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Social Problems, Vol. 37, No. 3 (Aug., 1990), 294-310.

Stable URL:
http://links.jstor.org/sici?sici=0037-7791%28199008%2937%3A3%3C294%3APIDACI%3E2.0.CO%3B2-I

Social Problems is currently published by University of California Press.

PTSD in DSM-III: A Case in the Politics of Diagnosis and Disease*

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The American Psychiatric Association published the third edition of its Diagnostic and Statistical Manual (DSM-III) in 1980. Unlike DSM-II, it included the listing "post-traumatic stress disorder" (PTSD). The PTSD diagnosis is the product of a concerted effort to reintroduce war neurosis into the official psychiatric nomenclature. This paper tells the sociological story of who put PTSD in DSM-III and how they did it.

> The essential feature is the development of characteristic symptoms following a psychologically traumatic event. . . . The characteristic symptoms involve reexperiencing the traumatic event; numbing of responsiveness to, or reduced involvement with, the external world; and a variety of autonomic, dysphoric, or cognitive symptoms.
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> The stressor producing this syndrome would evoke significant symptoms of distress in most people, and is generally outside the range of such common experiences as simple bereavement, chronic illness, business losses, or marital conflict. The trauma may be experienced alone (rape or assault) or in the company of groups of people (military combat). Stressors producing this disorder include natural disasters (floods, earthquakes), accidental man-made disasters (car accidents with serious physical injury, airplane crashes, large fires), or deliberate man-made disasters (bombing, torture, death camps). . . .
>
> The traumatic event may be experienced in a variety of ways. Commonly the individual has recurrent painful, intrusive recollections of the event or recurrent dreams or nightmares during which the event is reexperienced. . . . Diminished responsiveness to the external world, referred to as "psychic numbing" or "emotional anesthesia," usually begins soon after the traumatic event. . . . After experiencing the stressor, many develop symptoms of excessive autonomic arousal, such as hyperalertness, exaggerated startle response, and difficulty falling asleep (American Psychiatric Association 1980:236).

Post-traumatic stress disorder (PTSD) first appeared as a diagnosis in the American Psychiatric Association's (APA) third edition of its *Diagnostic and Statistical Manual of Mental Disorders,* DSM-III, in 1980. Used largely by practicing psychiatrists as a classification scheme for keeping records and processing diverse administrative work (e.g., insurance claims) both within psychiatry and in its dealings with outsiders, the manual also stands as an official map of mental illness and disorder in the United States. The manual establishes, in effect, what it is possible to suffer in the way of problems psychiatrists recognize and treat. Finally, it is in some sense the list of such illnesses that psychiatry "stands behind" in this regard.

In this paper, I describe how PTSD came to be an official psychiatric disorder. I examine the work done, by diverse people, that culminated in its appearance in DSM-III and hence its power as an official medical psychiatric reality offered as an index of various other realities behind it. The prime reality behind this and other medical and psychiatric diagnoses is the taken-for-grantedness of disease or physical disorder in the world. All of those whose activities I here describe saw PTSD, like all disease, as there to be gotten or suffered quite independently of the diagnostic category. What I seek to do here is to show how diverse champions of

* An earlier version of this paper was presented at the 1989 meeting of the Society for the Study of Social Problems, Oakland, Calif. I am indebted to the University of Oklahoma Research Council for funding, and to Malcolm Spector and anonymous reviewers for many helpful comments on previous versions of this paper. Correspondence to: Scott, Department of Sociology, University of Oklahoma, Norman, OK 73019.

this new diagnosis brought it to light as an always-already-there object in the world, relevant to medical work. This process has been shown in reverse for the diagnosis of homosexuality (Conrad and Schneider 1980:204-09; Bayer 1981), where we saw how a psychiatric disorder ceased to exist as an official diagnosis and as a relevant medical object in the world.

Like the disappearance of the disorder of homosexuality from DSM-II, the story of how PTSD appeared in DSM-III is one that belies the cool clinical language in which the manual's diagnoses and syndromes are described. Psychiatrist Robert Spitzer, director of the APA Task Force on Nomenclature that prepared the new volume and a central figure in the homosexuality controversy in the APA, notes in its introduction that each successive draft aroused "alarm, despair, excitement, [and] joy" among the psychiatric community. Similarly, the struggle for *recognition* of PTSD by its champions was profoundly political, and displays the full range of negotiation, coalition formation, strategizing, solidarity affirmation, and struggle—both inside various professions and "in the streets"—that define the term.

This story is important to tell for two reasons. First, it raises and examines substantive questions about what constitutes the normal experience and response of soldiers to warfare. We see that what psychiatrists once regarded as abnormal behavior is now thought by many to represent a "normal" response to situations of combat. With the PTSD diagnosis, psychiatrists now say it is "normal" to be traumatized by the horrors of war; "war neurosis,"[1] i.e., PTSD, occurs when this trauma is not recognized and is left untreated. Second, the story adds another sociological case to those that illustrate the politics of diagnosis and disease. What we see here is an especially clear instance of how medical scientists and their diverse allies successfully advanced a diagnosis as both an accurate description of objective reality and as a discovery of what was present but previously unseen.

In what follows I reconstruct the sequence of events, identify the protagonists, explore the claims and counterclaims (see Spector and Kitsuse [1977] 1987), and describe the evidence used to support the PTSD diagnosis. I gathered the evidence for my own account through personal and telephone interviews of several of the protagonists, and through newspapers, books, magazines, and archival sources.

War Neurosis in DSM-I and DSM-II

In 1952, the APA published the first edition of its physician's desk reference for psychiatrists, DSM-I. Drawing on the work of Abram Kardiner (1947) and other psychiatrists who served in the military during the Second World War, DSM-I contained the entry "gross stress reaction." The editors said the reaction could occur among soldiers in combat, even among those who showed no previous history of mental problems. They distinguished it from a neurosis or psychosis and described it as a temporary condition produced by extreme environmental stress. The reaction, they concluded, should disappear after the individual was removed from the stressful situation.

This diagnosis departed from relevant research on two points. Grinker and Spiegel (1945), who studied the reactions to combat by soldiers in the Second World War, had noted that many reactions did not occur on the battlefield but erupted afterwards. Their study, and Kardiner's, also revealed that symptoms could persist for months or even years. These observations suggested a need to recognize "delayed" and "chronic" components of gross stress reaction.

The United States sent combat troops to Vietnam in 1965. Coincidentally, the APA had begun work on the second edition of the Diagnostic and Statistical Manual (DSM-II). Psychia-

1. I use the term "war neurosis" in this paper to refer to the general category of mental disorders associated with warfare. As my presentation makes clear, observers have used many, more specific labels to refer to one or more of these disorders.

trists Paul Wilson and Robert Spitzer were responsible for assembling the materials and for writing the final draft under the direction of Ernest Gruenberg. DSM-II was to modernize the American psychiatric nomenclature and to bring it into line with the international system of classification.

The dominant, though not unchallenged, view of war neurosis within the APA at the time is expressed in the writings of psychiatrist Peter Bourne, which culminated in his 1970 book, *Men, Stress, and Vietnam*. Bourne had served in Vietnam during 1965 and 1966 as a team member from the Walter Reed Army Institute of Research. The Institute directed him to study psychiatric casualties among United States troops. During both the Second World and Korean Wars, military leaders considered war neurosis a significant problem, and they fretted that similar rates of depletion would occur in Vietnam. However, less than 5 percent of the total evacuations out of Vietnam between 1965 and 1967 were for psychiatric reasons. By comparison, Bourne noted, the flow of soldiers out of the Army on psychiatric grounds during the Second World War at one point exceeded the numbers of new recruits being inducted. During early phases of the Korean War, psychiatric casualties accounted for nearly one-fourth of all evacuations from the battlefield. In Vietnam, business was so slow that Bourne (1970:vii-viii) "elected to spend part of [his] time investigating areas quite removed from combat itself."

Bourne attributed the lower rates of emotional breakdown in Vietnam to two factors—the evolution of empirically grounded conceptions of war neurosis, and the implementation by the military of treatment techniques in the combat zone. Bourne (1970:7-22) verified this claim with a brief history of those developments.

During the First World War, British military physicians used the term "shell shock" to denote the dazed, disoriented state many soldiers experienced during combat or shortly thereafter, and attributed the condition to unseen physiological damage caused by exploding artillery shells. However, physicians noted similar symptoms among soldiers who had not been subjected to artillery barrages. Many military leaders and physicians contended that shell shock was a variety of cowardice or malingering and, further, believed that those who "cracked" on the battlefield were weaklings.

When the United States entered the war in 1917, Major Thomas Salmon was appointed as the senior psychiatric consultant for American forces in France. Following the French example, Salmon assigned a psychiatrist to each U.S. division and established procedures for treating war neurosis as quickly and as close to the front lines as possible. Treatment consisted of several days of creature comforts and the firm expectation that the soldier return to duty. The program directors considered it an immediate success: sixty-five percent of those treated returned to duty on the front lines.

Shortly after the First World War, Sigmund Freud appeared as an expert witness in Vienna for a government inquiry into the mistreatment of wounded soldiers by Austrian military physicians. He argued that shell shock was psychological in origin and distinguished it from the more common neuroses that originate in childhood. His recommended treatment for both was psychoanalysis. As other well-known psychiatrists emphasized the psychological origins of war neurosis, physiological explanations for shell shock fell into disfavor.

However, the notion that war neurosis afflicted weaklings persisted, especially in military quarters. During the Second World War, the military sought to screen out marginally adjusted inductees. Draft boards in the United States declared more than 1 million men psychologically unfit to fight. Subsequent U.S. psychiatric casualties in Europe, about 102 per 1,000 troops, prompted a fresh round of speculation. Medical personnel noted that psychiatric casualties had passed screening standards, and some were seasoned troops who previously had fought bravely. Medical personnel, and the troops themselves, commonly called the condition "combat fatigue." Some military men saw it simply as cowardice. In the effort to prevent war neurosis by culling out the unfit, the Salmon program for treating psychiatric casualties

had been forgotten. In 1944, the military re-instituted the Salmon program. As in the First World War, Bourne noted, the program significantly reduced the loss of combat troops to psychiatric breakdown.

By the time the Korean War broke out, most psychiatrists who served in the Second World War had returned to civilian life. The military set up a large psychiatric facility in Japan to provide the first line of treatment. Initially, about 50 per 1,000 troops became psychiatric casualties. To reduce this figure, Albert Glass, a consultant to the Surgeon General who had served as a psychiatrist in the Second World War, persuaded the military to reintroduce the Salmon program by setting up psychiatric centers within each division in Korea. As a result, Bourne showed, official rates of psychiatric casualties declined to about 30 per 1,000 troops.

In contrast, an updated Salmon program was firmly in place from the very start of the Vietnam War. The military command provided each battalion with medical personnel trained to treat psychiatric disorders, and assigned a psychiatrist and staff to each infantry and marine division. These personnel dealt with troops experiencing psychiatric difficulties as close to combat areas as possible, with the firm expectation that the troops would return quickly to duty. The rate of breakdown was about 5 per 1,000 troops between 1965 and 1967. Military leaders and psychiatrists lauded the results. Military psychiatry appeared to have licked the problem.

When the APA published DSM-II in 1968, it included previously unspecified disorders and omitted several that had appeared in DSM-I. One of the drop-outs was gross stress reaction. Hence, DSM-II contained no specific listing for a psychiatric disorder produced by combat.[2] A likely explanation is that those writing DSM-II had no first-hand experience with war neurosis from the Second World or Korean Wars, and initial indications from respected psychiatrists in Vietnam were that the standard nomenclature covered the range of disorders they encountered there.[3]

Some psychiatrists thought otherwise. For example, Archibald and Tuddenham (1962, 1965) conducted 15 and 20 year follow-up studies of veterans. They reaffirmed the significance of a diagnosis for war neurosis and documented the persistence of symptoms among those who had experienced combat stress during the Second World and Korean Wars. They also noted reports of similar findings in parallel studies of concentration camp survivors. However, they did not realize that the status of gross stress reaction in DSM-II was in doubt until after the manual's publication and had not made their concerns known to the editors.

In July 1967, a handful of Vietnam veterans marched in New York City to protest American involvement in Vietnam. They called themselves Vietnam Veterans Against the War (VVAW). They urged Vietnam veterans to unite in order to bring their "brothers" home and the war to an end. As we shall see, this rag-tag group slowly would become a focal point in the drive to place PTSD in DSM-III.

DSM-II and the Practice of Psychiatry

Sarah Haley, fresh with a master's degree in social work, began work for the Boston Veteran's Administration (VA) Hospital in September 1969. In later years, her work would bring her into contact with Chaim Shatan and Robert Lifton, and she would play a significant role in advocating the PTSD diagnosis as a member of the Vietnam Veterans Working Group.

2. The editors suggested that psychiatrists might code such symptoms under adjustment reactions, in this case, "adjustment reaction to adult life."

3. I could find no substantiating records in the official APA Archives. Psychiatrist Chaim Shatan suspected that gross stress reaction was omitted to reduce the financial liability of the VA following the Vietnam War (Shatan personal interview, 24 Oct. 1988, Dallas, Tex.).

Her father had served in North Africa during the Second World War as a special agent for the Overseas Secret Service. As a young girl, she had heard stories about war and atrocities from her troubled father. However, her first contact with a Vietnam combat veteran took place that first morning at work in Boston. As part of the customary intake process, Haley interviewed a new patient who was extremely anxious and agitated. The veteran told her that his company in Vietnam one day had killed a large number of women and children at a village called My Lai.[4] He himself had not fired any shots. Afterwards, several members of his platoon who had participated in the slaughter threatened to kill him if he told anyone about what happened. One of them said that he might kill him someday anyway just to make sure that he never blew the whistle.

A few days before coming to the VA Hospital, the veteran became unraveled. He felt terrified and was unable to rest or sleep well. He complained that war buddies were out to kill him, but he had no physical evidence to prove it. Although Haley was not aware of the My Lai story at the time, she accepted his account at face value. The staff met later that day to discuss the case. Haley recalls:

> The staff assembled to discuss all the information and reach a diagnosis and treatment plan. When we met, the intake log already had a diagnosis filled in: paranoid schizophrenic. I voiced concern. The staff told me that the patient was obviously delusional, obviously in full-blown psychosis. I argued that there were no other signs of this if one took his story seriously. I was laughed out of the room. I was told that it was my first day and just didn't understand how things worked. . . . I was aghast. These professionals denied the reality of combat. This [denial] clouded their clinical judgment. They were calling reality insanity! . . . I knew from my father's stories that [this man was] not crazy (Haley personal interview, 25 Oct.1987, Dallas, Tex.).

The staff members were not fully aware of the My Lai story at the time of the diagnosis. Even if the news story had been known, however, the veteran's narrative still might not have been taken at face value. Mental health professionals across the country assessed disturbed Vietnam veterans using a diagnostic nomenclature that contained no specific entries for war-related trauma. The DSM-II nomenclature, used by hospitals, insurance companies, and the courts, provided the official diagnoses for sicknesses. VA physicians typically did not collect military histories as part of the diagnostic work-up. Many thought that Vietnam veterans who were agitated by their war experiences, or who talked repeatedly about them, suffered from a neurosis or psychosis whose origin and dynamics lay outside the realm of combat.

Despite the absence of a listing in DSM-II, many psychiatrists still considered war neurosis, and the specific listing of it in DSM-I, gross stress reaction, diagnostically valid and useful. In 1969, psychiatrist John Talbott, in a critique of DSM-II published in the *International Journal of Psychiatry*, recommended that the future editors of DSM-III re-introduce the gross stress reaction listing. Talbott, who had served in Vietnam as a psychiatrist, recalled an incident that occurred in 1970 or 1971:

> I was asked to evaluate a disability case for the VA by Ed Koch, who then was a representative to Congress, now the Mayor of New York. . . . I looked at this kid . . . [and] . . . videotaped him. He was such a classic case . . . [of] mental disability related to combat experience, that I presented it to my class at Columbia [University Medical School] on stress disorders. [Psychiatrist] Larry Kolb was the senior person in that class and [he] came up to me afterward and said, "How on earth did you find this person? This person has everything imaginable!" . . . He had sleep disturbances, he had startle reaction, he had everything. Flashbacks. Had everything. And I had it all on videotape. And Larry said to me, "How did you find this guy?" I said, "This is a guy who has been disallowed benefits by the VA because he doesn't have a combat-related disorder!" (Talbott telephone interview, 24 Feb. 1989, Baltimore, Md.).

4. The Associated Press broke the "My Lai Massacre" story on 16 September 1969. Haley later believed the news story triggered the episode that brought the veteran to the Boston VA facility.

VA Psychiatrist Arthur Blank, who eventually would become the VA's Chief of Psychiatric Services, years later described the situation, in which "most American psychiatrists . . . based their encounters with Viet Nam veterans on the official view that no such thing as PTSD existed," as "dysfunctional and bizarre" (Blank 1985:73-74). Even within the VA, however, adherence to the nomenclature for purposes of treating patients varied according to therapists' personal and clinical experiences. Haley discovered some psychiatrists on the Boston VA medical staff who informally collected military histories from patients they privately considered to be cases of war neurosis. These staff altered the treatment plan accordingly:

> The three or four people in my clinic who were listing traumatic war neurosis . . . , they would see as their job, their task, to talk with the person about what had happened in Vietnam. . . . "Oh, you lost this buddy, you lost that buddy, and that happened. Well, do you think about it now? Oh, I see, you blame yourself. You think if you had only [acted differently], this wouldn't have happened. I see. No wonder you feel so terrible. . . ." The people who thought that these fantastic stories were, you know, just indications of psychotic thought-processes would give them anti-psychotic medication . . . [or] they were seen as . . . character disorders. . . . This person must still be having these symptoms because—it's not that combat is so bad—it's just that they're weak sisters (Haley telephone interview, 9 Nov. 1988, Somerville, Mass.).

In 1971, Haley provided a rating scheme for the local VVAW chapter to use in sending veterans to the Boston VA facility for treatment:

> I drew up a schedule of our intake meetings. There was a different team for each half-day. I highlighted in red the people who it was worthwhile for the vets to see, those people who would be empathetic. I marked others in black, skull-and-crossbones—don't send anyone to this team! (Haley personal interview, 25 Oct. 1988, Dallas, Tex.).

VVAW and Street-Corner Psychiatry

In November 1969, psychiatrist Robert Lifton, an ardent opponent of the Vietnam War, read an account of My Lai in *The New York Times*.. Through Sarah Haley, he later would meet the veteran who had been at My Lai but had not participated in the killing and would write extensively about the veteran's experience. Lifton had served during the Korean War as a military psychiatrist and was well-known in academic circles for his research on survival among Hiroshima victims (Lifton 1967). Upset now by the story, he vowed to intensify his public protests against the war. On December 15, his statement, "Why Civilians Are War Victims," appeared in *U.S.News and World Report* (Lifton 1969) and on January 27, 1970, he testified before Senator Alan Cranston's subcommittee on the psychological effects of the Vietnam War on veterans (Lifton 1970). Lifton argued that incidents such as those at My Lai were inevitable. The same psychological processes—psychic numbing and dehumanization of the enemy—that allow combat troops to carry out their mission of killing, he said, combine with features of the Vietnam War to produce a volatile, atrocity-producing situation.

On 29 April, the U.S. and South Vietnamese military embarked upon a major offensive into Cambodia against North Vietnamese and Viet Cong positions. Within days, college campuses across the United States exploded with protest and, on 4 May, Ohio National Guardsmen fired into a crowd of anti-war demonstrators at Kent State University, killing four students and wounding nine others. Psychiatrist Chaim Shatan had arranged previously for Lifton to speak at New York University. They changed the topic to the Cambodian invasion and Kent State killings, and plastered posters around New York City announcing the talk. The advertising attracted many nonstudents to the talk, including several VVAW members. From this meeting and others like it, Lifton and other anti-war psychiatrists formed a loose, ongoing association with VVAW.

The large, heady demonstrations against the Cambodian invasion proved to be a ripe organizing vehicle for VVAW. To spread the word to other Vietnam veterans, the New York City group placed ads in nationally syndicated magazines ranging from *The New Republic* to *Playboy*. The numbers of Vietnam veterans involved were small, but there were pockets of disgruntled veterans in most major cities and many already had formed their own informal groups. Some groups became VVAW chapters while others retained their distinctive identities. Local VVAW chapters often participated with other larger anti-war organizations in protest activity and also provided self-help activities for veterans. The exact mix of protest and self-help activities, and the form that these activities took, varied from chapter to chapter.

In November 1970, Jan Barry, then president of VVAW, wrote Lifton asking his assistance and advice. In response, Lifton and Shatan visited the New York City chapter. They sat in on the chapter's "rap groups"—informal sessions in which veterans discussed their war experiences. Group members invited Lifton and Shatan to join the sessions, not as therapists, but as equals who shared an opposition to the war. They reasoned that the veterans and the psychiatrists each brought specialized knowledge to the sessions. Shatan recalls: "They said shrinks could join provided that we joined as peers. They knew more about the war than we did, and we knew more about what makes people tick" (Shatan personal interview, 24 Oct. 1988, Dallas, Tex.). There was also an explicit political agenda. Lifton ([1973] 1985:80-81) later wrote:

> [T]he rap groups resembled various forms of street-corner psychiatry. . . . But the groups differed from street-corner psychiatry in the second function . . . of probing the destructive personal experiences of the Vietnam War for eventual dissemination to the American public. This investigative-publicizing function could come into conflict with the [first] goal, that of personal healing and change.

VVAW had developed on the streets a political strategy and a treatment for "delayed" gross stress reaction.

Shatan: "Post-Vietnam Syndrome"

In March 1971, the American Orthopsychiatric Association (AOA) held its annual meeting in Washington, D.C. Unlike the APA, which restricted its membership to psychiatrists, the AOA included a wide range of mental health professionals. The topics covered at its annual meetings and in its official publication often addressed the psychological implications of social issues. Lifton and Shatan both considered it an ideal forum for publicizing their ideas about the war and organized a panel discussion on Vietnam veterans that featured several veterans from the rap groups, including Jack Smith, Arthur Egendorf, and Jan Barry. About 800 AOA participants attended the session.

About a month later, on April 30, a Detroit liquor store clerk shot and killed a young black man named Dwight Johnson as he attempted to hold up the store at gunpoint. Ordinarily, an armed robber's death would not have attracted national attention. However, Johnson's case was destined to appear in the pages of *The New York Times*, *Journal of American Orthopyschiatry*, and other publications, and a play about his life would appear off-Broadway, around the country, and on television. Two and a half years earlier, President Lyndon Johnson had personally placed around Dwight Johnson's neck the Congressional Medal of Honor, the nation's highest award for heroism in combat.[5]

Shatan was deeply moved by Jon Nordheimer's (1971) front-page story in the *The New*

5. Dwight Johnson arrived in Vietnam in February 1967 and served with the same crew for eleven months in Company B, 1st Battalion, 69th Armor, 4th Infantry Division (Murphy 1987:233-36). On 14 January 1968, North Vietnamese soldiers ambushed the convoy on a road near Dak To, and the tank containing his customary crew caught fire. Johnson tried to save his buddies but the tank exploded, killing all but one of the crew. For the next forty-five

York Times about Dwight Johnson's death. He already had been involved for many years in veterans' issues. His father had fought in three wars—the Russo-Japanese War, the Balkan Wars, and the First World War—before moving his family from Poland to Canada. His father wrote short stories about his war experiences, and the younger Shatan translated some of them from Yiddish to English. Shatan attended medical school during the Second World War at McGill University and received thorough training in combat-related disorders. In 1963, he accepted a position on the faculty of the post-doctoral psychoanalytic training program at New York University.

Shatan (1971) regarded his participation in the VVAW rap group a valuable way to oppose the war and to assist Vietnam veterans. The director of the NYU training program supported this work and even authorized him to use letter-head stationary, staff, and copy equipment for rap-group activities. Shatan had been concerned for some time about the absence of a combat-stress diagnosis in DSM-II. He prepared an article on the rap groups for the Op-Ed page of the *The New York Times* in February 1971, but the article did not appear immediately. In the spring of 1972, he drafted a longer, scholarly version to present at the AOA meetings in Detroit. While in Detroit, he met with and consoled Dwight Johnson's family.

In both papers, Shatan wrote of a "post-Vietnam syndrome" that, according to his observations in the rap group, occurred nine to thirty months after return from Vietnam. He described the syndrome as "delayed massive trauma" and identified its themes: guilt, rage, the feeling of being scapegoated, psychic numbing, and alienation. He emphasized that these were not an accidental grab-bag of symptoms, but rather stemmed from the inability of soldiers to grieve in the combat zone:

> Freud elucidated the role grief plays in helping the mourner let go of a missing part of life and acknowledging that it exists only in the memory. The so-called Post-Vietnam Syndrome confronts us with the unconsummated grief of soldiers—impacted grief, in which an encapsulated, never-ending past deprives the present of meaning. Their sorrow is unspent, the grief of their wounds is untold, their guilt unexpiated. Much of what passes for cynicism is really the veterans' numbed apathy from a surfeit of bereavement and death (Shatan 1973:648).

After the AOA meetings, Shatan called the editor of *The New York Times* and suggested that this was an opportune time to publish the Op-Ed article he had prepared for them the year before. The editor agreed and, on 6 May 1972, the *Times* published "The Post-Vietnam Syndrome." Recalled Shatan: "After that, the telephone was jumping off the wall" (Shatan personal interview, 24 Oct. 1988, Dallas, Tex.). He kept track of the phone calls. Shatan and, by extension, the VVAW rap group became an informal clearinghouse for putting interested parties, heretofore unaware of each other, in touch. Summarizing the impact of the article, Shatan said: "After the Op-Ed article, things started mushrooming."

The St. Louis Watershed

In November 1972, Robert Lifton put the finishing touches on his book, *Home from the War*. In it, Lifton ([1973] 1985:9) carefully distinguished between "the nobility and bravery of individual men in facing death or saving comrades, and the dreadful, filthy, unnecessary war

minutes, Johnson went on a rampage, almost singlehandedly breaking the ambush and subduing the enemy. A few days later, he returned stateside.

After his discharge from the Army, Johnson sought work without success. His employment drought ended only after he received the Medal of Honor. Companies now sought his services, including the Army who lured him back as a recruiter and public relations person. Johnson had trouble with his new role, muffed assignments, and complained of stomach pains. The Army sent him to Selfridge Air Force Base for treatment in 1970, and he was reassigned to the Valley Forge VA Hospital. He was diagnosed as suffering from "depression caused by post-Vietnam adjustment problems." In March of 1971, Johnson left the hospital on a three-day pass. He never returned.

they were asked to fight." As in earlier Senate testimony, he argued that atrocities were endemic to all wars, and that the United States' lack of moral purpose and integrity in Vietnam accentuated this trait. He devoted part of the book to the My Lai massacre and the personal story of "My Lai survivor," the veteran seen by Sarah Haley on her first morning at work. (Lifton and Haley had met through the New York City and Boston VVAW chapters.) Lifton encouraged Americans to shed their romanticized notions about war and to place a portion of the blame for atrocities in Vietnam on the war itself, and upon themselves for allowing it, rather than exclusively on the Vietnam veterans who fought it.

Lifton also roundly criticized American psychiatry, particularly military psychiatry. He singled out two articles in the *American Journal of Psychiatry*, Bloch (1969) and Bey and Smith (1971), for special criticism. Both articles boasted of psychiatry's effectiveness in containing war neurosis and returning troubled soldiers quickly to the battlefield. Especially contemptible, Lifton argued, was the stance of military psychiatry as an advocate of the military's interests rather than those of the soldier-patient. "The aim of [military psychiatry]," Bloch (1969:292) had written, was "admittedly a very pragmatic one—to conserve the fighting strength." In Lifton's ([1973] 1985:167) view, this "unholy alliance" between psychiatrists (and chaplains) and the military command created a "counterfeit universe, in which all-pervasive, spiritually re-enforced inner corruption becomes the price of survival," and was the central roadblock to re-integration after combat.

By now Lifton and Shatan had established connections to the AOA, professional publication outlets, and prestigious universities. They next sought to formalize the VVAW's clearinghouse. They knew that small groups of veterans and others across the country were informally addressing the problem. This suggested a strategy: strengthen this grass roots movement and carry on the work through it. Among their many contacts outside the professional community was the National Council of Churches (NCC). Shatan and Lifton urged the NCC, and anyone else who would listen, to sponsor a conference in order to bring these people together face-to-face.

In early 1973, one of the NCC's ministries in New York City planned the First National Conference on the Emotional Needs of Vietnam-Era Veterans. The Missouri Synod of the Lutheran Church put up $80,000 for expenses and agreed to host the meeting in April at its seminary in St. Louis. Reverend Mark Hansen of the NCC worked with Vietnam veteran Arthur Egendorf of the original New York City rap group to develop a list of veterans, psychiatrists, and others across the country who were actively involved in rap groups or organizations that assisted Vietnam veterans. They also invited a delegation from the VA Central Office to attend.

Shatan recalls, "There were 130 attendees—60 vets, 30 shrinks, 30 chaplains, and 10 central office VA people who came on at the last minute" (Shatan personal interview, 24 Oct. 1988, Dallas, Tex.). The conference marked the first time that such a diverse collection of people working on readjustment issues among Vietnam veterans met and exchanged ideas. They discovered that their isolated groupings had several characteristics in common. Typically, they were self-generated, self-help groups that "met on the vets' own turf." There were, however, many differences. For instance, Twice-Born Men, founded in San Francisco by Jack McCloskey and Chester Adams, brought together Vietnam veterans who were coming out of prison. Their rap groups were run solely by the veterans themselves and eschewed the presence of any mental health professionals. Joe Garcia's Seattle-Area Veterans Action Center (SeaVAC), on the other hand, focused on practical advice—benefits counseling, assistance in finding housing or buying a home, help in finding a job. And Shad Meshad, though employed by the VA in Los Angeles, operated outside it as a street counselor (Meshad personal interview, 24 Oct. 1988, Dallas, Tex.).

The participants spent much of the time describing the different approaches and discussing which offered the right model. They concluded that circumstances had produced many

variations, and though they could learn from each other, that there was no one right model. The discussions were intense, boisterous, and usually friendly, except for some exchanges between veterans and VA officials. The animosity many veterans felt toward the VA itself spilled over into conversations with its representatives. Further, Shatan and Lifton spoke with reporters about extensive problems among Vietnam veterans in adjusting to civilian life. To the anger of many participants, the VA personnel disputed the claim that the problems were widespread.

The conference lasted three days. As it drew to a close, the participants created an organizational framework for carrying on the initiative. They named it the National Veterans Resource Project (NVRP) and elected twelve participants to serve as a board of directors. In the weeks that followed, the board drew up a list of candidates from which to select a director. The consensus at the conference had been that the board should find a black or Hispanic to head the clearinghouse, but as board members reviewed the options, they agreed upon Jack Smith.

Jack Smith was not black or Hispanic, but was hard for them to overlook. Passionate and outspoken, he was a tireless worker in behalf of the "cause." Smith had served in Vietnam as a Marine and had been a firm believer in American involvement. Unlike most soldiers, he had studied Vietnamese history and the Vietnamese language before going into combat. However, his experiences there led him to conclude that "whatever our intentions were, our policies had gone awry"[6] (Smith telephone interview, 22 Dec. 1988, Cleveland, Ohio). After returning home, he put the war behind him and went back to school. Shortly after the 1970 Cambodian invasion, he started thinking about the war again. In December that year, he saw the VVAW ad in *Playboy* and decided to join. By coincidence, he attended the very first rap group that included Lifton and Shatan, and moved from Storrs, Connecticut, to New Haven so he could commute regularly to the rap sessions in New York City. He participated vigorously in VVAW activities. The news of Smith's selection as director did not cause a stir one way or the other. The participants were back home, each "doing his own thing."

DSM-III in Progress: "No Change is Planned"

One of Smith's first tasks at NVRP was to raise money for the Project itself. Raising money for this task proved especially difficult. Smith explains the dilemma:

> What we kept running into was, the foundations were saying, well, this is really a government problem. Why are you coming to us? And we were saying, because the government denies there is a problem. . . . And so finally we said, look, if we're going to do anything, we're going to have to prove that we're not talking about something that's an illusion (Smith telephone interview, 22 Dec. 1988, Cleveland, Ohio).

The Project initially had intended to provide grants to groups across the country such as Twice-Born Men and SeaVAC. It now added to its priority list an empirical study of the consequences of Vietnam service and of the needs of Vietnam veterans. Smith sought ideas and funding. After long discussion with Lifton, Egendorf, and others, he eventually proposed a

6. For Smith, the final straw was a bizarre incident in which South Vietnamese troops fired Soviet-made rockets into a Marine base camp in order to convince American commanders that the area was "too hot" to relocate the Marines somewhere else. In retaliation, the Marines rigged a fire direction plan to shoot a few artillery rounds back at the South Vietnamese compound. Smith recalls:

> As soon as I started firing on my allies, I said, "Fuck this shit, this is crazy. . . . " I really insisted that my troops do their job. I said, "Other people's lives depend on you." And all of the meaning kind of came apart for me. . . . I said, "We're playing some kind of game and we're just pawns in this thing. And whatever its good intention initially," I mean, "the other side aren't the good guys, but this is crazy business here and I don't want any God damn part of it any more" (Smith telephone interview, 22 Dec 1988, Cleveland, Ohio).

"Vietnam Generation Study" comparing veterans with others of the same age who did not serve in the military.

A parallel event within the APA that spring introduced a new sense of urgency. In April 1974, 10,000 APA psychiatrists voted on a referendum regarding the status of homosexuality in DSM-II (Conrad and Schneider 1980:204-09). In an effort to resolve the heated confrontations over the issue, Robert Spitzer had proposed the substitution of "sexual orientation disturbance" for "homosexuality" in DSM-II. According to his proposal, homosexuality would qualify as a mental disorder only if the individual experienced distress or dissatisfaction with being gay. The change was approved in December 1973 by the APA's Nomenclature Committee. However, dissenting factions within the APA requested a vote on the change by the full membership. In a rancorous and divisive atmosphere, Spitzer's suggestion passed, 58 percent favoring the change.

The successful challenge to the homosexuality entry in DSM-II opened a floodgate of inquiries about additional changes. Spitzer felt that his handling of the homosexuality issue provided a model for evaluating these requests. His position also implied that DSM-II should be completely redone. John Talbott explains:

> [Spitzer] started out being a very data-driven person. . . . If the data aren't there, the thing doesn't exist. . . . The pressure groups began to rise and say, "Look, this should be in and this should be out. . . ." And he would say, "There aren't data!" . . . I think he started out saying, we're going to throw DSM-II out the window, we're going to have zero-based budgeting, as it were. . . . And what he ended up doing was a two-part process, one, setting up task groups who were experts in the field, and two, subjecting it to a political process in the American Psychiatric [Association] that ensured that it would be adopted by them (Talbott telephone interview, 24 Feb. 1989, Baltimore, Md.).

The news that DSM-III was in the works appeared in the June 1974, edition of *Psychiatric News*. About that time, a public defender in Asbury Park, New York attempted to use a "traumatic war neurosis" defense in a case in which his client, a Vietnam veteran, was charged with destruction of property. The judge denied the strategy, saying that there was no such listing in DSM-II. The defender telephoned Spitzer and asked him if stress reactions associated with combat would be reinstated in DSM-III. Spitzer reputedly told him, "No change is planned." Word of this conversation filtered back to Shatan through a reporter for the *Village Voice* (Shatan personal interview, 24 Oct. 1988, Dallas, Tex.).

The news caught Shatan by surprise. He recalls: "I was startled. I got together with Lifton and said, we must do something about this" (Shatan personal interview, 24 Oct. 1988, Dallas, Tex.). The significance of the developments within the APA had not been lost on Lifton and Shatan. They felt that they had sufficient empirical evidence for a diagnostic category devoted to combat-related stress. They had assumed that the battle was mostly won. It was clear now that the reverse was true: without concerted and effective effort on their part, DSM-III would contain no listing for combat-related disorders. A description and justification would have to be prepared specifically for this purpose. They also knew that they still would have to drum up support for the change.

The Vietnam Generation Study was proceeding very slowly. The initial interviewing had just began. Shatan, Lifton, and Smith would have to push on, leaving NVRP and the Generation Study to fend for themselves.[7]

7. Dozens of researchers, mostly on a part-time basis, participated in the Vietnam Generation Study at various points over the next few years. The plan was that each researcher would bring his or her own expertise and agenda, and that all of it would fit together at the end. The research was completed and published in 1981 under the title, *Legacies of Vietnam* (Egendorf et al. 1981).

Vietnam Veterans Working Group: "Post-Combat Disorder"

The strategy now, according to Jack Smith was very simple: "We realized that we needed to create some kind of public questioning. We needed to move from the arena of what did Spitzer think into the public arena, okay?" (Smith telephone interview, 22 Dec. 1988, Cleveland, Ohio).

To take their message to the public, Shatan, Lifton, and Smith first arranged with WBAI radio station in New York City for an all-day marathon broadcast on Vietnam veterans. They encouraged listeners in the New England-area to call in with comments and questions. Vietnam veterans camped out in the lobby of the station. The broadcast won a local award for the best radio broadcast of 1974.

John Talbott, then director of Manhattan State Hospital, was in a position to play a key role in this effort (Talbott telephone interview,29 Aug. 1989, Baltimore, Md.). To begin with, he could approach Robert Spitzer easily. They had been colleagues at Columbia University Medical School and were friends. Further, he was head of the New York City chapter of the New York Psychiatric Association and held prominence within the APA itself. (In 1984, Talbott would become national president of the APA.) Though participants at annual meetings of the APA, Shatan and Lifton were outsiders. Talbott sponsored monthly meetings within the New York City chapter. He invited Shatan, Haley, Egendorf, and others to give presentations on "Post-Vietnam Syndrome" in order to raise the issue's visibility within the APA. This group then arranged for a meeting with Spitzer at the 1975 APA convention.

Shatan and the others were especially excited by Sarah Haley's addition to the group. The rest of them worked outside the VA with veterans who mostly avoided the VA. Haley had years of experience treating Vietnam veterans within the VA. And, in June 1974, her article, "When the Patient Reports Atrocities," had appeared in the *Archives of General Psychiatry* (Haley 1974). The article detailed how a therapist's own feelings about war might interfere with the ability to treat patients traumatized by war experiences.

Several high-profile appearances at professional meetings followed in rapid succession. Shatan organized a roundtable discussion, "War Babies," for the 1975 AOA annual meeting that March in Washington, D.C. The panel addressed the intergenerational transmission of stress and introduced Haley's work with the children of Vietnam veterans (Shatan 1975; Haley 1975). Psychiatrist Leonard Neff put together a panel, "The Vietnam Veteran: Continuing Problems of Readjustment," for the APA annual meeting two months later in Anaheim, California. The panel featured presentations by Lifton and Shatan.

Shatan, Lifton, and others met briefly with Spitzer in Anaheim. Spitzer reminded them that other psychiatrists and researchers also studied Vietnam veterans, notably John Helzer and Lee Robins of Washington University, St. Louis. Helzer and Robins (1976a, b) argued, in their writings and in their own meetings with Spitzer, that no separate classification was necessary in diagnosing the problems of Vietnam veterans. Spitzer challenged Shatan's group to disprove that. Shatan recalls: "[After the meeting with Spitzer], we all sat down. Neff, Haley, Lifton, and I—we formed the Vietnam Veterans Working Group. I said, 'Who is going to do all this work [to disprove the claims of the St. Louis group]?' The others said, 'Well, you are, of course. We'll help!' " (Shatan personal interview, 24 Oct. 1988, Dallas, Tex.).

Back in New York, Shatan took charge. He rounded up financial support and hired Jack Smith to work full-time on the project. The Working Group designated the diagnostic category "post-combat disorder," and set about gathering evidence systematically. William Niederland, a long-time acquaintance of Shatan's, and Henry Krystal organized a conference on victimization at Yeshiva University. Krystal and Niederland's (1971) research focused on concentration camp survivors. Shatan, Archibald and Tuddenham, and others earlier had noted similarities in the readjustment process between these survivors and combat veterans. The Working Group now began to think of the diagnostic category as a more generalized

phenomenon of which post-combat disorder was but a single example. Niederland and Krystal joined the Working Group.

Committee on Reactive Disorders: "PTSD"

That summer, the Working Group invited Spitzer to lunch at Columbia Presbyterian Hospital in New York City. They brought him up to date on their thinking and data collection efforts. Spitzer listened but stressed that the burden of proof still rested with the Group. However, he now appointed a formal committee, the Committee on Reactive Disorders, to proceed with the inquiry and report to the DSM-III task force. The Committee consisted of three representatives from the DSM-III task force—Spitzer himself and psychiatrists Lyman Wynne and Nancy Andreasen. He instructed Andreasen, the committee chair, to work with Shatan, Lifton, and Smith in justifying and developing a diagnosis.[8] The APA committee provided the Working Group with formal entry into the writing of DSM-III and was Spitzer's way of giving the issue a genuine opportunity to find its way into the manual.

The appointments, however, did not obscure the political hard ball that lay ahead. The division of labor called for Shatan, Lifton, and Smith—the Working Group three—to convince the other three committee members with hard evidence that some combat-induced disorder should be included in the revised manual. Smith thought that Andreasen, a specialist in treating severely burned patients, would be the key vote (Smith telephone interviews, 22 Dec. 1988 and 12 Sept. 1989, Cleveland, Ohio). He reasoned that Spitzer himself would be distracted by problems arising out of the production of DSM-III, and noted that Andreasen had a reputation as a hard-bitten empiricist. She shared Spitzer's point of view and, though she also had other assignments, could devote attention to the details of this committee's work. Smith expected Spitzer to accept Andreasen's verdict, thumbs up or down.

The original Working Group—which had continued as the organizational vehicle through which Shatan, Lifton, and Smith carried out their work for the Reactive Disorders Committee—steadily widened. Smith met with Harley Shands, the chief of psychiatry at Roosevelt Hospital in New York, who worked extensively with people who had been injured severely on the job. They concluded that the symptoms of these compensation victims were very similar to those of concentration camp survivors and combat veterans. Likewise, the Group corresponded with Mardi Horowitz of the University of California, San Francisco, who was in the final stages of his research on the physiology of stress (Horowitz 1976). Shands and Horowitz joined the Working Group. The Group then reviewed the literature on victims of catastrophes of other sorts. They solicited the assistance of specialists in each of these areas. This strategy put them in touch with a wide range of researchers and clinicians, many of whom fed them additional evidence, encouragement, and support.

In March, the AOA held its 1976 annual meeting in Atlanta. The Working Group set up a workshop on combat disorders. They invited Andreasen to attend the session and marshalled their data for the new diagnostic category. They drew these data primarily from the case histories of Vietnam veterans who had attended the New York City rap groups. The Group also brought other evidence with which to persuade Andreasen. Haley recalls:

> What I did was stay after work at the VA and, without anybody knowing it, I went through the records of all the Vietnam veterans we had seen in a year. I looked at what their diagnoses were.

8. The appointment of Smith to the Committee on Reactive Disorders was highly unusual. Of the roughly 125 experts serving on the various advisory committees who were to write and justify descriptions of mental disorders, only six of the appointees were not M.D.'s. Of the six, only two were not Ph.D.'s, and of the two, only Smith did not have a graduate degree. In fact, as Smith recalls: "I didn't even have a bachelor's degree [at the time]. So, talk about irregular!" (Smith telephone interview, 29 Dec 1988, Cleveland, Ohio). Smith later obtained a B.A. in psychology from Columbia University and entered the doctoral program in psychology at Duke University (see Smith 1981).

> What I looked at was the official, the DSM-II, diagnosis—the official one that you had to put down coded in the record. But then in parentheses [for some] was a working diagnosis. The working diagnosis was usually "traumatic war neurosis." And so what I said was, "Look it, Nancy, we had to give these guys . . . diagnoses [consistent with DSM-II], but if you look at what [some] clinicians are actually doing . . . they're basing their treatment on the fact that they recognize in these fellows similar traumatic war neurosis as they saw in the Second World War and Korean War veterans. . . ." That really turned her around (Haley telephone interview, 9 Nov. 1988, Somerville, Mass.).

They also spoke with Andreasen about her experiences in treating burn victims. She confided that she had observed stress reactions of the sort the Group described among her burn patients as well. By the end of the workshop, the Group felt that they had won Andreasen over. They now regarded her as an ally rather than an obstacle.

The following year, the Working Group continued to collect and enrich the case histories of Vietnam veterans until they had data on more than 700 subjects. In a position paper written by Shatan, Haley, and Smith, the Group presented their specific recommendation and coding for DSM-III (Shatan et al. 1976). They called for an entry labelled "catastrophic stress disorder" (CSD), and provided for acute (ACSD), chronic (CCSD), and delayed (DCSD) manifestations. They argued that the only significant predisposition for catastrophic stress disorders was the traumatic event itself, and stated that the symptoms, course, and treatment differed by the cause and onset of the disorder. The paper also included a section on a subcategory of the catastrophic stress disorder, social catastrophe type—post-combat stress reaction (PCSR). In May 1977, they held a panel discussion at the APA annual meeting in Toronto to make the proposal public (Shatan et al. 1977).

Opposition to the proposal continued to come from the researchers at Washington University-St. Louis. Their basic position was that the standard diagnostic categories of depression, schizophrenia, and alcoholism adequately covered the symptoms manifested by Vietnam veterans and the veterans of previous wars. By this time, however, the Working Group was in good position to advance their case. They were members of the APA Committee on Reactive Disorders. Their evidence was well-prepared and well-rehearsed. In short, they were well-organized and politically active, and their opposition in St. Louis was neither of these.

In January 1978, Spitzer called in the Working Group to present their findings to the Committee on Reactive Disorders. Lifton, Smith, and Shatan presented their evidence in a meeting with Spitzer, Andreasen, and Wynne. Lifton, Shatan, and Smith summarized their research and argued in favor of a listing entitled catastrophic stress disorder. They emphasized a wide circle of victims within the war zone, and the similarities between these victim groups and those traumatized in other "man-made" disasters and, to a lesser extent, naturally occurring disasters. The meeting went well. Later that month, Spitzer, Andreasen, and Wynne released the final draft of the committee's decision. They recommended a diagnosis under the label, "post traumatic stress disorder." Their description of PTSD de-emphasized the distinction between humanly produced and naturally occurring disasters, but otherwise appeared almost exactly as the Working Group had prepared it.

Discussion

On March 5, 1978, Shatan (1978) wrote a letter to the members of the Vietnam Veterans Working Group. His letter signaled "the successful completion of our enterprise. . . . We are happy to have reached agreement on it." That he chose the word "enterprise" is, from the sociological view that informs my story, especially fitting, for the events described allow us to see elements of the routine politics of diagnosis and disease in an especially clear light. PTSD is in DSM-III because a core of psychiatrists and veterans worked consciously and deliberately

for years to put it there. They ultimately succeeded because they were better organized, more politically active, and enjoyed more lucky breaks than their opposition.

However, if we were to ask these participants to warrant such a view of what they did and why they succeeded, it would not be surprising to find that they might want to add that such a victory was also "just"; that the official diagnosis was "as it should be" because "that is the way it is" in the world of disease and bodily disorder. Their accomplishment was to make plain what had before not been seen.

I have sought here not to adopt an ironic stance toward such a view; not to suggest that this diagnosis—and diagnoses in general—are "merely" a social construction, or simply the result of self-interested psychiatric hegemony. Rather, in telling the story of PTSD I contribute another case to those that help us understand in detail how objective knowledge—and medical scientific knowledge in particular—is produced, secured, and subsequently used to create other objective realities, such as, in this case, acknowledgements of war's horrors, populations of treatable clinical cases of PTSD, patients entitled to insurance coverage, and the like. Each new clinical diagnosis of PTSD, each new warrantable medical insurance claim, each new narrative about the disorder reaffirms its reality, its objectivity, its "just thereness."

In the story of PTSD we see again how the orderliness of the natural world is to be found in its very accounts of orderliness. Theories represent competing sets of assumptions that are inseparable from the interpretation of the evidence taken to support and strengthen them and their predictions. Hence, scientists and those who adopt its discourse evaluate evidence and make claims about what they have discovered. The goal is to move disputed claims along a path toward acceptance as taken-for-granted fact. This calls for appropriate documentation, the ability to command the attention and respect of critical persons and groups, and the skills and resources necessary to marshal this effort. As Aronson (1984:9) notes, "successful scientists, rather than conforming to the Mertonian norm of disinterestedness, display a tenacious attachment to their ideas—not unlike, perhaps, the zeal of a moral reformer." This is, as we know, how facts are made.

The story of PTSD also informs our more specific understanding of how this process worked in this case. At issue was the question of what constitutes the normal experience or reaction of soldiers to combat. DSM-II subsumed emotional distress during or after combat under standard psychiatric syndromes of depression, alcoholism, and schizophrenia. Clinicians in agreement with this position regarded a soldier's combat experiences as incidental to a syndrome's onset and subsequent treatment. Other psychiatrists departed from the official diagnoses available in DSM-II. They identified the same symptoms in combat veterans as "war neurosis" or "post-Vietnam syndrome." These working diagnoses called for the clinician to take seriously the patient's combat experience. This orientation shifted the focus of the disorder's cause from the particular details of the individual soldier's background and psyche to the nature of war itself. Its advocates claimed: soldiers disturbed by their combat experiences are not, in an important sense, abnormal; on the contrary, it is normal to be traumatized by the abnormal events typical of war. At no time was the dispute over the question of whether or not diseases and disorders exist. Instead, it turned on whether in fact there was one, PTSD, that had yet to be discovered.

The drive to recognize some form of war neurosis as a disorder lays bare the processes by which sicknesses are identified, sustained, or challenged. Privately, psychiatrists may practice the art of medicine by doing what they think best for their patients. Professionally, however, they must conform to current scientific consensus or run the risk of being labeled "quacks." When a formal diagnosis is required, they must use the most recent DSM in order to state officially whether or not someone is sick. Two types of error thus may result in the application of these official diagnoses: well persons may be diagnosed as sick, and diseased ones may be misclassified or considered healthy. Champions of change in psychiatry's routine practice of designating who is to be treated, or not, and for what—such as gay activists and the people

described here—may seek to rectify one or the other of these errors by calling for changes in the manual itself.

The road to the discovery and objectification of PTSD took participants in and out of diverse arenas that required equally diverse strategies and skills for making successful claims and forming political alliances. To move war neurosis down the path from disputed condition to accepted diagnosis, its champions worked primarily with key psychiatrists and with the Vietnam veteran community. Activity within the APA was of critical importance because the APA owned psychiatric diagnosis in the United States. Advocates saw a fleeting opportunity in the early stages of DSM-III's production to legitimate, in one swoop, their many efforts on behalf of Vietnam veterans, and, of course, to right a wrong being done them. Such events allow us to see more clearly certain aspects of the routine process of medical discovery at work.

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