Hypnotherapeutic Approaches and Outcome of Combat Stress Reactions: 18 Years Later

Part 1: clinical description and treatment strategies

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To avoid chronicity, acute psychopathologic reactions in soldiers during combat should be regarded as emergencies. This calls for an individualized and flexible treatment plan. In this framework, hypnotherapeutic techniques are of great value and their implementation should be kept in mind when coping with these reactions. For this purpose, a therapeutic oriented classification of the more frequently acute psychopathological syndromes encountered in combatant soldiers is suggested. The corresponding therapeutic plan, including hypnotic techniques, is outlined. The approach is illustrated through case presentations.

One of the most traumatic events that man may confront is war. Unfortunately, war has been an integral part of Israel's existence for over 44 years. The 1973 Yom Kippur war can be considered the most traumatic event Israel has had to face. During the active combat phase of this war, the senior author was stationed as a psychiatrist at a field advanced hospital. In this framework, combat stress reactions were referred to the psychiatric unit and „first aid" treatment was provided. Treatment strategies included extensive use of hypnosis (Kleinhauz, 1976) which lasted 2 to 7 days contingent upon the recovery rate from the acute stage of the stress reaction. After this period, due to administrative reasons, most of the soldiers were referred to a rear unit for further evaluation and/or treatment. In 1991, 169 out of approximately 400 former patients were located, 109 of whom agreed to take part in a clinical study. The study included questionnaires designed to screen the incidence of post-traumatic stress disorders (PTSD) according to DSM-IV (American Psychiatric Association, 1994) and of psychopathologic symptomatology. Clinical descriptions and therapeutic strategies included in the treatment plan of the combat stress reactions encountered during war are presented here.

The use of hypnotic techniques in psychiatric casualties of war have previously been reported. Treatment modality has been hypnoanalytically oriented, often initiated after a

lapse of weeks to years from the traumatic event and localized at rear units (Watkins, 1949). This paper, however, deals with the hypnotherapeutic techniques used in emergency situations, as a first aid treatment in combat stress reactions during actual fighting in the 1973 Yom Kippur war in a field hospital. Hypnosis was used as a tool in an individualized comprehensive treatment approach. To determine a proper therapeutic approach to combat stress reactions, old terms such as „shell shock", „war neurosis", „battle exhaustion", „battle fatigue" are of no therapeutic use and „traumatic-" and „post-traumatic stress disorder" (TSD-PTSD) do not include all the psychopathologic reactions encountered during combat. For these reasons, an individualized therapeutic approach which relates to the psychopathologic entities was used. This approach increased the effectiveness in coping with the acute phase of the more common reactions encountered in combatant soldiers.

The following classification of combat stress reactions and their respective therapeutic approach, in order of frequency have been suggested (Kleinhauz, 1975): (1) Traumatic stress disorder, (2) combat exhaustion, (3) panic and/or visceral expression of anxiety, (4) conversion reaction, (5) bereavement, and (6) other reactions.

1. Traumatic Stress Disorder

Traumatic stress disorder is a response to the traumatic stressor which is characterized by a two-stage reaction. The first immediate reaction meets the criteria for traumatic stress disorders (TSD) (American Psychiatric Association, 1994). Generally, it is followed by the development of a post-traumatic stress disorder (PTSD) syndrome (American Psychiatric Association, 1994).

Description: The soldier is disoriented in time and place, disconnected from reality and from the surroundings, dazed, confused, and in a psychotic-like condition. Motor behavior is disturbed. Delusions or hallucinations can be present. Although thought processes are not unorganized, amnesia frequently appears. When it occurs, it refers mainly to the events following the trauma and the evacuation to the field hospital and not to the traumatic experience that preceded the reaction, which remains in „fixation", as if time stopped at the moment of the traumatic experience. One feels as if the patient goes through the same partial abreaction, which repeats itself in a stereotypical manner through verbal and/or nonverbal manifestations. In this state, an inclination to misidentification may be present and the soldier identifies the therapist, or another member of the staff, with one of his comrades (usually a friend who was killed in battle).

There are two sub-types of TSD but transition from one to the other may occur or mixed phenomena may coexist.

a. Excitatory type with motoric hyperactivity. Frequently the soldier arrives at the psychiatric unit while tied to a stretcher, behaving as if still in the battlefield, shouting orders or battle-cries to his comrades (often associated to a comrade who was killed in the battle).

b. Stuporous-catatoniform reaction with motoric inhibition. The soldier is motionless, usually with arms and legs shaking, a vacant, blank, expressionless look is typical and often there is an exaggerated startled reaction to sudden acoustic or tactile stimulus. At times, he is mutistic and speech may be impeded due to stuttering.

Hypnosis and treatment plan: Most patients went into a hypnotic state (clinically appreciated) in less than one minute. The operator would gently, but firmly say something like: „You are now in a field hospital ... I am a physician and I will help you ... Now I will count for you (thus hinting to an unauthoritarian approach) from one to ten and you will feel secure, drowsy and sleepy ... one ... sleepy ... two ... secure ...", and so on.

It was dramatic to treat a number of soldiers who arrived at the unit shouting and in varying degrees of psychomotoric excitation and who were induced, within a few seconds and almost simultaneously, into hypnotic sleep and silence. Later, it was possible to determine the timing of further treatment (especially when abreaction was considered) according to circumstances and need. This readiness to respond to hypnosis was because the patients were in acute distress and for this reason, highly motivated. They were also physically and emotionally exhausted and already in a dissociative-like state. Even when behaving psychotically they reacted and responded, with almost no exception, to this short induction procedure. This responsiveness also allowed us to use hypnotic techniques in a very direct way. As could be expected, also without formal induction procedures, operating under the assumption that the patient was already in a dissociative, „hypnotic-like" state, called forth the desired hypnotherapeutic results. Treatment was based on three major processes: abreaction, re-synthesis and desensitization.

a. *Abreaction:* This process serves to relieve the emotionally isolated material (catharsis). Although this is true for the stuporous type of reaction, abreactive processes are of value for the excitatory type, who are in a continuous, non-stop partial abreaction. The aim is the full expression of all repressed material. Time regression may be used to obtain a detailed account of the chain of events preceding, during and following trauma, and up to arriving at the Unit: „You are now in the battlefield ... you are there and fighting is going on ... you can hear the tanks ... you can hear the explosions ... you can hear the fighting airplanes and the missiles ... and while you are there you can tell me what is going on ... tell me now ... where are you? ... who is with you? ... what is happening? ... „ and other

relevant questions or remarks according to the information received and to the patient's reactions: „yes ... go on ... and now ..." or „it is OK to shout ... it is OK to cry ... just let ALL your emotions out ... ALL of them ..." At the end of the session, repeated suggestions to „forget or remember any or all events, conditional to your physical and emotional well-being" are given. Posthypnotic suggestions of ego-boosting („you will feel better with yourself ... there is no place for you to feel guilty ... you will be able to cope better ... you will be able to sleep better and to relate and cope better with yourself and with your surroundings ..." may be given. Suggestions for emotional and physical rest and wellbeing are also given. The session ends with the usual dehypnotization procedures.

During and after the abreactive process, the patient may remember and communicate most of the events. No attempt is made to „force" the patient to remember events after the abreactive session. Obviously if he does not remember spontaneously, it means that he is not ready to confront the experiences and amnesia is used as a defense mechanism that should not be violated.

It is very important to bear in mind that, when eliciting abreactive processes, proper measures should be taken to protect the patient and staff from physical harm. One patient, while abreacting, ran to a corner of the tent to seize an automatic weapon. Two soldiers who happened to be present prevented him from reaching the weapon.

As stated, the primary purpose of the abreactive process is to reconstruct and emotionally express, as specifically as possible, and in chronologic order, all events that preceded the trauma and events that ocurred after injury and up to admission to the psychiatric unit. It should be mentioned that to achieve this aim, abreaction need not be limited to a single session and flexibility is the rule. The number of meetings should be applicable to each patient. Generally, two to three meetings (1 to 2 hours each during the first 2 days) were optimal. The meetings should be terminated if there is conspicuous aggravation of the soldier's condition, no further progress occurs after three or four meetings, a „dependence" to abreaction develops and/or there is an inclination to spontaneous abreaction.

Previous traumatic (war) experiences should be checked and, if present also abreacted.

b. *Re-synthesis:* The second procedure is re-synthesis and ego-reintegration, which is achieved by a „working through" process of the material obtained at the former stage at a cognitive conscious level. The process is facilitated by inducing a relaxation response, since the patient is then more receptive to suggestions of selfcontrol and cognitive and emotional re-education. Essential in the re-synthesis process is to emphasize the existential meaning of the experience. Three basic aspects of the trauma should not be overlooked: the experience of imminent death and the emotions of guilt and anger. They are consequential to the combat situation in which the soldier confronts death, in which comra-

des are killed while he is alive, and in which anger „at everything and everyone" is an embedded emotional component. The working-through processes, aimed at achieving resynthesis and ego reintegration should be attempted at the individual as well as the group level. The guiding principle should be „here and now" approach and the therapist should stress expectations of rehabilitation within the military framework. (This is on behalf of the patient to avoid further guilt feelings and further deterioration of his selfesteem if he fails to rehabilitate.) Two daily group meetings of 2 to 3 hours each is recommended, as well as to reconstruct the traumatic experience under hypnosis, but this time in full control of the emotional expression: „This time you control the experience ... you control your emotions ... you can go through all the experiences and at the same time feel it under your own control ... no matter how traumatic it can be ... your emotions are under your control ... this time under your control ...".

In addition, it is worthwhile to introduce ego-boosting suggestions: „you will feel better and better and you will be able to cope better and better ... you will feel more and more secure and self-confident and more and more able to cope with your feelings ..." and ... etc.

c. *Desensitization:* The patients quickly developed symptoms that met the criteria for PTSD. The most prominent were phobias to the stimuli attached to the trauma (tanks, airplanes, explosions and other war noises). At this stage, hypnosis proved useful in achieving a basic relaxed condition during which desensitization procedures could be carried out. These procedures were further enhanced through hypnotic visualization and hallucinations of the stimuli to be provided.

Course and outcome: Usually, the psychotic reaction receded within a day or two. As previously stated, although the patient regained normal orientation in time and place and his contact with reality returned, a PTS symptomatology developed almost concomitant with the immediate reaction. Insomnia and nightmares related to the trauma, difficulty in concentration and memory, physical weakness and fatigue, and phobic reactions were frequently reported. Apathy, withdrawal, dreaminess, psychomotoric slowdown, spastic walk, light to heavy stuttering, startled reactions and reduction in functioning were frequently found. Amnesia would reappear and psychophysiological reactions were noted (headaches, dizziness). These reactions, commonly found in PTSD, required further treatment and, from the preplanned 2 day treatment, this period was postponed to 7 days. Treatment was based on a comprehensive plan that included individual and/or group therapy. Group psychotherapy was „here-and-now" oriented and aimed at group cohesion and further social support. The group sessions usually ended with 5 to 10 minutes of hypno-suggestive intervention (mainly ego-strengthening and symptom-amelioration techniques). Special attention was paid to the avoidance of regressive trends. In addition, sports and a fixed daily

time-schedule were included in the treatment plan. When indicated, drugs were also prescribed.

At the end of 1 week, for administrative reasons, most of the patients were evacuated to a rear unit for further evaluation. Some were evacuated to their original units and a few stayed at the field hospital, functioning as auxiliaries.

Case 1: A young soldier was admitted to the unit in a catatoniformic condition. His hands were trembling and frozen in place. They were half-open and in a forward position (as if serving something). He was mutistic and did not speak a single word. His entire body shook and he had a dazed and empty look. He would react only to tactile stimuli (a strong startled reaction even when slightly touched) but only to fall back into his former stuporous state. He went into a hypnotic response after a few seconds and was then able to communicate verbally. He was a tank driver. His tank was hit and the head of his commander was severed and dropped into his hands.

Treatment was provided along the lines described herein, and at 1 year follow up (he requested consultation concerning a new job), no gross psychopathology was evident. He remained in touch with his former commander's parents and has been „adopted" by them.

Case 2: Excluding the response to tactile stimuli, the clinical picture was very similar to Case 1, only that this soldier, also mutistic, had a stereotypical up-and-down movement with both hands (half-open, palms up). The meaning of this nonverbal behavior became intelligible when, in a hypnotic state, he was able to communicate verbally. He explained that the hand movements represented missiles falling in his direction, fired by enemy aircraft.

Case 3: Three days after the war started a soldier was brought to the unit by another soldier who had found him hiding in a battle shelter. He had three helmets: one on his head, one covering his heart and one covering his genital area. Otherwise, he was in a stuporous-catatoniform condition, mutistic, body shaking and unresponsive to any stimuli. Under hypnosis he related his fear and guilt. During the first day of fighting, enemy soldiers tortured and killed all of his comrades; he had survived by hiding.

Case 4: This soldier was in an infantry unit. He was the one who almost opened fire during the abreactive process. When admitted to the unit, he was excited, restless and kept shouting orders as if in the middle of battle: „Moshe ... move ... move ... fire ... what are you waiting for ... fire ... Eli give cover to Moshe ... cover him ..." etc. (Moshe was his commrade and friend and was killed at this point.) Treatment was successful and he returned to his unit.

2. Combat Exhaustion

Description: Battle exhaustion is a state of physical and mental fatigue that appears after a long and active battle. The patient is oriented in time and place, reality testing is unimpaired and mental processes are intact. The outstanding complaint is tiredness and in need of rest. The soldier appears „worn out", pale and slight shaking may be noticed. He shows lack of appetite, his behavior is indifferent and apathetic, has a low stimulus threshold and an inclination to restlessness can be apparent.

Treatment: The immediate treatment is to provide liquids (intravenously when a more serious dehydration is suspected) and food followed by an hypnotic-provoked sleep of 12 to 24 hours. Upon awakening, a supportive but firm conversation should be held in order to return the soldier back to his unit. It is advisable to prevent negative environmental influences. An exhausted combat soldier should not remain with patients suffering from more serious psychopathologic syndromes. This is to avoid possible stimulation of regressive trends and negative expectations concerning the return to the original combat. Therefore, combat exhausted patients were treated in the frame of an internal ward in the field hospital.

Course and outcome: It is expected that soldiers will return to their full functional capacity within 24 to 48 hours, and whenever it was administratively possible, they were returned to their original units.

3. Panic and Anxiety

Description: The soldier is oriented in time and space, contact with reality is normal, mental processes are intact. Symptoms of panic or acute anxiety are conspicuous with psychophysiologic reactions, such as cold sweat, cold and damp palms, nausea, diarrhea, frequency of micturition, enlarged pupils, rapid pulse, and rapid and superficial breathing, which could develop into a hyperventilation syndrome with tetanus features.

Treatment: An immediate pharmacological treatment to „cut down" the attack is suggested, usually 10 to 20 mg of Diazepam intravenously, will cease symptoms and induce sleep. Upon awakening, hypnosis can be used. It is worthwhile to present, under a hypnorelaxation state, suggestions, such as: „you are now feeling restful and able to cope ... you will soon be able to leave the unit ... you will feel fine ...".

Course and outcome: After being aroused, the soldier is usually asymptomatic, but is inclined to easily enter into anxiety states. Hypnosis and attempts at selfhypnosis for the purpose of achieving relaxation and tranquility were usually inefficient. Thus, soldiers were evacuated to a rear unit to continue treatment and military rehabilitation.

Case 5: An ammunition truck driver was admitted suffering from a panic state and

shaking. He had been attacked by enemy aircraft but succeeded in taking cover before the truck exploded. As the aircraft disappeared, the soldier was panic-stricken which subsided intermittently until he was admitted a few hours later. Verbal communication was impossible and 20 mg of Diazepam intravenous was administered for relaxation. During the next few days, he complained of anxiousness and was often observed looking up at the sky, searching for planes. He had trouble falling asleep, complained of irritability and nervousness, was restless, felt dizzy and nauseous. Although responsive to hypnorelaxation techniques, their effect was transitory. Tranquilizers also had a transitory effect. Since there was no further improvement, he was evacuated to a rear unit 48 hours later.

4. Conversive Reactions

Description: Although infrequent, a variety of conversive reactions of acute onset may appear. Motoric disorders, such as stuttering, monoplegia and hemiplegia, or sensory disorders, such as blindness and deafness were encountered as manifestations of combat stress reactions.

Treatment: In planning treatment, special care should be taken to exclude possible organic etiology. Careful clinical history and physical examinations should disregard cerebral commotion, back trauma, dehydration and other possible combat-related physical trauma. There is a very real danger of misdiagnosis with potential disastrous consequences.

To avoid fixation of the symptom and the development of secondary gain, treatment should be based on a firm, even authoritarian approach, aimed at the neutralization of the symptom in the shortest time possible. Treatment should not be postponed but provided immediately upon arrival. Under no circumstances should a soldier be evacuated to the rear unless therapeutic intervention has failed. Hypnotic „symptom removal" is the „first choice" treatment in these cases.

Course and outcome: The small number of cases does not allow us to draw any conclusions. Much depends on the patient's basic personality and on the possible existence of fixation of the symptom and secondary gain before the treatment attempt. In our experience, it was possible to return soldiers back to their units immediately after a successful symptom-removal attempt. For others, a prior rehabilitative treatment of a few days was necessary. During this time, hypnosis was widely used in a suggestive, ego-boosting fashion: „you are now feeling fine and this feeling will also continue when you return to your unit ... you will feel stronger and stronger ... you will be able to cope better and better ...", etc. In one case, treatment failed and the patient had to be evacuated to a rear unit for further evaluation/treatment.

Case 6: A soldier was admitted suffering from deafness in his left ear that developed

suddenly during shelling. Upon admission, although a clinical examination by an ear specialist was negative, it was impossible to determine a definite diagnosis. To avoid fixation and secondary gain from a delayed diagnosis of conversion reaction, a symptom-removal hypnotherapeutic approach was attempted. Induction was based on a firm, rather authoritative intonation: „I will count from one to ten and you will sleep ... one ... sleepy ... two ...", etc. At the count of ten, his eyes closed and he began to feel sleepy. At the count of twenty, he was told that: „your hearing in both your right ear and your left ear is back to normal ... NOW YOU CAN HEAR NORMALLY AND EQUALLY in both ears, also in your right ear and in YOUR LEFT EAR". He was then dehypnotized and reported that hearing was normal in both ears. This was confirmed during a physical examination. At his request he was immediately released to „rejoin his combatant comrades". No attempt was made to clarify the possible psychodynamic forces involved in the development of the symptomatology.

Case 7: A young officer was admitted to the unit due to a limp in his left leg. Physical examination discarded an organic basis for his affection that had started suddenly while running along a trench. At a specific time, he was to run over an open field that was under enemy fire. At this moment, he „dislocated" his left foot and started to limp, thereby not meeting his military obligation. A similar hypnotherapeutic plan based on a rather authoritative symptom-removal approach was attempted. Treatment was unsuccessful and limping continued. The officer, at his request, was recruited to our unit and functioned as an auxiliary therapist. He was very successful and stayed for 2 months, at which time limping was almost undetected. He was released and referred to a rear unit for further evaluation.

5. Bereavement Reactions

Description: The clinical picture is typical of a depressive condition with all the manifest symptomatology of a depressive state triggered by trauma. Trauma usually originates from the death of a friend or comrade. Frequently, guilt and/or guilty feelings are evident.

Treatment: Therapeutic intervention is based on an intensive psychotherapeutic plan aimed at coping with the „unprocessed" mourning reaction. The main therapeutic techniques include open discussion of the issues involved, (especially related to guilt feelings) and „ventilation" of their emotional context. The general therapeutic approach is supportive and cognitive oriented. Hypnorelaxation has a definite place since it facilitates the whole process and enhances the supportive aspects of the treatment plan.

Course and outcome: When there is no substantial damage to the soldier's basic personality, sypmtomatic clarity can be expected as well as reassignment to his unit. This step has therapeutic value since returning to the unit can act as a special step toward self-purifica-

tion.

Case 8: The soldier was admitted suffering from an acute and intense depressive reaction. He was uninterested in his surroundings, apathetic and psychomotor retardation was evident. He reported deep guilt feelings and suicidal ideation. He responded quickly to a hypnorelaxation induction and, when asked questions regarding potential etiologic factors, he associated his reaction to the death of a comrade. It appears that, while seated in the front seat of an open army truck, he asked his comrade (seated in the rear of the truck) to change seats, since he wished to smoke a cigarette. His comrade complied and was killed by gunfire 2 minutes later. Treatment along the lines that are described enabled him to return to his unit 48 hours later.

6. Other Reactions

There are some reactions to combat stress which appear sporadically. It should be mentioned that we encountered only one case of psychotic, regressive-schizophreniformic reaction. The same can be said for a psychotic-paranoid reaction. Obviously these two patients were evacuated to a rear mental hospital. As well, there was one patient who attempted suicide and one who attempted self-mutilation. These two patients were also evacuated to a rear facility.

Summary

Hypnotherapeutic techniques used as a first-aid, emergency treatment are useful in handling acute psychiatric casualties during combat. In general, a wide range of hypnotic techniques, including relaxation, unspecific and ego-boosting suggestions, time regression and time progression, symptom removal, ventilation, abreaction, hypnodesensitization, etc was used. The treatment plan varied according to the psychopathological syndrome which should be flexible and individualized.

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The Yom Kippur War Revisited: An 18-year Follow-up of Combat Stress Casualties

Part 2:
War induced psychic trauma: An 18 year follow-up of israeli veterans

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■ *Eighteen years after their participation in the Yom Kippur War two groups of Israeli veterans were examined. Psychiatric status of 112 combat stress reactions (CSR) casualties and 189 comparable controls was assessed. Results show that CSR casualties had higher rates and more intense posttraumatic stress disorder (PTSD) than controls. This was evident both in the past and in the present. Similarly, intrusion and avoidance tendencies and psychiatric symptomatology were endorsed more often by CSR casualties than by controls. Clinical implications of these findings are discussed.*

Combat-induced psychopathological reactions are an inevitable consequence of any war. The 1973 Yom Kippur War was no exception. Several hundred soldiers were diagnosed during this war as combat stress reaction casualties (Witztum, Levy, Solomon & Kotler, 1991). Combat stress reaction (CSR), also known as battle shock, battle fatigue, war neurosis and other names is the most common immediate pathological reaction occurring on the battle field. Combat stress reaction occurs when a soldier is unable to marshal effective coping strategies to deal with the threatening stimuli. It consists of a wide range of labile and polimorphic manifestations. The defining feature is that the soldier ceases to function militarily and acts in a manner that endangers himself and his fellow combatants (Kormos, 1978; Solomon, 1993). War induced psychopathology generally receives professional attention during the war and shortly thereafter, with very little in the way of sustained long term follow-up. As a result our knowledge of the long term effects of war-stress is quite limited.

With the end of a war, the pathogenic effects of combat stress may abate in some cases, while in others profound, prolonged and varied psychological sequelae may ensue. This variability is described through two perspectives: the „stress evaporation hypothesis“ and the „residual stress hypothesis“ (Figley, 1978). The stress evaporation hypothesis argues