

SILVER LININGS IN THE CLOUDS OF WAR: a Five-decade Retrospective
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The events of World War II propelled the specialty of psychiatry to an historically new high level of appreciation and recognition. At the beginning of the war, the Surgeon General's office had two major divisions: medicine and surgery. By the end of the war, a third division, psychiatry, had been established. It was ably led by Colonel William C. Menninger. A range of bio-psycho-social factors that impaired functioning were identified and treated as significant aspects of the military medical scene.

In the early days of the war, general hospital units arrived in North Africa without adequate psychiatric personnel. The medical teams were surprised to discover the urgent need for trained psychiatrists and nurses to treat combat casualties. Consequently, the School of Military Neuropsychiatry, under Colonel William Porter, was established at the Mason General Hospital in Long Island to meet this need. Psychiatrists, whose prior training had been focused on patients hospitalized with chronic mental illness, needed to be prepared to deal with a large population with no prior history of mental illness. The challenge was to identify and treat both the mentally healthy population, as well as those with pre-existing psychiatric vulnerabilities, whose ability to perform their duties had been psychologically impaired. The battlefield became a large-scale arena for observation, which obligated the professional to learn and devise therapeutic interventions to treat the effects of acute, overwhelming situational stress of war and combat on the behavior of a broad spectrum of individuals (H Spiegel 1944a, 1944b, 1973). Many of the lessons learned in the extreme duress of war have proven valid by subsequent clinical experience, and useful in other traumatic but non-combat situations.

INSTRUCTIVE EPISODES

The attack on Pearl Harbor caused an abrupt shift in my training from a psychiatric residency at St. Elizabeths Hospital in Washington, DC, to an Army psychiatry post at Ft. Meade, Maryland. Five

months later, I was assigned to the First Infantry Division as a battalion surgeon and immediately shipped overseas. I was part of the invasion of North Africa at Oran and the ensuing Tunisian campaign. This was the first military assault in World War II by the U.S. Armed Forces. The following episodes epitomize different issues that emerged in combat and that have relevance to the field of psychiatry today.

Episode I

We were a battalion of 1,000 men aboard the Llangibby Castle—part of an armada coming from the North Sea. At dawn, we landed and attacked on the west side of Oran. Our ship was struck by shell fire at midship above the water line. Many had feared they would lack courage to climb down the ropes to get onto the landing barge that would bring us toward shore. Under fire, with a focus on shore, courage emerged. We swam a few hundred yards to the beach, with a three-day supply of food, ammunition, and/or medical equipment on our backs. Our battalion's goal was to climb the steep rocky hill that overlooks Oran and attack the French fort capping the hill. Climbing upward, under cannon fire, and weighted down with supplies, seemed impossible. Yet we did it—we captured the fort and took our prisoners. Looking down to retrace our moves, it was difficult to believe what we had done.

Our commander, General Terry Allen, a World War I combat veteran, was fully aware that most of us had never been in combat and that we were clearly tense. He had prepared us for the probability that, like most battles he had experienced before, we would not have the air cover and support we were promised, the terrain would not be exactly what we were expecting, and the enemy would not be exactly where we thought they would be—but as he said confidently, "We'll do it anyway!"

Lesson: With preparation and a clear focus on a goal, men can overcome anticipatory anxiety and situational fear, and can move into action. A confident, knowledgeable leader can transform tension and uncertainty into inspired group action that surprises even the participants.

Episode II

Our battalion was trapped in a valley with German tanks attacking from the front and our own supply lines blocking our rear. Artillery shells and Stuka dive-bombers were clobbering us from above. Roy, one of our good medical aides, lost control. He had been carrying a wounded soldier on his back when the soldier was hit and killed on their way to the aid station. Roy was found wandering aimlessly, exposing himself to enemy fire; he was disoriented, confused, and mumbling, "I can't take it any more!" Our sergeant tackled him to the ground to protect him from rifle fire. I grabbed him by the collar and commanded him to dig a hole and stay put until he got permission to get out. He did.

The next morning, he apologized for his behavior and thanked me for "helping" him. Seven months later, I received a Christmas card from him. He reported that he had continued with our unit after I left (I had been wounded and evacuated back to the States) and had gone on to the invasion of Sicily, where he was lightly wounded. He wrote: "Now I have a safer job. I'm an aid man in a hospital." He thanked me for helping him "stay with the action." My firm orders "to dig a hole and stay there" helped him restore self-control and maintain self-respect.

Lesson: During the amorphous stage of emerging panic, bonding with the unit and maintaining personal integrity can be tapped, if someone in charge acts quickly and provides clear direction. Immediately re-structuring the situation with orders for appropriate action enabled this soldier to remain on duty. His regressive behavior was interrupted and his self-esteem was preserved with instructions that permitted him to take charge of himself. This crisis intervention, clearly therapeutic, focused on the interaction between the demand characteristics of the situation and the soldier's ability to maintain self-respect through appropriate action. In retrospect, he was grateful. The result was a "ripple effect" (Spiegel and Linn 1969). From his success in the immediate crisis, he was able to go on to new assignments with a sense of self-mastery and accomplishment instead of shame and failure.

Episode III

J.C. was a platoon staff sergeant who had been with his outfit for several years. He was a hard-working and efficient noncommissioned officer with a great deal of battle experience. For two months, he had been on night patrol duty in the Ousseltia Valley (Tunisia). One morning, after launching an attack with his platoon, he reached his objective—a hill that had to be held for further operations. Shortly after he took the hill, the enemy counterattacked. He was "caught short" in close fighting. Several shells landed near him. He was stunned but not hit. He continued to fight, but became increasingly tremulous until he was unable to hold his rifle. Helped by another soldier, he came to the aid station with gross tremors and a sickly smile. "Don't send me back to the rear, I'll be all right!" he insisted. In an effort to salvage him, we sent him to our battalion's kitchen area for two days and nights. When he came back, he had lost most of his tremors, but had developed facial tics. Obviously tense, he was still eager to rejoin his outfit.

For three months, he carried on in active combat. During one attack, all the officers in his company were killed or wounded in the first half-hour. As the ranking noncommissioned officer in the outfit, he led the company until a relief officer assumed command. He was later wounded and evacuated as a surgical casualty.

Lesson: Despite prolonged stress with physical symptoms, motivation and unit loyalty can enable soldiers to refuse evacuation. Temporary respite within the battalion group area can allow a soldier to reconstitute himself. Even though J. C.'s tics did not subside, he performed admirably until he was wounded and evacuated. Whether he was declared to be a casualty or not was a judgment call of the battalion surgeon. Had his condition of gross tics been labeled "combat exhaustion" and led to his evacuation, it would have taken him out of action, with a consequent loss of self-esteem. In spite of anxiety symptoms, he received medical clearance and psychological support that focused on his leadership abilities. This helped re-define his fear as "courage," kept him connected to the esprit of his unit, minimized attention to his involuntary expression of anxiety, and, of course, helped maintain needed manpower. By permitting him to persist on duty—even with symptoms—the battalion surgeon let J. C. replicate what unknown thousands of others did without documentation. When

presented with psychosomatic symptoms, the doctor, through diagnosis and related decisions, can encourage motivated performance, or invite psychological collapse and invalidism.

Episode IV

Lieutenant B. was a superb engineer officer of our battalion. He was courageous, ingenious, reliable, and respected by his men. One evening a medical aid man brought him to me to examine his right arm. He was holding it braced to his body but insisted he was "okay." I discovered that a shell fragment had fractured his right shoulder blade. Reporting that he felt no pain, he was asked to move his elbow away from his side. When this effort failed, I wrote orders to evacuate him. He shouted, "You're not sending me back, Doc!" I had to convince him that he needed surgical care and was no longer able to function in combat. Tearfully, he asked, "How will my men go on without me?"

After several months of rehabilitation, the Lieutenant B was able to return to active duty. But he used his knowledge of army bureaucracy to avoid combat, managing to get a rear-echelon assignment. After the war, I met with him. He was surprised and embarrassed that he, an enthusiastic combat officer, had lost his fighting spirit and had become desperate to avoid combat.

Lesson: With intense focus on a task and the motivation to keep going, dissociation becomes a powerful coping mechanism enabling one to maintain responsible action and manage pain. This officer blocked awareness of his injury and pain until a medical examination made it inescapable. Once the dissociation was reversed, it led to a break with his role identification and his unit bonding, making it increasingly difficult for him to return to the same hazardous assignment.

When separated from primary groups, and after enough time elapses to bond with new groups, incipient secondary gain often invades and corrodes preexisting motivation, and commitment. In World War I, it was observed that once a soldier left the sound of the guns, it was very difficult to get him back into combat. This lesson had been learned in World War I but forgotten, and had to be learned again in World War II.

Episode V

During a rest period between battles, a young rifleman became confused, hallucinated that he had heard his mother's voice, believed the war was over, and did not respond to his platoon leader's orders. He was obviously psychotic and was immediately evacuated. In due course, he was discharged with a diagnosis of schizophrenia and was transferred to a Veterans Administration hospital.

Lesson: Once a clear psychotic break occurs, internal coordination collapses and connection to the esprit of the group dissolves. There is no point of contact for reconstituting the soldier's inner resources. Quick evacuation is the only option.

These five episodes bring into focus the importance of determining where an individual fits on a mental health--illness spectrum. In these five cases, psychiatric disabilities ranged from transient reactions in the context of mental health to total, irrevocable collapse due to mental illness. There were many circumstances when men amazed themselves with effective action. Some faltered, then quickly recovered. Some felt fear and experienced physical symptoms, yet were able to persist in action. Some first denied their hurt, then later, as they recovered, lost their previous courage to face danger. Some collapsed and remained an invalid.

There were a variety of mediators in the various responses to danger. Motivation, morale, group loyalty, preexisting psychosocial factors, personality style, and leadership (expectations, direction and support) had a discernible but immeasurable effect on each person's participation. It was up to the doctor in charge to identify which mediators could play a role to preserve manpower and at the same time provide humane care to the disabled. Combat disability reflected a combination of an injury plus the reactive components to that injury. The challenge was to discriminate between the injury (disease) *per se* and the broad spectrum of behaviors that developed as a consequence of the physical (or emotional) insult.

GENERAL LESSONS FROM COMBAT

Disease-Illness Concepts

A personal event in combat taught me the clear difference between disease and illness behavior. On the last day of the Tunisian campaign, as we were closing in on Bizerte, a German tank gun hit our area. I saw the tank coming toward us, I heard the blast, and suddenly I felt pain. I couldn't localize the wound until I saw a sliver of steel poking through my boot into my right ankle. An aid man rushed to my side. I turned over and asked him to examine the rest of my body. When he found no other wounds, I was elated—no longer aware of the pain—just elated. He prepared a dose of morphine for me but I refused it. I didn't need it.

When I considered all the possibilities from gunfire and the spray of steel fragments, I felt lucky. I had the dream wound of an infantryman—good enough to get me out of the infantry honorably, but not bad enough to make much difference over time. My reaction was general euphoria and relief, with no complaints at all. I became convinced that pain was a two-factor experience—the physical hurt plus the reaction to the hurt. This idea became a prototype for exploring reactive components to medical problems.

At the Anzio beachhead, Beecher (1956) observed the same phenomenon with large numbers of wounded soldiers. Compared to those with similar wounds in a civilian population, these soldiers required less morphine because the pain signaled that they were alive, and their degree of apparent disability was noticeably less. The meaning of the wound was a factor in determining the degree of perceived pain and discomfort.

From a psychiatric point of view, these observations reveal a health--illness spectrum that requires a distinction between disease and illness behavior (Kleinman 1988a, 1988b; Mechanic 1961; Parsons 1951; Sigerist 1960). Disease is defined as an enduring disruption of the person's biological integrative capacity to cope with environmental (outer) and bodily (inner) perceptions. Illness behavior, on the other hand, is a combination of symptoms and disruptive, aberrant actions that represent a metaphorical response to stress with or without physical impairment.

In the military, it became critical to differentiate disease from illness behavior as a reaction to physical injury and acute situational stressors. There were unique features in the combat population that opened up the possibility that a soldier might develop sickness behaviors that would supersede his commitment to prior responsibility. Illness behavior included the possibility of a willful, conscious desire to abandon responsibility as a combat soldier. Mental disease meant a total collapse of executive functioning with no discernible ability to perform combat roles in response to comrades, officers, or a doctor. When the psychological integrative capacity of the person was not totally disrupted, an intervention was more effective when it included treatment of the reactive components to the external events. The potential for a successful psychotherapeutic intervention depended on the rapid identification of the individual's capacity for interactive interpersonal communication, where he fit on the health--illness spectrum, and differentiation of disease and illness behavior.

Inevitably, disease symptomatology and the illness experience are interactive. In combat, it became clear that this interaction could be influenced in specific directions. The dialectical relationship of the patient, doctor, and situation to each other could encourage or minimize secondary gain and subsequent chronic disability. As long as the patient had not experienced a total physical or psychological collapse, the physician could develop a perspective and a therapeutic strategy to maximize an individual's potential to contribute to his unit. From the Army's point of view, this approach maintained much-needed manpower; from the soldier's point of view, long-term secondary losses were prevented. This was a powerful example of the observer's paradigm influencing what was observed (Rettig 1990).

In land combat, where lines between friend and foe were clear, an exhausted soldier with mental illness behavior may have wandered aimlessly, but very likely toward the rear. Those suffering from non-psychotic reactive stress never wandered toward the enemy. With soldiers who had some degree of mental health, temporary dissociated states were observable as reactions to severe stress. In a non-psychotic dissociated state, there was always a fragment of awareness of a safe-space orientation and a malleability to respond to clear external direction. In contrast, a psychotic soldier with mental disease may have wandered aimlessly also, but there was an equal

likelihood that he would drift toward enemy lines, totally disorientated, without even a flickering sense of self-preservation. The psychotic breaks, characterized by a loss of cognitive flow with an inability to take in new information, were irreversible under combat conditions.

There is no evidence that the incidence of mental disease (e.g. schizophrenia) was greater during the war, but the incidence of mental "illness experience" (e.g., combat fatigue) certainly increased (Glass 1957). Combat conditions were so intense and compact compared to civilian life in peacetime, that it was like an *in vivo* laboratory rapidly producing an enormous variety of stress-related behavior. The new strains were characterized by a preponderance of illnesses due to transient anxiety and trauma of an immediate nature.

Paradigms and Nosology

Psychiatric observations in combat tend to mirror the bio-psycho-social conventions and standards of the times. Whatever can be observed, measured, and defined is identified and treated. During the Civil War, for example, the only recognizable aberrant behaviors among the soldiers were labeled "neurasthenia" and "homesickness." In World War I, when the neurological sciences were more developed, "shellshock" was the prevalent name given to mental illness behaviors on the battlefield. This was defined as the impact of explosive noise on the nervous system. Based on the work of Charcot, Freud, and Janet, somatic expressions of hysteria were recognized if they took the form of sensory-motor dysfunctions such as functional blindness, deafness, autism, and limb paralysis.

At the time of World War II, overt expressions of anxiety and depression were more readily accepted by society. As more enlightened and permissive attitudes filtered into army medical thinking, the extreme histrionic disabilities observed in World War I, such as hysterical paralysis and blindness, occurred less frequently. A wide range of fear, anxiety and depressive symptoms that had previously been ignored were now recognized and treated. This prevented the unconscious need for soldiers to develop extreme mental illness syndromes in order to have their psychological agony

expressed and acknowledged. The anxiety syndromes that emerged were generically labeled "battle fatigue." This diagnostic concept helped identify and legitimize interactions between the biological and the psychological.

From the 17th to the 20th century, there had been a gradual shift from defining all psychiatric conditions as semiotic (in terms of observable biological signs, gestures, and symptoms) to incorporating psychological factors that depend on sophisticated verbalized interpretations of conscious and unconscious dynamics. By the early 19th century, Pinel had introduced the concept of using personal history and family background as a means of understanding symptoms as part of a sequence of events. Later, Sigmund Freud and Adolph Meyer began to use a narrative approach to understand the meaning of symptoms (Kiceluk 1992). They stressed the importance of developmental history, focusing on early life traumatic events to account for clinical syndromes that occurred later in life.

In World War II, the model of unconscious drives—the libido theory with the notion of repression—was not easily adaptable to the need for quick decisions about, and dispositions of combat casualties. Nor were psychoanalytic formulations or conventional psychiatric classifications, based on subtle interpretations and pathological categories, helpful in managing coping behaviors observed in combat. Instead, clinical judgments about treatment responsiveness offered more useful guidelines. It was important to identify ego function, observable action-patterns, personality features, and psychosocial resources to mobilize function.

Soldiers exhibited momentary splits of consciousness as a coping mechanism for dealing with immediate circumstances. These splits showed up as spontaneous dissociative states (e.g. confusion, anxiety, panic, fugue, depersonalization, de-realization). But these forms of dissociation were typically reversible with firm persuasion and suggestion, with a return to a previous level of functioning in a relatively short time. The rapid reversibility suggested that symptom resolution did not require uncovering early developmental trauma. Military psychiatrists observed hysterical (or conversion) responses to traumatic events of the present rather than delayed reactions to traumatic events of the remote past.

In less extreme cases, men were able to redirect their attention away from frightening or painful stimuli, blocking psychologically or physically unacceptable stimuli from awareness, to increase comfort and permit more effective performance. The process was one of fragmenting incoming stimuli and re-associating the dissociated fragments into a new pattern (Spiegel 1963). This form of coalescence enabled some soldiers to turn off fear and pain sensations to maintain a commitment to combat goals.

The psychological rearranging of reality was observed to be a therapeutically valuable coping skill that some men were able to use more easily than others. It did not cause psychiatric impairment, but instead appeared as different forms of denial, avoidance, and dissociation used to maintain or protect psychological balance and functional ability.

Psychiatric Triage

Under the pressure of battle conditions, the issue was what to do immediately. Treatment possibilities were determined by considering the soldier's potential treatment responsivity in the context of available medical supplies and combat status. Each soldier was assessed for physical intactness, mental status, degree of emotional commitment to his unit and comrades, and the potential to be treated on site within a few days or less, while still under unit command, to maintain cohesion with his unit. When longer-term treatment was indicated, evacuation plans were based on battalion position, the status of the fighting, and available transportation.

In combat, the central task of psychiatry and the battalion surgeon was to maintain manpower. Light casualties were treated first and returned to duty. Then the more serious cases were attended to. Sometimes, as in the example of Roy (Episode II), it was necessary to order a soldier to gather himself together and stay with the action, even if he showed signs of severe stress. With this restructuring approach to overt psycho-physiological weaknesses, many soldiers tapped into resources they never knew they had and were able to keep going.

The need for rapid assessment and immediate treatment decisions encouraged a division of the clinical psychiatric population into two categories: first, the "psychologically intact"—soldiers who were able to respond to psychological interventions; and the second, the "psychologically non-intact"—soldiers who were unable to respond to psychological interventions. Those who were psychologically intact responded to the atmosphere of urgency with a focus on using their internal resources. They had an ability to interact with someone in authority who offered them direction. Those intact soldiers were still cognizant of their individual identity and had the potential to be reconnected to their combat group. The stage was set in terms of the time pressure and direness of the circumstance to maximize therapeutic potential and achieve a therapeutic effect. Those who were non-intact had lost that essential ability to feel connected to their own sense of self and to develop the necessary rapport to engage in the therapeutic discourse.

The task of the front-line military doctor, after making this gross differential diagnosis, was to treat the intact patients. These men responded to the external ministrations of someone in authority. Whether they were physically or psychologically wounded, their fear, anxiety, shock, or disorientation became the fertile ground of heightened sensitivity to external direction. With or without formal hypnotic induction, these men, to varying degrees, were in an hypnotic mode due to the effect of external events and circumstances that produced an intense focus of attention.¹ In this atmosphere, suggestion, persuasion, counseling, and direction had the potential to be rapidly incorporated by a given individual. The more direct and meaningful the suggestion, the more potential there was for the individual to encode and internalize a new perspective.

Dissociation, Trance and Treatment

Sometimes in combat, a wounded soldier would shift into a spontaneous dissociated trance state—not asleep, but alert and responsive. As bleeding was stopped with sutures and a pressure bandage, the soldier

¹ Hypnosis is defined as a state of receptive, attentive concentration. In this state, dissociation, absorption, and suggestibility all converge with motivation and direction to seek resolution of pain, anxiety, panic, and fear (Spiegel & Spiegel 1987).

would talk about his body part as if it were somebody else's. He would acknowledge some pain, but ignore it. This capacity to reduce peripheral awareness in order to focus attention, then to dissociate enough to be here and there at the same time, is the hallmark of hypnotic concentration. But this was not a typical response of all soldiers. Why the difference?

Three identifiable styles correlate with varying degrees of hypnotizability—those with a cognitive style test at the low end of hypnotizability, those with an affective style test in the midrange, and those with a dissociative style test at the high end of hypnotizability (Spiegel 1977; Spiegel and Spiegel 1987).² The stress of wartime conditions dramatically exposed this spectrum of individual differences. The key to a successful therapeutic intervention was to identify the fixity or rigidity of those who used cognitive dynamisms at the low end of the hypnotic spectrum, the extreme malleability or flexibility of those who could use controlled and reversible dissociative process at the other end of the hypnotic spectrum, and the middle group who demonstrated a mixture of these features.

Under severe combat stress, characteristic action and response patterns reflected correlations between pathological dynamisms and the degree of hypnotizability. The cognitive and cerebral types, at the low end of hypnotizability, were likely to develop cognitive impairment, with an avoidant interpersonal style and proneness to despair. The middle group, more fluid with their mix of cognitive-affective-dissociative features, were likely to develop problems of intimacy, fluctuating assumptions, and oscillating beliefs, with resultant confusion and mood swings. At the high end of hypnotizability, the situationally sensitive dissociative type was prone to experience disruption of self-integration, dependency to the point of helplessness and vulnerability to major depression. These individual differences demanded our attention in combat.

Under wartime conditions, these dynamisms reflecting personality style and hypnotizability formed the basis for effective treatment interventions. In civilian life, especially with the growing pressure for cost-

² The Hypnotic Induction Profile (HIP), a 5-to-10 minute procedure that measures hypnotizability, helps differentiate between those who have the ability to maintain a continuous ribbon of concentration and relate to external stimuli (the intact) and those who cannot (the non-intact) (Spiegel 1977). Without these features, the interactive ability necessary for psychotherapy is missing. This is a rapid way to identify patients who fit into the differential categories that were so helpful during World War II.

effective care, these differences in personality style offer rapid identification of the fixity or malleability of patients and make it easier to choose psychotherapy, pharmacotherapy, or a combination of the two.

Intact Groups

Within the intact group, there were noticeable differences between the men. As described below, three types of syndromes in this group involved cognitive disruptions, dissociation, and emotional disturbances. These differences shaped the choice of intervention and predicted the need for follow-up treatment and outcome.

(1) At one extreme were men who exhibited features of cognitive illness behavior (e.g., obsessions and compulsions, avoidance, anxiety, and panic). They were less flexible than those who presented in spontaneous dissociated states. They wanted explanations and information before entering into a therapeutic alliance, and they responded best when treated as organizers and co-directors in planning the care strategy. They were slower to accept direction but, once engaged in a treatment approach, they took over and were likely to internalize change with a discernible degree of closure.

2) At the other extreme were men whose illness behavior involved somatized emotional metaphors in response to external stress. These men presented in various degrees of identifiable spontaneous trance and dissociated states. The dissociation itself had become a protection against further physical or psychological trauma. Unlike those who experienced the psychotic break of schizophrenia, this group was exquisitely sensitive to suggestion, able to retrieve memories related to trauma, and responded to therapeutic interpretations. These dissociative states were controllable and reversible with the appropriate psychological intervention and a trusted therapeutic alliance. The transference became a bridge to transform repressed powerful episodes of the past into a consciously acceptable new "truth" (e.g., Episode II).

Another example of this malleability was a medical aid man who exhibited symptoms of physio-neurosis (Kardiner and Spiegel 1947), the biological part of what is now called posttraumatic stress disorder. He was haunted by flashbacks of a wounded man screaming behind a bush. He could see the man's leg when he was ordered to retreat. When he came for treatment, hypnosis was used to retrieve the memory of the man he had left behind. Based on his description of the position of the wounded soldier's leg, an

interpretation was made that the soldier was already dead and that the screaming he "heard" in his nightmares was his own. He had properly obeyed orders to retreat. He readily accepted the interpretation that there was nothing he could have done and that he was correct in staying with his unit to go on to the next engagement. This understanding enabled him to reconstitute his capacity for self-control.

Time was the important factor. The sooner the treatment, the better the effect. The transition from acute to chronic could be halted with proper treatment intervention. The focus of treatment was uncovering the amnesia, restructuring a perspective to recover from the insult of powerlessness, and reconstituting the pre-trauma sense of self. Analyzing the recent past served to bring about a return to mental health.

Those, such as this aid man, who were able to accept interventions rapidly and to experience profound hypnotic phenomena were immediately sensitive (and reactive) to outside suggestions whether or not they were in a formal trance state. The degree to which the new interpretation was accepted, retained, and perpetuated seemed to depend almost entirely on the ensuing external support systems, both positive and negative. This controlled and reversible dissociation was dramatically different from the impenetrable dissociation of schizophrenic psychosis.

3) A third middle group was emotionally expressive yet also responsive to cognitive input. They could access and verbalize their feelings and were able to explore a wide range of possibilities about their future role in the unit. Their illness behavior was not as rigid as that of the obsessive group, nor as easily swayed by command authority as those who coped by dissociating with very little self-control. The men who fit into this middle group characteristically vacillated between dependent and independent functioning. Collaborative therapeutic interaction helped them return to a psychological balance.³

³ In postwar years, these three styles were identified as Apollonian (cognitive), after Apollo, the Greek God of logic; Odyssean (affective), after Homer's Odysseus, a wanderer trying to find his home; and Dionysian (dissociative), after Dionysus, the Greek god of spontaneity (Spiegel 1977; Spiegel and Spiegel 1987). These categories reflect identifiable and enduring personality coping styles on a continuum from cognitive fixity at one end, to extreme malleability and ease of affiliation with new perspectives at the other—a fix-flex continuum (Spiegel & Greenleaf 1992).

Non-Intact Groups

Those in the non-intact group manifested evidence of major disorders: (1) bipolar illness, (2) schizophrenia, (3) depression, and (4) extreme obsessive-compulsive disorder. In other words, disease syndromes that were expressions of biological disorders were not responsive to crisis-oriented psychotherapy. Men with these syndromes were sedated and evacuated as quickly as possible.

If the signs and symptoms were psychological (e.g., fears, tremors, anxiety, tension, weakness, sadness, body aches, nausea, fatigue), then the metaphorical meaning of the stress symptoms was evaluated. If the soldier was so distressed that he was not able to reconstitute himself and accept a new perspective to keep going with his unit, then he required maximum psychiatric intervention with sedation and evacuation.

When the main psychological symptoms were manifestations of illness behavior (not mental illness or physical impairment) and firm counseling, persuasion, and direction did not salvage the soldier for combat, disciplinary action by the officer in charge was the final attempt to maintain manpower as well as to prevent psychiatric invalidism. When malingering was suspected, it, too, became a line officer issue and was dealt with accordingly.

When all procedures failed and the soldier was evacuated, the odds were high that invalidism would develop. Once invalidism emerged, it became a form of personal identification. A series of conscious and unconscious defenses were set in motion, enhanced by learned and situationally reinforced secondary gain. In the Army, this meant a lost combat soldier. It had a more malignant effect for the patient on a personal level because of the insidious secondary loss of self-esteem, which made reentry into positions of postwar responsibility difficult.

To summarize psychiatric triage in combat, we learned to choose divergent treatment approaches based on differentiating psychological intactness, degree of injury, and the time factor in our ability to intervene. These treatment approaches were:

- (1) psycho-pharmacological therapies and prompt evacuation for the non-intact;
- (2) psycho-social therapies (persuasion, suggestion and direction) within the unit command for the intact who were motivated to cope with recent trauma; and,

- (3) psycho-social therapies with pharmacological support to cope with recent trauma and reactivated remote trauma for the intact who were more seriously damaged and had been given a 2 to 3 day trial at the kitchen supply area before being evacuated.

SPECIFIC LESSONS LEARNED

- (1) In combat, well-timed direction, persuasion and counseling significantly improved the coping skills of stressed soldiers without the customary exploration of psychological history or on-going weekly sessions.
- (2) The sooner an intervention was provided, the more effective it was.
- (3) When circumstances delayed treatment interventions, there was a greater likelihood that secondary gain factors would take hold with an increase of complications. This would necessitate long-term treatment with a decreased probability of a successful treatment outcome (i.e., pre-war functioning was not likely to be restored).
- (4) Good morale depended on skilled leadership to maintain confidence, promote strong unit identity, and foster companionship with fellow soldiers. Good leadership was the key factor for operational effectiveness and prevention of illness behavior. It was also a powerful force for rapid therapeutic restructuring.
- (5) The psychotic syndromes and the severe anxiety-transient states that likely have a biological substrate could not be influenced by good unit morale, direction, persuasion, or counseling. For patients with these conditions, there was little or no ability to internalize new perspectives that permitted ongoing performance of duty. These casualties had to be evacuated for long-term treatment.
- (6) In the face of the same disaster, it seemed to be the person more than the circumstance that made the difference in behavioral adaptation and psychological response. This was observable on a spectrum from a total inability to learn a new point of view, on the one hand, to an extreme malleability that enhanced acceptance of leadership decisions and psychiatric interventions, on the other.

- (7) These differences among the men were related to individual coping styles reflected by cognitive, affective, or dissociative dynamisms, which, in turn, correlated with varying degrees of hypnotizability.
- (8) The need for brief psychotherapy during the war made techniques with hypnosis an important resource to treat pain and conversion reactions as well as to study a spectrum of phenomena related to trauma, memory, regression and abreactions. Unlike Grinker and Spiegel (1945), who studied Air Force casualties, we found that abreactions induced with hypnosis were far more effective than abreactions induced with Pentothal or Amytal.⁴

THE RELEVANCE OF THESE LESSONS

Content and Context

Effective psychotherapy in combat was based on identifying action patterns without recourse to psychosocial history. A key to developing treatment interventions was to understand the difference between the actual difficulty and the way the person reacted to that difficulty. With an emphasis on the present and future, it was possible to understand the meaning of a symptom and to use restructuring therapies to achieve symptom resolution. Contrary to the mythology of the times, symptom substitution was infrequent, as was the need for exploration of the remote past. This raises the question of when past history is relevant for treating situational stress and trauma.

Kleinman (1988a, 1988b) has persuasively emphasized critical differences between illness behavior and disease. Illness behavior is defined as a complex reaction to symptoms and/or disability by the patient within the context of the patient's social and cultural network. Disease is the medical

⁴ One month after a combat-induced trauma in a soldier showing anxiety, tremors, and spotty amnesia, I attempted to uncover the repressed events with a Pentothal interview. The needle punctured the skin and caused the soldier to wince and move. Before the needle entered his vein, the soldier abruptly erupted into a violent abreaction with writhing and body thrashing, reliving terrors of the battle experience. After about 5 minutes, he became quieter and was told to open his eyes. He felt relieved, regained his memories, and marveled at the effectiveness of the drug. He did not know that not one drop of Pentothal had left the syringe. Along with other similar experiences, we learned that persons with good hypnotic capacity were the ones who responded best with Pentothal. However, hypnotizable persons responded even better without Pentothal because they were able to use their trance capacity to recover material without the handicap of barbiturate blurring of recall. Those who were not hypnotizable usually fell asleep.

formulation, usually in biological terms, that accounts for physiological alteration or dysfunction.

Confusing the two creates a crisis in any medical care system. In combat, fast evacuation of those with severe physical trauma was most effective and helpful. Yet that very same system, when applied to combat fatigue cases, was counterproductive. Because illness behavior was mistakenly regarded as disease, those soldiers were gobbled up and evacuated long before they had a chance to receive relevant corrective treatment on the spot.

Many men were caught up in a secondary gain atmosphere of the rear echelon and became unnecessary casualties of the war. Kleinman presents numerous case illustrations to assert that much unnecessary patient suffering occurs in today's medical and mental health systems when the treating doctor overlooks the psychosocial factors of the patient's illness experience. This is seen in increased visits to medical doctors in the areas of chronic disability in and out of medical rehabilitation institutes and mental health facilities.

When treating illness behaviors, it is critical to explore the relevant contextual events associated with the symptom complex and the personality style. In other words, a narrative approach incorporating meaning, perspectives, motivation and morale rather than a more physically oriented semiotic approach is more appropriate. This represents a shift to a paradigm that includes psychosocial factors as they interact with biology. It has formed the basis of Engel's (1977) bio-psycho-social formulations, which are basic to many therapies today.

Hermeneutic Narratives⁵

We have learned to balance the pursuit of causation and developmental history with a focus on the context of the clinical picture. What was once regarded as "insight" or "truth" about early development through memory recall and episodes interpreted via dreams and free association is now proposed to be a

⁵ *Hermeneutics* (from the Greek "to interpret") is a useful and expanding concept in psychiatry. Although originally devised for "correct" interpretations of the Bible, it has evolved as an exquisite clinical art form which integrates understanding, interpretation of symbolic meaning and appreciation—a disciplined interaction between general principles and specific experience. For an excellent elaboration, see *Key Concepts: Hermeneutics*, by James Phillips (Philosophy, Psychiatry and Psychology 3:61-69, 1996 [Johns Hopkins University Press]).

form of story-telling (Schafer 1981, 1992; Spence 1982). Humans, unlike all other living creatures, have imagination and are fascinated by stories with a beginning, a middle, and an end. If the evolving theme of a narrative, as it develops in the dialectical interaction between therapist and patient, leads to a perspective that translates into a more satisfactory way of living that is effective therapy. Whether it is validated as historical truth or narrative truth is secondary to its effectiveness for desired therapeutic change.

In part, it is "man's search for meaning" (Frankl 1959) that interferes with the accurate retrieval of memory and may lead to psychological disability or therapeutic gain. In both recent and remote memory, pieces of information and facts are interwoven in a search for order. It is a constant series of dissociations and re-associations (Spiegel 1963). Rather than regarding this process as a failure of encoding, storing, and retrieval, it is useful to note psychologist Jerome Bruner's disenchantment with the cognitive revolution of the 1970s. He urged a return to an appreciation of "making meaning" (Bruner 1990). This marks a major shift from an inferred stance of a therapist as an authority who offers a direct pipeline to the truth, to more modest expectations of an interactive process between therapist and patient. As a participating listener, the therapist joins with the patient to identify relevant themes. One's training is used to provide timely interpretations to develop a story that encourages the patient to move in a more satisfying and fruitful direction.

The philosophical shift from "ultimate" truth to a "narrative" truth implied that actual causation was elusive, but that clinical causation was composed by the story makers—the patient and the doctor in a dialectical interaction in search of a cure (Rettig 1990). If the narrative satisfied the doctor and the patient in a way that led the patient out of a dilemma, it was a good therapeutic achievement.

If the disease is biological or of recent psychosocial origin, a reductionist search for causation is a useful approach. The focus is on signs and symptoms that can be contained or neutralized by various medications. But if the syndrome is dominated by illness behavior, the patient's personal history is most effective as a narrative used within the context of a psychotherapeutic strategy. The therapeutic goal is to free the patient from a preoccupation with causation from the past and, instead, to focus more attention on meaning and direction for the present and the future.

On the psychological track, the lessons from combat psychiatry can be most aptly applied: problem formulation and resolution were used to restructure the patient's focus of attention away from the wound or

disability and onto an affirmative identification with some purpose. Unless the therapeutic interaction propelled the soldier from fixating on what went wrong to focusing on his purpose, he was lost—to himself and the armed forces.

Similarly, in developing a clinical model for brief psychotherapy, the same principles can apply in civilian life. If the patient is locked into old traumata with a reductionist model of causation (blame), the ability to escape the past is severely impaired. The past can be a fruitful ground for exploration to the extent that it develops a therapeutic alliance and provides the patient with motivation and meaning to move forward. This is the basis of brief psychotherapy—problem formulation and problem resolution through restructuring pathological perspectives (Spiegel and Spiegel 1987).

I propose that somatic metaphors that outlive the initiating event be viewed in the illness model. Here we need to use a multi-factorial approach that identifies: (1) major personality features, (2) the fixity or flexibility of these features, (3) the problem, (4) the resources available, (5) issues of secondary gain or loss, (6) meaningful goals, and (7) the therapeutic strategy that will propel the patient forward, out of the morass expressed by the presenting symptoms.

In combat, we learned to pay attention to issues of willingness and motivation. We worked fast to elicit the assets of the person. If the disability received more attention than the whole person, the disability was likely to become reified, tempting the doctor to deal with the crisis as a disease with little hope for a therapeutic outcome, or to select medication as the primary intervention without other indicators.

However, when somatic symptoms are understood as metaphors in a context of how the crisis came about, a sequence of events yields a story line. Ironically, this approach transforms a reductionist pursuit for causation into a narrative development that enables the patient to generate meaning, feel better, and face the future with more confidence. Thus the therapeutic task becomes one proposed by Adolph Meyer in the 1940s: to accumulate facts and events regarding the person's past and present life, with the expectation that a useful narrative will emerge. "The facts of the case would speak for themselves" (Kiceluk 1992, p. 349). Rather than seek to find the truth, the therapist and patient discover a truth. This perspective is similar to that of the Zen artist who paints the background in such a manner that the theme of the art piece emerges.

Balance

Interactions among biological systems, psychosocial forces, and medications can—and frequently do—become chaotic. But when we consider environmental events, psychological processes, and biological processes as a series of reverberating objective and subjective phenomena, we can, perhaps, become more humble in our attempts to find definitive relationships of causation. This substantial shift alleviates the pressure to persist in looking for causation no matter how long it takes to achieve a therapeutic change.

The bio-psycho-social paradigm pioneered by Meyer (1957) and developed by Engel (1977) created a fertile ground for bringing a sense of order to the panoply of clinical data. Yet even this paradigm has become a transition to yet another exciting breakthrough, as described in *The Second Medical Revolution* (Foss and Rothenberg 1988) and endorsed by Engel himself, who wrote in the foreword:

Essentially it involves a conceptual shift from a biological systems infrastructure to a self-organizing systems infrastructure....Biomedicine has always relied heavily on the logical-possibility argument. This argument commits the scientist to continue the search for ultimately single-level physical explanations of all phenomena because, although the task may seem difficult, there are no logical barriers to achieving such understanding. But...such a defense of biomedicine's single-level reductionist agenda fails, not so much because it is impossible in principle, but because it is impossible in fact. Once postmodern principles of interactionism, emergence, loop structure, mutual causality, and self-organization are in place, neither what is human nor what is ecological can any longer be ignored or excluded by being deemed reducible to something else (Foss and Rothenberg 1988, p. ix)

The cluster of personality styles, conceptualized along a fix-flex continuum, is like a zoom lens through which we can view the self-organizing infrastructure of the person. From this vantage point, we can develop an understanding of the individual as he relates within himself and to the outside world. We can then use our clinical judgment to focus on specific events, time frames, and provocations to generate meaning and develop a sense of order.

To achieve a sense of balance in this person-in-conflict dilemma, the bio-psycho-social paradigm is expanded into an interactive systems paradigm. Like the invasion of North Africa, when all factors had to be considered, this expanded paradigm expedites a disciplined evaluation of the available resources for coping with present and impending stress.

CONCLUSION

The lessons of combat psychiatry in World War II have taught us the benefits of the purposeful use of existing resources and goal-directed interventions. Past history and personal narratives,

whether precisely veridical or not, whether short or long, are therapeutically effective when used as a plateau from which new perspectives can be generated to clarify and focus on what a patient is for instead of against. The critical task of the therapist and the patient is to develop a hermeneutic narrative. The resulting story line becomes the theme for problem resolution.

The combat triage concept is as useful today as it was in World War II. We are dealing with limited time for treatment (dictated by budget cuts and administrative decisions by nonmedical personnel) and are faced with a need to be parsimonious with our psychiatric and medical treatment resources. We can maximize our efforts and improve efficacy of treatment outcome by assessing the range of an individual's rigidities and malleabilities. Those with mental or physical disease (when the biological dysfunction is paramount) are candidates for a pharmacological approach with or without supportive long-term psychotherapy. Patients displaying illness behavior (when the reactive components to a physical and/or psychological trauma are primary) without significant biological comorbidity are assessed on the fix-flex continuum to determine appropriate psychotherapy along a spectrum of exploration, confrontation, consolidation, persuasion, and/or supportive care (Spiegel and Greenleaf 1992). Timely, common sense intervention strategies are critical. Delay fosters incipient secondary gain and promotes invalidism.

With this clinical model, persons are encouraged to tap their imagination and motivation to explore possibilities for the future. The therapeutic alliance is used to affirm the individual's resources and develop a meaningful direction to live life as an imperfect human in the context of an imperfect world.

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