

Trauma-induced dissociative amnesia in World War I combat soldiers. II Treatment dimensions

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Objective: This is the second part of a study of posttraumatic amnesia in World War I (WW I) soldiers. It moves beyond diagnostic validation of posttraumatic amnesia (PTA), to examine treatment findings, and relates these to contemporary treatment of dissociative amnesia, including treatment of victims of civilian trauma (e.g. childhood sexual abuse).

Method: Key WW I studies are surveyed which focus on the treatment of PTA and traumatic memories. The dissociation-integration and repression-abreaction models are contrasted.

Results: Descriptive evidence is cited in support of preferring Myers' and McDougalls' dissociation-integration treatment approach over Brown's repression-abreaction model.

Conclusion: Therapeutic findings in this paper complement diagnostic data from the first report. Although effective treatment includes elements of both the dissociative-integrative and abreaction treatment approaches, cognitive integration of dissociated traumatic memories and personality functions is primary, while emotional release is secondary.

Key words: childhood sexual abuse, dissociation-integration treatment model, posttraumatic amnesia, repression-abreaction treatment model, war trauma.

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The prevalence of posttraumatic amnesia (PTA) and related symptoms and syndromes of posttraumatic stress in both military and civilian arenas has been debated for over 100 years [1,21]. In the first of two papers, we sought historical validation for PTA by examining World War I (WW I) studies. In this article, we contrast the two main WW I treatment models for PTA and traumatic memories. The dissociation-integration and repression-abreaction approaches,

Freud was one of the first to emphasise actual sexual trauma, but he subsequently repudiated this [3]. As in Janet's traumatic neurosis [4], Breuer and Freud [5] initially acknowledged dissociative inaccessibility of traumatic memories and related personality functions, Freud subsequently eschewed dissociation, and replaced this with unconscious repression [6] relieved therapeutically by abreaction,

Janet employed, among several other conceptual models (e.g. hierarchical models reviewed by Ellenberger [7]. and Brown [8]), a dissociative aetiological model [9], and a dissociative-integrative approach to treatment [10]. Posttraumatic dissociation and amnesia were seen as due to weakening of ego-integrative functions occurring under the impact of traumatic emotions and ideas. Traumatic memories are dissociated as subconscious fixed ideas, leading to posttraumatic amnesia. They re-emerge both spontaneously and under the influence of treatment as posttraumatic re-

experiencing phenomena (e.g. automatisms). Janet saw sexual trauma as but one of the traumatic neuroses [4]. As summarised by Van der Hart [10], he adopted a three-stage cognitive approach to the recovery and reintegration of traumatic memories (and somatosensory and other personality deficits), accompanied by the relief of posttraumatic amnesia.

Despite the findings of Janet at the turn of the 19th century, widespread professional (and societal) neglect and denial of dissociation and amnesia ensued. In regard to sexual trauma, and in the wake of the feminist movement, these negative diagnostic trends have only recently been reversed. Recent studies [11, 12] demonstrate amnesia for childhood sexual abuse. Further clinical studies (e.g. [13,14]) and empirical research findings [15-17] show that memories can be accurately recovered, and lend support to the accuracy of many spontaneous and therapeutically recovered traumatic memories. Hammond [17] nevertheless felt that therapeutic material may at times be only partially accurate or subject to confabulation, and that it is incumbent on the therapist to view therapeutic material 'realistically'. The validity of post-traumatic amnesia and of therapeutically recovered memories thus remains the subject of repeated challenge and counter-challenge [18].

Denial of psychological trauma in the civilian sphere has been accompanied by denial in the military arena. Karon and Widener [19] noted negation of posttraumatic dissociative amnesia in World War II combatants. In the first paper [20], we described the parameters of posttraumatic amnesia in WW I soldiers, as reported in the contemporaneous scientific literature. Posttraumatic amnesia in WW I soldiers was accompanied by high external validity. At first, amnesia was thought to be due to the physical impact of the trauma, for example, shell shock. It was subsequently seen to be due to a complex interplay of neurological and psychological ('functional') factors, anticipating the biopsychosocial model of Engel [21]. Premorbid aetiologic contributions were nevertheless played down. Amnesia was described as either local for the actual event, or global to include events from the subject's prior life history. The terms dissociation and repression were used interchangeably, and there was thus considerable diagnostic confusion. Further, repression was used either in the Freudian sense as an unconscious mechanism [22], or as evidence of a conscious process compatible with dissociation [23], and with suppression the result. Hypnosis was regarded as capable of reversing dissociation, recovering memories and relieving posttraumatic amnesia. Further dimensions of the evolution of PTA in WW I combatants, and the process of its therapeutic relief through the recovery of traumatic memories are described below. These findings are related to the current debate on the status of recovered traumatic memories, specifically those recovered in treatment. It is further suggested that traumatic memories can not only be recovered for sexual and combat trauma, but also for the gamut of traumatic events.

Spontaneous recovery of memory

According to McDougall [24], some cases of combat-related PTA remitted spontaneously. In this, he emphasised the role of 'triggers'. For example, he described the case of a soldier who recovered his memory when his fellows entered his hospital room. Sight of their helmets was sufficient to trigger recall of all previous combat experience. Spontaneous recall also often followed exposure to further emotional shock, or accompanied 'honorable' service discharge and termination of the war.

Acute versus chronic course

It was well known that those who received psychiatric treatment shortly after exposure to WW I combat trauma had a better prognosis than those in whom treatment was delayed, and in whom PTA had become well established [22-28]. Regrettably, there are limited data on chronic PTA (the work of Brown, 1928, is an exception), and none on the impact of postwar psychological treatment,

In chronic cases, Kardiner [26] believed that resistance to therapy ensued from secondary neurotic gratifications: 'Too many tributaries to the main psychopathology process have themselves become organized and lost contact with the original main stream (...) memories can be found back by hypnosis, but with no therapeutic effect whatever' [29, p.362]. For reasons such as these, it was felt that treatment for chronic conditions should be orientated differently from acute cases. The principal

goal was to dissolve secondary defences, and prevent the development of secondary gain. By way of contrast, treatment in acute cases aimed at recovering and transforming traumatic memories, and restoring personal effectiveness.

Therapeutic memory revival: the dissociation-repression and abreaction-synthesis controversies.

In a series of articles in the *Journal of Medical Psychology* entitled 'The revival of emotional memories and its therapeutic value' [30], Brown, Myers, McDougall and Jung debated their views on the essential step in the recovery of traumatic memory and related symptomatology (cf. [31,32]). Their discussion was solely based on findings in WW I cases of posttraumatic dissociative amnesia.

Brown

Brown [25], who adhered to Freud and Breuer's model [5], opened the discussion. He linked repression, the pent-up accumulation of posttraumatic emotions and associated traumatic memories in the unconscious, with abreaction. The release of this repressed emotion, He felt that inadequate repression resulted in dissociation. Brown advocated Freud's cathartic treatment approach, stating: 'In certain cases of emotional memories one finds that as a matter of experience, there does seem to be an overburdening of the memory with emotion, and that the excessive emotion can be worked off by revival, with relief to the patient's mind. If the same emotional experience is again aroused later, he no longer shows such excessive emotional reaction' (p.18).

Brown [22] illustrated his combined suggestive and abreaction approach by describing the treatment of an acute patient who was rendered mute and locally amnesic when blown up by a shell. Brown informed the subject that he would restore speech within minutes, and followed this with hypnotic induction. He successfully suggested that the patient relive and verbalise the traumatic event as if he were in the trenches. Commenting on this case, Brown emphasised that while suggestion alleviates symptoms, abreaction removes their causes by ensuring adequate re-association of posttraumatic memories. According to Brown [25]. Abreaction was easier to perform in the field shortly after traumatisation than when subjects were seen back in the UK. Thus, although a returned patient suffering from functional deaf mutism had recovered his traumatic memories, he did not regain speech or hearing until reliving these memories in their entirety when waking from a vivid dream. Brown ascribed this treatment failure to insufficient therapeutic emotional revival, and felt that it would never have occurred had abreaction been carried out in the field.

Brown also emphasised the role of adjunctive 'autognosis', the intellectual augmentation of abreaction. This process, consisted both in fostering reintegration of dissociated elements of personality functioning, and in 'contextualising' the trauma by promoting insight into its relationship with the patient's overall life history and life experience. He wrote: 'The abreaction of excessive emotion was there not merely a mechanical process, but was controlled at every step by the principle of relativity and intellectual adjustment' (p.19). It brought the patient from 'a state of dissociation to one of harmony and unity.

Myers

Myers [33] criticised Brown's adumbration of abreaction. He wrote: 'My own experience in recovering memories in both the waking state as well as by hypnosis. was that the acting out of the emotional experience was of relatively little consequence, but that what was of importance was the revival of the unpleasant memory of the scene, the revival of dissociative affective and cognitive experience' (p.20),

As previously mentioned by us [20], Myers rejected Brown's view of dissociation as the outcome of ineffective repression. Nor did he agree that dissociated emotions encountered under hypnosis were novel, writing: 'I generally believe that what we obtained in such cases during hypnotic revival was a little re-enactment. a living

through again, of the scenes and experiences of actual warfare accompanied by their original excitement' (p.19).

Myers discouraged emotional display during hypnotic recovery and re-experiencing of traumatic memories. Rather, he advocated a 'suggestive method', in which the subject was encouraged to remain calm, feel no pain, and not be afraid.- Myers felt that the value of Brown's 'autognosis' principally lay in the relief provided by reintegration of affective-cognitive dissociated contents. However, Myers did not make explicit the meaning of 'reintegration'. In a later study evaluating shell shock [34], and specifically regarding hysterical PTA. he proposed that: 'The integration consists of restoring by the method of suggestion the "emotional" personality deprived from its pathological, distracted, uncontrolled character, and in effecting its union with the apparently normal personality hitherto ignorant of the emotional experiences in question. When this 'reintegration' has taken place, it becomes immediately obvious that the normal personality differed widely in physical appearance and behaviour...', (pp.44-45).

McDougall

In rejecting Brown's ideas concerning abreaction. McDougall [24,35] held that the essential therapeutic step was relief of dissociation rather than promotion of 'emotional excitement'. In support of his view, amnesic soldiers frequently fell into 'fits', in which they relived rather than relieved their traumatic experiences. Untreated, the condition of many of these patients appeared to worsen, tending to become fixed and chronic. Moreover, in some, abreaction increased rather than diminished their symptoms. Finally, McDougall argued that the relief of dissociation and consequent general improvement were often effected without any marked emotional display,

McDougall specifically rejected the Freudian conception of emotion as a 'quantum of energy' in which a disruptive parcel of emotional energy was said to become attached to traumatic memories, and was released by abreaction [35]: 'Dissociation ... never involves an emotional centre or affective disposition as such. It affects rather the various channels through which our intellectual or cognitive processes play upon one another and upon the affective dispositions' (p.28), This did not imply that McDougall rejected the importance of emotional working through: catharsis in Freudian terms, Rather, he assigned release of 'emotional excitement' a subordinate role consisting merely in facilitating abolition of the dissociation. Conscious 'repressive' tendencies were countered, and abolition of dissociation further enhanced by progressively eliciting the train of recollection (i.e. by fostering recall without necessarily promoting emotional expression),

In McDougall's opinion, Brown had indirectly recognised the marginality of emotional revival, Rather, Brown strove to ensure relief of dissociation by promoting waking recall of amnesic material recovered under hypnosis, This approach was made manifest in an earlier article [36]: 'The patient goes through his original terrifying experiences again, his memories recurring with hallucinatory vividness, It is this which brings about the return of his powers of speech. and not directly suggestion, as the ordinary method of hypnosis, Remembering that his condition is due to a form of dissociation and that in some cases hypnosis accentuates this dissociation, I always suggest at the end of hypnotic sleep, that he will remember clearly all that has happened to him in his sleep. More than this I wake him gradually, talking to him all the time and getting him to answer: passing backwards and forwards from the events of his sleep to the events in the ward, the personality of his sister, orderly, doctor, and patients, i.e. all the time re-associating or re-synthesizing the train of his memories' (pp. 198-199),

McDougall [35] similarly considered the essence of treatment of posttraumatic dissociative disorders to be, 're-synthesis' of the personality, He subsequently [24] formulated two essential therapeutic steps, basing these on the pioneering work of Pierre Janet [4], For the latter, the goal was control of dissociation and integration of traumatic experience 'as a chapter in the patient's life history'. McDougall's first step was one of exploration, using either hypnosis or free association. In this he elucidated the origin and nature of the dissociative state, and clarified this with the patient. The second step consisted in facilitation of the patient's psychological and in particular emotional readjustment. It enabled the patient to face his fears and led to reintegration of the personality, In less complex dissociative disorders. McDougall

regarded breakdown of the 'dissociative barrier' as the all important step. He realised that this could result in a 'new emotional shock' which, for prevention of symptomatic recurrence, had to be overcome. In more complex and chronic cases, treatment was necessarily less ambitious, and was often no more than 'a matter of mental hygiene rather than therapy'.

In responding to the critiques of Myers and McDougall, Brown [25] agreed that the 'removal of the shock amnesia' may elicit harmful emotions and result in repression: 'Therefore I stated that an application of the method of autognosis, over and above that of psychocatharsis is always needed to give him true insight in his condition and to prevent relapse' (p.31), He did not claim greater success than Myers' 'suggestive method', but insisted that better results occurred when emotional revival was most complete.

Jung

Finally, Jung [37] joined McDougall in rejecting abreaction, and Freud and Breuer's theory and methodology: 'McDougall is right when he points out that there occur a considerable number of cases where abreaction is not only of no use but is actually harmful. He has laid his finger on the right spot when he argues that the essential factor is the dissociation of the psyche and not the existence of a high tension affect, and hence the essential problem in the therapy is the integration of the dissociation and not the abreaction. This argument entirely corresponds with our experience that a traumatic complex creates a dissociated condition of the psyche: it is removed from the control of the will and therefore possesses the quality of psychical autonomy, From this point of view abreaction appears in an essentially different light: it is an attempt to reintegrate once more into consciousness the complex that has become autonomous' (p.15).

Jung added that effective integration of traumatic memory and personality factors in general greatly depends on reinforcement of the relationship with the therapist. The latter's 'personal devotion and human interest', enables the patient to return autonomous complexes to the control of the will.

In summary, Brown pursued Freud and Breuer's abreaction therapeutic approach to the recovery of repressed traumatic memory. This was eschewed by McDougall, Myers, and Jung, who instead adhered to Janet's dissociation-integration model. These technical differences notwithstanding, all strove for reintegration of traumatic memories and related dissociated contents of combat experience. McDougall gave the most lucid and comprehensive clinical description of the means by which this was achieved.

Summary and discussion of treatment

The historical evidence demonstrated that recovery from posttraumatic disorders in WW I combatants depended on prompt and complete recovery and reintegration of traumatic memories and lost personality functions, Taking into account the possible contribution of therapist insufficiency, chronic cases were characterised by inaccessibility of traumatic memories, by refractoriness to treatment, and by secondary gain, Thus, Kardiner [26] found that even though traumatic memories could be recovered, this was often to no therapeutic avail, These findings are relevant to the current diagnosis and treatment of adult amnesia for early, life trauma, particularly that related to childhood sexual abuse. The more chronic and complex, the posttraumatic, dissociative symptomatology, the more complicated the required treatment [1.38-42].

A major controversy arose following WW I regarding the nature of traumatic memories, and flowing, on from this, regarding the nature of the treatment indicated. This controversy continues to the present day. It has been underpinned by two distinct models of posttraumatic dissociation and associated PTA. The repression-abreaction model emanated from the work of Freud, while the other, the dissociation-integration model, while initially informing Freud's work was quickly abandoned by him. It originated in Janet's conceptualisations.

The principal adherent to the Freudian model was Brown [25], for whom dissociation was seen as secondary to failure of the defense mechanism of unconscious repression. The essential therapeutic step was seen as abreaction, the therapeutic release and re-experiencing of repressed emotions, Further 'autognosis'

ensured more complete recovery, by providing meaning and value to therapeutic and life experiences. This was analogous to therapeutic reframing described by Janet [10-43].

The Janetian model adopted by McDougall [24-35] and Myers [33] instead regarded dissociation as due to the ego's inability to assimilate the affective and cognitive contents of traumatic experience. For them, the essential therapeutic step was the abolition of dissociation, the recovery of traumatic memories, and the re-integration of mental contents. Adherents of this model discouraged emotional abreaction, warning of its potentially destructive effects through retraumatisation.

The Janetian dissociation-integration approach was initially eclipsed by that of Freud, but has been gaining ground since the seminal studies of Ellenberger [7]. Van der Hart *et al.* [32] critically reexamined historical concepts of abreaction, and presented a contemporary version of Janet's dissociation-synthesis treatment model [10,44]. According to these authors, over the last century, treatment of trauma has mostly been considered in terms of repression and abreaction. However, close examination of actual reports reveals that many authors extended the term abreaction beyond emotional revival of traumatic memories to encompass re-integration of dissociated mental contents.

This combination of abreaction and integration was no less a feature of the treatment provided by those working during WW I, McDougall [35] acknowledged the therapeutic contribution of emotional discharge, but assigned this a role subordinate to the relief of dissociation and promotion of personality integration. In a similar vein, Brown [25] recognised that abreactive 'removal of the shock amnesia' required deeper insight, and described a method of 'autognosis' which promoted greater 'harmony and unity. Clearly, aspects of the abreaction-integration controversy were semantic rather than substantive, reflecting varying degrees of congruence at the clinical level.

This therapeutic congruence extends to the present day. With an increasing emphasis on integration over abreaction [1]. Thus, Van der Hart *et al.*'s [44] neo-Janetian dissociation-integration model is but one of a number of comparable contemporary stage models for the treatment of psychological trauma [38,45-48]. World War I models focused more on resolution of traumatic memories *per se*. This was because rapid return to combat was regarded as the first priority [27,28]. Furthermore, the contemporaneous medical tradition emphasised symptom elimination, and knowledge of psychological models of trauma and its treatment was slow to diffuse within military psychiatry. As Ingram and Manning [49. p.30] wrote; '... the army in 1916 was far behind the civilian sector in the application of the new psychiatric knowledge'. Given these limitations it is not unlikely that, following return to combat, many soldiers developed serious secondary symptoms of posttraumatic stress.

Conclusion

Those working at the time of WW I generally adopted one of two main models of diagnosis and treatment: either the Freudian repression-abreaction model or the Janetian dissociation-integration approach. These models held important elements in common, including an element of emotional release, but much more therapeutic, an element of psychological integration, primarily of traumatic memories, but also of personality functions. The models are reflected in modern stage-orientated approaches to the management of psychological trauma, whether combat-related or occurring in civilian settings, such as childhood sexual trauma.

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