BRIEF PSYCHOTHERAPY IN WAR NEUROSES

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The American people are not satisfied unless a problem or situation new to their cognizance is rapidly treated by some new discovery. Hence when the lay and military minds were rudely awakened to the fact that war neuroses formed such a large proportion of living casualties, they demanded from psychiatrists whose words and writings of the last 25 years had largely been unheard, new and rapid methods of prevention and treatment. The publicists seized upon two technics of therapy which seemed to fulfill these requirements. The first, treatment in forward evacuation hospitals with rest, sedation and pursuit, was used in the last war and completely described by competent observers. The second, narcosis therapy whether in the form of continuous sleep, narcohypnosis or narcosynthesis cannot be called new since it has been used in civilian practice for at least ten years.

Without equivocation it can be stated that the only knowledge newly applied to the prevention and treatment of war neuroses up to the present, whether in forward hospitals, general hospitals overseas or at home is a sound, rational understanding of the dynamic conflict between the unconscious sources of anxiety and the ego forces and an understanding of the symptoms produced by psychological defenses, regressions and collapse. Furthermore, based on such knowledge, the only new technic evolved in the treatment of war neuroses is brief psychotherapy derived from psychoanalytic principles.

Because of many misuses of the terms war neuroses and psychiatric casualties even by psychiatrists, it is wise to interpolate at this point a rough segregation of neuroses as they are related to phases of military life:

1. Neuroses of war time occurring before or at induction before exposure to military life has had any effect.
2. Neuroses caused by the restriction, complications, hardships and dangers of military training or service in the United States.
3. Neuroses caused by foreign service in which the factors of separation, loneliness, severe climatic conditions, poor living conditions, lack of work, overwork, etc. are important.

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† Army Air Forces.

4. War neuroses caused by actual combat or exposure to enemy attack by bombing etc. It is only the last category that we can justifiably term war neuroses and label those afflicted as psychiatric casualties of war. It must be stressed and thoroughly understood that this group is indeed made neurotic by the psychological stresses inherent in warfare. One's entire grasp of the principles of therapy and the goals to be achieved depends on such an understanding. Men who develop disabling neuroses in the first three stages in their preparation for combat can as a whole be categorized as suffering from latent or active neuroses of considerable severity. They become ill or their illnesses are exaggerated by stresses little more severe than may be met in civilian life and the clinical syndromes are little different from those seen in civilian practice. Air corp cadets in training are an exception in that their lives are in constant jeopardy, and biological reactions to falling stimulate intense anxieties.

One can understand the attitude of lay people, many military officers and some psychiatrists that the development of neuroses among the first three groups indicates some sort of weakness which they term inherent, that therapy under army auspices is likely to be prolonged and unsuccessful, and that return to the more stabilized civilian environment is probably necessary to achieve a re-establishment of the old, more or less, successful equilibrium. But such an attitude is erroneous when applied to the group of war neuroses, and when held, even among psychiatrists, indicates a lack of understanding of the condition. It must be re-iterated even at the risk of appearing trite that: War neuroses are caused by war. No one is immune from a war neurosis; anyone, no matter how strong or stable, may develop a war neurosis under proper circumstances. The importance of these premises lies in their relation to therapeutic attitudes, since, as we well know, the more an external stimulus in reality is important in causing a psychological disturbance, the more favorable is the prognosis for recovery of equilibrium.

Many psychiatrists are loath to recognize that conditions of war bring new factors to play upon the soldier's ego and insist on using the term traumatic neurosis, indicating the identity of war neuroses with a type of disturbance seen in civilian life as a result of accidents, especially in industry.
But there are many differences. The civilian traumatic neuroses usually occur as a result of a single violent stimulus, the latent period is short, some sort of physical injury is usually concomitant, the secondary gain is huge and socially acceptable, and ego ideals are usually not in conflict with the illness. War neuroses are rarely the result of a single experience but many factors including monotonously repetitive dangerous stimuli, difficult physical activity, intolerable external environmental conditions, protracted and repeated evidences of desertion by all supporting and friendly human relations, and violent disruption of close personal ties with dead and wounded comrades, are a few of these factors. There is a long latent period before the soldier succumbs, physical injury is usually absent and the ego disruption is tremendous, often leading to severe regression and long-persisting disorientation. The illness is the stimulus for a new and serious conflict with the ego ideal incrementing anxiety, so that removal from combat may become more secondary loss than gain. The anxiety of the illness is less tolerable than the fear of battle. Finally, war neuroses develop after the protective factors such as morale and the widened ego spans in closely knit groups have collapsed.

In order to give you a glimpse of the total picture of therapy we shall enumerate our four general goals:

1. Prophylaxis against breakdown. This is accomplished in the AAF by adequately instructed squadron surgeons; in the ground forces, by a psychiatrist recently assigned to each combat division.
2. To return the cured or markedly improved psychiatric casualty to his combat unit if possible.
3. To return the rehabilitated soldier to limited non-combatant duty in an occupation and a locality which do not contribute to a relapse.
4. To treat the more serious case early and adequately, or send him where such treatment is possible (zone of interior or all phases of psychiatric treatment, the very magnitude of the program in terms of numbers involved, requires speed, and hence briefness, as far as treatment for the individual soldier is concerned. It has been stated that brief psychotherapy does not always mean briefness in terms of the total period of time over which the therapist sees his patient occasionally and for brief periods. The military situation actually demands a literal interpretation of the term brief. The soldier patient can be treated for short periods of time only—in every sense of the word. You can therefore understand how appealing can be the promise of such pharmacological panaceas as sleep treatment or how alluring the temptation to shock by electricity, in rapid tempo, hundreds of soldiers into temporary amentia, then too benumbed to appreciate their anxieties. Psychotherapy is challenged to produce results in quantity quickly. Can it do the job alone or in combination with other methods? We shall attempt to answer this question on the basis of personal experience and observation of the work of many other psychiatrists overseas.

Let us consider war neuroses, in simple terms, as the effect of an interaction between the dynamic forces of anxiety and the protective devices of the ego. Although we do not minimize the latent and overt anxieties of the individual’s previous neurosis and character or ignore the limitation of his ego span produced by the scarring of previous psychological traumas, we are dealing with the personality functions in relation to a new and crucially vital situation—the battle scene and all its stresses. It is the war situation that brings him into disequilibrium and forces him into new adaptations that may surpass his limitations. We are forced to make a psychological survey of the psychiatric casualty before deciding on proper therapeutic procedures. Is the patient’s anxiety of such strength that his ego cannot cope with it and has already partially or completely adopted defensive techniques which we recognize as emergency, uneconomical and which have reached the quality of illness that we call neuroses? Or has the ego strength been weakened by fatigue, sleeplessness, cold, hunger and other physical privations or has it been weakened by psychological stimuli of disturbed interpersonal relationships, loss of confidence in leaders and other factors which we term weakened morale?

For the latter it is obvious that our therapeutic procedures will encompass sedation, opportunity for sleep, warmth, food, increased physical com-
fort and rest from battle. On the psychological side procedures calculated to strengthen the ego will be employed. These include persuasion, strong suggestion, re-identification with the all-powerful group and stimulation of the ego-ideal. In brief this is a "covering up" method. As will be described, it works well when the stage of actual neurosis has not yet been reached and only when evidences of anxiety are becoming manifest on the surface. For ground troops four or five days in a forward evacuation hospital and for air force personnel a like period in a rest camp succeeds in returning many such men to combat. To catch these men before they reach base hospitals is important, hence in the combat zone psychiatrists are now stationed well forward and special psychiatric evacuation hospitals are being established.

For those whose anxieties have reached an excessive quantity and do not become reduced on cessation of the stimulus and for those whose anxieties have already stimulated neurotic ego defenses or broken the ego completely, "covering up" technics are of little value. Such procedures as continuous sleep treatment are ineffective. Ego strengthening results in no benefit until the terminal period of therapy. First and foremost must be the use of "uncovering technics." These require the reliving of the traumatic experience with a closed emotional release as the ego is strengthened and guarded by the psychiatrist. Subsequently a variety of methods are used to increase the ego's span, and to restore its discriminatory and reality-testing functions.

In one case we assist the ego in repressing or enduring anxiety if it can do so in a relatively non-symptomatic fashion. In the other case we unleash the forces of repressed, displaced or converted anxieties and the experiences related thereto, after which we direct our attention and therapy to a reconstituted ego and superego. The polar extremes inherent in these two methods necessitate experience in selection of patients for each. To make only one generalization: those patients with moderate amounts of free-floating anxiety and little ego deformation are best suited for repressing technics.

We are now ready to discuss brief psychotherapy and its adjunctives in the forward areas. In the African theater of operations Majors Wishart, Tureen and Hanson were largely responsible for this work. The medical care is simple and logical. Predicating that the ego forces have been weakened by cold, hunger, exposure, lack of sleep and physical exertion, the patient is given sleep with the help of adequate sedation, warmth, food, baths and clean clothes. The psychological attitude within the hospital containing men from the same unit with minor wounds, is set for rapid return to duty. The discipline is military rather than hospital and the patients are required to eat from the mess line and generally care for themselves.

The psychotherapy given by the psychiatrists at these installations was very brief indeed and involved mostly suggestion and persuasion, technics which they had used in civilian life with success. Thus there was present the necessary therapeutic enthusiasm on the psychiatrist's part—truly a necessity for success by these methods. Each man was interviewed in the open ward. Only when highly personal matters were discussed was the conversation inaudible to others. The convincing reassurances that the psychiatrist had no doubt of the patient's ability to go back, the pseudo-physiological explanations of anxiety, discussions of the universality of fear and the leading questions "You want to go back and try again don't you?" were all loudly given so that the entire ward heard the same procedure repetitively. There was no effort at uncovering sources of anxiety, no lending of support but a gradual increasing firmness in the pressure to return. Whenever sleep had to be prolonged by barbiturate narcosis, it was utilized as a hypnotic state and repetitive deep suggestion was given to return to the fight. The final step in pressure was an intensification of the superego demands. Tension was stimulated or increased by indicating that relief from the fight was dishonorable, that family, friends, comrades and country expected the soldier to return and finish the job. The maximum stay at the forward hospital was four to five days; longer than this was considered indulgence and conducive to binding anxiety to a symptom.

The dynamics of this technic will be familiar to all of you and we have already indicated that patients without full-blown neuroses are chosen for the procedure. Certainly it can only be this type that some psychiatrists have reference to when they state that war neuroses are not neuroses because there is no lasting ego change. They surely cannot have reference to those cases seen in rear areas. Sixty percent of cases chosen for this treatment are returned to combat duty. We shall not indicate to you the basis of our doubts regarding these statistics or our observations on the rate of relapse. Sufficient is it to say that at least for a time troops are returned to combat, effective or not is hard to say. Furthermore, the end-result in many of these soldiers carrying a reservoir of repressed anxiety will be a post-war problem, if not before. There can be no doubt that the work is necessary and if done early, close to the front lines and with therapeutic enthusiasm, it will return many men to combat. But it requires a fine psy-


The uncovering technics can only be employed to the breakdown. However certain general criteria can be hastened, the significance of which you will:

1. The patient's history: his previous neurosis, his assets and capacities. 
2. The degree to which exhaustion contributed to the breakdown. 
3. Previous recent psychological traumata. 
4. Severity of precipitating traumata. 
5. Quantity of anxiety. 
7. Capacity for psychological understanding. 
8. Degree of repressed hostility (these become fixed and chronic early.) 
9. Type of clinical syndrome. 
10. Time available for therapy.

The uncovering technics can only be employed in our hospital: The patient is isolated in a semi-darkened room and is told that he is going to receive an injection which will make him sleepy. The drug is then injected in the antecubital vein at a slow rate (0.1 gram per min.) while the patient is asked to count backwards from the number 100. Shortly after the counting becomes confused and before actual sleep is produced, the injection is discontinued. If the patient is mute or stuporous and therefore cannot count, a corresponding depth of narcosis must be estimated from the tonus of the eyelids and the pupillary reflexes. In rare instances, the injection is difficult because of violent tremor of the arm. In almost every case there is some increase in the symptoms of anxiety as the injection is initiated. As it proceeds, however, the tremors disappear, and the patient becomes quiet. Speech, if present, becomes somewhat thick and there may be some spasmodic coughing, but we have not seen the development of pulmonary edema with this dosage and technique.

The national committee for the study of the prisoner of war problem.

By the time a satisfactory level of narcosis is reached, a few individuals will begin to talk spontaneously, and if the patient is on the subject of his battle experience, he is allowed to proceed without interruption. In the greater number of cases verbal stimulation is necessary. The patient is told in a matter of fact manner that he is on the battle-field, in the front lines. Depending upon the amount of known history, specific details are added corresponding to the actual situation at the time of the trauma. If little or nothing is known of the original situation, a typical scene is depicted. The patient is told that mortar shells are flying about, that one has just landed close, planes are overhead or that tanks are from the flank, and that he is penned. The amount of such is necessary to start the patient tremendously. Some react with and launch into a vivid account. Others resist for varying periods of resistance is maintained, the more dramatic and realistic, the role of a fellow soldier, patient, in an alarmed voice, to come over, or asking him to come home. Persistence is required by an account of the scene.

It is impossible to describe during a pentothal narcosynthesis act out the traumatic parts of this is their reaction, they are of bed and to wander about the slit trench, a lost friend, the whatever the piece of action. Some live through the scene tionally without the product activity. They talk to unseen unheard explosions, bury the pillow when the shells come selves out on the bed as if they of their foxhole.

It is electrifying to watch in the moments of supreme imminent explosion of shells, before the patient's eyes, or under a heavy dive bombing becomes increasingly tense a widening, and the pupils dilate, covered with perspiration. It convulsively, seeking a weapon of the danger. Breathing become and shallow. The intensity of becomes more than they can at the height of the reaction, and the patient falls back in bed for a few minutes, usually to a more neutral point. Some over and again to one short it through repeatedly, as if, around a cracked record, this point. In such cases, narcosis is required, bringing out new pieces of. This situation is more common and amnesic anxiety states incapable of digesting the except in small divided doses.

Other patients in whom the without much overt anxiety
that one has just landed close by, that enemy planes are overhead or that tanks are approaching from the flank, and that he must tell what is happening. The amount of such stimulation which is necessary to start the patient talking varies tremendously. Some react with the first few words and launch into a vivid account of the action. Others resist for varying periods, and when such resistance is maintained, the stimulation is made more dramatic and realistic. The therapist plays the role of a fellow soldier, calling out to the patient, in an alarmed voice, to duck as the shells come over, or asking him to help with a wounded comrade. Persistence is rewarded in almost every case by an account of the scene in progress.

It is impossible to describe the varied reactions during a pentothal narcosynthesis. Some patients act out the traumatic parts of the battle scene. If this is their reaction, they are allowed to get out of bed and to wander about the room looking for a slit trench, a lost friend, the Command Post, or whatever the piece of action in hand calls for. Some live through the scenes verbally and emotionally without the production of much motor activity. They talk to unseen buddies, wince at unheard explosions, bury their heads under the pillow when the shells come close and flatten themselves out on the bed as if they were in the bottom of their foxhole.

It is electrifying to watch the terror exhibited in the moments of supreme danger such as at the imminent explosion of shells, the death of a friend before the patient's eyes, or the absence of cover under a heavy dive bombing attack. The body becomes increasingly tense and rigid; the eyes widen, and the pupils dilate, while the skin becomes covered with perspiration. The hands move about convulsively, seeking a weapon, or a friend to share the danger. Breathing becomes incredibly rapid and shallow. The intensity of emotion sometimes becomes more than they can bear and frequently at the height of the reaction, there is a collapse and the patient falls back in bed and remains quiet for a few minutes, usually to resume the story at a more neutral point. Some patients return over and over again to one short traumatic scene, living it through repeatedly, as if, like a needle traveling around a cracked record, they could not get past this point. In such cases, more than one pentothal narcosynthesis is required, each further session bringing out new pieces of repressed material.

This situation is more common in the stuporous and amnesic anxiety states where the ego seems incapable of digesting the traumatic experiences except in small divided doses.

Other patients in whom there has been amnesia without much overt anxiety become suddenly blocked in the account of their experience as they approach the moment of the trauma. As the anxiety begins to appear in anticipation of the traumatic scene, they cease talking and resume their characteristic defenses; they don't know what happened next. At this point the therapist applies pressure, demanding, forcing the patient to proceed. More than one session of narcosynthesis may be necessary to uncover the trauma. Frequently, especially among the milder anxiety states, the patient does not live out the scene in the present, but tells it as a story. That he has thus been able to achieve some distance from the traumatic experience and is able to regard it as an event of the past does not militate against the release of the violent emotions connected with the experience.

During the time that the patient is thus wrestling with his traumatic experiences, the therapist plays an active or passive role in the performance to the degree required by the situation. No attempt is made to produce a hypnotic situation. The therapist remains as a vague background figure from which vantage point he can step into other roles as it becomes necessary. Some patients, especially those with only mild anxiety, good personality, and good contact with reality, are aware of the Medical Officer's presence throughout the treatment. They realize that they are telling the story to him and rely upon him only for moderate support and sympathy during the moments of strong emotion. The severe cases, however, in which there is much "living through" of the experience in the present tense, are actually plunged in the battle situation. Here the Medical Officer is called upon to play a variety of roles. When the patient becomes convulsed with the violence of the terror, he must step in as a protective and supporting figure, comforting and reassuring the patient, and encouraging him to proceed. If this is not done there is a tendency for the initial protective reactions of stupor or amnesia to be re-established, and the patient makes no progress. When intense grief and anger is exhibited over the death of a best friend or guilt over the killing of a young German soldier, the patient frequently throws himself into the arms of the therapist who sits at the bedside, as if seeking forgiveness and consolation from a kindly parent. Such consolation the therapist supplies, because since the need of the moment is so great, the effect of appropriate response to the patient is much more beneficial at this time than during later psychotherapeutic interviews when the problem is discussed in a more calm and detached mood. Some patients who talk constantly throughout the session to their friends become blocked at certain points of emotional height. The therapist then plays the part of the friend, stepping, as it were,
into the battle scene proper in an active role. He discusses plans of action, ways of evacuating wounded comrades, or whatever is cogent to the particular situation in order to further the progress of the events at hand.

When the initial problem is one of overcoming a somatic symptom such as mutism, deafness, or paralysis, the therapist may be required to adopt an authoritative role and command the patient to talk, to hear, or to move his limbs. Such direct interference is not always necessary. As the anxiety related to the traumatic situation emerges the symptom disappears spontaneously. A patient with a severe conversion symptom under pentothal may begin to talk about his experiences in a calm detached manner, but as he progresses, increasing quantities of anxiety are liberated. The somatic symptom disappears as the appropriate emotional reaction is initiated and has obvious infantile dependent characteristics which the therapist encourages by his sympathetic interest, his assumption of complete responsibility for the patient’s progress. At this stage he supports and comforts the patient who at first, convinced that the whole world is hostile, accepts the support only provisionally. But the soldier’s need is so great that he soon learns all his weight heavily on the psychiatrist. Transference relationship is less easily established when ego strength is less altered in the hysterias and psychosomatic disturbances. When the transference starts as a negative feeling in an irritable, sullen, withdrawn individual we have learned that this patient usually suffers from considerable repressed hostility, is the type that becomes fixed early in a chronic state and has a less favorable prognosis for recovery. At least in the combat zone working through transference resistances require too much time.

Release of unconscious tensions is mainly concerned with the emotion of anxiety, the excessive quantity or the persistence of which is the nuclear problem of war neuroses. When the ego has been able to successfully ward off the overpowering subjective aspects of anxiety by the formation of conversion or phobic symptoms, resistance to conscious re-experiencing of anxiety is too great to overcome in a short time. When the ego has regressed before the onslaught of anxiety, the physical expressions of which then dominate the somatic symptomatology, too little ego remains to work with. Therefore, in most of these cases we must have recourse to the method of narcosynthesis which has already been described. Without going into the psychophysiology the observed effects are reappearance of ego functions, revivification of free anxiety and loss of somatic symptoms of conversion and of excessive autonomic excitation. Sometimes more than one treatment is necessary. Often the anxiety is too powerful especially in cases with profound somatic regression, (the extrapyramidal syndromes) and the ego regresses anew under therapy. The therapist must

Positive transference to the psychiatrist is established rapidly in almost all cases. The psychiatrist is the one man whose main concern is the individual soldier as a person and not as a cog in a tremendous machine. He represents to the neurotic soldier the nearest approach to that for which his whole sick being cries—in the throes of his devastating anxiety—a kindly interested parental figure in sharp contrast to the authoritative demanding voices of his officers. You can readily understand that when the psychiatrist “goes military” on donning his uniform he ceases to function as a psychiatrist.

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learn by experience the amount of anxiety that can be tolerated at each stage of ego recovery.

We have noted two phenomena of significance. A soldier may collapse in a battle but the uncovered anxiety may be related to episodes in battles which had occurred several months ago. Many cases with severe ego breakdowns were not greatly improved by re-living the situations of battle which initiated the collapse. They revealed old anxieties and resentments dating back to civilian life. It is as if a wave initiated in the battlefield swept everything before it as it found added velocity in old gradients of unresolved conflicts. These naturally have to be dealt with at the moment.

Pentothal overcomes resistance against the repressed anxiety and often a partial recovery intensifies these resistances. But the patient in psychotherapy must be encouraged and often firmly persuaded to relate his traumatic experience to the therapist many times. Often gaps in memory and remnants of repression can be observed. The soldier may forget what he has related under pentothal and must be reminded thereof. The resistance of the ego representing its incapacity to tolerate anxiety is decreased as confidence in the psychiatrist expands. As the ego absorbs strength and support from the therapist its capacity to endure anxiety increases. But the psychiatrist must maintain a constant pressure in his interviews but never too intense or regression will recur. Experience soon produces skill. We shall not recount the interpretations and demonstrations given to the patient since in reality he only endures the pain of the liberated anxiety because of his emotional need for the therapist.

 Gratification of dependent needs is of course begun in the initial interviews, is carried on during pentothal treatment and in psychotherapy afterward. It is the basis of the transference. When I discussed the liberation of unconscious anxiety no reference was made to the danger that this signal foreboded. It now becomes apparent why gratification of dependent needs is more than a trick to hasten transference feelings. As anxiety reaches consciousness the source of anxiety becomes apparent in every incident, every story and every reaction of the patient. He sob’s, weeps violently, throws himself into the psychiatrist’s arms demanding support and comfort as he tells how he was deserted by every semblance of a protective, supporting or kindly figure. Officers, other soldiers, friends and buddies all suddenly become impotent in the face of the ever present enemy fire and activity. He is an isolated individual in the darkness and all interpersonal relations are violently torn asunder. True we see the automatic emergency reactions to danger in reality—the ducking, digging, running movements revived under pentothal but these subside and the infantile cry still resounds. True we see a semblance of rage as with clenched fists pounded on the bed the soldier screams at the Nazi bastards and what he will do to them. But these are impotent displaced hostilities. We do not wish to deny that some patient’s anxieties are signals of distress because of intense activation of their unacceptable hostilities or that in many patients the emergency mechanisms stimulated by the external dangers become excessive and overpowering to the ego or fail to decrease as the danger disappears. But in the vast majority of cases the source of anxiety is a feeling of desertion, of being left alone like a child in a dark room with the door shut and no human voices audible. It is now apparent why so much gratification and affection must be given these men. They have also given far beyond their capacities and the overdraft on their psychic banks must be replenished before they can resume their resemblance to the adult.

 Re-cognition of the temporal and spatial present is a process which proceeds rapidly up to a certain point under pentothal but the final reorientation in severe cases is slow and beset with relapses. By virtue of the dangerous and helpless situation, the ego has reacted as an infant might. It abandons the scene—stupor; refuses to listen to the noises—deafness; refuses to talk about it—mutism; or refuses to know anything about it—amnesia or in milder cases develops phobic mechanisms. During pentothal and shortly after, the patient will give up these defenses as long as the psychiatrist maintains a feeling of desertion, of being left alone like a child in a dark room with the door shut and no human voices audible. In appropriate cases as early as possible the ostrich technics of the ego and this must be dispelled in appropriate cases as early as possible by strong re-assurances. The process of learning that the world is not entirely hostile is achieved at first by an identification with the therapist as a non-combatant still serving a useful purpose. The patient’s ego span and strength are increased as he
borrows the strength of the psychiatrist. This is done initially through powerful and persistent suggestion—later by rational interpretation of each and every apparent stimulus to regression. Thirdly, time is necessary for the patient, at first with the therapist's support, to test the human environment's sincerity. Here our troubles are great for the army is not conducive to such testing. Many soldiers return to us for further working through of their reactions to relatively mild rebuffs and rejections, which in severe cases may assume the status of paranoid trends. This phase of therapy is not new to any of you who have dealt with patients whose early lives were filled with real rejections and you know the patience required and the time necessary for "working through."

Release of repressed hostility: This is the hardest task of all and often fails completely. These patients either have developed excessive quantities of aggression which their egos cannot permit escape into consciousness or they are psychologically incapable of dealing with even moderate quantities of hostility by any other method than repression. These are the stubborn rigid characters with much reaction formation often of the compulsive type. They suffer from repeated battle dreams, tend to withdraw from social contacts and show a high degree of continuous irritability. Under pentothal the release of some of their aggressions often shakes them into violent symbolic gestures or even convulsive spasms. They tend to develop into a chronic stationary state early in their course and constitute the type of patient we have seen for years in Veteran's Bureau Hospitals as sequelae of the last war.

For this type of patient, pentothal is used for several interviews until it is obvious no more can be done for them. We then use convulsive shock treatment and in a few selected cases can expect very good results. With subsequent psychotherapy recovery for reclassified service may be effected. Depressions precipitated by the loss of a buddy are also often recalcitrant to other forms of therapy. In such cases the ambivalent relationship had left much unconscious hostility to the dead comrade unacceptable to the conscious ego. Brief psychotherapy is usually not possible since the amount and extent of interpretation of displaced hostility to the immediate environment can only be accomplished by a slow pace with much repetition. No one patient can obtain enough personal attention for the treatment to accomplish a great deal.

Identification with the therapist, we have seen as a potent first step in the viewing of the world as a not altogether hostile place. It serves another dynamic purpose. The hostility of the superego is one of the principal forces that harass the ego and weaken it. Every patient suffers in varying degree from a sense of failure, most severe in those with strong overcompensations and those who endure anxiety for long periods of time. As regression recedes, depression over the failure to maintain the standard of military effectiveness demanded by conscience, becomes apparent. The soldier's ego ideal insists that he is yellow, a coward, an impotent useless failure, with not even a scratch to account for his desertion of duty. As long as the superego maintains its identification with the dead and living friends on the battle field, it will remain angry and demanding. Often the ego ideal stems from a father who carried on valiantly in the first World War, and return home in the condition of neurotic illness becomes so painful a thought that many demand to return to the battlefield as a displaced suicide attempt. The step in therapy familiar to you is the weakening of the old superego demands by identification with the therapist and appropriate interpretation. As such identification is slowly increased the depression lifts and the patient sees himself as one who did the best, often better, than he could and one who still has a valuable function in the army as a noncombatant. This process is not difficult or lengthy. It is hastened by occupational therapy of a military nature and is completed when the soldier makes new identifications with a non-combatant unit and its group ideals.

Development of an independence of the therapist. This is the terminal stage of therapy and can only be begun in the hospital. It requires much working through and persists for months. The reconstituted ego with its re-established contact with a safe and secure reality, convinced that return to the battle is not to be its fate, is now directed to view the future. Still smarting and shameful at its fate, is now directed to view the future. Still smarting and shameful at the gibes of conscience, its self respect is furthered by identification with the non-combatant psychiatrist. But it still had to be convinced of its ability to function without continuous support. This is aided by means of occupational therapy: not basket weaving or making objects of art but real work of value to the war effort. Clerking, typing, litter bearing and a hundred and one jobs around the hospital are used to busy the soldiers and hasten the return of their self respect. Soon they ask to be discharged and rejoin an outfit in which they can work out their own salvation in order to return home with heads high as men who have done their job well. By working through their rehabilitation in the framework of the army itself dependency on family and government pension can be reduced to a minimum. In the severe anxiety states, however, persist with great obstinacy the case when the patient cannot admit the significance of the case. In many patients in whom or both, continue long after the army is returned to civilian life; they have become clear that the concealed purpose, of their act as a bribe and appeasement of the fear of the superego. The ego says, as it often says, "I was weak and helpless in combat. You must take my fault."

We have mentioned the problem of the serious cases which are difficult to treat. These are the cases where the ego is not in a position to function effectively either because of a certain amount of neurosis or because of the lack of a serious case. The psychiatrist trainee has not yet learned how to handle these cases effectively. Under present circumstances, the number of cases is small but the problem is important. The psychiatrist trainee must be prepared to handle these cases effectively. The psychiatrist trainee must be prepared to handle these cases effectively. The psychiatrist trainee must be prepared to handle these cases effectively. The psychiatrist trainee must be prepared to handle these cases effectively.
anxiety states, however, dependent trends may persist with great obstinacy. This is particularly the case when the patient refuses to recognize or to admit the significance of his dependent needs. In many patients in whom anxiety and depression, or both, continue long beyond the period when the ego should have begun to assume control, it becomes clear that the continued helplessness has a concealed purpose. Whereas initially the ego has considerable justification in regarding itself as injured and unable to cope with the environment, after a prolonged exposure to a protected environment such justification no longer exists. The persistence then is due to the attempt of the ego to bribe and appease the demands of the ego ideal. The ego says, as it were, "This is what you have done to me. I stuck it out to the limit at your behest until I was broken and maimed; now I am weak and helpless, and in no state to return to combat. You must forgive me because it is not my fault."

We have mentioned factors important in prognosis. Let us now see what clinical syndromes in general are efficiently treated. The free-floating anxiety states offer a good prognosis although many severe cases require longer time only available at home. This holds true when severe somatic regressions are also present. The conversion states, phobias, many types of depression, likewise promise well for recovery. Psychosomatic visceral disturbances unless very mild and without history of previous similar illness usually have to be sent home. The same holds true for those showing paranoid trends. We believe that with adequate facilities, proper use of adjunctive treatment such as shock and narcoanalysis and the proper use of psychotherapy of the uncovering type, based on sound dynamic principles, followed by a sound work rehabilitation program, most of even the severe cases can recover in hospitals in this country. These men need more time for the working-through process.

Under present circumstances, however, our optimism is unjustified because firstly we do not have enough psychiatrists and secondly we have few psychiatrists trained in the type of brief psychotherapy we have been discussing. But we should like to answer the question raised earlier in this presentation. Can properly used psychotherapy do the job of rehabilitation? The answer is emphatically, "yes," as we have shown in a limited number of cases personally studied. We need more time and more trained therapists and of these requirements, the latter is more urgent.

Never before has there been so much interest among medical men in psychiatry as we have seen expressed in the army. They are interested in dynamic psychiatry for they have seen how little value there is in diagnostic labelling, persuasion, suggestion and authoritative forcing. They are interested intensely in psychosomatic medicine as in the army they really observe hundreds of such cases. Lastly, they are interested and demand knowledge regarding short methods of psychotherapy. It is from this group that the army can select a limited number of talented individuals, expose them to clinical teachers actually working with patients and give them enough knowledge so that they can function as brief psychotherapists at first under direction and later independently.

The AAF teach squadron flight surgeons psychosomatic and psychosomatic psychiatry in didactic courses. One class taken to a clinic in a nearby general hospital where several types of cases were presented asked the Major in charge such questions as what is the man's conflict? how do you analyze his resentments? what treatment do you use? etc. When they were informed frankly that the Major had no time and didn't know the conflicts and only observed the cases and sat on boards discharging them to the Veteran's Facility, this class of 150 men became disturbed. At least 10 in this group wanted further training in the field. We have a grand chance in our service schools to find needed additional help in rehabilitation. These physicians will not necessarily become psychiatrists; some of them will continue their training after the war. Most of them will be far better physicians after the war is over. Therapeutically they will have a fresh and enthusiastic optimism which psychiatrists unfortunately as a group have lacked. We have had to convince many psychiatrists coming overseas that war neuroses are amenable to therapy, are not found in weak and useless characters and deserve active help every step of the way from evacuation hospitals to zone of the interior.

Everyone—neophytes and trained psychiatrists have a great deal to learn from a study of war neuroses, much of which will be applicable to problems in civilian life. Especially is this true in the field of therapy. We predict that dynamic brief psychotherapy will be well established as a technic by the time this war is finished.