. Burkett, *Stolen Valor: How the Vietnam Generation was Robbed of its Heroes and its History* (Dallas: Verity Press), 1998.

## The Development of Military Psychiatry during the Civil War and the First World War

The way in which combat trauma is identified, treated, understood, and described has developed in parallel with advances in military technology, the conduct of modern war, and the medical profession. The following section describes the professional discourse on combat trauma which developed in the first half of the twentieth-century and how this discourse was shaped by continued negotiation between military psychiatrists and the larger, civilian mental health profession.

The attention given to war-induced psychological trauma in the twentieth century has made this condition appear to be a phenomenon of modern warfare. This is not the case. As early as the sixteenth century European military physicians developed language to describe soldiers who ceased to fight for reasons other than physical injuries. During the Thirty Years War of 1618-1648 Spanish doctors described such soldiers as *estar roto* or "to be broken or breaking" while Germans employed the term *Heimwee*. Perhaps the most commonly used term which carried over well into the nineteenth century was *nostalgia*, a phrase used by the Swiss as early as the sixteenth century and later appropriated by French physicians who treated soldiers of the Napoleonic Wars. It was understood that *nostalgia* presented symptoms such as fatigue, lack of concentration, and poor appetite.[14] The word itself was chosen to reflect what doctors believed to be the true underlying cause of the condition, chronic homesickness. This belief led many doctors to hypothesize that *nostalgia* was more

[14] Hans Binneveld, *From Shell Shock to Combat Stress: A Comparative History of Military Psychology*, trans. John O'Kane (Amsterdam: Amsterdam University Press, 1997), 3.

likely to develop between periods of fighting when the soldier's thoughts turned to home and not after instances of heavy fighting.[15]

When the Civil War broke out in the United States in 1861 and Confederate and Union doctors began to encounter otherwise healthy soldiers who simply refused to fight they, too, began to apply the term *nostalgia* to their patients. Over time other terms began to slowly appear in the physician's lexicon. During the Civil War *nostalgia* was replaced by new language that was used both officially and unofficially to describe a "healthy" soldier's inability to fight. Often, however, these words reflected cultural norms or advances in medical science and not necessarily a better understanding of the soldier's condition. For example, many soldiers who fled battle were simply referred to as "stragglers" or "cowards," their current mental state a result of a flaw in their character and not the brutality of battle. Sometimes military doctors did provide an official medical diagnosis to these soldiers; only instead of looking to the mind of the individual they turned instead to his body, in particular, his heart. Physicians came to use phrases such as "soldier's heart" or "effort syndrome" to describe the soldiers afflicted in this way because in many cases they presented with an elevated heart rate and palpitations, often so severe that the soldier could no longer sustain physical activity.[16] The desire to find a physiological explanation for what is now understood to be a psychological problem is indicative of late nineteenth-century medicine and its increased focus on internal medicine. However, the inclination to label sufferers of combat trauma as the possessors of either physical ailments or flawed characters continued to

[15] David H. Marlowe, *Psychological and Psychosocial Consequences of Combat and Deployment: With Special Emphasis on the Gulf War* (Santa Monica: RAND, 2001), 14.

[16] Ibid, 20.

permeate the professional discourse - and popular perception - until well into the mid-twentieth century.

The military once again encountered soldiers suffering from psychological breakdown with the outbreak of hostilities in Europe in 1914. This time, however, these soldiers were referred to doctors dedicated to the treatment of mental disorders. The field of psychiatry or "mental hygiene" had gained official recognition and a degree of respect from medical circles by the end of the nineteenth century. Men like Jean Martin Charcot of France, Sigmund Freud of Austria, and others shaped the discipline and brought terminology such as "neuroses," "psychoanalysis," and "hysterias" into a developing discourse on mental illness.[17]

Military doctors who specialized in mental health began to apply these terms to the patients they encountered in the trenches or in the hospitals of France and Great Britain. Early in the war, military psychiatrists began to develop new terminology as well. Perhaps the most famous being "shell-shock," a term which attributed the mental breakdown of a soldier to physical trauma caused by the concussion of an exploding shell. This phrasing first appeared in a 1915 *Lancet* article written by Dr. Charles S. Meyers of the Royal Army Medical Corps. The article, entitled "Contribution to the Study of Shell Shock," argued that

[17] Binneveld, 70-71. Most of the following discussion will be drawn from Binneveld's *From Shell Shock to Combat Stress* and Ben Shepard's *A War of Nerves* because of the succinct and accessible manner in which they detail the history of military psychiatry. A near identical telling of this same historical narrative can be also be found in such works as: David H Marlowe, *Psychological and Psychosocial Consequences of Combat and Deployment: With Special Emphasis on the Gulf War*, (Santa Monica: RAND, 2001).; Bessel Van der Kolk, et al., Editor,. *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society* ( New York: The Guilford Press, 2007).; Richard A.. Gabriel, *No More Heroes: Madness & Psychiatry in War* (New York: Hill and Wang, 1987); Wilbur J. Scott, *The Politics of Readjustment: Vietnam Veterans Since the War* ( New York: Aldine De Gruyter, 1993).; William Hausman, and David McK. Rioch, "Military Psychiatry: A Prototype of Social and Preventative Psychiatry in the United States," *Archive of General Psychiatry* 16 (1967): 727-739.

wounds from artillery shells could be invisible just as easily as they could be visible to the treating physician. In subsequent articles Meyers described symptoms of shell shock that ranged from blindness and paralysis to exhaustion and a slight headache.[18] Psychiatry during this time was in no way a precise science and much like during the Civil War the current medical trends, in this case the mind-body connection, influenced the understanding of mental health and the language used to discuss it.

During the First World War military psychiatrists were not only responsible for diagnosing psychological trauma they were expected to treat it as well. In a war in which daily casualties could be in the thousands every soldier was needed for the fight. Thus, military psychiatrists set out to treat and "cure" their patients suffering from shell-shock or other forms of mental exhaustion. This was the challenge facing Dr. Thomas Salmon, the civilian Medical Director of the National Committee for Mental Hygiene in the United States, who traveled to Europe in 1917. His trip had a dual purpose, to learn from the experiences of his European colleagues and to make recommendations for the psychiatric treatment of the American soldiers joining the Allied forces.[19]

After two months in Europe Salmon presented his recommendations on military psychiatry, many of which became the foundational tenets of the field later built upon by both the military and the psychiatric profession. The first step was rigorous psychological testing of new recruits to weed out the "insane, feeble-minded, psychopathic and neuropathic individuals."[20] Salmon anticipated that this measure alone would not eliminate all war

[18] Binneveld, 84-85.

[19] Shephard, 123-124.

[20] Dr. Thomas Salmon, quoted in Ibid, 125.

neuroses casualties so he also recommended methods of psychiatric treatment as well as the logistical structure needed to support this treatment. When possible the shell-shocked soldier was to be seen by those medical officers who had received specialized psychiatric training. Salmon also recommended that the soldier be treated as close to the line of battle as possible.[21] This technique, later termed "proximity," is still in use today, demonstrating how crucial the World War I era was for pioneering new methods of military psychiatry. Also influential were Salmon's suggestions for the placement of mental health professionals in order to best meet the needs of American soldiers. He developed a three tier system comprised of Division level psychiatrists responsible for the immediate care of war neuroses casualties close to the front, Advanced Neurological Hospitals designed to hold particularly ill soldiers in relative proximity to combat with intent of returning them to their units as quickly as possible, and finally a Base Hospital about fifty miles from the front where the most severe psychiatric casualties would be treated with state-of-the-art therapies and equipment. To some extent the second and third tiers of Salmon's plan reflected the system already established by the British and French to treat their own shell-shock casualties, however, Salmon's introduction of a Division level psychiatrist was fairly innovative.[22]

The extent to which Salmon's methods achieved success can be debated. Many of his recommendations were not put into place in time to be of any real assistance to soldiers or military psychiatrists. As late as July 1918 American General John Pershing complained about "the prevalence of mental disorders" in the American troops serving in France, which

[21] Shephard, 125
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[22] Ibid, 125-131.

he felt was largely due to poor screening when the soldier joined the Army.[23] Upon reflection after the war a British doctor voiced his opinion that American shell-shock casualties "were [not] much minimised by this elaborate preparation."[24] Despite this apparent lack of immediate results it can be argued, however, that some of the methods established by Salmon and his European colleagues, particularly those involving logistical structure, had a lasting impact on the field of military psychiatry. The mechanism for gradual evacuation established by military psychiatrists during the First World War became the standard model of the United States military for the treatment of psychiatric casualties in all of its subsequent, large-scale military engagements of the century.

[23] General John Pershing, quoted in Ibid, 126.

[24] Ibid, 132.

# Military Psychiatry during the Second World War

In the decades between the First and Second World Wars the military and the psychiatric profession devoted little attention to the further development of military psychiatry. Indeed, when the United States began major military operations in 1942-1943 the military psychiatrists serving with the soldiers and Marines utilized many of the methods first practiced during WWI or in some cases simply "rediscovered" the techniques developed by their predecessors.

There were, however, some major differences between the military psychiatry of the First World War and the Second. These changes were largely due to developments within the larger psychiatric profession during the interwar years, changes that subsequently influenced how military psychiatrists approached their field and understood their patients. Perhaps the most significant was the introduction of psychiatric pharmaceuticals to treat the mentally ill. Biomedicine, particularly biochemical reactions in the body, increasingly fascinated psychiatrists in the 1930s. The desire to treat the body instead of the mind manifested in new treatment techniques that involved the use of insulin, barbiturates, electroshock therapy, and even lobotomy. Initially developed to treat schizophrenia, psychiatrists eventually applied these techniques to the aid - or detriment, as some may argue - of many ailments. During WWII psychiatric drugs were used in a variety of capacities to

treat psychiatric casualties, ranging from a small dose of sedative for the mildly agitated soldier to enough insulin to put a man into a medically induced coma. [25]

Military psychiatrists altered not only the way they treated war neuroses, but also the way in which they talked about the condition. The term "psychoneurosis" dropped from the professional vernacular of military psychiatrists in the opening months of American involvement in WWII. War neuroses had earlier been categorized by mental health professionals as a form of psychoneurosis, a reflection of the widely held professional belief that soldiers who experienced a breakdown in combat were predisposed to do so because of some preexisting character or personality defect.[26] As evidence that the discourse on combat trauma was moving outside of just professional circles, soldiers in WWII appropriated the term "psychoneurosis" for their own use. They shortened the word to "psycho," a term that found its way back into the professional discourse amongst mental health practitioners near the front-lines as well as combat troops, much to the dismay of psychiatric professionals. A negative connotation was affixed to the word, resulting in fewer soldiers willing to admit to psychological problems for fear of being ostracized by their comrades. Those soldiers who were willing to seek help felt that they had to display or at the very least pretend to display the "dramatic and bizarre reactions with dissociative or regressive behavior which seemed to portray the fearful plight of the individual unable to cope with the battle conditions."[27] In other words, in order to be removed from battle potentially ill soldiers - and undoubtedly

[25] Ibid, 206-215. See also Binneveld, 73.

[26] Albert J. Glass, "Introduction," in *The Psychology and Physiology of Stress: With Reference to Special Studies of the Viet Nam War,* ed. Peter J. Bourne (New York: Academic Press, 1969), xv.

[27] Ibid, xvi.

some malingerers as well - adopted the actions they considered stereotypical of a "psycho" individual.

Ultimately the term "combat exhaustion" was adopted by professionals and soldiers alike in lieu of outdated phrases like "shell-shock" or controversial language like "psychoneuroses." "Combat exhaustion" was used interchangeably with the phrase "battle fatigue" for the rest of the war. The concept of exhaustion adeptly described the mental and physical stressors encountered by soldiers in the mobile warfare of World War II. Mental health professionals came to believe that warfare characterized by constant movement over long distances, continual physical exertion, lack of sleep, and intense combat could contribute to the mental or physical collapse of even the healthiest soldier.[28]

This subtle change in language also reflected a larger shift in the public and professional perception of the psychological trauma caused by war. David Marlowe argues that "World War II marked an extraordinary paradigmatic shift from a doctrine of vulnerability based upon constitutional and inherited factors to one based almost entirely upon environmental determinacy."[29] At the start of WWII psychiatric professionals as well as the general public believed that only those individuals with weak characters or preexisting conditions were susceptible to a mental breakdown in a combat situation. The sheer volume of psychiatric casualties and the breakdown of soldiers previously decorated for bravery called these views into question early in the war. Before long both military psychiatrists and soldiers subscribed to the belief that "every man has his breaking point," thus even the strongest and bravest soldier could become a psychiatric casualty if subjected to the brutality

[28] Binneveld, 95.

[29] Marlowe, 53.

of war for a long enough period.[30] The change in the professional understanding of combat trauma in turn influenced the popular perception of the condition as well. Men who broke down in combat were no longer considered to be cowards and instead of being treated with derision, they were thought of with pity by civilians back home. Marlowe cites the general response to General George Patton's famous slap of a soldier suffering from battle fatigue as an example of this change in public sympathy. Patton received a strong rebuke from General Eisenhower and was forced to make a public apology as a result of the incident. With so many Americans serving in Europe and the Pacific it is no surprise that the general population took such an interest in the psychiatric discourse on battle fatigue. Many had an emotional investment in the wellbeing of a father, son, brother, or husband overseas and as such they closely followed the newest medical developments.

The experiences of military psychiatrists in World War II led to a profound shift in the professional discourse on war neuroses. Internal predisposition was no longer the deciding factor of who broke down in combat. Instead, medical professionals accepted the notion that external trauma could be a powerful catalyst for short term mental illness. In some ways this shift in the professional understanding of combat trauma foreshadowed coming debates that questioned whether or not trauma could be the instigator of chronic, long-term mental illness. As we shall see in the next section, the military, mental health professionals, and the general public historically ignored the plight of traumatized veterans once a war had ended. This changed, however, during the Vietnam era, in part due to the changes to the professional discourse on combat trauma which developed during and after the Second World War.

[30] Ibid, 54.

## Abram Kardiner and Chronic War Neuroses in the Psychiatric Discourse before the Second World War

During the Civil War military physicians made some effort to treat the soldiers who presented symptoms of what is now understood to be a combat-induced mental breakdown. This attempt at treatment ended, however, once the afflicted soldier left the field hospital. One historian described the consideration given Civil War veterans as, "psychologically wounded soldiers were simply escorted to the gate of the barracks or the military encampment and abandoned to their lot. If they were lucky, they were put on a train with their name and place of residence pinned on their jacket." The military felt no obligation to care for these men, believing them to be cowards or deserters, and civilian physicians - particularly those with little or no training in mental health - expressed little interest in caring for them either. As a result the psychologically wounded Civil War soldier "passed into oblivion."[31]

In the aftermath of the First World War a similar outcome seemed likely. As the armistice approached an American doctor informed Congress that "2,100 of the 2,500 shell-shock patients awaiting return to the United States had been 'restored to normal,'" again indicating the optimistic belief that once a war ended so did all psychological illnesses.[32] For some veterans this may indeed have been the case and upon their return home they no longer

[31] Binneveld, 4.

[32] Shephard, 150.

experienced any mental dysfunction. For many other veterans, however, the psychological issues that first developed in Europe followed them back to their civilian lives.

In the post-war years many veterans petitioned the government for financial relief through federally funded veterans' pensions. This included veterans suffering the continued effects of psych trauma. Unfortunately for these men the psychiatric discourse, which at the time still linked psychological breakdown in war to cowardice and weakness of character, profoundly influenced the construction of the popular conception of psychologically traumatized World War I veterans. According to historian Ben Shephard "increasingly, a moralistic, judgmental tone emerged" in opposition to this particular group of veterans and publically "it was even suggested [they] lacked the will and guts to pull themselves together; they didn't *want* to get better."[33] In light of such beliefs it is not surprising that no large-scale effort developed to help these veterans in the interwar years.

One man, Dr. Abram Kardiner, did attempt to make some sense of the post-war neurotic conditions displayed by some WWI veterans. In 1922 Kardiner began working for a Veteran's Bureau hospital in the Bronx where he encountered hundreds of former American servicemen who served in Europe. Having worked with Sigmund Freud immediately after the war, Kardiner was aware of many of the current trends in psychiatry and the study of war neuroses. However, he was unprepared for the severe symptoms displayed by his patients four, five, and six years after the war's conclusion. Many of his patients remained troubled by their wartime experiences, but some were simply unable to function in a civilian environment.[34]

[33] Ibid, 151.

[34] Ibid, 154-155.

Kardiner witnessed firsthand the lasting effects of trauma on the mental wellbeing of an individual but found little discussion of this topic in the medical literature of the time. In 1941 he published his own findings in a book entitled *The Traumatic Neuroses of War*. Despite its applicability to the U.S military's newest venture into Europe, the work received little attention from professional and nonprofessional circles. Its value was not recognized until the final years of the Vietnam War when the psychiatric profession was scrambling to discover any information on manifestations of chronic war neuroses in Vietnam veterans. Kardiner is credited with creating one of the foundational works on what is now called Post-Traumatic Stress Disorder. Ben Shephard writes of *The Traumatic Neuroses of War*,

> Kardiner's was by far the most sophisticated interpretation of the war neuroses yet offered… In the 1970s, when American medicine was confronted by an epidemic of mental disorders in Vietnam veterans, his book was a bible, almost the only thing the psychiatrist could turn to.[35]

*The Traumatic Neuroses of War* was an important contribution to the professional discourse on combat trauma for four reasons. The first was simply Kardiner's recognition of a void in the post-WWI medical scholarship and his subsequent attempt to provide perspective on what he considered to be a salient topic. He applauded the work of WWI military psychiatrists on the "psychopathology, treatment, and the complicated forensic issues" of war neuroses but he lamented that "the conclusions of this work did not get much attention, and hardly influenced the conception of the peacetime traumatic neurosis, which is the same in structure as those precipitated in war."[36] Reflecting upon the approaching war

[35] Ibid 156-157.

[36] Abram Kardiner, *The Traumatic Neuroses of War* (New York: Harper & Brothers, 1941), v.

and already cognizant of the aerial bombardments of large European cities Kardiner hypothesized that "traumatic neurosis is now no longer likely to be confined to combatants" and as a result the condition "bids well to be one of the commonest neurotic disturbances in the world." He argued the mental health community could no longer ignore the complexity of war neuroses as it had done for the past thirty years.[37]

The second reason Kardiner's work was significant was due to its sophisticated synthesis of the existing research on combat neuroses and Kardiner's own insights into the symptomatology of the condition, particularly as it related to the realities of modern warfare. He cautioned that "the use of high explosives, gas, submarine, airplane makes the dangerous situations in modern warfare more frequent and more difficult to escape,"[38] resulting in a greater incidence of psychological breakdown. His warning would prove prescient when, in the wake of WWII, many psychiatrists encountered civilians with symptoms of a traumatic neurosis.

Kardiner also challenged the present psychiatric discourse on combat trauma through his decision to address chronic war neuroses. He did this by relating his professional observations to the concurrent national conversation on compensation for wounded veterans. "The importance of this neurosis" he wrote, "is due, not only to the severe incapacities which result from it, but also to the many and complicated forensic problems which it brings in its wake." He concluded that "the chief of these is the problem of compensation and the management of the veteran with such a neurosis."[39]

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[37] Ibid.

[38] Ibid, 69.

[39] Ibid, 3.

At first glance it would seem as though Kardiner's opinion towards the sufferers of what he called "persistent traumatic neurosis" mirrored the unfavorable opinion held by many professionals and non-professionals before the Second World War. In reference to war veterans afflicted by a lingering psychological condition he wrote "The victims are a social problem because there are difficulties of rehabilitating them to become socially independent individuals." As this statement reveals, however, Kardiner considered sufferers of a chronic traumatic neurosis - whether they be civilian or veteran - victims. He took issue with the pervasiveness of vague words like "hysterical" or "functional" in the national discourse on traumatic neuroses, words he considered indicative of the stereotype of the neurotic as a "predatory individual." His research led him to believe that "many aspects of the traumatic neurosis which become social problems are of such character as can be prevented by good medical practice." In other words, "the neurosis is curable" and the current sufferers of prolonged traumatic neurosis were victims of a disorganized and inadequate medical system.[40]

In anticipation of the approaching war Kardiner advocated for a better understanding of the psychopathology of traumatic neurosis, immediate treatment of psychiatric casualties, and the permanent removal of such casualties from the line of battle. He believed with the implementation of these measures that most instances of long-term traumatic neurosis could be prevented, thereby reducing the need for compensation. He still considered it likely that some veterans would suffer from the long-term effects of combat trauma, in which case he suggested that compensation only be given to "those cases proven to be incurable after treatment for two or three years."

[40] Ibid, 234-235.

Kardiner's argument that a person's environment could influence his or her mental health was also indicative of a shift in thinking that began to occur in the psychiatric profession during the 1940s.[41] On the one hand he, like his colleagues, maintained the belief that individuals who suffered from traumatic neuroses did so because they were predisposed to the condition. Early in the work he stated "modern war has introduced certain conditions conducive to neuroses in those so predisposed." At the same time he and other psychiatrists who worked with combat veterans, began to question whether or not external factors could influence the development of the illness. Kardiner acknowledged the potential for external factors to affect the mental health of combatants when he theorized that "the war situation definitely contributes to the frequency of incidence of traumatic neuroses and allied diseases."[42] Finally at the end of the work he concluded "it must be empathically stated that predisposition alone cannot produce this disease. It always needs a violent precipitating factor and only the confluence of both factors can create a traumatic neurosis."[43] *The Traumatic Neuroses of War* was not widely read until decades later and Kardiner alone cannot be credited with initiating a shift in the professional discourse. However, his work should be considered an excellent example of the gradual way in which a new understanding began to develop in the 1940s.

Abram Kardiner's *The Traumatic Neuroses of War* had no immediate effect on the contemporary discourse. Its only mention in the psychiatric profession came in the form of a single review in the *American Journal of Psychiatry*. In the review Dr. Harry Steckel of the

[41] With the support of men like William and Karl Menninger and their research on military psychiatry and WWII veterans, this would become the dominant trend in mental health in the 1950s and 1960s.

[42] Ibid.

[43] Ibid, 238.

Syracuse Psychopathic Hospital called it a "most valuable treatise on a timely subject." Steckel's review focused largely on Kardiner's discussion of the psychopathology of traumatic neurosis, but did include some mention of Kardiner's conjectures on the causes of the condition as well.

The way in which Steckel discussed Kariner's theories demonstrated a desire to try and mold Kardiner's work into the dominant professional discourse of the time, namely that traumatic neurosis was an inherent condition and combat neurosis in particular was most often suffered by those with either a predisposition to the illness or a weak character. For example, when it came to book's hypothesis on environmental stimuli, Steckel mentioned it only briefly, first stating that Kardiner's "approach is made on the premise of a functional rather than an organic etiology," but then he quickly added that Kardiner also "admitted that 'many factors may contribute to the formation of the traumatic syndrome, organic lesions, self-preservation interests and conflicting ideals.'"

When the review turned to Kardiner's theories on chronic traumatic neurosis, it was more of the same. Steckel again mentioned the author's strong belief in external influences, "Regarding the course of the disorder Dr. Kardiner observes that it 'is influenced not only by intrapsychic factors but by a large number of external ones.'" But instead of mentioning the myriad of external factors given by Kardiner through the course of the book Steckel followed this quote only with Kardiner's statement that traumatic neurosis "'is likely to be chronic if it serves the patient the use of a secondary conscious or unconscious gain," after which Steckel added "There can be no disagreement on this score, I am sure." Such a statement implied strong support for the common belief that all sufferers of chronic traumatic neurosis were malingers or "predatory individuals," an understanding which Kardiner believed to be

incorrect. No mention is made in Steckel's review of Kardiner's certainty that a disorganized medical system was actually to blame for much of the chronic neuroses he witnessed. The review, while positive overall, did not indicate widespread acceptance of Kardiner's arguments nor any alteration in the dominant beliefs of the professional discourse at the time.[44] The impact of Abram Kardiner and his research would have to come later.

[44] Harry A. Steckel, "Book Review," Review of *The Traumatic Neuroses of War*, by Abram Kardiner, *American Journal of Psychiatry* 98 (Jan, 1942): 624. *The Traumatic Neuroses of War* also received a positive review from sociologist Kimball Young of Queens College. Unlike Steckel, Young applauded Kardiner's inclusion of external influences on mental health, writing "Social psychologists and sociologist, for the most part, are pleased to know that psychiatrists, and especially psychoanalysts, are coming to recognize the importance of the social and cultural conditioning upon the growing individual." He then chastised the rest of the psychiatric community for their "amazing lack of understanding on the importance of interaction in the whole developmental process." Sociology at this time was evidently moving in a direction that psychiatrists such as Kardiner wished to follow. Kimball Young, "Book Review," Comparative Review of *The Neuroses in War* edited by Emanuel Miller and *The Traumatic Neuroses of War* by Abram Kardiner, *American Sociological Review* 7, No. 3 (June 1942): 453-454.

## The Professional Discourse on Acute and Chronic Psychological Trauma in the Post-WWII Era

In the years immediately following the Second World War the mental health community, as well as the military, made a greater effort to understand acute combat neuroses as well as the long-term suffering experienced by many veterans. This was accomplished in two ways, through the study and treatment of chronic war neurosis in WWII veterans and the practice of military psychiatry in the Korean War. In 1945 the Veterans' Administration (VA), under the administration of General Omar Bradley, began a massive overhaul in anticipation of the flood of new veterans. This remodeling placed special emphasis on creating space for neuropsychiatric patients. By 1950 almost half of the Veterans' Administration's 124,158 beds were taken up by veterans suffering from neuropsychiatric illnesses. The VA anticipated that the number of neuropsychiatric patients would rise to almost 112,000 by 1975, the majority of whom would need long term hospitalization.[45]

Psychiatrists also studied the continued manifestation of combat trauma in former soldiers. In 1945, Roy R. Grinker and J.P. Spiegel published *Men Under Stress*, an analysis of the psychological breakdown amongst a group of American airmen during their time in Europe and once they returned to the United States.[46] Abram Kardiner also published an

[45] Roy R. Kracke, "The Medical Care of the Veteran," *The Journal of the American Medical Association* 143, No. 15 (1950): 1325.

[46] R. R. Grinker and J. P. Spiegel, *Men Under Stress* (London: J & A. Churchill, Ltd., 1945).

additional work on war neurosis in 1947, *War Stress and Neurotic Illness*. These two works would prove to be very influential to the future professional discourse on chronic war neuroses.

In 1951 Samuel Futterman and Eugene Pumpian-Mindlin presented a paper entitled "Traumatic War Neuroses Five Years Later" at the annual meeting of the American Psychiatric Association. In this paper - later published as an article in the *American Journal of Psychiatry* - Futterman and Pumpian-Mindlin described how "even at this late date, 5 years after the end of the war, we still encounter fresh cases [of traumatic war neuroses] that have never sought treatment until the present time."[47] Much like Kardiner, whom they cited in the article, Futterman and Pumpian-Mindlin argued that "it is apparently necessary to have a combination of accidental circumstance superimposed upon a receptive soil in order to precipitate an overt, chronic traumatic war neurosis."[48] In other words, a combination of predisposition and environmental factors determined which soldiers would be affected by a long-term psychiatric condition. What exactly "predisposition" looked like remained elusive. The authors of this paper admitted, "Our material does not clarify the problem of what specific character structure predisposes to war neurosis." Their research did allow them to suggest that patients who were generally thought to be outgoing prior to their traumatic experience should be given different forms of therapeutic treatment than those thought to

[47] Samuel Futternman and Eugene Pumpian-Mindlin, "Traumatic War Neuroses Five Years Later," *American Journal of Psychiatry* 108 (1951): 401. A second follow-up study was published in the *American Journal of Psychiatry* in 1962. Herbert Archibald, et al., "Gross Stress Reaction in Combat - A 15-Year Follow-Up," *American Journal of Psychiatry* 119 (1962): 317-322. Archibald et al. made no new observations than those seen in the Futtermman and Pumpian-Mindlin article. They concluded that additional, long-term research into this "severely disabling condition" was needed.

[48] Ibid, 402.

have been more introverted before the manifestation of their condition.[49] As evidence of the effects of environmental factors Futterman and Pumpian-Mindlin also observed an increased number of WWII veterans seeking treating following the outbreak of the Korean War in the summer of 1950 and noted "a number of our cases that had previously improved under treatment returned with a reactivation of their symptoms."[50]

Articles such as this suggest that after WWII the psychiatric community was more accepting of the notion that chronic war neuroses were the result of predisposition and environmental factors working in tandem. As mental health professionals conducted additional research it became more and more evident that outside stimuli could no longer be ignored when talking about any psychological condition. The terms "reaction" and "stress" became more common in the professional discourse during the 1950s and 1960s, indicating a shift in perceptions about the cause of mental illness.

The mobilization of the United States military once again shifted the focus of military psychiatrists and the psychiatric community from chronic war neuroses to the immediate psychological trauma caused by combat. However, when the U.S began full-scale military operations on the Korean Peninsula in 1950, military officials initially failed to utilize the extensive knowledge on combat psychiatry gained during the previous two wars. The reasons for this delay of large scale military psychiatric services are unclear, but it demonstrated yet again the tendency for advances in combat psychiatry to be implemented only after the start of a conflict and the accrual of many psychiatric casualties.

[49] Ibid, 408.

[50] Ibid, 401.

In the opening months of the war approximately ten-percent of American soldiers, in either combat or non-combat roles, required evacuation for psychiatric disorders.[51] Faced with such an alarming number of casualties, military commanders and the mental health community finally took steps to introduce military psychiatrists into the Korean Theater. Psychiatrists were soon placed at the division level - a technique already known to be effective from prior experience during WWI and WWII. Perhaps more importantly, medical officers working in either regimental or battalion aid-stations were educated to recognize combat stress and encouraged to treat any potential psychiatric casualties as close to the frontlines as possible. During WWII mental health professionals discovered the value of treating psychiatric casualties close to the line of battle because it eliminated the potential for the soldier to associate mental distress with removal from combat and maintained a semblance of connection between the soldier and his unit.[52] By providing frontline medical personnel some rudimentary techniques for treating early signs of psychological distress the needs of both the military and patient could potentially be met.

After implementing these changes the number of psychiatric cases in the Korean Theater began to drop significantly. In 1951 the percentage of soldiers evacuated for psychiatric treatment fell to five-percent and by the end of combat operations in 1953 the

[51] Frank A. Reister, *Battle Casualties and Medical Statistics: U.S. Army Experience in the Korean War* (Washington, D.C.: Department of the Army, 1973), 117. In the months of July through December 1950 there were approximately 3,470 recorded admissions due psychiatric disorders. Resiter calculates this to be 99.04 soldiers per year per 1,000 average strength. "Admissions" were defined as "instances of medical treatment given on an 'excused-from-duty' basis," such as patients treated in hospitals or aid-stations. It is likely that many more men suffered from combat related psychological trauma and were not given the designation "excused-from-duty." Therefore, it is possible that the number of soldiers experiencing combat stress during the opening months of the Korean War was significantly higher than officially reported.

[52] Shepard, 342.

number was smaller than two-percent.[53] Such a drastic reduction in the number of psychiatric casualties can be attributed to the military's adoption of more effective combat psychiatry techniques, though the changing combat conditions of the Korean War must be considered as well. Nonetheless, many professionals recognized that a large number of these psychiatric casualties could have been prevented if the mechanisms for treatment had been established much earlier in the war. Thus, when the United States took a more active role in Southeast Asia in the early 1960s many of these psychiatric procedures, developed in WWII but perfected in Korea, were mobilized with greater speed.

Despite the large number of WWII and Korean War veterans likely suffering from chronic combat neuroses, the professional discourse on the trauma of war was somewhat limited in the years leading up to U.S. involvement in Vietnam. For a number of years the *American Journal of Psychiatry* published an article every January that summarized the work done on military psychiatry during the previous twelve months. From these annual summaries the disparate directions of the professional discourse in the early 1960s can be discerned. For example, the applicability of military psychiatry to space exploration were one area of concern in 1959, as well as the mental health of soldiers and sailors relegated to a military stockade or brig for an extended period of time.[54] Other themes in the professional discourse, evident in these summary articles as well as articles published in the *American Journal of Psychiatry* itself, included the role of psychiatrists in a military setting, the often difficult relationship between the soldier and the mental health provider, the logistics of

[53] Reister, *Battle Casualties and Medical Statistics,* 117.

[54] Joseph Skobbra, "Military Psychiatry," *American Journal of Psychiatry* 116 (1960): 651-653.

record keeping, and critiques of the medical education of military psychiatrists.[55] The desire of the psychiatric profession to understand the field of military psychiatry as well as place it within dialogue with the larger study of mental health is apparent in the number and variety of articles published in the leading journal of the discipline. The research conducted by mental health professionals in the post-Korean War era led to a much more complex and multifaceted knowledge of military psychiatry than had existed at the beginning of the twentieth-century. However, exploration into the long-term effects of combat on the mind remained limited.

One of the most prevalent topics of discussion in the psychiatric discourse during the early 1960s was the importance of preventative psychiatry in the military as a means to both avert war neurosis but also, to maintain the fighting strength of the American military.[56] It was within this avenue that the discussion of chronic war neurosis often reemerged. In 1961 Dr. Albert Glass, a military psychiatrist with service in the Korean War, and three other high-ranking military psychiatrists published a state of the field piece that addressed the role of preventive psychiatry in the Army. According to Glass, et al. "the Army psychiatric program has made significant contributions towards achieving the lowest recorded psychiatric hospitalization and medical discharge rates, and a marked reduction of the Army prisoner

[55] See: Ingram Cohen, "The Isolated Psychiatrist in a Military Setting," *American Journal of Psychiatry* 119 (1962): 571-572.; L. James Grold and William G. Hill, "Failure to Keep Appointments with the Army Psychiatrist: An Indicator of Conflict," *American Journal of Psychiatry* 119 (1962): 446-450.; J. Thomas Ungerlieder, "The Army, the Soldier and the Psychiatrist," *American Journal of Psychiatry* 119 (1963): 875-877.; For a response to Underlieder's article see Heber S. Hudson, "Letter to the Editor," response to "The Army, the Soldier and the Psychiatrist" by J. Thomas Ungerliender, *American Journal of Psychiatry* 120 (1963): 509-510.; Stephen J. Barrett, "Psychiatric Record-Keeping in the Military," *American Journal of Psychiatry* 120 (1964): 887-889.; William J. Dickerson, "Teaching Psychiatry in a Military Setting," *American Journal of Psychiatry* 119 (1963): 1082-1086.

[56] For further discussion on preventative psychiatry in the military, including reevaluations of training programs and the extension of psychiatric services within the military system see: Joseph Skobbra, "Military Psychiatry," *American Journal of Psychiatry* 117 (1961): 651-653; Joseph Skobbra, "Military Psychiatry," *American Journal of Psychiatry* 118 (1962): 644-646.

population."[57] They attributed these results to a three-level preventative system in which military psychiatrists worked closely with soldiers in a military setting instead of in a hospital or clinic. They also argued that "the employment of milieu as the principal therapeutic tool for persistent and severe mental disorders" had the potential "to reduce chronic disability and produce a sufficient degree of rehabilitation so that favorable cases can be returned to effective military duty."[58] In the early 1960s persistent traumatic neuroses while not frequently discussed in medical circles, did remain an area of interest and concern for some psychiatrists, both civilian and military.

The beginning of the 1960s also witnessed a growth in research into chronic mental illness related to noncombat situations. These works challenged the current psychiatric discourse which maintained that long-term mental illness in the survivors of traumatic events was likely the result of either two things: predisposition or the desire for monetary compensation. In 1963 Drs. Robert Leopold and Harold Dillon published "Psycho-Anatomy of a Disaster: A Long Term Study of Post-Traumatic Neuroses in Survivors of a Marine Explosion" in which they analyzed data "pertinent to the psychological effects of sudden, life-endangering trauma" in the hopes of determining "useful theoretical formulations with regard to the short term and long term psychological effects of sudden life-endangering trauma."[59] In March 1957 a gasoline tanker named *Mission San Francisco* collided with a freighter, the *Elna II*, in the Delaware River. Ten men were killed, including the captain of the *Mission San Francisco*, and many of the survivors were forced to abandon ship. At the

[57] Albert Glass, et al., "The Current Status of Army Psychiatry," *American Journal of Psychiatry* 117 (1961): 683.

[58] Ibid, 673-674.

[59] Robert L. Leopold and Harold Dillon, "Psycho-Anatomy of a Disaster: A Long Term Study of Post-Traumatic Neuroses in Survivors of a Marine Explosion," *American Journal of Psychiatry* 119 (1963): 913, 918.

request of the National Maritime Union Leopold and Dillon interviewed twenty-seven survivors of the *Mission* crew within forty-eight hours and thirteen days of the collision. Twenty-five of these men were reexamined by Leopold and Dillon between three and a half and four and a half years later.

Leopold and Dillon considered the case study of the *Mission* crew especially useful for the study of post-traumatic neuroses for three reasons. First, the men had all experienced the same traumatic event that could act as a common baseline from which to study different reactions. Second, none of the victims had received any kind of psychotherapy in the interim three or four years and therefore, any instances of emotional adjustment would have been achieved "without the potentially ameliorating effects of therapy." Finally, the circumstances of the litigation were such that the victims could not expect to receive significant compensation for the display of any debilitating mental illness.[60] Thus, Leopold and Dillon concluded that monetary gain could not be a motivating factor behind any claims of continued emotional distress.

Leopold and Dillon observed that among the thirty-four seamen they interviewed "the amount of psychological deterioration that took place between 1957 and 1960/1 was impressive." At least twenty-six men had sought help for psychiatric complaints and of these twenty-six, twelve survivors had to be hospitalized for brief periods of time.[61] Only eighteen of the men were able to return to work at sea and all admitted to feeling "tense, anxious, nervous, and fearful aboard ship." In addition to these eighteen men, twelve of the survivors

[60] Ibid, 913.

[61] Ibid, 915.

had tried to return to maritime employment, but ultimately their psychological state forced them to seek jobs on land.[62]

Based upon their interviews of the survivors of the *Mission San Francisco* Drs. Leopold and Dillon concluded that "psychological damage incurred in life-threatening trauma, if untreated, tends to grow worse with time."[63] This understanding led them to make an important critique of the doctrine currently adhered to by so many of their colleagues, that traumatic events could not be the cause of a chronic mental illness:

> The psychiatric community as a whole has failed to recognize the significance of the nature of the accident itself, and particularly its suddenness, in the development of post-traumatic states. For reasons not entirely clear, it appears more usual [within the mental health community] to regard the pre-accident personality as a major factor, and to relegate the accident itself to the role of a mere triggering circumstance which sets off an illness considered almost certain to have occurred in any case.[64]

In an effort to better understand the condition and those claiming to suffer from it, Leopold and Dillon made the recommendation that post-traumatic neuroses be given their own diagnostic category. These categories would be "unique" because of the "cognizance they give to the role of the accident itself in producing a discrete illness." In other words, new terminology was necessary in order to spur official recognition of a condition that "in all likelihood, would not have occurred had there been no accident."[65]

Mental health professionals in the United States and Europe were also drawing conclusions about the possible connection between traumatic events and long-term mental illness through interviews conducted with survivors of Nazi extermination camps. Abram

[62] Ibid, 917.

[63] Ibid, 919.

[64] Ibid, 920.

[65] Ibid.

Kardiner's grim prediction in 1941 that traumatic neuroses would no longer be confined to a war's combatants was realized in the form of thousands of men and women seeking psychiatric assistance decades after the fall of the Nazi regime.

In the early 1960s a series of articles discussing what was termed "concentration camp syndrome" appeared in the *Archives of General Psychiatry*. The wide array of conclusions found within these articles offers a telling picture of the various opinions within the psychiatric profession about the effect of trauma on the mind. For example, Dr. Leo Eitinger's study of one hundred Norwegian concentration camp survivors led him to conclude that in most cases the symptoms described by the survivors could be attributed to organic changes in the brain caused by "mechanical and toxic injuries as well as by starvation and exhaustion."[66] After extensive interviews with twenty-three repatriated European Jews, Dr. Paul Chodoff argued however, that organic brain disease, such as that proposed by Eitinger, could not account for the behavior displayed by his patients.[67] Chodoff instead attributed their current condition to "the stress imposed by the Hitler regime," stress which produced a neurotic state he likened to the one displayed by soldiers suffering from battle fatigue. [68]

By making this connection between the symptoms displayed by combat veterans and survivors of the Holocaust, Chodoff was able to note a difference in the way the psychiatric profession approached these to seemingly similar conditions of battle neuroses and "concentration camp syndrome." He stated early in his article that "the principal paradigm of

[66] Leo Eitinger, "Pathology of the Concentration Camp Syndrome" *Archives of General Psychiatry* 5 (1961): 378.

[67] Paul Chodoff, "Late Effects of the Concentration Camp Syndrome," *Archives of General Psychiatry* 8 (1963): 328-329.

[68] Ibid, 332, 329.

the traumatic neurosis is the war or battle neuroses" and cited both Abram Kardiner's *Traumatic Neuroses of War* and Roy Grinker and J.P. Spiegel's *Men Under Stress* as evidence of the current scholarship on the condition. This recognition of the applicability of earlier studies of combat trauma to the understanding of "concentration camp syndrome" is largely absent in other works. By making this comparison Chodoff was able to highlight an important deviation between the way psychiatrists were treating the etiology of "concentration camp syndrome" and the way they conceptualized the foundations for a traumatic neuroses caused by war. "Most recent theories of the traumatic battle neurosis pay great attention to the precipitating stress" wrote Chodoff and he noted similar attention was granted to the precipitating stresses in the symptoms identified in concentration camp survivors. A dichotomy developed, however, when psychiatrists sought the etiological foundations of each condition. With regards to combat neuroses Chodoff argued that members of the psychiatric community "attribute etiological importance to preexisting personality factors which may provide a 'specific emotional vulnerability.'" This was in contrast to the research produced on concentration camp survivors where "in none of the articles on [concentration camp syndrome] have premorbid, predisposing personality factors been considered to be of importance."[69]

Based upon his experience with victims of the Holocaust, Chodoff was more inclined to believe that predisposition had little to do with whether or not a concentration camp survivor would develop a chronic condition as a result of his or her traumatic experience. "When one considers the intensity of the stress undergone by these patients," he stated, "there seems little necessity to postulate any preexisting personality weakness or

[69] Ibid, 327.

predisposition."[70] Leo Eitinger also discounted the potential influence of predisposition in his study as well, citing a lack of evidence to prove a significant connection.[71] Chodoff, however, took this conclusion a step further and asked his colleagues to consider whether or not "psychiatry has gone too far in its at least implied insistence that every state of emotional illness must result from the impact of a trauma on a personality somehow predisposed to react adversely to the trauma." It was his opinion that case studies such as those presented by concentration camp survivors had to be considered before "such explanations can be regarded as universal" in the psychiatric community.[72] In this way Chodoff's recommendations are in line with those proposed by Leopold and Dillon after their own study of survivors of a traumatic event.

It is evident that at the outset of the Vietnam War little consensus about persistent traumatic neuroses existed amongst mental health professionals. Many questions still needed to be addressed. Was a chronic reaction to a traumatic event possible or were victims simply trying to collect compensation? If the illness was real, were those who suffered from the condition predisposed to mental illness? Should traumatic neuroses, persistent or otherwise, be given their own diagnostic category? What methods of treatment were most suitable for those individuals who presented symptoms of the condition? Psychiatrists would face all of these questions again when the Vietnam War produced a new crop of individuals presenting symptoms of traumatic neuroses.

[70] Ibid, 327-328.

[71] Eitinger, 376.

[72] Chodoff, 327.

**Military Psychiatry in Vietnam: "Guardians of a Painful Reality" or the "Psychiatry of the Executioner"?**

With American military involvement in Vietnam the psychiatric community once more mobilized to assist the United States military in the treatment and prevention of acute combat neuroses. Military psychiatry in the three previous conflicts was marred by the delayed deployment of psychiatric professionals and a failure to utilize the techniques developed during earlier wars. In Vietnam, however, the early statistics seemed to indicate that military psychiatry had finally achieved some measure of success in their goal of preventing and treating acute combat neuroses. But in the politically charged atmosphere of the late 1960s some psychiatrists began to question the ethics of military psychiatry and the role of the mental health community as a participant in war. Psychiatrists began to ask themselves, who would truly benefit from a psychiatrist's ability to treat or even prevent acute combat neuroses, the soldier-patient or the military? If a soldier could be made to withstand the horrors of combat was this actually a benefit to his mental health? The professional discourse on combat neuroses took on new dimensions during the Vietnam War. There was success to be celebrated in the seemingly effective techniques for preventing and treating combat neuroses. But mental health professionals also questioned their relationship to the military and its goals.

In July of 1965 President Lyndon Johnson ordered 50,000 American ground troops into Vietnam, effectively changing the role of U.S. soldiers and Marines from advisors to

combatants in the war against Communist North Vietnam.[73] By December 1965 there would be approximately 180,000 American military personnel in Vietnam. In 1966 that number would rise to 280,000 before reaching a peak of 543,000 in June of 1969. American forces suffered approximately 36,000 casualties during 1966, including 5,008 fatalities. By the time of the first significant drawdown of forces in 1969 the Department of Defense would report approximately 301,400 American casualties since the beginning of U.S. involvement in 1961. This included some 40,000 servicemen killed and 1400 either missing or captured.[74] All told, approximately 8.7 million Americans saw service in the Vietnam War during the years of 1964-1973, second only to the number of men and women who served during WWII. 57,702 men and women lost their lives in Vietnam during this same period - 47,253 in combat operations - and 313,616 were reported as wounded.[75]

Unlike their delayed involvement in Korea, the U.S. military inserted military psychiatrists into Vietnam with the first significant wave of combat troops in 1965. Between 1965 and 1970 there were, on average, three psychiatrists, two psychiatric social workers, and twelve enlisted mental health specialists for every 50,000 Army troops in Vietnam. These mental health personnel were deployed to different regions throughout South Vietnam where they served either as a part of a division mental health team, in a hospital, or as a member of one of two neuropsychiatric special treatment teams. Approximately one-half of

[73] George C. Herring, *America's Longest War: The United States in Vietnam 1950-1975* (New York: McGraw-Hill, 1986), 141.

[74] John S. Bowman, *The Vietnam War: An Almanac* (New York: World Almanac Publications), 158, 246.

[75] Ibid, 358.

the mental health workers who served in Vietnam were deployed in echelons farther forward than a hospital.[76]

The treatment of psychiatric casualties in Vietnam incorporated many of the techniques developed and perfected by military psychiatrists in previous wars, including treatment close to the front lines and tiered levels of evacuation. In an ideal situation the treatment of a neuropsychiatric casualty in Vietnam would appear as follows. A soldier displaying signs of mental distress would be referred by his commanding officer or platoon medic to the division's mental hygiene team. Each division in Vietnam was supplied with one psychiatrist, one psychiatric social worker, and between six and ten enlisted mental health technicians. The afflicted soldier would be interviewed by the enlisted technician who would then recommend an initial course of action. This might involve medication given by the general medical officer, a private conversation with the man's immediate superior or possibly his friends, or the technician might decide the case was beyond his capability and recommend that the patient return to limited duty until evaluated by the division psychiatrist.[77]

[76] Edward M. Colbach and Matthew D. Parrish, "Army Mental Health Activities in Vietnam: 1965-1970," *Bulletin of the Menninger Clinic* 34 (1970): 333-334. At the time this article was published Colonel Parrish was serving as Chief, Psychiatry and Neurology Consultant Branch of the Office of the Surgeon General. Major Colbach was the Assistant Psychiatric Consultant. Additionally, each man had served in Vietnam, Colonel Parrish as the Consultant in Psychiatry in Vietnam from 1967-1968 and Major Colbach from 1968-1968 as the Chief of Psychiatry at the 67th Evacuation Hospital in Qui Nhoun.

[77] Ibid, 335. Mental health technicians in Vietnam were usually college graduates who subsequently received 360 hours of additional training in developmental psychology and aspects of psychiatric diagnosis. On occasion enlisted men who met basic educational requirements and displayed aptitude for mental health work while in Vietnam were appointed as mental health technicians without completing the 360 hours of training. Given their proximity and close connection to combat personnel, mental health technicians were often considered to be the primary purveyors of preventative psychiatry in Vietnam. For more information regarding the education of mental health technicians and their role in a division's psychiatric services see: Douglas Bey, "Mental Health Technicians in Vietnam," *Bulletin of the Menninger Clinic* 34 (1970): 363-371.

The division psychiatrist, responsible for anywhere between 15,000 and 20,000 men often spread over hundreds of miles of rough terrain, cycled between various outposts via jeep or, when available, helicopter. If the division psychiatrist deemed the soldier's condition to be severe enough the soldier would be sent to either the division's clearing hospital for brief hospitalization or possibly for further evaluation at one of the larger 200-400 bed hospitals found throughout Vietnam.[78]

The final stop for a soldier who resisted all other treatment was to one of the two neuropsychiatric specialty teams located in either the northern or southern area of operations. Referred to as KO Teams because of their Army code designation, they were usually comprised of a large, specialized group of mental health professionals that included psychiatrists, social workers, a clinical psychologist, psychiatric nurses and as many as two dozen enlisted men. Each KO Team was attached to a hospital where they operated an inpatient psychiatric ward capable of handling up to thirty patients for thirty days. With few exceptions, only the psychiatrists of KO Teams had the power to evacuate a psychiatric casualty from Vietnam to Japan.[79]

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[78] Colbach and Parrish, 335. For a better understanding of the division psychiatrist's role see Douglas Bey's memoir *Wizard 6: A Combat Psychiatrist in Vietnam*. Bey served as the division psychiatrist for the 1st Infantry Division from 1969 to 1970. Douglas Bey, *Wizard 6: A Combat Psychiatrist in Vietnam* (College Station: Texas A&M University Press, 2006).

[79] Colbach and Parrish, 335-336. A similar description of the chain of evacuation for psychiatric casualties can be found in H. Spencer Bloch, "Army Clinical Psychiatry in the Combat Zone - 1967-1968," *American Journal of Psychiatry* 126 (1969): 289-298. Bloch also describes his experience as a psychiatrist working with one of the two KO neuropsychiatric teams. At least one psychiatrist who served in Vietnam during the initial build-up of U.S. troops questioned the quality of medical personnel being deployed to Southeast Asia, particularly psychiatrists. Dr. Robert Huffman, who served as an Army psychiatrist in Vietnam from May 1965 to April 1966, considered himself to be "unsophisticated about psychological observations and practices in… combat situations" given that upon his arrival in Vietnam he had only "just completed an on-the-job training course of fourteen weeks in psychiatry." He identified a similar lack of experience in his colleagues, noting that a career Army psychiatrist was a rarity in the mid-1960s and therefore, most psychiatrists deployed to Vietnam in the initial months were "very recently drafted from civilian training of widely varying duration and quality." Robert E. Huffman, "Which Soldiers Break Down: A Survey of 610 Psychiatric Patients in Vietnam," *Bulletin of the Menninger Clinic* 34 (1970): 343-344. The extent to which Huffman's observations reflect the education and recruitment status of Army psychiatrists in later years of the

The initial neuropsychiatric casualty statistics reported by military psychiatrists in Vietnam were very positive. In 1965 only 1.17% of U.S soldiers in Vietnam required admittance into an Army hospital for neuropsychiatric casualties, compared to 6.16% of soldiers who were admitted for combat wounds or the 3.31% who were admitted to the hospital with a skin disease. In 1966 the number of psychiatric admissions rose to 1.23% before falling to a low of 1.05% in 1967. After 1967 the percentage of soldiers hospitalized for a psychiatric condition began to rise again, but remained at about 1% until 1970.[80]

Professional works on combat neuroses that appeared in the early years of the war described the same success reflected by the Army statistics. In "The Mental Health of Army Troops in Viet Nam" Colonel William J. Tiffany, a psychiatrist serving in the Medical Corps, proudly announced that "the incidence of neuropsychiatric illness in U.S. Army troops in Viet Nam is lower than any recorded in previous conflicts." He went on to cite marked improvement over earlier wars, noting that during the Second World War "23 percent of all

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war is unclear. Medical personnel were not exempted from the draft and as a result, many of the men who served as military psychiatrists in Vietnam did not do so by choice. Unfortunately, only limited statistics on the average education of Army psychiatrists are readily available. In 1966 the Chief of Psychiatry for the Surgeon General stated there were 227 clinical psychiatrists in the United States Army serving in both the United States and Vietnam. Of these 227 clinicians, 18 had achieved a board certification in psychiatry, 127 had completed their training but lacked board certification, and 32 had partial training in psychiatry and had not yet completed the three years of formal training needed for board certification. William J. Tiffany, "Army Psychiatry in the Mid-1960s," *American Journal of Psychiatry* 123 (1967): 811. In recognition of the need for psychiatrists the U.S Army created an "On-The-Job-Training-Program" to train drafted physicians in the techniques of psychiatry. For a description of this program see: Louis Bozzetti, "The Army and the Untrained "Psychiatrist," *American Journal of Psychiatry* 123 (1967): 825-828.

[80] Spurgeon Neal, *Medical Support of the U.S. Army in Vietnam* (Washington, DC: The Department of the Army, 1973): 36. I calculated these percentages through a conversion of the data provided by Neal. For example, he reports that in 1965 11.7 soldiers per annum per 1,000 strength were hospitalized for a neuropsychiatric condition. This is approximately 1.17%. It should be noted that under the guidelines of the chain of evacuation, only the most severe psychiatric casualties were ever hospitalized. Undoubtedly many more soldiers presented symptoms of combat trauma and were treated without hospitalization, either by a general medical officer or a division psychiatrist. Statistics on such casualties are not readily available and in most circumstances were probably not even gathered. Colbach and Parrish included a similar set of statistics in their article "Army Mental Health Activities in Vietnam: 1965-1970". Their numbers were slightly different but still reflected psychiatric casualties as about 1% of total Army personnel in Vietnam. They considered a psychiatric casualty to be a soldier who missed twenty-four hours or more of duty due to psychiatric reasons. They noted that, "for practical purposes, this is equivalent to hospitalization." Colbach and Parrish, 338.

cases evacuated medically were evacuated for psychiatric reasons," considerably higher than the approximately six percent he identified during the current war in Vietnam.[81] In 1969 Dr. Herbert Bloch published an article detailing his experiences as a psychiatrist in Vietnam and also reiterated the successful implementation of military psychiatric techniques. Bloch noted that this success was in spite of the relatively small number of mental health professionals serving in Vietnam at the time.[82] Spurgeon Neal observed that "contrary to experience in recent wars, neuropsychiatric illness did not constitute a significant problem" and in fact, "until 1970, the rate and types of neuropsychiatric illness approximated those in the United States."[83] Perhaps the most succinct statement came from Edward Colbach and Matthew Parrish of the U.S. Army who stated simply, "the American soldier in Vietnam has generally been psychologically healthier than his counterpart in previous wars."[84] Indeed, given the statistics in the opening years of the war, it seems that few members of the mental health community would have taken issue with the observation made by Army psychiatrist Dr. Larry Morris, that "psychiatrically speaking then, a year in Vietnam is not perilous."[85]

Mental health professionals attributed the early success of military psychiatry in Vietnam to a variety of things. Peter G. Bourne, a psychiatric researcher who spent time in Vietnam with the Walter Reed Army Institute of Research, argued that the potential reasons

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[81] William J. Tiffany, "The Mental Health of Army Troops in Vietnam," *American Journal of Psychiatry* 123 (1967): 1585-1586.

[82] H. Spencer Bloch, "Army Clinical Psychiatry in the Combat Zone - 1967-1968," *American Journal of Psychiatry* 126 (1969): 289-298. A similar observation was made by Douglas Bey in his 1970 article: Douglas Bey, "Division Psychiatry in Viet Nam." *American Journal of Psychiatry* 127 (1970): 228-232.

[83] Neal, 172.

[84] Colbach and Parrish, 339.

[85] Larry Morris, "'Over the Hump' in Vietnam: Adjustment Patterns in a Time-Limited Stress Situation," *Bulletin of the Menninger Clinic* 34 (1970): 359.

for low psychiatric casualties could be placed into two categories: the nature of the fighting in Vietnam and the manner in which troops prepared for their service in Southeast Asia. The high instance of acute combat neuroses in previous wars, Bourne hypothesized, was caused by "situations where there [were] fixed lines of defense and the defenders [were] subjected to constant enemy bombardment for weeks at a time without effective ways to retaliate." He observed that this was not the case in Vietnam, a war he considered to be "above all else a moving war" characterized by only brief contact with the enemy. Bourne also believed that the soldiers fighting in Vietnam, unlike their predecessors in earlier wars, had been given the best training and equipment with which to enter battle, allaying some of their fears and allowing each soldier to develop "confidence in his ability to survive the vicissitudes of war."[86] In their article, Colbach and Parrish also credited the nature of the fighting and the training of American soldiers, in addition to citing U.S. military superiority and the quality of leadership most soldiers experienced while in-country.[87] Spurgeon Neal agreed that the leadership was "magnificent" and also cited the "high caliber and morale of the soldiers manning combat units… and an aggressive and effective preventative medicine program with strong command support" as important factors in keeping psychiatric casualties low.[88]

There is no single factor that could have led to such low instances of acute combat trauma in the first five years of American involvement in Vietnam. In all likelihood, it was an amalgamation of different reasons, including the ones suggested by the mental health professionals reviewing the data at the time. There was no denying, though, the feeling of

[86] Peter G. Bourne, *Men, Stress, and Vietnam* (Boston: Little, Brown and Company, 1970), 74-77.

[87] Colbach and Parrish, 339.

[88] Neal, 172.

success amongst members of the psychiatric community at potentially meeting the goal given to them by the U.S. military as early as the First World War, to successfully treat and even prevent acute combat-related traumatic neuroses. An optimistic Peter Bourne concluded an article to the *American Journal of Psychiatry* with the bold prediction that given the current state of military psychiatry in Vietnam and promising research being conducted in the field of combat psychiatry "there is reason to be optimistic that psychiatric casualties need never again become a major cause of attrition in the United States military in a combat zone."[89] Colbach and Parrish were more reflective on the continuing need for military psychiatrists. "The primary goal of Army mental health services is to preserve the fighting strength," they wrote, because "it is expected that soldiers in a combat zone will experience varying degrees of discomfort." This was, they recognized, "a sacrifice which society expects [soldiers] to make." Thus, it fell upon mental health personnel, they concluded, to be constantly mindful of their own role as the "guardians of this painful reality."[90]

Not all psychiatrists were willing to accept this responsibility. There were a growing number of mental health professionals during the Vietnam War who began to question the ethics of psychiatry's participation in military ventures. These questions became more pointed, and their proponents gained more support, as the public grew increasingly disenchanted with American involvement in Southeast Asia. Various members of the mental health community asked their colleagues to consider whether or not military psychiatrists were actually serving the best interest of their patients or if instead, they were serving the interests of an impersonal military complex currently undertaking an unpopular war. With

[89] Peter J. Bourne, "Military Psychiatry and the Vietnam Experience," *American Journal of Psychiatry* 127 (1970): 129.

[90] Colbach and Parrish, 341.

the perennial problem of battle neuroses seemingly solved or at least under control, the professional discourse on combat trauma dropped off. Into its place stepped a heated debate about the principles of military psychiatry.

The first article to address a possible ideological conflict between military psychiatry and civilian psychiatry was published in 1966 by Colonel Roy Clausen of the United States Army and Dr. Arlene Daniels of the University of California, Berkley. This joint military-civilian research effort produced a thoughtful delineation of potential areas of divergence between a psychiatrist's civilian training and the realities of his role as a military psychiatrist. For example, the focus of a military psychiatrist is on quick consultation with a patient instead of extended psychotherapy. Also, the rules of confidentiality which governed civilian medical practices were vastly different in the hierarchy of the military system. With regards to these areas of potential rupture, Clausen and Daniels were optimistic that no long-term problems would arise to prevent the military psychiatrist from completing his primary objective of maintaining the fighting strength of the United States military.[91]

As for the larger, looming charge that "Army aims come before patient needs should the two conflict," Clausen and Daniels admitted that no clear answer presented itself. The only observation they could make was that "this difficulty is one which must be faced by any psychiatrist, civilian or military, when he acts as an agent for the organization in which he practices." This was especially true of military psychiatrists who "sometimes must act as an agent of society irrespective of his personal view or individual professional responsibility,"

[91] Roy Clausen and Arlene Daniels, "Role Conflicts and Their Ideological Resolution in Military Psychiatric Practice," *American Journal of Psychiatry* 123 (1966): 284.

particularly in wartime "when the Army's purpose most clearly represents the needs or wishes of the society at large."[92]

A similar discussion can be found in Joseph Dubey's 1967 article "The Military Psychiatrist as Social Engineer." Dubey, an Air Force psychiatrist, observed that "like any large organized corporation, the military, in pursuing its own interests, must of necessity upon occasion ignore the needs and interests of the individuals who serve it." In such cases, he argued, it fell upon the military psychiatrist and other medical personnel to undertake "the humanitarian considerations of those whose personal needs conflict with those of the institution." The military psychiatrist was thus a combination of industrial psychologist who must act as a "kind of personnel screen" but also a regular civilian psychiatrist capable of treating the mental distress of a patient.[93] These articles were met with no debate in the *American Journal of Psychiatry* (*AJP*), despite their direct engagement with a controversial subject. The articles that ultimately provoked a response from the readers of the *AJP* were of a very different sort.

In September 1967 two Navy psychiatrists, Lieutenant Commander Robert Strange and Commander Robert J. Arthur, published a piece on the effectiveness of Navy hospital ships for treating psychiatric casualties. The article did not seek to provoke debate, but merely to discuss a successful implementation of military psychiatry techniques.[94] Despite this seemingly banal intent, Strange and Ransom received a scathing rebuke in the form of a letter to the editor written by Dr. Edmund Levin of Berkley, California. Levin charged that

[92] Ibid, 284-285.

[93] Joseph Dubey, "The Military Psychiatrist as Social Engineer," *American Journal of Psychiatry* 124 (1967): 92-93, 95.

[94] Robert E. Strange and Ransom J. Arthur, "Hospital Ship Psychiatry in a War Zone," *American Journal of Psychiatry* 124 (1967): 281-286.

the two Navy psychiatrists were attempting to "nicely evade war's realities by focusing too narrowly on their particular role in our Viet Nam misadventures." He accused the men of viewing their patients as nothing more than "defective cogs in the military machine, to be repaired as quickly as possible so that they could be speedily returned '… to combat and possible death or mutilation,'" and asked whether the authors "were too busy or too enamored with the task of secondary and tertiary prevent to ponder what primary prevention might have meant to the 13,000 Americans and the uncounted Vietnamese who have already died in the war." He concluded his letter with a pointed rhetorical question, asking "might not the greatest mark of personal and professional maturity lie in the willingness to work to lead men out of battle rather than into it?"[95] Strange and Ransom responded that they felt "ill-used by Dr. Levin," and his utilization of their article "as an excuse for the presentation, in a medical journal, of his worries about the state of American foreign policy." They claimed that research and experience led them to conclude "premature discharge from the Armed Forces for psychiatric reasons may itself exert a life-long deleterious effect on the individual" and unless the patient's condition is especially severe, all effort should be made to enable the individual to complete his "obligation to his nation and his comrades."[96] No further discussion between the three parties appeared in the *AJP*.

There was, however, another heated exchange in the January 1970 issue of the *American Journal of Psychiatry* on the ethics of psychiatry in Vietnam. Dr. Thomas Maier contended that Albert Bloch's description of military psychiatry in the September 1969 issue of *AJP* "perpetuates the fiction, long nurtured by professional military psychiatrists" that

[95] Edmund Levin, "Evading the Realities of War," *American Journal of Psychiatry* 124 (1968): 1137-1138.

[96] Robert E. Strange and Ransom J. Arthur, "Cdrs. Strange and Arthur Reply," *American Journal of Psychiatry* 124 (1968): 1138.

combat psychiatry was focused primarily on healing inter-unit personality conflicts. According to Maier, who had served as a psychiatrist in Vietnam from 1965 to 1967, the most common psychiatric casualty in Vietnam appeared in the guise of a young man "with symptoms directly reflecting his confrontation with the tragic absurdity of risking his life or of killing other human beings in this meaningless military exercise and whose entire being is devoted to extricating himself from the situation." Maier ended with a bold pronouncement:

> By acting to 'conserve the fighting strength' in this war of boundless immorality [a military psychiatrist] partakes of the passive complicity that is the mark of guilt in our time… Whatever else Army psychiatry may be, I see neither moral nor scientific justification for the dignity of its definition.

Bloch replied to Maier:

> Dr. Maier's point that psychiatrists who make decisions to return soldiers to duty in Viet Nam are guilty of passive complicity in immoral acts… is an opinion. I will simply state another view. This is not the best of all possible worlds. But if reality is that America's youth are now fighting then they deserve the best psychiatric care that can be afforded them.

These admittedly brief confrontations in the official organ of the American Psychiatric Association suggested a growing divide within the mental health community over the ethics of military psychiatry, a rupture that mirrored the fracturing of American society as public support for intervention in Vietnam dwindled.

Perhaps the harshest critique of combat psychiatry came in the form of a book chapter published by a veteran military psychiatrist. Robert Lifton served as an Air Force psychiatrist in 1952 and was well known in the mental health community for his work with survivors of the nuclear bomb blast in Hiroshima. As a result of these experiences, Lifton developed strong anti-war sentiments and as such, took umbrage with his profession's

involvement in Vietnam.[97] In 1973 he published *Home from the War: Learning from Vietnam Veterans* in which he devoted a chapter to a review of military psychiatry. Mental health professionals in Vietnam, he believed, were in "collusion" with a military involved in "a particularly evil and counterfeit war." Their predecessors who served the military during WWII were absolved of some of their guilt because "their collusion in killing and dying was in the service of combating a force that promised killing and dying on an infinitely larger and more grotesque scale." The circumstances of American involvement in Vietnam, he felt, made this excuse inapplicable.[98]

Lifton also offered commentary on the military psychiatry articles he saw published in the *American Journal of Psychiatry*. Douglas Bey and Walter Smith's 1971 article, "Army Psychiatry in the Combat Zone - 1967-1968," particularly incurred Lifton's ire for what he called "the authors' combination of easy optimism and concern for everyone's feelings" that he thought served to distract the reader from the reality of combat psychiatry in Vietnam.[99] According to Lifton, this reality was actually characterized by psychiatrists in Vietnam who, purposefully or inadvertently, supported a military system that conveyed to soldiers the message, "'Do your indiscriminate killing with confidence that you will receive expert medical-psychological help if needed.'" This resulted in efforts made by combat psychiatrists to "help men adjust to their own atrocities." The tacit consent the American

[97] Robert J. Lifton, *Home from the War: Learning from Vietnam Veterans* (Boston: Beacon Press, 1992, originally published: New York: Simon and Schuster, 1973), 16-17.

[98] Ibid, 414-416.

[99] Ibid, 416-417. Lifton also took issue with H. Spencer Bloch's, "Army Clinical Psychiatry in the Combat Zone - 1967-1968" (1969). He did offer praise to William Barry Goult's article "Some Remarks on Slaughter" (1971) which Lifton called a "particularly welcome antidote," for - among other things - demonstrating "an appropriate sense of outrage." Lifton, 417-418. See also, William Barry Goult, "Some Remarks on Slaughter," *American Journal of Psychiatry* 128 (1971): 450-453.

Psychiatric Association seemed to give military psychiatry through the publication of articles on the subject led Lifton to wonder whether or not the profession was on the precipice of a decent into "ethical corruption." Truly, he felt, combat psychiatry was "the psychiatry of the executioner."[100]

At the conclusion of five years of American involvement in Vietnam the field of military psychiatry was viewed with pride by some and severe consternation by others. On the one hand the successful implementation of psychiatric techniques developed by military psychiatrists in three previous wars had yielded positive results to the practitioners of combat psychiatry in Vietnam. Instances of acute combat neurosis were at an all time low and to many it appeared that modern medicine had finally conquered war's injurious grip on the mind. To others this development did not signal success, but instead, indicated the willingness of psychiatry to yield to institutional needs instead of protecting the well-being of an individual. To these men and women the low neuropsychiatric casualty statistics to come out of Vietnam indicated no reason for celebration. If anything, they felt the mental health community should be more concerned than ever before. Psychiatry, they believed, should be used to assist the growth of humanity, not service the desires of those who would impede that growth through violence.

The debate between these two factions came to dominate the professional discussion on combat psychiatry. During the first five years of American involvement in Vietnam this tension within the mental health community served to shift attention away from *chronic* traumatic neuroses. This changed starting in 1970. Research into the short and long-term effects of trauma on the mind began to draw attention once again as the number of psychiatric casualties in Vietnam began to noticeably increase. But perhaps the greater

[100] Ibid, 414.

catalyst to renewed focus on war neuroses was the large number of veterans who sought assistance for combat-related mental illness months or even years after they returned home. The discussion on the psychological trauma of war evolved into a conversation between an impassioned section of the public, a committed and politicized faction of mental health workers, and a reluctant group of psychiatric professionals. What was unique about the discourse that followed was that much of it developed outside of the professional journals. But as this next section demonstrates, facets of the conversation still appeared within the professional sphere. Much of the ensuing debates, both public and professional, relied upon the theoretical foundations established by earlier generations of interested and concerned psychiatric researchers.

## DSM-III and the Post-Vietnam Era

The mental health profession was changing in the 1960s and the 1970s. Many psychiatrists were increasingly convinced that their role in society was not just that of the educated observer, the detached researcher, or the insightful analyst. Instead, they felt they possessed a greater calling, that of guardians of the mind. Such a responsibility required a closer connection to the public. "Social psychiatry" and "community psychiatry" became the dominate focuses of the profession. The psychiatrist was encouraged by these movements to leave his or her insulated hospital or university office and instead, take up his or her practice amongst the patients, in their neighborhoods or communities. As protectors of mental health, the psychiatric community also attempted to formulate opinions and recommendations on social issues such as civil rights, education, and foreign policy. All this was done with the goal of promoting an optimum mental health for the nation. Of course, these changes to the profession were met with resistance and debate amongst psychiatrists. It was during this tumultuous period of self-examination that the professional discourse on traumatic neuroses reached its climax.

The direction of the discourse on combat neuroses changed radically in the 1970s. Before this decade nearly all of the conversation -- limited thought it may have been -- took place within the confines of medical journals and in collaboration between the military and psychiatric professionals. Of course, there were instances when the discourse moved into a more public realm, for example, in the wake of the First World War when some American

veterans sought government pensions for psychiatric problems. But for the most part discussions of acute and later chronic war-related psychological trauma, occurred between concerned professionals and interested military parties. This changed during the 1970s when Vietnam veterans, suffering from continued psychiatric distress and frustrated by a shortage of answers from the psychiatric community and a lack of support from Veterans' Administration hospitals, allied with a group of concerned and vocal members of the mental health community.

There are excellent studies that address the subsequent interactions and activities of veterans and psychiatrists. Their story is accurately captured in works such as Wilbur Scott's *The Politics of Readjustment: Vietnam Veterans Since the* War (1993) and Gerald Nicosia's *Home to War: A History of the Vietnam Veterans' Movement* (2001). Less has been written about what discussion on combat neuroses, if any, developed in parallel within the professional journals of psychiatry. The following section describes the discourse on the psychiatric trauma of war as it unfolded in two of the primary journals of the psychiatric profession: the *American Journal of Psychiatry* (AJP), the official mouthpiece of the American Psychiatric Association (APA), and the *Archives of General Psychiatry* (AGP), which, created in 1960, serves as the primary neuropsychiatric journal of the American Medical Association (AMA).

The various aspects of the professional discourse on military psychiatry and war neuroses as it existed during the Vietnam War were encapsulated in the October 1970 edition of the *American Journal of Psychiatry*. The issue included an article from Peter Bourne in which he discussed the remarkably low number of neuropsychiatric casualties in Vietnam, lauded the successful implementation of military psychiatry methods and remarked upon the

"significant increase in psychiatric knowledge and sophistication among the general medical officers."[101] Along the same vein there appeared an article by Frank Hayes extolling the use of helicopters to evacuate psychiatric casualties during the combat operations.[102] This particular edition of the *AJP* also included a piece by Ira Frank and Frederick Hoedemaker in which the authors discussed the ethical dilemmas that arise when young men seek a false psychiatric diagnosis in order to evade the draft. This article by Frank and Hoedemaker engaged the tensions currently permeating the mental health profession about the intersection of psychiatry with controversial political and social issues.[103]

Perhaps most significant about the October 1970 edition is its inclusion of the first article in the *AJP* to address readjustment issues among returning Vietnam veterans.[104] Commander Robert Strange and Captain Dudley Brown of the United States Navy published a piece entitled "Home From the War: A Study of Psychiatric Problems in Viet Nam Returnees" in which they discussed their findings from a study of fifty patients exhibiting psychiatric problems after returning from Vietnam. From this sample they speculated that Vietnam veterans, when compared to members of the military with no combat deployment, demonstrated a greater propensity for depression, alcoholism, and suicidal tendencies. The

[101] Peter G. Bourne, "Military Psychiatry and the Viet Nam Experience," *American Journal of Psychiatry* 127 (1970): 487.

[102] Frank Hayes, "Psychiatric Aeromedical Evacuation Patients During Tet I and Tet II Offensives, 1968," *American Journal of Psychiatry* 127 (1970): 503-508.

[103] Ira Frank and Frederick Hoedemaker, "The Civilian Psychiatrist and the Draft," *American Journal of Psychiatry* 127 (1970): 497-502. No other article on psychiatric involvement in Vietnam provoked a greater reaction amongst readers of the *AJP*. There were no less than five letters to the editor written in response to Frank and Hoedemaker, the final one appearing over a year later. The opinions were mixed as to whether or not a psychiatrist was ethically permitted to protest American involvement in Vietnam by providing false or exaggerated diagnoses in order to assist in the evasion of the draft.

[104] There was an earlier article on this same topic which appeared in the *Archives of General Psychiatry*: W. Goldsmith and C. Cretekos, "Unhappy Odysseys: Psychiatric Hospitalization among Vietnam Returnees," *Archives of General Psychiatry* 20 (1969): 78-83.

take-away from this article was not, however, a call for action to assist the veterans, but instead a reassurance from Strange and Brown that "although Viet Nam returnees face significant readjustment stress, their reactions are generally internalized and their potential for violent aggression is no greater than in those without Viet Nam experience."[105] Already the long-term effects of traumatic neuroses were being minimized in the professional discourse.

As has been the case with this complex debate, an alternate opinion was soon provided. The next AJP article to address Vietnam veterans did so from the perspective of a stateside military psychiatrist with experience treating American soldiers after they had returned from Vietnam. William B. Gault's encounters with these veterans led him to offer up a piece simply entitled, "Some Remarks on Slaughter." The essay detailed Gault's thoughts on how otherwise normal men could commit atrocities during war. More important for the discourse on traumatic neuroses, however, was Gault's observation of persistent psychological suffering in the veterans he treated. Unfortunately, he openly declined to "discuss the clinical psychiatric phenomena related to leaving combat" despite his observation that "when soldiers observe or participate [in atrocity], they often feel profoundly and enduringly guilty, and often they do not." [106] Despite a lack of speculation, it

[105] Robert E. Strange and Dudley E. Brown, "Home From the War: A Study of Psychiatric Problems in Viet Nam Returnees," *American Journal of Psychiatry* 127 (1970): 488.

[106] William Barry Gault, "Some Remarks on Slaughter," *American Journal of Psychiatry* 128 (1971): 451. Gault's study into the psychology of atrocity and why men kill can be seen as a progenitor for later studies on the psychology of killing, particularly Dave Grossman's *On Killing.*

is clear that in Gault's opinion, the veteran's experience was not "generally internalized," as suggested by Strange and Brown.[107]

After "Some Remarks on Slaughter" the *AJP* did not publish another article on readjustment issues until 1973 and then it was only a single article that seemed again to suggest post-deployment stress could be avoided through the implementation of "prevention programs" within the military.[108] The next article did not appear until 1977 and it called only for future research.[109] As a whole, the topic of Vietnam received little attention from the APA after 1970, despite an increase in the number of psychiatric casualties reported by the United States military. The articles on Vietnam that did appear in the *AJP* tended to either address issues related to the draft or drug use amongst service members.

The APA did take one significant step with regards to the Vietnam War that should be mentioned. In 1971, in his presidential speech at the APA's annual meeting, Dr. Robert Garber addressed the increasing politicization of psychiatry, a change he viewed as positive, but one he felt should be undertaken with great caution. "We, as an Association," he said, "cannot discharge our social responsibilities without becoming involved in politics… not merely the process by which legislation and decision making occur, but [the process which] encompasses values and world views." The APA "must help define 'the good society' to

[107] Gault's article was well received in professional circles and was awarded the APA's Essay Prize on Aggression and Violence. Robert Lifton, the vocal critic of military psychiatry, praised Gault for his "combination of professional insight and ethical awareness." Lifton was so impressed by the empathy Gault expressed for the veterans that he went so far as to suggest that Gault became "a survivor of Vietnam by proxy" and the construction of an article on slaughter was "his way of giving form to that survival" as well as resolving an internal ethical conflicts that might be lingering as a result of Gault's role as a military psychiatrist. Lifton, 418-419.

[108] Jonathan F. Borus, "Reentry II: 'Making It' Back in the States," *American Journal of Psychiatry* 130 (1973): 850-854.

[109] EP Nace, et. al, "Depression in Veterans Two Years after Viet Nam," *American Journal of Psychiatry* 134 (1977): 167-170.

'influence the moral and public weal.'" But, he argued, increased activism must be undertaken carefully:

> Let us never forsake a critical scientific judgment on the validity of the evidence that we must lest our pronouncements appear silly and ridiculous. Let us make certain that our public positions emanate from within the realm of our special knowledge and clearly identify the mental health component of the issue to which we address ourselves.[110]

Perhaps with this very call to action in mind, but certainly in the spirit of psychiatry's role as the guardians of the mind, the APA's Board of Trustees passed the following resolution at the conclusion of the annual meeting:

> Be it resolved: That the Board of Trustees of the APA wishes to add its voice to that of the great masses of the American people who have so firmly expressed their agony concerning the war in Southeast Asia. Also, as psychiatrists we have specialized deep concerns about its grave effects on morale and on the rise of alienation, dehumanization, and divisiveness among the American people.
>
> Therefore**:** The Board hereby expresses its conviction that the prompt halt to the hostilities in Southeast Asia and the prompt withdrawal of American forces will render it possible to reorder our national priorities to build a mentally healthier nation.[111]

This declaration was met with mixed reviews. One group of mental health professionals lauded the Association for addressing one of the "most profoundly important social issues

[110] Robert S. Garber, "The Presidential Address: The Proper Business of Psychiatry," *American Journal of Psychiatry*, 128 (1971): 3.

[111] George Tarjan, "Highlights of the 124th Annual Meeting," *American Journal of Psychiatry* 128 (1971): 139.

with which psychiatry is confronted."[112] Another psychiatrist felt the APA had over-stepped its bounds into an "illegitimate area" well beyond the expertise of the profession.[113]

Regardless of how it was received, the resolution from the APA Board of Trustees did not appear to translate into increased attention from the Association's members to the mental health of the war's many participants. This is evidenced by the dearth of research on the topic of acute and chronic combat neuroses published in the APA's primary professional journal after the Board made its stance public. The reason for this lack of attention is unclear. There is no way to know if research was simply not being conducted or if articles dealing with Vietnam veterans were submitted and subsequently rejected by the *AJP* editor. It could be suggested that the APA -- like many others at this time -- was attempting to disassociate itself from anything related to the war, leading -- perhaps inadvertently -- to a separation from the plight of the veterans as well. Also, there was still no concrete diagnostic category for trauma-related neuroses nor a consensus for what caused a chronic form of this condition. With no clear label to affix to the veterans who presented themselves for treatment it was also easier for some members of the psychiatric community to shy away from the war and the suffering in its wake.

In contrast to the silence of the *AJP*, the American Medical Association's *Archives of General Psychiatry* (*AGP*) was fairly prolific on the topics of military psychiatry and combat neuroses amongst Vietnam veterans. It published, on average, one article a year between 1971 and 1977 that addressed one or both of these issues. Regrettably, the *AGP* did not add a section for readers to respond to its articles until the late 1970s so it is difficult to gage the

[112] Viola Bernard, et al., "The Role of Psychiatry in War and Poverty," *American Journal of Psychiatry* 130 (1973): 109.

[113] Ed J. Gunderson, "Viet Nam: The Board of Trustees Steps Out of Bounds," *American Journal of Psychiatry* 130 (1973): 610.

impact these articles had upon the *AGP* readership. However, the content of these articles, spanning over the course of a half dozen years, demonstrates the uncertainty that still dominated the mental health profession when it came to the subject of traumatic neuroses.

The first article on Vietnam to appear in the *AGP* was published in December 1971 by a group of psychiatrists from Stanford University, two of whom also worked at a VA hospital in Palo Alto, California. The piece included provocative accounts of illicit drug use by soldiers in Vietnam, as well as a description of the killing of an unarmed civilian girl. Much like William Gault, the authors concluded that feelings of intense and continual guilt were common amongst the patients they interviewed. They attributed this guilt to a "negative attitude to the war, reinforced after return to civilian life" and also the "unique features of the Vietnam conflict."[114]

Two years later Drs. Theodore Van Putten and Warden Emory contributed an article to the *AGP* which called to task the mental health community for not paying closer attention to the recurrent symptoms displayed by so many Vietnam veterans. "Vietnam returnees have received little psychiatric attention," they wrote, and those articles which did address veterans, such as Strange and Brown's 1970 *AJP* article, they argued "make no reference to traumatic neuroses." Even more disturbing were the instances of misdiagnosis. Veterans that Van Putten and Emory felt exhibited clear signs of traumatic neuroses were instead being labeled by colleagues as epileptics, schizophrenics, or chronic drug abusers. The authors implored the mental health community to review the previous research on traumatic neuroses, such as Leopold and Dillon's study of the marine disaster and the interviews gathered from concentration camp survivors. "Appropriate treatment of combat neuroses is

[114] George R. Solomon, et al., "Three Psychiatric Casualties from Vietnam," *Archives of General Psychiatry* 25 (1971): 524.

crucial," they argued, "since follow-up studies document that symptoms may not pass with time."[115]

Sarah Haley, a psychiatric social worker assigned to a VA outpatient clinic in Boston, combined the arguments of both the California researchers and Van Putten and Emory in her famous article, "When the Patient Reports Atrocities: Specific Treatment Considerations of the Vietnam Veterans," published in the February 1974 issue of the *AGP*. Mental health professionals, she argued, must be more cognizant of the unique therapeutic challenge presented by Vietnam veterans, particularly those veterans who admit to committing some form of atrocity. The nature of the fighting in Vietnam has created patients who are "chronically anxious, angry, or frankly paranoid" and in order to treat this group successfully, she concluded, therapists must engage with them through the establishment of a "therapeutic alliance." In other words, mental health professionals must no longer ignore the plight of Vietnam veterans and instead, work to understand the entirety of the veteran's experience -- even if it is disturbing -- in an effort to assist the patient.[116]

Haley's conclusions were drawn from her experiences with Vietnam veterans -- including a witness of the My Lai massacre -- but her article also included references to earlier works regarding war neuroses, including Abram Kardiner's *The Traumatic Neuroses of War* and Grinker and Spiegel's *Men Under Stress*. Van Putten and Emory cited the research of these men as well. The professional discourse on the psychological trauma of war was beginning to come full circle. Works published decades before were finally being

[115] Theodore Van Putten and Warden H. Emory, "Traumatic Neuroses in Vietnam Returnees: A Forgotten Diagnosis?," *Archives of General Psychiatry* 29 (1973): 695, 697-698.

[116] Sarah Haley, "When the Patient Reports Atrocities: Specific Treatment Considerations of the Vietnam Veteran," *Archives of General Psychiatry* 30 (1974): 191-196. Gerald Nicosia's *Home to War* contains an interesting narrative account of Haley's work and the creation of her article. See Nicosia, 181-188.

brought to the attention of the psychiatric profession, but in an effort to help men who had not yet been born when the author's first conceived the ideas. As Van Putten and Emory concluded, "It would appear that much of what has been learned about traumatic neuroses in World Wars I and II has been forgotten and needs to be relearned."[117]

A marked difference between the discourse on the psychological trauma of war which developed after the World Wars and the one which subsequently developed in immediate aftermath of the Vietnam War was the extent to which the discourse developed outside of professional circles. This does not mean that all mental health professionals were absent from the subsequent debate that enveloped the 1970s. Two psychiatrists in particular, were instrumental in crafting the public discourse on war neuroses and bringing the conversation to a national stage. The first of these was Robert Lifton, whose anti-war sentiments led him to form a close relationship with the Vietnam Veterans Against the War (VVAW), an organization of Vietnam veterans who protested America's continuing actions in Southeast Asia. The second psychiatrist was Chaim Shatan of New York Univeristy. A Polish immigrant and the son of a veteran of three wars, Shatan spent much of his time in medical school at Canada's McGill University interviewing Canadian WWII veterans. Also profoundly anti-war, Shatan was drawn to the plight of Vietnam veterans through his interactions with former soldiers in New York.[118] In the winter of 1970 Lifton and Shatan, at

[117] Van Putten and Emory, 698.

[118] Wilbur J. Scott, *The Politics of Readjustment: Vietnam Veterans Since the War* (New York: Aldine de Gruyter, 1993), 15. Much of the chronology and some of the evidence of the following section, are drawn from two chapters found in Scott's *The Politics of Readjustment*. This book and Scott's earlier article, "PTSD in DSM-III: A Case in the Politics of Diagnosis and Disease" (1990), are often used by scholars attempting to reconstruct the events that led to the inclusion of PTSD in the *DSM-III*. Scott based his narrative on numerous unpublished interviews with the main actors who took part in the private meetings that were crucial to the construction of the *DSM-III*. Because many of these people have since passed away, Scott's work is one of the best - and only - sources for understanding the politics that went into the "creation" of PTSD. Wilbur J. Scott, "PTSD in DSM-III: A Case in the Politics of Diagnosis and Disease," *Social Problems* 37 (1990): 294-310.

the invitation of Jan Berry of the VVAW, joined the informal "rap groups" being held by Vietnam veterans to discuss their war experiences. The information gathered by Lifton and Shatan from these sessions would be instrumental to helping them formulate a definition of what would later become Post-Traumatic Stress Disorder (PTSD).[119]

Despite the example set by Lifton, Shatan, and a few other psychiatrists, the majority of the mental health community during much of the 1970s remained uncertain about how to proceed when confronted by the growing number of Vietnam veterans who required treatment. One former Army chaplain who took a position as a social worker at a VA facility in Los Angles in 1973 observed, "Psychiatrists I met during this period had not the slightest clue how to deal with Vietnam veterans… Psychiatrists and clinical psychological could function within their well-defined parameters, but they didn't know how to treat combat-related stress."[120] A psychiatrist writing in the same year was inclined to agree with this assessment:

> The current emphasis on 'the here and now' in psychotherapy, in conjunction with the combat veteran's reluctance to discuss his traumatic experiences and the therapist's wish to be done with the war, may easily create a tacit agreement between therapist and veteran to avoid the subject [of combat trauma].[121]

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[119] Gerald Nicosia, *Home to War: A History of the Vietnam Veterans' Movement* (New York: Crown Publishing, 2001), 162. Much has been written about the "uniqueness" of the rap groups and the subsequent Vet Centers that sprung up as a result. It should be noted, however, that community psychiatry, which promoted a close relationship between therapist and patient operating within the patient's own environment, was the trend currently dominating psychiatric practices in the 1960s and 1970s. Lifton and Shatan, while taking important steps to engage veterans on their own "turf," were not doing anything revolutionary in the eyes of psychiatrists. Ironically, the tenets of community psychiatry were thought to have foundations in military psychiatry, the field so abhorred by Lifton.

[120] William Mahedy, quoted in Scott, 36.

[121] Van Putten and Emory, 698. Though not cited by Van Putten and Emory in the article, this quote appeared earlier - and nearly verbatim - in Herbert Archibald and Read Tuddenham's 1965 article on persistent combat-neuroses in WWII veterans. Thus, it should be noted that the original form of this quotation referred to an earlier generation of veterans, though Van Putten and Emory's application of the opinion to psychiatrists

One likely cause of the confusion and uncertainty exhibited by mental health professionals was a lack of a diagnostic category for the symptoms they were encountering. Confronted with numerous psychiatric nosologies in the late 1940s, all being called different things by different doctors, the American Psychiatric Association published the first *Diagnostic and Statistical Manual [of] Mental Disorders* or *DSM-I* in 1952.[122] The lessons learned from WWII and the research of men like Abram Kardiner and Karl Menninger heavily influenced this first codification of psychiatric terminology. Though some beliefs about the organic nature of psychiatric illness remained, the *DSM-I* largely embraced the theory put forth by Menninger that mental illness was fluid and could be profoundly affected by a person's environment.[123] Words like "stress" and "reaction" were used liberally in *DSM-I*. The first *DSM* was also significant to the discourse on combat neuroses for its inclusion of the diagnostic category "gross stress reaction." The editors noted that this was a condition which could occur amongst soldiers who had no previous history of mental illness, but it should be considered a temporary state caused by the extreme environment of war and once removed from combat, the soldier's symptoms should improve. No mention was made of the potentially chronic nature of traumatic neuroses.[124]

In the late 1960s the APA began work on a second *DSM* to update the language of classification. For reasons that are unclear, perhaps in reaction to the low instances of

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interacting with Vietnam veterans is certainly valid. The dual use of this quote also provides yet another interesting example of the cyclical nature of military psychiatry.

[122] Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, Inc., 1997), 298-299.

[123] Mitchell Wilson, "DSM-III and the Transformation of American Psychiatry," *American Journal of Psychiatry* 150 (1993): 400.

[124] Scott, *The Politics of War*, 32.

psychiatric casualties in Vietnam, "gross stress reaction" was removed from the final *DSM-II* published in 1968. In fact, *DSM-II* made no mention of a psychiatric disorder caused by combat. If a mental health professional was confronted by symptoms that seemed to suggest a "gross stress reaction" the doctor was encouraged to view the patient as having an "adjustment reaction to adult life."[125] Thus, when Vietnam veterans began to seek treatment for psychological problems related to their combat experiences, psychiatrists had no official diagnostic category to use.

In the absence of an official diagnostic term some psychiatrists, particularly those working closely with veterans, began to improvise. On May 6, 1972 the *New York Times* published an article written by Chaim Shatan in which he described the characteristic symptoms of what he called "Post-Vietnam Syndrome." Veterans who suffered from this syndrome experienced intense feelings of guilt, rage, or sometimes an "alienation from their feelings and other human beings" as a result of "systematically numbing their humane responses" while in Vietnam. "The post-Vietnam Syndrome," Shatan concluded, "confronts us with the unconsummated grief of soldiers -- 'impacted grief' in which an encapsulated, never-ending past deprives the present of meaning." Shatan reiterated his thoughts on Post-Vietnam Syndrome in an article published in the *American Journal of Ortho-Psychiatry* entitled, "The Grief of Soldiers in Mourning: Vietnam Combat Veterans' Self Help Movement."[126] The origins of the term "Post-Vietnam Syndrome" are uncertain; Lifton attributed it to VA psychiatrists in the late 1960s and early 1970s, while others credited Lifton. He actually considered the term to be "dubious" and an "easily-abused category,"

[125] Ibid, 33.

[126] Chaim Shatan, "The Grief of Soldiers in Mourning: Vietnam Combat Veterans' Self Help Movement," *American Journal of Ortho-Psychiatry* 45 (1973): 644.

and thus, stated that "I have never used the term."[127] The phrase "Post-Vietnam Syndrome" also did not appear in the *AJP* until after 1980 and the creation of an official diagnostic category for Post-Traumatic Stress Disorder. There were a few minor references in the *AGP*; for example, when Sarah Haley referred to Shatan's article, though she avoided the use of the term herself. Despite a lack of official recognition however, the phrase Post-Vietnam Syndrome often appeared in the public discourse on chronic war neuroses.

Lifton and Shatan, now joined by Sarah Haley as well, began to advocate for an official diagnostic category in the next edition of the *DSM*. This was not the first call for APA recognition of chronic, trauma-related mental illness. In 1965, Dr. George Thompson did a study on five hundred court cases involving traumatic neuroses, most often caused by accidents. His research led him to conclude, above all else, that "post-traumatic psychoneurosis is probably the most misunderstood condition that occurs in medico-legal cases…[the condition] must be made tangible, clearly-cut, definite and therefore diagnostically valid."[128] His plea went unheeded -- in fact, "gross stress reaction" was dropped only three years later. Lifton, Shatan, and Haley, however, had two advantages over Thompson and the numerous others who had tried to garner official recognition of chronic traumatic neuroses in the past: a dedicated and vocal group of Vietnam veterans, and an APA under pressure in the activist atmosphere of the post-Vietnam era.

*DSM-II* was only a few years old when the APA began to face pressure for either a new edition or significant changes to the existing volume. The largest complaints were directed at the inclusion of homosexuality as a mental disorder. In *DSM-I* homosexuality

[127] Lifton, 420.

[128] George Thompson, "Post-Traumtic Pscyhonerosis: A Statistical Study," *American Journal of Psychiatry* 122 (1965): 1048.

was considered a "sociopathic disturbance" and *DSM-II* reclassified the lifestyle as "sexual deviation" similar to transvestitism or sadism. Members of the Gay Liberation Front and the Gay Activist Alliance loudly protested this classification, going so far as to invade and disrupt the 1970 and 1971 APA national meetings. In the midst of this pressure from outside forces and faced by internal pressure about the direction of psychiatric research and diagnosis, the APA announced in 1974 that it would begin work on *DSM-III*.[129] Dr. Robert Spitzer of the New York State Psychiatric Institute, and a former member of the drafting committee for *DSM-II*, was put in charge of the task force to develop the new manual.[130]

Right away Spitzer addressed the issue of homosexuality in *DSM-II* and the manner of its inclusion in *DSM-III*. A sub-committee assigned the job of determining more suitable language -- the term "amorous relationship disorder" was considered for a time, among other options -- failed to reach a consensus and Spitzer's task force was again forced to make the decision. Spitzer and his committee decided to just delete the classification all together. In its place they chose to insert more cautious language which suggested the potential for both heterosexual and homosexuals to suffer from mental distress from confusion over their sexuality. The APA membership passed a referendum in 1974 confirming the language and, as one historian noted, "at a stroke, what had been considered for a century or more a grave psychiatric disorder ceased to exist."[131] Perhaps more significant for Lifton, Shatan, Haley,

[129] Scott, 39-40.

[130] Shorter, 300-301.

[131] Ibid, 303-304. See also: Scott, 48; and Robert Spitzer, et al., "DSM-III: The Major Achievements and an Overview," *American Journal of Psychiatry* 137 (1980): 153, 160. Even this wording was reevaluated and eventually removed with the publication of *DSM-III -R* in 1987.

and the veterans agitating for an official category for chronic traumatic neuroses, it indicated that, with enough outside pressure "it was clear that the psychiatrists could be rolled."[132]

In 1974 Spitzer received a phone call from a New York public defender who asked if traumatic war neuroses would be reintroduced in the new *DSM*. Courts, insurance companies, and the U.S. government all relied upon the diagnostic standards set by the APA in their *Diagnostic and Statistical Manual*. For people like the lawyer in question, the lack of a classification for traumatic neuroses was impeding their ability to assist Vietnam veterans and others like them. In response to the lawyer's question, Spitzer replied, "no change is planned." When Lifton and Shatan learned of this conversation they decided that now was the time act and they began to formulate a diagnosis for combat-related stress for submission to Spitzer and the task force designing *DSM-III*.[133]

The group of concerned psychiatrists met with Spitzer in 1975 to discuss their early ideas for a diagnostic category that addressed combat stress. Though unconvinced, Spitzer appointed a Committee on Reactive Disorders to further research the idea. This committee was comprised of three members of the *DSM-III* task force, including Spitzer himself, Lyman Wynne and Nancy Andreasen. Andreason was to work closely with Lifton and Shatan to help them gather the evidentiary proof needed to convince the APA that their diagnosis was justified.[134]

At this time there were still those in the mental health community who needed to be convinced about the importance of a diagnostic category for traumatic neuroses.

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[132] Shorter, 304.

[133] Scott, 58-59.

[134] Ibid, 61.

Psychiatrists John Helzer and Lee Robins of Washington University in St. Louis were not certain if the symptoms they encountered in their work with Vietnam veterans warranted the creation of a separate diagnostic category. While they were convinced that "wartime combat… is predictive of later depressive symptoms" they categorized the symptoms as simply that, forms of depression.[135] They later argued, "Veterans 3 years after Viet Nam show little evidence of more serious maladjustment compared with nonveterans."[136]

Dr. Jonathan Borus of the Harvard Medical School and formerly of Walter Reed Institute of Research, also published an article which questioned what he called "politically colored reports" about pervasive mental illness amongst Vietnam veterans. Borus conducted his own study of approximately 750 veterans, 577 of whom had service in Vietnam. He found that "only 23% had some record of maladjustment in their first seven months back in the United States" and he concluded that in "contrast to more subjective reports of widespread post-Vietnam readjustment difficulties," only a relatively small number of active-duty veterans displayed actual signs of severe maladjustment. It was Borus' opinion that some members of the mental health community had allowed their "political convictions" and the "public media" to "lure them beyond the limits of their data," resulting in a spurious number of Vietnam veterans with lasting mental illness.[137] While Lifton and Shatan would not have to directly disprove the theories of Borus and Helzer, they would have to supply enough evidence to convince the APA that such opinions were of the minority and that traumatic neuroses deserved recognition as a legitimate mental illness.

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[135] John Helzer, et al., "Depressive Disorders in Vietnam Returnees," *Journal of Nervous and Mental Disease* 168 (1976): 184.

[136] John Helzer and Lee Robins, "Drs. Helzer and Robbins Reply," *American Journal of Psychiatry* 137 (1980): 132.

[137] Jonathan F. Borus, "Incidence of Maladjustment in Vietnam Returnees," *Archives of General Psychiatry* 30 (1974): 554-556.

In January of 1978 the Committee on Reactive Disorders requested a final meeting with Shatan and Lifton to discuss their findings. Lifton and Shatan, working closely with Sarah Haley and Vietnam veteran Jack Smith of the VVAW, had compiled evidence drawn from hundreds of veterans and mental health professionals who had worked with veterans. By now they were also in contact with psychiatric researchers whose studies involved victims of accidents and concentration camp survivors. Additionally, they formed a relationship with Dr. Mardi Horowitz of the University of California, San Francisco, who was conducting extensive research into the physiology of stress.[138] With this information they developed, and presented to the Committee on Reactive Disorders, a diagnostic model for what they termed "catastrophic stress disorder." They also recommended a sub-category of the disorder, tentatively called "post-combat stress reaction."[139] After a few weeks of deliberation the Committee on Reactive Disorders agreed to recommend "Post-Traumatic Stress Disorder (PTSD)" to the *DSM-III* task force for inclusion in the upcoming manual. The PTSD category accurately reflected the recommendations -- absent the specific category of "post-combat stress reaction" -- made by the psychiatrists and the Vietnam veterans with whom they worked. Shatan, in a letter to a group of veterans who had assisted in the research, proclaimed, "We are happy to say that the latest draft version of *DSM-III* incorporates most of our formulations on stress disorders, not only for combat veterans but also for Holocaust and victims of other disasters… We are happy to have reached an agreement on it."[140]

[138] Scott, 62-63.

[139] Ibid, 64-66. See also, Shorter, 304.

[140] Shatan, quoted in Scott, 66. See also: Nicosia, 207-209.

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In 1980 the *Diagnostic and Statistical Manual III* was published with the following simple definition of Post-Traumatic Stress Disorder. Within the phrasing it is possible to see various aspects of the extended debates on traumatic neuroses. A dismissal of predisposition, the potential for the condition to be chronic, the role of a traumatic event, and the importance of guilt and memory in the development of the disorder were all included. Thus, this diagnostic category was a true reflection of the culmination of decades of professional and public discussion on the effect of trauma on the human mind.

**Post-Traumatic Stress Disorder**[141]

Differential Diagnosis: Adjustment Disorder with Anxious Mood

Diagnostic Criteria:

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:

    a. Recurrent and intrusive recollections of the event

    b. Recurrent dreams of the event

    c. Sudden acting or feeling as if the traumatic event were reoccurring, because of an association with an environmental or ideational stimulus.

[141] *Quick Reference to the Diagnostic Criteria from DSM-III* (Washington, DC: Division of Publications and Marketing, American Psychiatric Association, 1980), 137-138.

C. Numbing of responsiveness to or reduced involvement with the external world, beginning some time after the trauma, as show by at least one of the following:
    a. Markedly diminished interest in one or more significant activities
    b. Feeling of detachment or estrangement from others
    c. Constricted affect

D. At least two of the following symptoms that were not present before the trauma:
    a. Hyperalertness or exaggerated startle response
    b. Sleep disturbance
    c. Guilt about surviving when others have not, or about behavior required for survival
    d. Memory impairment or trouble concentrating
    e. Avoidance of activities that arouse recollection of the traumatic event
    f. Intensification of symptoms by exposure to events that symbolize or resemble the traumatic event.

E. Post-Traumatic Stress Disorder, Acute
    a. Onset of symptoms within six months of the trauma
    b. Duration of symptoms of less than six months

F. Post-traumatic Stress Disorder, Chronic or Delayed
    a. Duration of symptoms six months or more (chronic)
    b. Onset of symptoms at least six months after the trauma (delayed)

## Conclusion

The professional discourse on PTSD and the psychological trauma of war has not abated since the inclusion of PTSD in *DSM-III*. In the years after its creation psychiatrists discussed the validity of the diagnostic model, some calling it accurate while others suggested the criteria for the disorder be reevaluated.[142] Thirty years later mental health professionals are still debating aspects of the condition, from the wording of the diagnosis to what exactly defines a traumatic event, as the APA gets ready to publish *DSM-V* in 2013.[143] A diagnosis as complex as PTSD will certainly engender debate for years to come and regrettably, the future will undoubtedly continue to provide suffers of the condition to initiate further study. If the professional discourse on psychological trauma remains as forward-thinking in the coming years as it was for much of the twentieth century it is likely that the future holds the promise of increased understanding of this affliction upon the human mind.

A handful of scholars such as Jerry Lembke and Allan Young have argued that PTSD is a social construction and to some extent, they are correct. The diagnostic category of Post-Traumatic Stress Disorder is a social construction in that its ultimate creation was dependent upon various aspects of society coming together to move the professional discourse from simply theorizing to action. Psychiatrists, the media, members of government, and activist

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[142] R. Atkinson, et al., "Diagnosis of Posttraumatic Stress Disorder in Viet Nam Veterans: Preliminary Findings," *American Journal of Psychiatry* 141 (1984): 694-696.; R.S. Laufer, "Symptom Patterns Associated with Posttraumatic Stress Disorder Among Vietnam Veterans Exposed to War Trauma," *American Journal of Psychiatry* 142 (1985): 1304-1311.

[143] Carol North, et al. "Toward Validation of the Diagnosis of Post-Traumatic Stress Disorder," *American Journal of Psychiatry* 166 (2009): 31-41.; Robert Spitzer, et al. "Saving PTSD from itself in DSM-V," *Journal of Anxiety Disorders* 21 (2007): 233-241. Note that this is the same Robert Spitzer who was the primary architect of *DSM-III*.

Vietnam veterans all contributed to the construct the specific diagnostic category of PTSD. The psychiatric profession was also under-going a period of self-evaluation and redirection in the 1960s and 1970s. This made for a professional environment conducive to a new perspective on trauma-related mental illness. It was this collision of forces in the tumultuous atmosphere of the post-Vietnam era that succeeded in bringing official recognition to the debilitating effects of the psychological trauma of war when, in the past, it had been relegated to only theory inside of a few professional journals.

However, the foundations for an understanding of traumatic neuroses were constructed within a professional discourse long before Robert Lifton and Sarah Haley began to work with Vietnam veterans. The experiences of military psychiatrists such as Thomas Salmon and Douglas Bey and civilian psychiatrists like Abram Kardiner and Paul Chodoff all added to the professional understanding of psychological trauma and the impact of that trauma on a person's long-term mental health. Without these earlier works a satisfactory negotiation between the public or professional conversations on trauma-related mental illness would have been unlikely. Thus, to say that PTSD is solely a product of the Vietnam War ignores the importance of the complex professional discourse that developed during the twentieth century.

# Bibliography

## Books


Bey, Douglas. *Wizard 6: A Combat Psychiatrist in Vietnam*. College Station, TX: Texas A&M University Press, 2006.

Binneveld, Hans. *From Shell Shock to Combat Stress: A Comparative History of Military Psychiatry*. Translated by John O'Kane. Amsterdam: Amsterdam University Press, 1997.

Bleakney, Julia. *Revisiting Vietnam: Memoirs, Memorials, Museums.* New York: Routledge, 2006.

Bourke, Joanna. *An Intimate History of Killing: Face to Face Killing in 20th Century Warfare*. New York: Basic Books, 1999.

Bourne, Peter G., Editor. *The Psychology and Physiology of Stress: With Reference to Special Studies of the Viet Nam War*. New York: Academic Press, Inc, 1969.

----- *Men, Stress, and Vietnam*. Boston: Little, Brown, and Company, 1970.

Bowman, John, Editor. *The Vietnam War: An Almanac*. New York: World Almanac Publications, 1985.

Burkett, B.G.. *Stolen Valor: How the Vietnam Generation was Robbed of its Heroes and its History*. Dallas: Verity Press, 1998.

Dean, Eric T.. *Shook Over Hell: Post-Traumatic Stress, Vietnam, and the Civil War*. Cambridge: Harvard University Press, 1997.

Egendorf, Arthur. *Healing from War: Trauma and Transformation after Vietnam*. Boston: Houghton Mifflin Company, 1985

Frey-Wouters, Ellen, and Robert S. Laufer. *Legacy of a War: The American Soldier in Vietnam*. New York: M. E. Sharpe, Inc., 1986.

Figley, Charles R., Editor. *Stress Disorders Among Vietnam Veterans: Theory, Research, and Treatment*. New York: Brunner/Mazel Publishers, 1978.

----- Editor. *Mapping Trauma and its Wake: Autobiographic Essays by Pioneer Trauma Scholars*. New York: Routledge, 2006.

Gabriel, Richard A., Editor. *Military Psychiatry: A Comparative Perspective*. Connecticut: Greenwood Press, 1986.

Gabriel, Richard A.. *No More Heroes: Madness & Psychiatry in War*. New York: Hill and Wang, 1987.

Grinker, R. R., and J. P. Spiegel. *Men Under Stress.* London: J & A. Churchill, Ltd., 1945.

Grossman, Dave. *On Killing: The Psychological Cost of Learning to Kill in War and Society.* New York: Little, Brown and Company, 1995.

Herring, George C.. *America's Longest War: The United States in Vietnam 1950-1975*. New York: McGraw-Hill, 1986.

Kardiner, Abram. *The Traumatic Neuroses of War*. Menasha, Wisconsin: George Banta Publishing Company, 1941.

Lifton, Robert Jay. *Home From the War: Learning from Vietnam Veterans*. Boston: Beacon Press, 1992. Originally published as: Lifton, Robert Jay. *Home from the War: Vietnam Veterans—Neither Victims nor Executioners*, New York: Simon & Schuster, 1973.

Marlowe, David H.. *Psychological and Psychosocial Consequences of Combat and Deployment: With Special Emphasis on the Gulf War*. Santa Monica: RAND, 2001.

Micale, Mark S., and Roy Porter, Editors. *Discovering the History of Psychiatry*. New York: Oxford University Press, 1994.

Nicosia, Gerald. *Home to War: A History of the Vietnam Veterans' Movement*. New York: Crown Publishers, 2001.

*Quick Reference Guide to the Diagnostic Criteria from DSM-III.* Washington, DC: Division of Publications and Marketing, American Psychiatric Association, 1980.

Reister, Frank A.. *Battle Casualties and Medical Statistics: U.S. Army Experience in the Korean War.* Washington, D.C.: Department of the Army, 1973.

Scott, Wilbur J.. *The Politics of Readjustment: Vietnam Veterans Since the War*. New York: Aldine De Gruyter, 1993.

Shay, Jonathan. *Achilles in Vietnam: Combat Trauma and the Undoing of Character*. New York: Simon & Schuster, 1995.

Shepard, Ben. *A War of Nerves.* London: Johnathan Cape, 2001.

Shorter, Edward. *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*. New York: John Wiley & Sons, Inc., 1997.

Solomon, Zahava. *Combat Stress Reaction: The Enduring Toll of War*. New York: Pelnum Press, 1993.

Spurgeon, Neil. *Medical Support of the U.S. Army in Vietnam, 1965-1970*. Washington, DC: Department of the Army, 1973.

Van der Kolk, Bessel, et al., Editors. *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*. New York: The Guilford Press, 2007.

Young, Allan. *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder*. Princeton: Princeton University Press, 1995.

## Articles

Archibald, Herbert, et al. "Gross Stress Reaction in Combat - A 15-Year Follow-Up." *American Journal of Psychiatry* 119 (1962): 317-322.

Archibald, Herbert, and Read Tuddenham. "Persistent Stress Reaction After Combat: A 20-year Follow-Up." *Archives of General Psychiatry* 12 (1965): 475-481.

Atkinson, R., et al.. "Diagnosis of Posttraumatic Stress Disorder in Viet Nam Veterans: Preliminary Findings." *American Journal of Psychiatry* 141 (1984): 694-696.

Bey, Douglas, and Walter Smith. "Mental Health Technicians in Vietnam." *Bulletin of the Menninger Clinic* 34, no. 6 (November 1970): 363-371.

Bernard, Viola, et al.. "The Role of Psychiatry in War and Poverty." *American Journal of Psychiatry* 130 (1973): 109.

Bloch, H. Spencer. "Army Clinical Psychiatry in the Combat Zone - 1967-1968." *American Journal of Psychiatry* 126 (1969): 289-298.

----- "Dr. Bloch Replies." *American Journal of Psychiatry* 126 (1970): 1039-1040.

Borus, Jonathan. "Reentry I: Adjustment Issues Facing the Vietnam Returnee." *Archives of General Psychiatry* 28 (1973): 501-506.

----- "Reentry II: 'Making It' Back in the States." *American Journal of Psychiatry* 130 (1973): 850-854.

----- "Incidence of Maladjustment in Vietnam Returnees." *Archives of General Psychiatry* 30 (1974): 554-557.

Bourne, Peter G.. "Military Psychiatry in the Viet Nam Experience." *American Journal of Psychiatry* 127 (1970): 481-488.

Bozzetti, Louis. "The Army and the Untrained "Psychiatrist." *American Journal of Psychiatry* 123 (1967): 825-828.

Chodoff, Paul. "The Late Effects of the Concentration Camp Syndrome." *Archives of General Psychiatry* 8 (1963): 323-333.

----- "The German Concentration Camp." *Archives of General Psychiatry* 22 (1970): 78-87.

Clausen, Roy E., and Arlene Daniels. "Role Conflicts and their Ideological Resolution in Military Psychiatric Practice." *American Journal of Psychiatry* 123 (1966): 280-287.

Colbach, Edward M., and Matthew D. Parrish. "Army Mental Health Activities in Vietnam: 1965-1970." *Bulletin of the Menninger Clinic* 34, no. 6 (November 1970): 333-342.

Dubey, Joseph. "The Military Psychiatrist as Social Engineer." *American Journal of Psychiatry* 124 (1967): 52-58.

Eitinger, Leo. "Pathology of the Concentration Camp Syndrome: Preliminary Report." *Archives of General Psychiatry* 5 (1961): 371-379.

Frank, Ira, and Frederick Hoedemaker. "The Civilian Psychiatrist and the Draft." *American Journal of Psychiatry* 127 (1970): 497-502.

Friedman, Henry. "Military Psychiatry: Limitations of the Current Preventive Approach." *Archives of General Psychiatry* 26 (1972): 118-123.

Futterman, Samuel, and Eugene Pumpian-Mindlin. "Traumatic War Neuroses Five Years Later." *American Journal of Psychiatry* 108 (1951): 401-408.

Garber, Robert S.. "The Presidential Address: The Proper Business of Psychiatry." *American Journal of Psychiatry* 128 (1971): 1-11.

Glass, Albert, et al. "The Current Status of Army Psychiatry." *American Journal of Psychiatry* 117 (1961): 673-683.

Goldsmith W., and C. Cretekos. "Unhappy Odysseys: Psychiatric Hospitalization among Vietnam Returnees." *Archives of General Psychiatry* 20 (1969), 78-83.

Goult, William Barry. "Some Remarks on Slaughter." *American Journal of Psychiatry* 128 (1971): 450-453.

Gunderson, Ed J.. "Viet Nam: The Board of Trustees Steps Out of Bounds." *American Journal of Psychiatry* 130 (1973): 610.

Haley, Sarah A.. "When the Patient Reports Atrocities: Specific Treatment Considerations of the Vietnam Veterans." *Archive of General Psychiatry* 30 (1974): 191-195.

Hausman, William, and David McK. Rioch. "Military Psychiatry: A Prototype of Social and Preventative Psychiatry in the United States." *Archive of General Psychiatry* 16 (1967): 727-739.

Hayes, Frank. "Psychiatric Aeromedical Evacuation Patients During Tet I and Tet II Offensives, 1968." *American Journal of Psychiatry* 127 (1970): 503-508.

Helzer, John, et al.. "Depressive Disorders in Vietnam Returnees." *Journal of Nervous and Mental Disease* 168 (1976): 177-185.

Helzer John, and Lee Robins. “Drs. Helzer and Robbins Reply.” *American Journal of Psychiatry* 137 (1980): 132.

Huffman, Robert E. “Which Soldiers Break Down: A Survey of 610 Psychiatric Patients in Vietnam.” *Bulletin of the Menninger Clinic* 34, no. 6 (November 1970): 343-351.

Keane, Terence M, and John Fairbank. “Survey Analysis of Combat-Related Stress Disorders in Viet Nam Veterans.” *American Journal of Psychiatry* 140 (1983): 348-350.

Kracke, Roy R.. “The Medical Care of the Veteran.” *The Journal of the American Medical Association* 143, No. 15 (1950): 1321-1331.

Laufer, R.S.. “Symptom Patterns Associated with Posttraumatic Stress Disorder Among Vietnam Veterans Exposed to War Trauma.” *American Journal of Psychiatry* 142 (1985): 1304-1311.

Lembcke, Jerry. “The ‘Right Stuff’ Gone Wrong: Vietnam Veterans and the Social Construction of Post-Traumatic Stress Disorder.” *Critical Sociology* 24 (1998): 37-64.

Leopold, Rober, and Harold Dillon. “Psycho-Anatomy of a Disaster: A Long Term Study of Post-Traumatic Neuroses in Survivors of a Marine Explosion.” *American Journal of Psychiatry* 119 (1963): 913-921.

Levin, Edmund C.. “Evading the Realities of War?” *American Journal of Psychiatry* 124 (1968): 1137-1138.

Maier, Thomas. “The Army Psychiatrist - An Adjunct to the System of Social Control.” *American Journal of Psychiatry* 126 (1970): 1039.

Meerloo, Joost. “Neurologism and Denial of Psychic Trauma in Extermination Camp Survivors.” *American Journal of Psychiatry* 120 (1963): 65-66.

Modlin, Herbert. “The Postaccident Anxiety Syndrome: Psychosocial Aspects.” *American Journal of Psychiatry* 123 (1967): 1008-1012.

Morris, Larry. “‘Over the Hump’ in Vietnam: Adjustment Patterns in a Time-Limited Stress Situation.” *Bulletin of the Menninger Clinic* 34, no 6 (November 1970): 352-362.

Nace, EP, et. al. “Depression in Veterans Two Years after Viet Nam.” *American Journal of Psychiatry* 134 (1977): 167-170.

North, Carol, et al.. “Toward Validation of the Diagnosis of Post-Traumatic Stress Disorder.” *American Journal of Psychiatry* 166 (2009): 31-41.

Sadock, Benjamin. “Role Conflicts in Military Psychiatry.” *American Journal of Psychiatry* 123 (1966): 747.

Scott, Wilbur J.. “PTSD in DSM-III: A Case in the Politics of Diagnosis and Disease.” *Social Problems* 37 (1990): 294-310.

Shatan, Chaim. "The Grief of Soldiers in Mourning: Vietnam Combat Veterans' Self Help Movement." *American Journal of Ortho-Psychiatry* 45 (1973): 644.

Skobbra, Joseph. "Military Psychiatry." *American Journal of Psychiatry* 116 (1960): 651-653.

Solomon, George F., et al. "Three Psychiatric Casualties from Vietnam." *Archives of General Psychiatry* 25 (1971): 522-524.

Spitzer, Robert, et al.. "DSM-III: The Major Achievements and an Overview." *American Journal of Psychiatry* 137 (1980): 151-164.

----- "Saving PTSD from itself in DSM-V." *Journal of Anxiety Disorders* 21 (2007): 233-241.

Steckel, Harry. "Book Review." Review of *The Traumatic Neuroses of War* by Abram Kardiner. *American Journal of Psychiatry* 98 (1942): 624-625.

Strange, Robert E., and Ransom J. Arthur. "Hospital Ship Psychiatry in a War Zone." *American Journal of Psychiatry* 124 (1967): 281-286.

----- "Cdrs. Strange and Arthur Reply." *American Journal of Psychiatry* 124 (1968): 1138.

Strange, Robert E., and Dudley Brown. "Home from the War: A Study of Psychiatric Problems in Viet Nam Returnees." *American Journal of Psychiatry* 127 (1970): 488-492.

Talbott, John E.. "Soldiers, Psychiatrists, and Combat Trauma." *Journal of Interdisciplinary History* 27: 3 (Winter, 1997): 437-454.

Tarjan, George. "Highlights of the 124th Annual Meeting." *American Journal of Psychiatry* 128 (1971): 137-140.

Thompson, George N.. "Post-Traumatic Psychoneurosis - A Statistical Survey." *American Journal of Psychiatry* 121 (1965): 1043-1048.

Tiffany, William J.. "The Mental Health of Army Troops in Viet Nam." *American Journal of Psychiatry* 123 (1967): 1585-1586.

Tiffany, William J. and William S. Allerton. "Army Psychiatry in the Mid-1960s." *American Journal of Psychiatry* 123 (1967): 810-821.

Van Putten, Theodore, and Warden Emory. "Traumatic Neuroses in Vietnam Returnees: A Forgotten Diagnosis?." *Archives of General Psychiatry* 29 (1973): 695-698.

Van Putten, Theodore, and Joel Yager. "Posttraumatic Stress Disorder: Emerging from the Rhetoric." *Archives of General Psychiatry* 41 (1984): 411-413.

Wilson, Mitchell. "DSM-III and the Transformation of American Psychiatry: A History." *American Journal of Psychiatry* 150 (1993): 399-410.

Yager, Joel. "Personal Violence in Infantry Combat." *Archives of General Psychiatry* 32 (1975): 257-261.

Young, Kimball. “Book Review.” Comparative Review of *The Neuroses in War* edited by Emanuel Miller and *The Traumatic Neuroses of War* by Abram Kardiner, *American Sociological Review* 7, No. 3 (June 1942): 453-452.