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THE PSYCHODYNAMIC TREATMENT OF COMBAT NEUROSES (PTSD) WITH HYPNOSIS DURING WORLD WAR II

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Abstract: In a large Army hospital during World War II, a full-time program in hypnotherapy for battle trauma cases was developed. Symptoms included severe anxiety, phobias, conversions, hysterias, and dissociations. Many hypnoanalytic techniques were used, especially including abreactions. Good therapeutic results were frequent, as demonstrated by typical cases. There was no evidence that the abreactive procedure tended to retraumatize patients or initiate psychotic reactions.

During World War II, the U.S. Army had expected a large number of battle casualties. Experienced psychologists and psychiatrists at that time were in short supply in all the Armed Forces, and they were quite unprepared when many of the casualties were not surgical, but psychiatric. In World War I, these cases were called “shell shock.” In World War II, we referred to them as “war neuroses,” or “battle fatigue.” Today, they would be diagnosed as Posttraumatic Stress Disorder (PTSD).

In 1945, I served as chief psychologist at the Army’s Welch Convalescent Hospital in Daytona Beach, Florida, and treated soldiers suffering from these “war neuroses.” For 15 years after World War II, I applied the same techniques to patients in veterans’ clinics and hospitals, most of them combat-related.

From 1972 to 1997, through hypnoanalysis and Ego State Therapy (Watkins & Watkins, 1997), my wife, Helen Watkins, and I treated numerous patients with dissociative disorders. Many of these cases involved severe childhood abuse that had occurred some 20 or more years earlier, the DSM-IV diagnosis for which would probably have been PTSD with delayed onset. Between my wife and I, we have treated several hundred patients who suffered severe traumas within a wide range of acute, chronic, and delayed onset duration.


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THE TRAUMAS OF WAR

In 1945-1946, the patient population of the Welch Convalescent Hospital consisted of some 5,000 battle casualties, one half orthopedic cases, one half psychoneurotic. These men were transferred from emergency centers in the European Theater upon determination that they could not be sufficiently rehabilitated to be returned to combat. They had “broken down” during the African campaign, the Italian and Sicilian campaigns, the Anzio Beachhead, and the invasion of France. Their period of combat stress varied widely, ranging from a day or two to more than a year of continuous fighting. Physical illness was minimal, but psychological damage was severe.

The battle scenes of trauma and horror that these soldiers had experienced were almost indescribable (and barely comprehensible by those mental health professionals who had not personally experienced combat). Ambrose (1997), of all current writers, most closely depicts the kind of personal stories that we in the Welch Hospital heard from those GIs who were admitted to our unit.

Most of these patients had experienced some type of brief, supportive therapy at intermediate stations when their conditions were acute. At that time, they were generally motivated to rejoin their outfits, because among combat soldiers there is a strong attachment to “buddies.” However, some arrived at Welch Hospital several months later with a well-structured neurosis and considerable resistance to treatment. By this time, the motivation for many of them had changed to a strong desire for discharge and a return home.

Many of these veterans manifested hysterical paralyses and other dissociative reactions, as well as depressive reactions and phobic disorders. However, the majority were given a diagnosis of anxiety reaction, severe, (with the symptoms listed). Also included was an estimate of predisposition (mild, moderate, or severe) based on an evaluation of the patient’s preservice life, back to childhood when possible. Some of these men had indeed suffered severe abuse as children, more often neglect, but the majority were simply normal young Americans with at most only a mild predisposition that could be considered relevant to their presenting condition.

Precipitating stress related not only to battle fatigue but also included stresses encountered during induction, training, shock at change of lifestyle, and transfer to the battle zone. A prognosis was also recorded based on the examiner’s estimate of motivation, ego strength, and psychological test data.

Initially, I was assigned to the first treatment team, consisting of a psychiatrist, psychologist, and psychiatric social worker. This team trained new mental health personnel who were transferred to our hospital to form additional such teams. Each new treatment team was then
assigned to one of 14 treatment companies, containing 100 to 150 patients each.

At that time, the organization of clinical reports was conceptualized as follows:

1. The diagnostic formula: Predisposition plus stress equals neurosis.
2. The therapeutic formula: Motivation plus insight equals "cure."
3. The primary factors to be addressed: (a) symptoms, (b) dynamics, (c) secondary gain, and (d) motivation to get well.
4. Treatment: (a) motivate to get well, and (b) develop insight.

In many of these cases, there was little evidence of predisposing factors in their histories. The combat casualties with PTSD seemed to be largely caused by battle trauma. In others, the known history data of the patient indicated that there was a latent neurosis, or a breakdown ready to happen, that was activated by the trauma of combat as a precipitating stress. The specific symptomatology (anxious, phobic, dissociative, depressive, hysterical) may then have reflected intrapsychic factors covert prior to the patient’s army experience.

In the summer of 1945, I, being the only professional with experience in hypnosis, was assigned to a “Special Treatment Company,” which included a psychiatrist, who practiced “narcosynthesis” with sodium amytal and sodium pentothal, and a psychiatric social worker, who was experienced in progressive relaxation techniques (Jacobson, 1938) and nondirective therapy (Rogers, 1942).

My job was to accept or reject difficult patients from the other companies who were considered suitable for hypnotherapeutic treatment. Acceptance often was based on the patient’s responses to informal hypnotic susceptibility tests, such as arm-drop or postural-sway.

I read literature on hypnosis and traumatic neuroses available at that time (Alexander & French, 1946; Alpert, Carbone, & Brooks, 1946; Erickson, 1945; Fisher, 1943; Grinker & Spiegel, 1944; Jacobson, 1938; Janet, 1925; Levin, 1945; Rogers, 1942; Sandler, 1945; Scott & Mallinson, 1944; Young, 1931) and added to my armamentarium of hypnotherapeutic techniques.

The first hypnotic inductions were generally eye-fixation or postural-sway, and the therapy itself consisted primarily of relaxation suggestions, symptom relief, and motivation administered under as deep a hypnosis as could be induced.

Therapeutic success was moderate but positive. It may have also been facilitated because the Special Treatment Company was the only unit in which patients received individual attention. In most companies, group therapy plus reassurance, support, and medications were the order of the day.

Patients were kept until it was felt they had sufficiently recovered from the acute conditions they suffered prior to arrival at Welch Hospital,
or it was judged that no further progress was possible. They were then generally discharged from the Army and sent home or transferred to a veterans' hospital. In a few cases, they returned to limited duty, which was not combat-related.

Dissatisfied with the restrictions of suggestive hypnosis, I began searching for ways to integrate hypnosis with my beginning psychoanalytic experience, which emphasized the achieving of insight. At that time, publications by Kubie (1943), Simmel (1944), and Wolberg (1945) were about the only publications available on hypnoanalysis. I first focused on the technique of abreaction.

Abreaction

In case after case when the patient proved hypnotizable, a regression to his battle experiences and the abreactive reexperiencing of them resulted in a striking loss or mitigation of symptoms, such as anxiety, nightmares, depressions, dissociations, and hysterical paralyses.

A protocol of procedures for the initiating and carrying through of abreactions was gradually developed. It involved much more than simply suggesting the patient back into combat and inducing him to reexperience his fear, rage, suffering, or guilt. Although these abreactions were initiated in many dozens of patients, not once was a psychotic reaction precipitated nor did there appear to be any case in which the abreaction itself retraumatized the patient, a question I have been repeatedly asked ever since. During this same period, a number of more complex hypnoanalytic techniques were developed that are reported in Watkins (1949, 1992).

Abreaction has usually been defined as an emotionally corrective experience involving a reexperiencing of trauma and a release of bound affect. It may also be regarded as the completion and closure of an unfinished gestalt or, as Kubie (1943) put it, of the "repetitive core" of a neurosis.

It may be of value to describe a few cases typical of those seen in the Special Treatment Company at Welch Hospital.

Neurotic Depressive Reaction, Severe

Sometimes the released rage stemmed primarily from earlier transference situations, although precipitated by combat.

"Hilton" was hospitalized after 60 days of combat, and the following traumas were noted in his chart: (a) bayonetting a sleeping enemy soldier, (b) machine-gunning another, and (c) watching his buddy being shot through the stomach and killed. After the last event, he manifested continuous depression and feelings of guilt, including suicidal preoccupation and bizarre battle dreams. Under hypnoanalysis, he disclosed severe hatred and murderous impulses toward his father. These impulses had been reactivated by his combat experiences.
An abreaction was initiated by a direct question in the conscious state: "Why do you want to kill your father?" He exploded violently, with hysterical crying, tremors, and pounding his hands together. This catharsis lasted 15 to 20 minutes, followed by reassurance and interpretations concerning the transference of his angry feelings about his father onto the killing of enemy soldiers. Expansion and "working through" continued during several therapist-patient walks in the camp. He responded with relief and strong emotional insight. When discharged, there was no trace of depression. He had released his anger, forgiven himself, and begun planning to go to college. The course of treatment involved five sessions.

Phobic Reaction (fear of the dark)

Sometimes abreactions that related to childhood traumas, as well as to battle fears, were initiated.

"Jordan's" phobic symptom appeared after 90 days of combat. However, his combat experience tripped off delayed reactions from many childhood traumas, including being beaten by his father and escaping by running off into the dark, being put into a dark closet for punishment, having nightmares after murder movies, being attacked by a man with a knife, and seeing a neighbor lady commit suicide by pouring Lysol over herself. This case constituted a delayed-onset PTSD, precipitated by his battle experiences. Following a five-session abreactive reexperiencing and mastery of these early traumas, his phobia of the dark seemed completely resolved. Two weeks later, he was discharged.

Dissociative Reaction, Amnesia

"Richard" was hospitalized after being knocked unconscious by a shell concussion subsequent to 1 month of combat. He had total amnesia of his past. When sent home on furlough, he was not able to recognize his wife and parents.

His condition was considered hysterical. Narcosynthesis with sodium amytal was a failure, and he was referred for hypnotherapy. Attempts to induce hypnosis were largely unsuccessful.

In desperation, we decided on a pressure method of motivation—which I have never used since. He was told that every effort would be made to recover his memory, but one final possibility remained, namely, to return him to the scene where he lost it (i.e., back into combat in Germany). The military, of course, does not carry out such implied threats.

He immediately began to respond more fully to hypnosis. Following hypnotic suggestions of regression, his childhood, marriage, and induction into the Army were explored. An abreaction was then induced, during which he (and I) emotionally relived his battle experience up to the time of the shell explosion.
The suggestion was then made that he could remember everything, which he did after emerging from hypnosis. After a total of three treatment sessions, he was discharged and sent home.

However, treatment based on such motivational pressure, without personal acceptance or any genuine insight, may result in a symptomatic remission which masks an underlying and unresolved problem, as illustrated by a letter received 9 months later from his wife.

Dear Sir:
My husband received your letter some time ago, but refuses to answer it. [Obviously, he had not forgiven me for forcefully dragging him out of his amnesic defense and back to a family that he did not wish to rejoin.] He is just fine, and has had no trouble at all. A few headaches—I think drinking was the cause of them. You see, sir, my husband is mean, very mean. Those who are good have to suffer.

*Psychogenic Skeleto-Muscular Reaction (severe chronic back pain)*

In some cases, abreacting a specific, immediate trauma became possible only after related experiences in childhood had been worked through.

In the first of 10 sessions, "Harry" was hypnotized, and his back pain reacted positively to suggestion. However, after three sessions, the symptom would no longer respond to hypnosis.

Interviewing during hypnosis disclosed strong feelings of inferiority, rejection by his mother who abandoned the family, by his classmates in school, and by his teachers. He was sent to reform school and left feeling utterly worthless. To prove himself, he enlisted in the Army and joined the paratroopers, where he suffered a mild back sprain. His pain became much worse in combat after he was thrown to the ground by the explosion of a fire grenade. The grenade set his buddy on fire, and the patient, unable to get to his feet and put out the fire, watched his screaming buddy die an agonizing death. From that time on he suffered the most excruciating back pains and had to be hospitalized.

In a 2-hour session, his entire life history (as derived from hypnotic interviews) was emotionally reviewed (in metaphor story form, i.e., "I once knew a fellow who . . ."), focusing on severe feelings of inferiority and traumatic childhood humiliations. We then proceeded to interpretations (also in metaphor story form, i.e., "That man felt so guilty that he had to punish himself . . ."), concerning the dynamic meaning of his excruciating back pains. As the metaphoric story proceeded, he became increasingly identified with "that man," and with many tears he relived the traumatic death of his buddy.

The next day he came to my office all smiles, stating, "Doc, I feel grand. The pains are all gone—I haven't got any back pains." After 2 weeks with no return of the pains, he was discharged.
Hysterical Reaction (paralysis of the right hand)

Sometimes abreactions released repressed guilt rather than fear or rage. "Barkley" was very angry at the Army and its doctors. For 13 months he had been assigned to an orthopedic ward because the fingers in his right hand, with the exception of the thumb and index finger, were paralyzed and clenched shut. He came to my company angrily declaring, "The damn Army doctors can’t find out what is wrong with me, and so they send me to the psycho ward." After much difficulty obtaining his cooperation, I was able to hypnotize him, whereupon he relived an experience that involved his moving into enemy territory as point man of a patrol, the most dangerous position.

Suddenly he shouted, "They got him, the sons of bitches, my buddy, the best damn soldier in the army. And it’s my fault." When I asked why, he exclaimed, "Why didn’t I throw it?" "Throw what?" I asked. "You know, the grenade I had in my hand." Had he thrown the grenade, he could have knocked out the enemy machine-gun nest and saved his buddy. Now all his guilt was focused onto the hand. "And if thy right hand offend thee, cut it off and cast it from thee," says the Good Book (Matthew, 5:30, King James version). His "offending," and hence guilty, hand had been psychologically "cut off" and "cast" away.

After abreactively reexperiencing the event with much violent emotion, his hand opened for the first time since combat. He could then be referred for physical therapy and occupational therapy—which had previously been unsuccessful in altering the symptom. He had forgiven himself. The hand remained open, and he was soon discharged. This treatment involved 15 sessions, some of them 2 hours in length.

Anxiety Reaction (hand tremor)

Some cases involved transferred rage and not battle trauma. "Major Johns," a battalion surgeon, had a severe tremor in his right hand, which (self-diagnosed) he called a "Parkinson’s syndrome." Our examining psychiatrist, however, said the surgeon didn’t know his neurology very well and rediagnosed it as hysterical. He was referred for hypnotherapy. The treatment lasted one session.

The patient recounted to me the many humiliations he had received from the colonel who commanded his hospital unit and vividly described what he would do to "that son of a bitch" if "I could ever get him on my operating table."

He was given "that S.O.B." on his "operating table." After placing a pillow on the desk, I hypnotically hallucinated the operating table and told him, "There he is. What do you want to do?" And for the next 10
minutes, he, this 6 ft. 3 in., 220 lb., officer, (and I) committed murder, he cursing and slashing with his "scalpel," while I was shouting, "Give it to the son of a bitch. He deserves it."

Finally, through physical and emotional exhaustion, he stopped. I intended to do a repeat, but he held up his hand with no sign of a tremor and said, "I don't feel like it any more."

He had noted that this colonel resembled his dominating father, a point that was then interpreted to him. He left my office relaxed and smiling. During the next 2 weeks, the tremor did not return, and he was discharged, feeling certain that he could return to his practice of surgery. (Sometimes one might think of an abreaction as a brief "psychological surgery" itself.) Total treatment time: 1 hour.

I have been asked by colleagues, "Weren't you afraid that in his rage this powerful man might have attacked you?" The answer is "No." I was resonating with him. I was not the target, an object lying on his operating table. We were therapeutically allied in a togetherness—but I was glad that the commanding officer and not me was the object of his transference. That is the difference between resonance and transference.  

From 1953 to 1964, I used these procedures further in treating PTSD cases within Veterans' Administration hospitals and clinics, initially, at the V. A. Regional Office (outpatient) Clinic in Chicago. It was a large installation, and, as chief psychologist, I was responsible for a substantial staff plus 20 interns from nearby universities. The clinic was very psychoanalytically oriented and associated with the Chicago Psychoanalytic Institute, headed by Alexander and French (1946), and most of our consultants came from the Institute. Having published a book on hypnotherapy, I was considered within that installation as an oddity, because "Freud has proven that hypnosis by-passes the ego, and that it achieves only temporary symptomatic benefits."

Many PTSD veterans there were by now chronic and difficult to treat, because they were "being paid to stay sick" by their V. A. disability pensions. If they showed any progress, their pensions were reduced or eliminated. They were in fact resistant to any treatment that might be effective, hypnotic or otherwise—and they were expected to stay that way.

This situation was epitomized by a humorous incident. A former patient who had been successfully treated for a battle-related phobia and was symptom-free visited me 2 years later and related the following:

"I went back to the Spokane V. A. Center and requested discontinuation of my disability pension on the grounds that I no longer had a neurosis, and it was ridiculous for the government to keep paying me money."

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3A detailed discussion of the relation of "transference" and "resonance" to each other is published in Watkins (1978).
“How did they respond?” I inquired.  
He laughingly replied, “They thought I was psychotic.”

The Resolution of a Personal, Acute PTSD Experience

During my service in World War II at the Welch Convalescent Hospital, Daytona Beach, Florida, I personally suffered a life or death trauma as follows.

At the end of each working day, I would swim around the long pier at Daytona Beach, which extended approximately a quarter of a mile out into the ocean. This one day was very stormy, a weather disturbance that the paper later called a “baby hurricane.”

Unwisely, I went for my usual swim but, recognizing a severe side-ways current, I began it about a half mile further up the beach. Midway during the swim, it was clear that I was being dragged by the current into the pier and was in danger of being dashed against its barnacle-covered pilings. Even with redoubled efforts (and I had been a competition swimmer), I got no nearer to the end of the pier as the same two end posts visually continued to line up. I became desperate.

At the last minute, a huge wave rushed me past the end of the pier, with maybe 5 feet to spare. Then, swimming back to shore, I found that the current turned out toward the sea. I became panic-stricken as the harder I tried to swim shoreward, the less progress was made. Finally, exhausted, I gave up and prepared to die. But at that moment, during a wave trough, I felt sand under my toes and, encouraged, was able to struggle to the beach, where I collapsed. After being taken by the Coast Guard to a shelter, warmed, given coffee, and rehabilitated sufficiently, I returned to my barracks. However, every night for the next week, I was overwhelmed by nightmares of being engulfed by enormous waves. Obviously, this was an acute PTSD experience, not unlike that of the combat soldiers whom I was treating but of a lesser magnitude.

Realizing that something must be done while it was still acute and had not yet consolidated into a chronic condition, I made two decisions:

1. It was unwise to be swimming around that pier. I must stop it.
2. I had to master the experience by doing it one more time.

The next weekend the weather was calm, and I easily swam around the pier. The nightmares immediately ceased and did not return.

The therapeutic principle here was also confrontation and mastery of the situation but in vivo (not internalized hypnotically with a coexperiencing therapist, as in the other cases). This was possible because my ego’s strength relative to the trauma was raised by absence of the storm. The threat was attenuated.4

4 A humorous aspect: After rounding the pier and swimming for shore the second time, I was followed by a lifeguard who shouted, “You’re not allowed to swim around the pier.” I replied (undoubtedly to his bewilderment), “Go on back. You’re a week too late.”
SUMMARY

I have been asked frequently why at that time we seemed to have such success with abreactive treatment administered under hypnosis. The following factors may be relevant:

1. Most of the combat cases were acute, not chronic.
2. The therapist was a male, who could provide a more fatherly supporting role to battle-traumatized soldiers.
3. The abreactions involved an emotional coliving (resonant) experience with both therapist and patient, a loaning of the ego strength of the therapist to the patient. They were not merely techniques, that is, emotional reactions induced in the patient (as object) by a cognitive, unemotional, personally uninvolved, therapist—and thus more like the interventions of a mechanic repairing an engine. This factor alone may make the difference between an abreaction which is a corrective, mastery experience, and not merely "beating" the patient into a retraumatization.

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Die psychodynamische Behandlung von Kriegsneurosen (PTSD) mit Hypnose während der zweiten Weltkriegs

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Le traitement psychodynamique des névroses de combat (PTSD) par l'hypnose pendant la deuxième guerre mondiale

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Résumé: Pendant la deuxième guerre mondiale, dans un grand hôpital militaire, un programme par hypnotherapie a été développé à plein temps pour les cas de traumas de bataille (PTSD). Les symptômes ont inclus l’anxiété sévère, les phobies, les conversions, les hystéries, et les dissociations. Beaucoup de techniques hypno-analytiques ont été utilisées, comprenant particulièrement des abréactions. Les bons résultats thérapeutiques étaient fréquents, comme démontré par des cas typiques. Il n’a pas été mis en évidence que le procédé abréactif tende à traumatiser à nouveau les patients ou initient des réactions psychotiques.

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El tratamiento psicodinámico de neurosis de combate (PTSD) con hipnosis durante la segunda guerra mundial

John G. Watkins

Resumen: En un hospital grande del ejército, durante la segunda guerra mundial se desarrolló un programa de tiempo completo de hipnoterapia para casos de trauma de batalla (PTSD). Los síntomas tratados incluyeron ansiedad severa, fobias, conversiones, histerias, y disociaciones. Se usaron muchas técnicas hipnoanalíticas, especialmente abreacciones. Típicamente fueron frecuentes los buenos resultados terapéuticos y no se encontró evidencia de
que los procesos de abeacción retraumatizaran a los pacientes o provocarán reacciones psicóticas.

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