

OUR HEARTS AND OUR HOPES ARE TURNED TO PEACE:

ORIGINS OF THE INTERNATIONAL SOCIETY FOR TRAUMATIC STRESS STUDIES

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INTRODUCTION

"Our hearts and our hopes are turned to peace as we assemble here in the East Room this morning", said President Johnson on the morning of November 19, 1968. *"All our efforts are being bent in its pursuit. But in this company we hear again, in our minds, the sound of distant battles".* President Johnson was addressing these words to those gathered for the Medal of Honor ceremony in honor of five heroes of the undeclared war in Vietnam. One of those heroes was a young African-American man from Detroit, Sgt. Dwight Johnson. Dwight, or "Skip" to his family and friends, had always been a good kid, an Explorer Scout and an altar boy, who could only recall losing control of his temper once in his life, when his little brother was being beaten by older boys. But in Vietnam, when the men whose lives he had shared for eleven months were burned to death before his eyes, he suddenly became a savage soldier, killing five to twenty enemy soldiers in the space of half an hour. At one point, he came face to face with a Vietnamese soldier who squeezed the trigger on his weapon aimed point blank at Skip. The gun misfired and Skip killed him.

According to the psychiatrist who saw him several years later, it was this soldier's face that continued to haunt him.

After receiving the Medal of Honor, Skip, who had been unable to even get a job as a simple veteran, became a nationally celebrated hero. But his body and mind started to give way. In September of 1970 he was sent to Valley Forge Army Hospital where the psychiatrist there diagnosed him with depression caused by post-Vietnam adjustment problems. *"Since coming home from Vietnam the subject has had bad dreams",* read the psychiatric report, *"He didn't confide in his mother or wife, but entertained a lot of moral judgement as to what had happened at Dakto. Why had he been ordered to switch tanks the night before? Why was he spared and not the others? He experienced guilt about his survival. He wondered if he was sane"* (Nordheimer, 1971).

On April 30, 1971, Dwight Johnson, now married and the father of a little boy, was shot and killed while attempting an armed robbery of a Detroit grocery store. The store owner told the police: *"I first hit him with two bullets but he just stood there, with the gun in his hand, and said, 'I'm going to kill you . . .' I kept pulling the trigger until my gun was empty"*. In the exchange, Dwight Johnson, an experienced combat soldier, never fired a shot. His mother's words echo down to us, twenty-seven years later, *"Sometimes I wonder if Skip tired of this life and needed someone else to pull the trigger"* (Nordheimer, 1971).

It is with this dramatic behavioral re-enactment of one young, despairing African-American soldier that the curtain opens on the first act of the story of the International Society for Traumatic Stress Studies. The ISTSS is one organizational part of a late twentieth century social movement aimed at raising consciousness about the roots of violence by enacting and reacting to that violence everywhere. The ISTSS was born out of the clashing ideologies that became so well articulated in the 1960's and 1970's. War crimes, war protests and war babies; child abuse, incest and women's liberation; burning monks, burning draft cards and burning crosses; murdered college kids and show trials of accused radicals; kidnappings, terrorism and bombings; a citizenry betrayed by its government and mass protests in front of the Capitol in Washington – all play a role in the backgrounds of the people who founded the organization and in the evolution of the organization itself.

If I have learned anything from my contact with victims of violence, I have learned that it is vitally important to remember – and honor – the lessons of the past. We have to know where we came from if we are to know who we are now. But it is extremely difficult to write history as history is being made. Since this chapter can only serve as a marker along the way, I have chosen to concentrate my attention on the origins of the Society, before those roots become even more lost in the darkness that envelopes those who move offstage.

There are two fundamental aspects of the growth of this group. First, there are the individuals who provided the action – both the victims and their advocates. One remarkable aspect of the ISTSS history is the extent to which the founding mothers and fathers have had personal experience with trauma (van der Kolk, Weisaeth and van der Hart, 1996). It may be that it was this close brush with the Angel of Death that has given the growing field such a continuing sense of passion, devotion and commitment. Whatever the case, there are a multitude of stories begging to be told, severely limited here by time and space. The second aspect of organizational growth is the group-as-a-whole growth that I hope will emerge in the structure of the chapter. The origins can not be placed at the foot of one powerful individual and did not derive from a clearly thought-out, hierarchical, managerial demand. Instead, it has grown organically, from the grassroots, and has remained multidisciplinary, multinational and multi-opinioned.

WAR TAKES CENTER STAGE

Dr. Chaim Shatan was familiar with the symptoms of war. His father had fought in three – the Russo-Japanese War, the Balkan Wars, and the First World War before moving from Poland to Canada. His father wrote short stories about his war experiences and the son translated them from Yiddish to English. Shatan had gone to medical school during World War II, when physicians still received training in combat-related disorders and had evaluated men suffering from the traumatic neuroses of war (Scott, 1993). A New Yorker, Shatan read the *New York Times* routinely and when he read the story about Dwight Johnson, he felt compelled to respond. Further, as codirector of the postdoctoral psychoanalytic training clinic at New York University (NYU), he could even harbor hope that it would get published. His editorial to the *New York Times* was published in May, 1972 and titled, “Post-Vietnam Syndrome”. In his editorial, Shatan described what came to be called post-traumatic stress disorder, and told how he had noticed these symptoms in the Vietnam veterans he and his colleagues had been seeing in “group rap” sessions (Shatan, 1972; 1978a). One of these colleagues that Shatan referred to was Robert Lifton.

Lifton was an ardent antiwar activist who had served in Korea as a military psychiatrist and had already studied and written about the survivors of Hiroshima (Lifton, 1967). Lifton met Sarah Haley through the New York and Boston chapters of the group, Vietnam Veterans Against the War (V.V.A.W.). Sarah Haley was a social worker at the Boston Veterans Administration Hospital. Unlike most of her colleagues at the time, Haley recognized that many of her patients who had served in Vietnam were being misdiagnosed as paranoid schizophrenics or with character disorders because mental health professionals were failing to recognize the symptoms related to combat. But

she knew them. She had grown up with a father who was a veteran of World War II, a special agent for the O.S.S. and an alcoholic. She had heard stories of trauma and wartime atrocities from the time she was a little girl and she had personally experienced the long-term impact of war on her father's behavior. What other colleagues found unbelievable, she found entirely realistic. When she met a Vietnam veteran who claimed to have been involved in the massacre of a village called My Lai, she believed him. It was through Haley that Lifton met and interviewed that soldier (Scott, 1993).

In January 1970, Lifton testified to a Senate subcommittee about the brutalization of GIs in Vietnam, a brutalization that he believed "*made massacres like My Lai inevitable*" (Lifton, 1973, p.17). In April 1970, the U.S. invaded Cambodia and students across the country rose up in protest. Within days, the Ohio National Guard fired into a crowd at Kent State, killing four students and wounding nine others. Chaim Shatan had previously arranged for Lifton to speak at N.Y.U. but they decided to change the topic to address the Cambodian invasion and the Kent State killings, and advertised it widely around New York City. Many people came who were not students, including some Vietnam veterans who were members of the V.V.A.W. (Scott, 1993). The rap groups in New York evolved from this meeting and from correspondence and phone calls between Jan Crumb, then president of the V.V.A.W., Al Hubbard, a veteran from New York, and Lifton, beginning in November, 1970 (Lifton, 1973; Shatan, 1998).

EAST COAST RAP GROUPS

When the clinicians sat down with Hubbard and several others from V.V.A.W., the vets described the way the members "rapped" with each other about the war, American society and their own lives. They told the clinicians that it would be helpful if they were able to turn to professionals who could teach them more about the complex psychological processes attendant upon war experience. Lifton suggested they form more regular rap groups with some professional involvement. With the support of the chairman of the psychoanalytic training program at N.Y.U., Shatan circulated over three hundred memos asking for professional volunteers to join in efforts to provide clinical consultation to the rap groups. He urged his colleagues to help, telling them that "*This is an opportunity to apply our professional expertise and anti-war sentiments to help some of those Americans who have suffered most from the war*" (Shatan, 1971). He outlined for them three theoretical questions that he believed needed to some clinically-informed answers: What are the differences between Vietnam veterans and World War II veterans? Can the psychodynamics of war atrocities be clarified and demonstrated to grow organically out of modern combat training? What is happening in the group process experience between veterans and professionals?

The enticements worked. Within five days, his memo had drawn forty volunteers. A panel of professional psychological and psychiatric colleagues in the New York area was formed. Most came from the NYU Postdoctoral Psychoanalytic Program, others from prestigious programs like the W. A. White Institute for Psychoanalysis and the New York Psychoanalytic Institute. These clinicians participated in the groups until at least 1976 (Shatan, 1987). They called themselves “professionals” rather than “therapists” because they “. . . had a sense of groping toward, or perhaps being caught up in, a new group form. Though far from clear about exactly what that form would be, (we) found ourselves responding to the general atmosphere by stressing informality and avoiding a medical model” (Lifton, 1973, p.77). Through word of mouth, announcements from church pulpits, and some media coverage, veterans began to hear about the rap groups and the numbers of people attending the groups began to grow. Jack Smith and Arthur Egendorf, both veterans, were early members of the rap groups in New York.

THE V.A. RESPONSE AND THE “COUNTER-V.A.”

In 1971, Shatan and Peter Bourne testified at the court martial of a Marine POW who was being charged with desertion, though he clearly suffered from traumatic stress. The papers written by Bourne and published in 1969 and 1971 about war neurosis were ignored. The refusal to see the damage that had been done to these men motivated Shatan even further. The response to Shatan’s op-ed article was overwhelming. He heard from over 1,250 rap groups from around the country as well as student health and financial aid offices on many campuses, and even veterans in prison. Groups had already been meeting informally with psychiatrists in Philadelphia, Atlanta, and Boston (Shatan, 1987). All were functioning outside of the established Veterans Administration services either because they were past the two-year limit for service-connected disabilities or because they found those employed to administer traditional service geared to World War II veterans, hostile to them and unwilling to meet their needs (Scott, 1993).

At this time there was tremendous hostility towards the returning Vietnam veterans, particularly those who had become disillusioned with the war. And the hostility came from the left and the right sides of the political spectrum. John Kerry (now Senator John Kerry) was a founder of the V.V.A.W. and holder of three Purple Hearts, a Bronze Star and a Silver Star for his service in Vietnam. He reported that a Minnesota American Legion post excluded Vietnam vets because they had lost the war. Meanwhile, there were antiwar activists and pacifists calling the veterans “baby-killers” (Shatan, 1987). Even the military victimized the vets as they were leaving the war through the practice of giving “bad discharge numbers”. According to a discreet coding system, numbers

were entered on discharge papers that identified veterans who had been seen as “troublemakers” while in the service, and then these codes were distributed to employers and personnel officers. In the media, especially television, the stigmatization was furthered by the portrayal of Vietnam veterans as dangerous and psychotic freaks, murderers and rapists (Leventman, 1978).

In 1978, Leventman, citing an earlier article of his own said: *“Nothing reflects so much of what is wrong with American society as its treatment of Vietnam veterans . . . one can only reiterate that the negative legacy of Vietnam lies more in civilian society than in the psyches of veterans”* (p. 295).

In response to this discrimination, the veterans and their supporters organized a counter-VA consisting of therapeutic communes, storefront clinics, vet centers, and bars. They organized social and political protests. They conducted street theater with mock pacification operations in New Jersey villages. In December, 1970 another veterans’ group, the “Citizens’ Commission for Inquiry into U.S. War Crimes in Vietnam”, held the first war crime hearings in Washington at the Dupont Circle Hotel. Shatan and Lifton testified there as well as Congressmen Conyers and Dellums, who made sure that a report was entered in the Congressional Quarterly in 1971 (Shatan, 1998). In January of 1971, the V.V.A.W. organized war crime hearings in Detroit called the “Winter Soldier Investigation”, sponsored by Jane Fonda, among others. One hundred and fifteen veterans, as well as Robert Lifton, presented testimony about atrocities committed in Vietnam. Fonda and antiwar activist, Mark Lane, filmed the testimony and arranged for distribution. However, the event got very little national media coverage.

In April 1971, the V.V.A.W. organized a march on Washington. The military had called the invasion of Cambodia and Laos “Operation Dewey Canyon II, and the V.V.A.W. named their action “Operation Dewey Canyon III”, designating it as a *“. . . limited incursion into the country of Congress”*. Their week-long occupation of Washington culminated in a ceremony on the Capitol steps, a “medal turn-in” ceremony. Jack Smith recalls, *“I can still hear the dings of those medals, the Bronze Stars and the Silver Stars bouncing off the statue of John Marshall, and the Purple Hearts, behind the barricades”* (Scott, 1993, p.23).

The veterans published an anthology of war poems and used the money to help a Quaker rehabilitation center in South Vietnam and to help rebuild Hanoi’s foremost hospital, destroyed in the carpet-bombing. They founded free clinics in poverty areas and staffed them with former nurses and medics. They offered legal aid and regular visits to vets in prison. Mental health professionals, moving beyond therapy and detachment to advocacy, participated: *“We went, with the vets, wherever we could be heard: to conventions, war crimes hearings, churches, Congress, the media, and abroad. We, too, suffered insomnia and had combat nightmares”* (Shatan, 1987, p.8).

WEST COAST RAP GROUPS

Meanwhile, out on the West Coast, a schizophrenia expert, Dr. Philip May, was director of psychological services for the Brentwood Veterans Administration Hospital. In 1971, he recognized that Vietnam veterans were not getting the services they needed, so he hired Shad Meshad, a social worker and Vietnam vet himself, to evaluate the situation. Meshad had already started one of the nation's first rap groups in the Los Angeles area and was highly critical of the VA services. He had been a medic in Vietnam, was seriously wounded, and had endured several painful operations in the States. He knew what veterans were contending with from a first-hand perspective (Meshad, 1997; Scott, 1993). So did William Mahedy, who had served as a chaplain in Vietnam and was working as a social worker at Brentwood, *"Most Brentwood psychiatrists that I met during this period had not the slightest clue how to deal with Vietnam veterans . . . they didn't know how to treat combat-related stress. Nor could they provide any guidance to the kind of total reintegration into society that we knew was necessary"* (Mahedy, 1986, p.56). In response, Meshad created the highly unconventional Vietnam Veteran Resocialization Unit within the Brentwood VA hospital, with the support of the director at Brentwood and set up storefront clinics where rap groups were held.

THE CHURCHES HELP THE CAUSE

By 1973, Robert Lifton's book *Home from the War* was published, the first widely read book about the plight of the Vietnam veterans. He and Shatan had made strong and supportive connections with the American Orthopsychiatric Association and several universities. Both were impressed by the growing grassroots movement and believed that it could be strengthened even further. In 1970, the National Council of Churches (NCC) had established an office under Reverend Richard Kilmer, an ordained Presbyterian minister, in order to help those hurt by the war in Vietnam. At first the NCC focused efforts on draft resisters and antiwar protestors. However, in 1973, at the urging of Shatan and Lifton, the NCC began laying plans for the First National Conference on the Emotional Needs of Vietnam-Era Veterans. According to Jack Smith, the veterans had pointed out to Reverend Kilmer that they had an obligation to minister to people who were *in* the war as well as *out* of it.

The churches began to listen. The Missouri Synod of the Lutheran Church put up \$80,000 for expenses and agreed to host the meeting at its seminary in St. Louis, appropriately situated right in the middle of the country. Arthur Egendorf developed a list of veterans, psychiatrists and others who were actively involved in helping Vietnam veterans around the country. According to Shatan, about 130 people attended the conference: *" . . . 60 vets, 30 shrinks, 30 chaplains, and 10 central office people [VA] who came on at the last minute* (Scott, 1993, p.45). At the conference, Lifton and Shatan spent time with reporters talking about the problems of Vietnam veterans. The conference

lasted for three days, April 26-28, 1973, and out of the conference the National Vietnam Veterans Resource project (N.V.R.P.) was created with a governing council of 16 people co-directed by Chaim Shatan and Jack Smith, with representatives from all three groups – veterans, chaplains and mental health professionals. The project was to have several functions: to search and gather data on the effects of combat stress and to help coordinate a self-help movement of veterans groups (Shatan, 1987; 1997a).

THE GOVERNMENT RESPONDS

There were direct consequences for this kind of advocacy. Beginning in 1970, Shatan came under government surveillance. Returning from a meeting at the Pentagon in June of 1973, he found his phone had been tapped. After a visit to Washington to offer assistance to American POW's returning from Hanoi, he discovered that someone had tampered with his mail. In July of 1973, Shatan had been contacted by William Kunstler's Center for Constitutional Rights for help in preparing a "post-Vietnam syndrome" defense for the "Gainesville Eight", veterans who had been charged with planning to blow up the 1972 Democratic and Republican conventions. After this, the interference with his mail was stepped up so that if mail came from veterans' organizations, people who worked with Vietnam vets, or Robert Lifton, it was bound to be searched (Scott, 1993). The FBI tried to infiltrate the rap groups by sending in informers posing as veterans seeking help (Lifton, 1978). Shatan found that plans were even afoot to entrap him with blueprints of government munitions plants. A veteran who was suspected of being a part of the security apparatus of the time, sent both blueprints and letters to Shatan, detailing to him how easy it was to get letters out of the Pentagon. Shatan had friends at the Center for Constitutional Rights and they urged him to get the documents out of his office and lock them in their safe because they were convinced that he was being set up for a raid. His response was to talk longer, louder and more frequently in order to bring attention to the readjustment problems of the veterans and to make their cause more publicly visible and therefore less vulnerable to government sabotage (Shatan, 1987; 1998).

The VA Central Office attacked Lifton and Shatan in the press when the two psychiatrists estimated that 20% of men who had served in Vietnam were paying a heavy psychological price, when the VA claimed that only 5% of the men had combat-related psychological symptoms. Both were labeled as being "hung up on the war" and accused of "dishonoring brave men" (Shatan, 1985). Both Shatan and Lifton knew that it was impossible to separate the professional work they were doing with these men from their political activism. As Lifton recalls, *"I believe that we always function within this dialectic between ethical involvement and intellectual rigor, and that bringing our advocacy "out front" and articulating it makes us more, rather than less scientific . . . From the*

beginning the therapeutic and political aspects of our work developed simultaneously” (Lifton, 1978, pp. 211 & 212).

TURNING THE GOVERNMENT AROUND

It was difficult for Vietnam veterans to get the services they needed from the VA for several reasons, besides the existing, sometimes virulent, prejudice against the men who had fought in Vietnam and were suffering from the delayed effects of combat stress. First, there was no diagnostic code for combat stress in DSM-II. This latest edition of the *Diagnostic and Statistic Manual for Mental Disorders* had been published by the American Psychiatric Association in 1968. As Art Blank, points out, “*As the return of troops from Viet Nam was reaching a crescendo, the psychiatric profession’s official diagnostic guide backed away from stress disorder even further, and the condition vanished into the interstices of “adjustment reaction of adult life”* (Blank, 1985, p.73). But even under DSM-I there had been no classification for delayed stress reactions. So, if the symptoms presented more than two years after discharge from active duty, the VA did not consider them to be service-related problems. If veterans presented with post-traumatic psychiatric symptoms, they were misdiagnosed as suffering from depression, paranoid schizophrenia, character or behavior disorders (Blank, 1985; Wilson, 1988).

Senator Alan Cranston, a World War II veteran and a member of the Senate’s Committee on Veterans Affairs, became convinced that the psychological needs of Vietnam veterans were different from those of older veterans. Starting in 1971, he tried to bring about changes in the VA system by seeking better funding for the Vietnam veterans to obtain drug and alcohol rehabilitation as well as specialized readjustment counseling services. The bill he proposed passed the Senate in 1973 and 1975, but the House refused to pass it. The House was dominated by World War II veterans, who had an unwillingness to concede that the Vietnam War had produced different problems than had been previously recognized. In addition, the American Legion as well as the Veterans of Foreign Wars lobbied against the bill. Taking a more long-term approach, Cranston appointed Max Cleland as a member of his staff to review the VA hospitals. Max Cleland was a Vietnam veteran who had lost an arm and both legs in the war and had testified for Cranston at the Senate Committee on Veterans Affairs in 1971. In his new position, Cleland visited Shad Meshad’s storefront operations at Brentwood. Both Cleland and Meshad testified in 1975 before Senator Cranston’s Subcommittee on Health and Hospitals, providing clear evidence that the VA hospitals were not meeting the needs of Vietnam veterans (Scott, 1993).

Besides the problems with the psychiatric diagnostic schemas, there was no organized Vietnam veterans' pressure group advocating for a change in benefits (Scott, 1993). The work of the National Vietnam Veterans Resource Project (N.V.R.P.), created during the First National Conference on the Emotional Needs of Vietnam-Era Veterans, began immediately after the conference. By 1974, the N.V.R.P. had catalogued 2,700 diverse veterans' self-help programs, 2,000 of them on college campuses, some out in the community and others in prisons (Lifton, 1973; Shatan, 1974). Jack Smith sought funding for an empirical study and called it the Vietnam Generation Study, since the intention was to study both veterans and draft resisters. He and a colleague obtained funding from the National Council of Churches, the Russell Sage Foundation, and the Edward F. Hazen Foundation to begin a pilot study (Scott, 1993). In 1975, the Senate Committee for Veterans Affairs initiated a bill, approved by Congress, mandating the VA to conduct a study to assess the needs of Vietnam veterans. As a result, the VA provided funds to Arthur Egendorf and the NVRP to complete the Vietnam Generation Study, which eventually culminated in *Legacies of Vietnam* (Egendorf et al., 1979; 1981; Laufer, 1985).

THE MYSTERIOUS DISAPPEARANCE OF COMBAT STRESS

The first version of the *Diagnostic and Statistical Manual* formulated by the American Psychiatric Association was published in 1952, while American psychiatrists were actively treating veterans of World War II and Korea. "Gross Stress Reaction" was used to describe the after-effects of previously healthy persons who began having symptoms related to intolerable stress. DSM-II was published in 1968, at the height of the Tet Offensive in Vietnam and "Gross Stress Reaction" was replaced with "(transient) adjustment disorder of adult life". The only mention of combat – as ". . . fear associated with military combat and manifested by trembling, running, and hiding" – was put in the same category as an "unwanted pregnancy" (Shatan, 1985).

As Chaim Shatan wrote many years later, "*The disappearance of stress reactions from DSM-II remains a mystery. Its causes have not been established. I have not been able to find a soul who will say they know how or why it happened . . . [but] we can say that the diagnostic lacuna in DSM-II had great political value during the Vietnam war . . . every diagnosis is a potential political act*" (1985, p.2-3). For Figley, the absence in DSM-II of a diagnostic category specific to combat trauma can be attributed to the lack of American involvement in a war during that period, as WWII and Korean veterans became integrated into the community (Figley, 1978a).

But Blank also believed that the elimination of "Gross Stress Reaction" had been politically motivated, if not consciously, then unconsciously. On looking back he concurs with Shatan, "*These dramatic shifts from DSM-I to DSM-III*

suggest the hypothesis that – as part of a highly complex social and intellectual phenomenon – irrational influences have deeply affected the recognition and appreciation of accurate guidance by organized psychiatry” (Blank, 1985, p. 74). Wilson has puzzled over this mystery as well, pointing out that after the death of Freud the collective knowledge about psychological trauma seemed to go underground and by the time of DMS-II had all but evaporated. “What makes this so peculiar is that by 1968, the cumulative historical events involving war, civil violence, nuclear warfare, etc., produced more trauma, killing, mass destruction, and death in a limited time frame than at any prior time in recorded history” (Wilson, 1995, p.15). Blank even now predicts that, for similar reasons, there will be a move to exclude PTSD as a diagnostic category when the DSM-V is formulated in the future (Blank, 1997a).

Whatever the reasons – and there probably were many - as early as 1969, John Talbott recommended that the future editors of DSM-III re-introduce the gross stress reaction listing. Talbott, later to become President of the American Psychiatric Association, had served in Vietnam as a psychiatrist. He conducted some of the initial interviews for the Vietnam Generation Study and was stunned by how much of this “post-Vietnam syndrome” he had been failing to diagnose in part because there was no way to make the diagnosis under DSM-II (Scott, 1990; 1993).

ORGANIZATIONAL EFFORTS EXPAND

Shatan says that he first heard that traumatic war neurosis had disappeared in 1974 as a result of a phone call from an Asbury Park, New Jersey public defender. A Vietnam veteran had been charged with violence against property and had amnesia regarding his behavior. The public defender entered a plea of not guilty based on traumatic war neurosis and the judge rejected the defense because there was no longer such a diagnosis. Shatan recommended that the public defender contact the DSM-III Task Force headed by Robert Spitzer. He did so and was told that there were no plans to reinsert any form of traumatic war neurosis in the DSM-III. A reporter from the *Village Voice* got this word back to Shatan and he was shocked. He got together with Lifton to decide what to do. They realized they had to mobilize, and mobilize quickly (Shatan, 1985).

Their response was to form the Vietnam Veterans Working Group (V.V.W.G.), supported, in part, by the American Orthopsychiatric Association, the Emergency Ministry of the United Presbyterian Church and the National Council of Churches, with some assistance from Amitai Etzioni at the Center for Policy Research, Columbia University (Scott, 1993; Shatan, 1997a; Shatan et al, 1977). In 1974, Sarah Haley published her landmark paper, “When the patient reports atrocities” in the *Archives of General Psychiatry*, one of the publications of the American Psychiatric Association (APA), and it was widely read. John Talbott had easy access to the APA. He sponsored meetings at the New York chapter of the APA, inviting Shatan, Haley, Arthur Egendorf and others to

present on “Post-Vietnam syndrome”. He also helped them get access to Robert Spitzer at the 1975 APA convention. Jack Smith developed a questionnaire as part of his doctoral thesis, “American War Neurosis, 1860-1970” and Shatan sent the questionnaire to 35 members of the VVWG in 1975, many of whom had been working closely with the veterans in rap groups and individual sessions, some as far back as 1970 (Shatan, et al., 1977). He asked them to go through their caseload with the questionnaires. Shatan and Lifton, joined by Jack Smith and Sarah Haley, tabulated the results on 724 veterans and arrived at a classification system very close to the one Kardiner had proposed in 1941 (Shatan, 1997b, Shatan, Haley & Smith, 1977; Van der Kolk et al, 1994).

Meanwhile, Charles Figley organized panels in 1975 at the American Sociological Association. He met with Chaim Shatan, Robert Lifton and others while beginning to work on an edited volume. In 1978, this volume would become a landmark book on Vietnam. Figley, a psychologist, had served in Vietnam in 1965 with the Marines and was one of the first Vietnam veterans to return home. He completed graduate studies and participated in Dewey Canyon III. On campus, he met other Vietnam veterans and became aware of the widespread nature of their adjustment problems. After obtaining his degree, he took a position at Purdue University where he founded and directed the Consortium on Veteran Studies and started studying the post-Vietnam effects intensively. He developed a bibliography about combat trauma and began corresponding with other people interested in similar studies (Scott, 1993).

Meanwhile, John Wilson, a conscientious objector during the Vietnam War, began working on the “*Forgotten Warrior*” project. Wilson had completed his Ph.D. in 1973 and performed three years of alternative service in a crisis intervention center. When two close friends returned from Vietnam as radically changed people, a seed was planted in his mind. His first academic position was in Cleveland where a student of his presented a report on some Vietnam veterans he had interviewed on campus. John was intrigued. He sent out letters to the veterans on campus and more than 100 responded. He and the student he was working with, Chris Doyle, recorded narratives of their lives before, during and after Vietnam. The work became consuming. His department chairman threatened to block his tenure or promotion if he continued this work, but John was undeterred. He set up rap groups at the university and requested funding from various organizations for a study. But only in 1976 was he able, through the assistance of a disabled veteran, to get the Disabled American Veterans to provide the money he needed to complete the study (Scott, 1993). Drawn from over 450 interviews, Wilson and Doyle published a report on “*The Forgotten Warrior Project*” (Wilson & Doyle, 1977).

In 1977, Figley chaired a research symposium at the American Psychological Association conference where he was able to arrange for the presentation of three papers: Egendorf and colleagues' first version of what would ultimately become the *Legacies of Vietnam* study, (Egendorf et al., 1977), his own work from the Consortium (Figley & Southerly, 1977), and Wilson and Doyle's *Forgotten Warrior Project* (Wilson & Doyle, 1977). Each separate study supported and extended the other (Figley, 1978b) and provided even more support for the efforts of the V.V.W.G. in their attempt to change DSM-III.

THE LOST IS FOUND: POST-TRAUMATIC STRESS DISORDER

Ironically, the decision to alter the DSM-III in relation to homosexuality may have had something to do with subsequent changes in the DSM allowing PTSD to enter the lexicon. The argument over whether or not homosexuality was a disease entity was so heated and politically loaded, that Spitzer decided it should be put to a vote. This indicated that the DSM-II could end up being completely redone, opening up negotiating room for those who wanted to reintroduce stress reactions into the classification schema.

Shatan had known Spitzer since the 1950's when they were both at Columbia. Spitzer invited Shatan to come to Disneyland to present his findings as a result of his work with Vietnam veterans. The irony that this momentous occasion was opened with greetings from Mickey Mouse and Pluto was not lost on the participants. So, in 1975, Shatan, Lifton, Jack Smith, Sarah Haley, and Leonard Neff presented their work opposite a psychologist from Washington University in St. Louis. The position of the Washington University group was that all of the symptoms seen in the Vietnam veterans could be explained by depression as a pre-existing condition. Spitzer challenged the Shatan, Lifton, Haley and the others to refute these findings (Shatan, 1998). In the summer of 1975, the V.V.W.G. invited Spitzer to lunch at Columbia Presbyterian in New York City. The group filled him in on their activities and he was willing to appoint a formal committee, the Committee on Reactive Disorders, to proceed with the inquiry. He appointed himself, Dr. Lyman Wynne and Dr. Nancy Andreasen to be the representatives on the committee with Andreasen as chair. Andreasen had previously worked with burn victims and knew about the long-term psychological as well as physical suffering that was involved in recovery from severe trauma. Spitzer instructed Andreasen to work with Shatan, Lifton, and Smith. The appointment of Jack Smith, a non-professional, was a highly unusual move. But the burden of proof still remained with the V.V.W.G. (Scott, 1993).

Convincing Andreasen of the validity of the long-term reactions to overwhelming stress was key to the success of the venture. The Working Group reckoned that persuasion would be easier if they could show the similarities between combat stress and other forms of traumatic experience. So they

recruited Harley Shands who had experience working with job-related trauma and Mardi Horowitz who was working on the physiology of stress. They combined this with the research related to concentration camp victims that William Niederland and Henry Krystal had been doing, and contacted researchers working with other survivor groups to join in their mission. Sarah Haley pointed out to Andreasen that in reviewing the charts of the Vietnam veterans in the VA hospital, she had discovered that many of the clinicians were treating the patients *as if* there was a diagnosis of traumatic war neurosis available. This practical reality had a particularly strong impact on the discussions (Scott, 1993; Shatan, 1997a). Shatan, Haley and Smith presented their position paper at the 1977 annual meeting of the American Psychiatric Association, representing the accumulated work of the V.V.W.G. and making specific recommendations to the DSM-III Task Force for changes in the categorization system (Figley, 1978a; Shatan et al, 1977).

Early in 1978, Spitzer called the Working Group together to present their findings to the Committee of Reactive Disorders. Lifton, Smith and Shatan presented their evidence in a meeting with Spitzer, Andreasen and Wynne. They emphasized a wide circle of war zone victims and the similarity between them and other victim groups. Later that month, the Committee released its decision, recommending a diagnosis of "Post-Traumatic Stress Disorder". The DSM-III was completed and published two years later, having incorporated most of the recommendations made by the V.V.W.G., which were very similar to the observations made by Kardiner in the 1940's (Kardiner, 1941; Scott, 1993; Shatan, 1978b). Interestingly, at the same time as the V.V.W.G. were endeavoring to establish criteria for the DMS-III, another group of mental health professionals were working on a diagnostic system for dissociative disorders. There was no communication between them and the PTSD working group, largely because very little academic conversation had yet occurred about the relationship between dissociation and trauma. As a result, a separate classification for the dissociative disorders was also entered into DSM-III and separate organizations subsequently developed to study these two related fields (Van der Kolk et al., 1994).

VET CENTERS

In the meantime, President Carter had appointed Max Cleland as Director of the Veterans Administration and Alan Cranston assumed the chairmanship of the Senate Committee on Veterans Affairs. Cleland called a meeting with Art Blank, Charles Figley, Shad Meshad, John Wilson, William Mahedy and others to make specific recommendations for a VA readjustment counseling program. Art Blank, a psychiatrist, had been drafted to serve in Vietnam in 1965. When he returned and was appointed to a position at Yale, one of his clinical positions was at the West Haven VA Hospital treating Vietnam vets. As a result of his own experience, he began diagnosing traumatic war neurosis in 1972,

long before his colleagues were willing to see the effects of war on the returning veterans. He made contact with Sarah Haley after reading her 1974 paper and through her, had met Figley and Shatan (Blank, 1998). Once the Vet Centers became a reality, he became the VA's chief psychiatrist of the Veterans Readjustment Services.

As a result of the changed political climate, at the same time as the APA was changing the DSM-III, Congress directed the Veterans Administration to create a nationwide system of specialized counseling centers (Vet Centers) for a wide range of readjustment problems in Vietnam veterans, including PTSD (Blank, 1985). The first Vet Center opened in 1979 and by 1990 there were almost 200 around the country (Blank, 1993). The *Legacies of Vietnam* study was published in 1981. In that year, Robert Laufer, the principle investigator of the study, testified before the Senate Committee on Veterans Affairs. Senator Alan Simpson wrote the Senate report summarizing the testimony and in it he said: *"It does appear clear from the report that there is a continuing need for the Vet Center program and, as the findings of that study become more widely known, that need may become greater as veterans and their families come to realize that service during the Vietnam-era may have had an impact on an individual's ability later in life to adjust satisfactorily to his or her social environment"* (United States Senate, 1981, p.16).

CONVERGENCE CREATES A SOCIAL MOVEMENT

Although the Vietnam War provided the *"... general tendency to change which is apparent in many spheres during wartime"* (Jones, 1953), other converging and significant social forces played a role in bringing the recognition of the effects of trauma into the public consciousness in the United States and around the world. The two most significant, events were the Nazi Holocaust and Hiroshima-Nagasaki. Robert Lifton had published an extensive study of Hiroshima victims (1967). The adjustment problems of the Vietnam veterans, the long-lasting problems of Holocaust survivors, and the suffering of Hiroshima victims were subjects few people wanted to address since they were all *"politically incorrect survivors of atrocities"* (Milgram, 1998).

HOLOCAUST STUDIES AND WORLD WAR II SURVIVORS

William Niederland (1968) had already devoted twenty-five years to working with concentration camp survivors, noting that the same delay preceded their *"survivor syndrome"* as was being recognized in the work with Vietnam veterans. (Shatan, 1974). Niederland, who Shatan had known for a long time, and Henry Krystal, who had also studied concentration camp survivors (Krystal, 1968), organized a conference on victimization at Yeshiva University in 1975 and joined the V.V.W.G. (Scott, 1993). Shatan, Lifton and others working with the Vietnam veterans had already made international contacts as early as 1973

with other professionals working with veterans – in Canada, Switzerland and Australia as well as Israel (Shatan, 1974, 1998).

In the early 70's, Shatan traveled to Israel and met with military psychiatrists there (Scott, 1993). In a letter to the director of the American Orthopsychiatric Association in 1978, Shatan reported that a liaison had been established with the National Institute for Research in the Behavioral Sciences of Israel (1978b). There, Dr. Rappaport and an American consultant, Dr. Israel Charny, were working on a project called the "Genocide Early Warning System", hoping to isolate and identify features in a society which prefigure the later development of genocide (1978b). Studies also began to be published and conferences held in Israel on the effects of war stress, a logical occurrence given the unremitting nature of warfare in the region (Benyakar & Noy, 1975; Milgram, 1978; Moses et al., 1975; Noy, 1978; Sohlberg, 1975; Steiner & Neumann, 1978).

Noach Milgram organized the first of four international conferences on psychological stress and coping in time of war and peace in January, 1975 in Tel-Aviv, a year after the Yom Kippur War, and the second in June, 1978 in Jerusalem. Both were attended by Israeli and U.S. participants (Milgram, 1998). Israel was naturally the home for a large number of Holocaust survivors, yet there was a "conspiracy of silence" in Israel about listening to their stories (Danieli, 1981), similar to the phenomenon Neff had described in reference to the Vietnam veterans with his observation that Vietnam veterans were invisible patients with an invisible (non-existent) illness (1975). Danieli and Solomon have both provided a framework for understanding the gradual transformation of Israeli society towards a willingness to comprehend the magnitude of post-traumatic problems (Danieli, 1981; Solomon, 1995a; 1995b, 1995c, 1995d).

Yael Danieli had served in the Israeli Defense Forces before emigrating to the United States, where she founded the Group Project for Holocaust Survivors and their Children. During this period she had already begun her life work, exploring the intergenerational transmission of victimization, styles of adaptation to victimization, survivor guilt, and the attitudes and difficulties of mental health professionals working with survivors and children of survivors of the Nazi Holocaust (Ochberg, 1988b). She would later go on to establish strong connections with the United Nations and become instrumental in bringing the concepts of traumatic stress to a wider international audience (Danieli et al.;1996). Ellen Frey-Wouters, originally from the Netherlands and a specialist in international law, co-authored with Robert Laufer the third volume of the *Legacies of Vietnam* study while also writing about survivors of the Nazi Holocaust and working on social policy issues around the area of traumatic stress.

Many studies of concentration camp survivors were being conducted in Europe as well, including comprehensive long-term follow-up studies from Denmark, the Netherlands and Norway (Bastiaans, 1974; Eitinger 1961, 1964; Thygesen et

al, 1970). Meanwhile, also in Norway, Askevold studied the effects of prolonged stress on men who had served in the Merchant Marine in World War II (1976). Nazi occupations and the terrorism perpetrated by the Gestapo played a significant role in sensitizing the European community to the long-term consequences of excessive stress (Malt et al, 1996).

Another effect of World War II was the vast movement of refugees. Eitinger began studies of refugees in Norway and of concentration camp survivors (1960). The Vietnam War and the fall of Saigon in 1975 brought a flood of Vietnamese and Cambodian refugees to the United States. As early as 1979, reports were published about the adjustment problems these refugees were having (Lin et al, 1979), opening up a discourse on how Westerners could most effectively intervene and help refugees from the East (Kinzie, 1978).

Independent of the DSM-III process and the effects of war, a number of other significant developments took place during the 1970s. One was Mardi Horowitz' *Stress Response Syndromes* (1976) Building on Selye's earlier work (1956), this began to provide a psychophysiological basis for understanding the body's responses to overwhelming experience and how that response connected to psychological processes. Charles Figley (1978a & b), edited the first significant collaborative book on Vietnam War veterans. In doing so, he introduced a new psychosocial series for Brunner/Mazel that by 1990 would grow to eighteen volumes of literature spanning every victimization category.

VIOLENCE AGAINST WOMEN

Crime rates in the United States rose rapidly in the 1960's and attention was also brought to bear on crime against women and children, probably for the first time in history. The women's movement was instrumental in bringing attention to the incidence of rape and domestic violence that was being perpetrated against women. The first public speak-out on rape was organized by the New York Radical Feminists in 1971 and the first International Tribunal on Crimes Against Women was held in Brussels in 1976 (Herman, 1992). In 1974, Ann Burgess and Linda Holstrom at Boston City Hospital described the "rape trauma syndrome" noting that the terrifying flashbacks and nightmares seen in these women resembled the traumatic neuroses of war. Susan Brownmiller and other feminist writers and thinkers redefined rape as an act of violence directed at maintaining dominance. In doing so, they placed the act of rape squarely in a political framework of power relationships, laying the groundwork for cross-fertilization with colleagues working with other survivor groups (Herman, 1992).

The feminist politicization of violence deepened understanding of the abuse of power within the family, leading to the "discovery" of domestic battering and sexual abuse. As in the cases of delayed combat stress and rape trauma, domestic violence and sexual abuse awareness began at the grassroots,

emerging out of feminist consciousness raising groups. Lenore Walker published her landmark study on victims of domestic violence (1979), while Gelles and Straus released the results of major studies on family violence (Straus, 1977; Gelles and Straus, 1979). Around the same time, Judith Herman and her colleagues in Boston began to document the effects in adult women of having been sexually abused as children (1981). Rape crisis centers and battered women's shelters began to spring up in various communities around the country, outside of the traditional mental health systems.

VIOLENCE AGAINST CHILDREN

Finkelhor has described the increasing professional concern about child abuse over the last several decades as being the “. . . *result of a broad social movement and a historic moral transformation*” (1996, p.ix). C. Henry Kempe, pediatrician at the University of Colorado, first described the “battered child syndrome” in 1962 (Kempe et al, 1962; Kempe, 1978). This conceptualization of child abuse brought the medical profession into this social movement with all the authority, prestige and legitimacy necessary to bring about legislative change. At first, clinicians and researchers like Green focused on the physical abuse of children (1978a, b). The 1970's saw the establishment of mandatory child abuse reporting laws and a widened system of child protection that was furthered and supported by the growing feminist movement (Finkelhor, 1996). But then Susan Sgroi (1975), David Finkelhor (1979) and others began to document the widespread incidence of the sexual abuse of children and the harm it caused. In 1973, the Children's Division of the American Humane Association testified before a Senate Committee, estimating that 100,000 children were sexually abused each year. Burgess and her colleagues noted in 1978 that “*concern for the victims of sexual assault has become a national priority only during the past five years. In that time, both public awareness of and knowledge about sexual assault and its victims have grown immeasurably*” (Burgess et al., 1978, p.ix).

As early as 1975, Shatan was studying the effects of other kinds of trauma on children. In 1972, he chaired a roundtable discussion at the IV International Psychoanalytic Forum in New York, comparing delayed survivor reactions in two parent groups: Vietnam veterans and concentration camp inmates, having noted significant symptoms of unresolved mourning in young adults who were children of World War II veterans from 1965-1970. He presented a paper at the 1975 meeting of the American Orthopsychiatric Association (1975) looking at the delayed impact of war-making, persecution and disaster on children. But there was a great deal of professional resistance to recognizing that previously normal and healthy children could be severely damaged by exposure to psychologically traumatizing events. In 1979, Lenore Terr published the first of her series of papers and a book on the children of the Chowchilla, California kidnapping which introduced a developmental focus on the effects of trauma.

Elissa Benedek recalls hearing Terr present her data before a mocking and hostile professional audience who were determined to deny the effects of trauma and disaster on previously healthy children. As she puzzled over this seemingly irrational response on the part of a professional group she knew well, she concluded that *“This meeting was but another form or manifestation of a long tradition of denying psychological and psychiatric sequelae in the child victim of trauma. The audience’s response of disbelief in the face of carefully collected documentation, might have been so intense because it was difficult for professionals to accept that traumatic events, caused by fellow humans, in the lives of children might color and shape their lives for years to come”* (Benedek, 1985, p.4).

CRIME AND DISASTER

Crime victimization surveys in the U.S. led to the development of the Law Enforcement Assistance Administration, a federal agency designated to provide victim service programs in the 1970’s. While new services were starting, researchers were gathering data about the consequences of victimization to the individual and to the entire society. In 1975, the National Organization of Victim Assistance (NOVA) was founded and other victim-centered groups emerged, such as Mothers Against Drunk Driving and Parents of Murdered Children (Young, 1988). Morton Bard became involved in the crime victim movement in the 1970’s when he consulted with law enforcement agencies in New York City and later the National Institute of Justice (Bard & Sangrey, 1979; Bard & Shellow, 1976). Bard and his associated, Dawn Sangrey published a volume for crime victims in Figley’s psychosocial series for Brunner/Mazel in 1979 that was the first text published on the subject. Both Robert Rich and Susan Salasin became involved in developing mental health programs and social policies to meet the needs of victims (Rich, 1981; Salasin, 1981).

The study of disaster survivors played a vital role in the development of the field. On February 26, 1972, a dam burst in Buffalo Creek, West Virginia, destroying houses, a community, and many lives. K. Erikson wrote a book about the survivors of the Buffalo Creek disaster (1976) and other researchers, including Bonnie Green, and later, Jacob Lindy, followed up on the long-term effects of this disaster on the survivors (Gleser, Green & Winget, 1981; Lifton & Olson, 1976; Titchner & Kapp, 1976).

On March 28, 1979, a sizeable portion of the Unit 2 reactor at Three Mile Island experienced a meltdown, outside of Harrisburg, Pennsylvania, in the most serious U. S. commercial reactor accident to date. Some gaseous, but inert material was released, and no serious health consequences were expected. The population, however, had to be evacuated and a Task Force was rapidly set up to evaluate the highly publicized effects of this event (Dohrenwend, et al., 1981). Other disaster studies began to emerge in the literature throughout this

time period as well (Boman, 1979; Parker, 1977; Quarantelli & Dynes, 1977), building on a knowledge base that dated back to Lindemann's landmark paper on the Coconut Grove fire (Lindemann, 1944; Leopold & Dillon, 1963). Manuals on helping disaster victims began to be developed and published (Tierney & Baisden, 1979). An Australian clinician, Beverly Raphael, began publishing her work on disasters and bereavement. She and John Wilson in the U.S. made early contacts with each other, thereby establishing a firm connection between traumatic stress research in Australia and the United States (Raphael, 1977; Raphael & Maddison, 1976; Wilson, 1997). This growing body of literature on the psychological effects of disaster indicated that there could be long-term consequences of overwhelming stress in populations generally considered by the public to be free from any culpability in their experienced victimization. The high level of publicity given to disasters helped to increase the general level of consciousness about the consequences of trauma.

TERRORISM AND HOSTAGES

Through the seventies and early eighties there were a number of hostage-taking incidents and terrorist actions that caught the attention of the public. In 1974, a robber in Stockholm, Sweden took a bank teller hostage. They fell in love and had sex during a long siege in the bank vault (Ochberg, 1996). In the same year, the granddaughter of William Randolph Hearst and heiress to the Hearst fortune, Patty Hearst, age 19, was kidnapped by a terrorist group, while sitting at home with her boyfriend. Until September of 1975, she was a captive of the group and was physically, sexually, and emotionally tortured. She developed a new persona and a new name, "Tanya" and was caught by the FBI while participating in a bank robbery with the group. In 1976 she was convicted and sentenced to seven years in jail, three of which she served (Hearst, 1981). This odd form of bonding between kidnapper and victim was later recognized in other types of captivity situations and came to be known as the "Stockholm Syndrome" (Strenz, 1982).

Frank Ochberg, a psychiatrist whose career decisions had been in part shaped by the assassinations of Martin Luther King and Robert Kennedy, co-authored a book on violence even as a psychiatric resident (Daniels, Gilula and Ochberg, 1970). He went to work for the National Institute of Mental Health and became the NIMH representative when the U.S. Department of Justice commissioned an inquiry into terrorism in 1975. As a result, he began to focus on victims of terrorism and hostage negotiations. He served as Associate Director for Crisis Management at NIMH in the late 1970's, consulted to the U.S. Secret Service, and trained Air Force personnel in methods of coping with terrorism and sabotage (Ochberg, 1988a). He published an article on terrorism as early as 1978 in a new journal devoted to the study of terrorism and in 1982 he co-edited one of the first books on terrorism (Ochberg & Soskis, 1982). In England,

a study was published showing that people not seriously harmed in a terrorist bombing were more incapacitated than would have been expected. This post-terrorism phenomenon was termed an “aftermath neurosis” (Sims et al, 1979)

Across the nation and around the world, the growing global communication network was tuning many people in to tragedy everyday. Trauma was in the air and a budding awareness began to emerge that the various forms of traumatic experience might be similar and even interconnected. As early as a 1977 paper, Shatan, Haley, and Smith were already comparing the catastrophic stress of natural and man-made disasters, combat trauma, incarceration, Buffalo Creek, Hiroshima, and internment in the death camps. The time was ripe for a convergence, for people to come together and share their knowledge, experience, and sorrow.

THE ISTSS IS BORN

Between November and December, 1983, Charles Figley sent a letter to over 60 internationally known scholars inviting them to form an organization, tentatively titled the Society for Traumatic Stress Studies:

*“I believe that an organization, tentatively titled the Society for Traumatic Stress Studies, would be a useful contribution. Moreover, that the central purpose of this Society would be to sponsor a scholarly publication, tentatively titled, **Trauma and Its Wake: The Journal of the Society for Traumatic Stress Studies**. Such a journal would publish important advancements in the field of traumatic and post-traumatic stress. A distinguished Editorial Board is already in place in connection with the book I am editing, with the same primary title, that will be published next year . . . How appropriate is such a society and journal, in particular, and the emergence of a separate field of traumatic or post-traumatic stress in general?” (Figley, (1986a).*

The response to Figley’s letter was positive and enthusiastic. He believed that the formation of such a group was essential if the establishment of a journal to promulgate research findings about traumatic stress was to become a reality. Creating a journal was an expensive proposition that required a subscription base of at least 600 members to get off the ground (Figley, 1998; Meshad, 1997). Figley recognized that he could use the resources of his organization, the Consortium on Veteran Studies, to provide initial support to start the organization, but a much wider constituency was going to be necessary for a journal to be successful. He sent another memorandum the following year to the people he had previously contacted, and finally, after the birth of his daughter and the completion of *Trauma and Its Wake* by Brunner/Mazel in 1985, he contacted a group to join him at a meeting in Washington, D.C.

A breakfast meeting was held in Washington on March 2, 1985 and at this meeting the Society for Traumatic Stress Studies (STSS) was formally established. Those who attended comprised most of the Founding Board and their names are recognizable from the previous history: Ann Burgess, Art Blank, Yael Danieli, Sarah Haley, Bernard Mazel, Frank Ochberg, Robert Rich, Susan Salasin, Chaim Shatan, and Marlene Young. Charles Figley was selected as President, Ann Burgess as Vice-President and Scott Sheely as acting Executive Director. Others subsequently were elected – John Talbott, Robert Lifton, Bonnie Green, Morton Bard, Peter Erlinder, and John Wilson.

It was agreed that the purpose of the Society would be: *“to advance knowledge about the immediate and long-term human consequences of extraordinarily stressful events and to promote effective methods of preventing or ameliorating the unwanted consequences”*. The objectives of the organization were to 1) recognize achievement in knowledge production; 2) disseminate this knowledge through face-to-face contact with colleagues and 3) through other knowledge transfer media, especially print media.

It was decided to call the group a Society, since the term connotes a small group of like-minded colleagues while the concept of traumatic stress signifies the area that encompasses the entire process of traumatization, including the initial and long-term reactions and recovery (Figley, 1986a,b).

OBSERVATIONS AND CONCLUSIONS

We will leave the story here, as the work of the International Society for Traumatic Stress Studies is just beginning. In the decade of 1973-1983, individual suffering, collective experience, and clinical observation had merged and had begun to develop into a field of study. In the subsequent years, this field would begin to present a significant challenge to the existing psychiatric paradigm. In the introduction to their important volume on the state of the traumatic stress field, published in 1993, Wilson and Raphael observed the changes for themselves, *To establish some perspective on the rate of growth of the field, one only has to recognize that a decade ago there were no reference books on traumatic stress syndromes, few standardized psychological measures of the disorder, little knowledge about the biological basis of disorders associated with PTSD, and a limited understanding of effective therapeutic approaches* (Wilson & Raphael, 1993, p. xxi).

Today, books on the various aspects of traumatic stress fill rooms, not bookshelves. Traumatic stress has, indeed, become a true field of study if we use the criteria that Figley articulated a decade ago. *“The criteria for a true field of study must include a body of knowledge and standards of practice that are subsumed within 1) a history, 2) professional organizations, 3) publications, 4) theory, 5) measurement, 6) research methodology, 7) intervention technology,*

8) actions affecting policy and the judicial system” (Wilson, Harel & Kahana, 1988, p.ix).

The development of such a field cannot come about without the simultaneous development of supporting organizations that provide the safety, mutual exchange, and collegiality that stimulates individual creativity, while also encouraging and supporting opportunities for group contributions. The ISTSS has provided the leaders in the field of traumatic stress with that kind of an intellectual “home”.

As demonstrated by this history, the organization began as a grassroots, multidisciplinary, activist, war-biased but multi-interest group. For many reasons, some perhaps inevitable, the grass-roots nature of the organization diminished over time and as a result, many of the original voices faded from the ongoing life of the group. This shift came about as a result of a need to professionalize and thereby legitimize, the field of traumatic stress so that the accumulated evidence about the effects of trauma could be recognized by and influence social policy makers, i.e. lawyers, judges, legislators, health care administrators, etc.

But as this account has demonstrated, the ISTSS was founded only as a result of the most profound social activism, and that is the existential heart of the organization. As Art Blank has recently pointed out, *“There is no trauma field without advocacy”* (1997). Just as the early workers in the field had to be concerned about personal and professional safety, the danger has not really passed. As the results of traumatic experience become more widely known and accepted, the need to deny these results – and their implications - becomes simultaneously more frantic. Perhaps it is only a coincidence that as we gain the knowledge we require to treat, and perhaps even, prevent, post-traumatic stress disorders, funding for mental health services in the United States is minimized or cut-off entirely. Perhaps it was only a coincidence that at the height of the TET offensive, the psychiatric establishment dropped “gross stress reactions”. But it is logic and experience, not coincidence, that tells us, as Blank has pointed out (1997b), that organizations that stand to lose financially by paying compensation or damages have a vested interest in denying the profound and long-term effects of trauma. Perpetrators of assault and abuse have a highly vested interest in finding protection from exposure and criminal penalties by continuing to “blame the victim” as they have always done. The larger society will continue to deny the magnitude of the problem, not only because of the emotional arousal exposure causes, but also because it is becoming increasingly clear that fixing the problems and actually preventing trauma, will cost a great deal.

There is a moral danger inherent in our work, perhaps best thought of as the medicalization and privatization of what is a socially determined problem (Bloom, 1995). If we fail to provide evidence-based treatment for our patients

who suffer from the chronic disorders related to exposure to traumatic experiences, we fail as healers. But, if we focus our attention exclusively on deciphering the complex brain processes that lead to the symptoms of post-traumatic stress, we may ignore the social context within which the traumatic stress originally occurred. A senior army officer and Vietnam veteran nurse points out, *"It's the government and the country at large that suffer from PTSD: anger, guilt, shame, denial, mistrust, and all the rest. We've been saying that for years. It's good politics to blame the victims. Then America avoids the consequences of its own actions and condemns the veterans to pay the price"* (Davis, 1994, p. 134). This is the same charge that has been leveled at mental health professionals from the women's movement as well, *"Psychiatry and psychology on either side, believing or disbelieving women and children, defuses the issue by medicalizing it. That, in removing it from the political sphere to that of individual pathology, it is an excellent vehicle for problem management rather than for social change"* (Armstrong, 1994, p. 183). It is a discourse that pervades those who work in the field of human rights abuses, *"In a context of human rights violations, this problem must also be related to the political context. To be on a survivor's mission in Chile was not only a question of one's own survival but also of the survival of democracy and human dignity . . . It appeared that therapists were exposed to the same kinds of trauma as their patients. . . . Their work, which helped the enemies of the regime, was fraught with danger and could bring on traumatization by direct actions from the regime. . . . The work could, however, also be experienced as healing for therapists because of the commitment to a higher goal, the struggle for prosocial change and human rights"* (Agger & Jensen, 1994, p. 284 & 285). We are mental health professionals, trained to diagnose and treat mental illness. We are not as well-trained – or even comfortable with – social activism. However, the ISTSS was created as an organization clearly directed at mobilizing the power of scientific knowledge in the service of social change and we forget – or neglect - this heritage at our peril.

Our work is far from over. It has only just begun. Ahead, for the organization, lie the same challenges that we pose for our traumatized patients. Can we continue to balance conflicting needs without disintegrating into chaos? Can we contain overwhelming affect and manage the anxiety of change and lack of predictability without becoming destructive? Can we ultimately find ways to successfully integrate conflicting desires, needs, points of view, and agendas into a creative, dynamic whole? Can we hold onto our memories of what we have learned, defying the every-present tendency to deny and forget the effects of trauma? Zahava Solomon urges us to *"constitute a professional system that will retain information so that lessons, once learned, shall not be forgotten . . . I believe that it is our duty as the International Society for Traumatic Stress Studies to chip away, however slowly, at these denial tendencies, at professional blindness, and at the tendency of the establishment*

to refuse responsibility for the treatment and rehabilitation of casualties and their families” (Solomon, 1995d, p. 281).

We still have the opportunity to decide if we, as individual clinicians and as part of a larger whole, are going to ultimately become a part of the problem or a part of the solution. As Chaim Shatan summed it up, “*I propose that our next professional assignment is to go beyond the treatment of new trauma populations: the long-range cure of war-related trauma requires prevention of traumatic stress. We traumatologists can continue to provide first aid as “stretcher bearers of the social order”, sophisticated, compassionate, with growing scientific knowledge, but picking up the wounded rather than preventing them from being wounded. Or we can try to eliminate the sources of PTSD in the social order, to dismantle the army-and-enemy system, a human invention, an institutionalized manhunt . . . Otherwise, PTSD – an outgrowth of war and persecution – will remain with us unchanged – under whatever name from shellshock to K.Z. syndrome, from DSM-III to DSM-X* (Shatan, 1992, p.20).

DEDICATION

This chapter is dedicated to all those who have played a critical role in transforming trauma into wisdom, particularly those I have neglected to mention in this brief, and by necessity, incomplete historical summary.

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