Regressive experiences in Vietnam veterans: Their relationship to war, post-traumatic symptoms and recovery.

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Brende, J. O., & McCann, I. L. (1984). Regressive experiences in Vietnam veterans: Their relationship to war, post-traumatic symptoms and recovery. *Journal of Contemporary Psychotherapy: On the Cutting Edge of Modern Developments in Psychotherapy, 14*(1), 57–75. https://doi.org/10.1007/BF00956736

Abstract

Regression has been commonly associated with war and postwar symptomatology. Posttraumatic symptoms have been considered regressive when manifested by chronic dependent behavior or outbursts of primitive, aggressive behavior. Recovery from regressive symptoms may in itself induce regressive experiences since recovery necessarily leads to another change in ego boundaries; rigid or fused boundaries becoming realigned, intact, and flexible. Recovery therefore requires a stable and trusting therapeutic relationship to gradually permit such changes. Psychological treatment of Vietnam veterans has often occurred in phases with immediate management of regressive symptoms occurring during early phases; induction of regressive states has often occurred during late phases to facilitate integration of "split-off" traumatic experiences and emotions. (58 ref) (PsycINFO Database Record (c) 2019 APA, all rights reserved)

REGRESSIVE EXPERIENCES IN VIETNAM VETERANS: THEIR RELATIONSHIP TO WAR, POST-TRAUMATIC SYMPTOMS AND RECOVERY

ABSTRACT: Regression has been commonly associated with war and post-war symptomatology. Posttraumatic symptoms have been considered regressive when manifested by chronic dependent behavior or outbursts of primitive, aggressive behavior. Recovery from regressive symptoms may in itself induce regressive experiences since recovery necessarily leads to another change in ego boundaries; rigid or fused boundaries becoming realigned, intact, and flexible. Recovery therefore requires a stable and trusting therapeutic relationship to gradually permit such changes. Psychological treatment of Vietnam veterans often has occurred in phases with immediate management of regressive symptoms occurring during early phases and induction of regressive states has often occurred during late phases to facilitate integration of "split-off" traumatic experiences and emotions.

Posttraumatic symptoms in Vietnam combat veterans, referred to as Posttraumatic Stress Disorder (APA, 1980) has included sensory, cognitive, motor, and autonomic nervous system disturbances (Horowitz, 1976; Figley, 1978, 1980; Brende, 1982) as well as characterological (Brende, in press) and identity disturbances (Blank, 1979; Parson, 1981; Shatan, 1974; Wilson, 1977, 1980). Such symptoms are in part manifestations of pathological regression and reflect a significant degree of helplessness and attempts to control helplessness, including the following: dependency, withdrawal, impulsiveness, loss of rootedness, need for protectors, loss of purpose, futility, paralysis, overcontrol, narcissism, exploitation, and aggressive outbursts (Wilson, 1977; Horowitz & Solomon, 1975).

Combat veterans have often been fixed in post-traumatic regressed states (Fenichel, 1945), where they suffer from "developmental suspension" (Parson, 1981). Although attempting to return to peaceful civilian life, they often remain in a state of combat readiness—suffering from hypervigilance, startle reactions, and aggressive outbursts, as if never having entirely left the battlefield. Although attempting to return from warlike, subhuman jungle warfare to civilization Vietnam veterans frequently have remained emotionally detached and fearful of allowing their 'human' emotions expression. Although attempting to focus on the reality of civilian life, they are often distracted by flashbacks of 'embedded' combat experiences (Blank, 1979).

THE MEANING OF REGRESSION

Among the definitions of regression are included a return to earlier modes of functioning and a descent to diminished autonomy. As such, regression is a means of defense and not necessarily abnormal. Diminished autonomy and increased helplessness are often common experiences, particularly during military conditions.

However, throughout psychoanalytic history, regression has been more often described as a pathological descent to more primitive mental processes or behaviors in response to a traumatic event - usually resulting from a traumatic fixation and subsequent attempt to undo or redo the traumatic event (Freud, 1917).

The severity of the regression has been described as dependent on the enormity of the stimulus as well as to the vulnerability of the ego's stimulus barrier, which when overwhelmed, 'sets in motion archaic pathologic attempts to master what could not be mastered in the usual way" (Furst, 1968, p. 20).

Three aspects of regression will be discussed in more detail during the remainder of the presentation: 1) Regression and the trauma of war; 2) Regression and post-traumatic symptoms, and 3) Regression and recovery.

REGRESSION AND THE TRAUMA OF WAR

Military training and combat - both stressful situations - bring about significant changes in ego functioning and personality organization. Both promote regression, and will be examined in more detail separately.

Training Experience

Regression as a normal human experience, associated with trust in respected leaders, was part of military training, particularly during World War II. It has been described as the loss of individual autonomy to achieve a higher level of combat effectiveness within a group of men as depicted by Menninger (1946):

> When the man became a soldier. . . he had to give up his individual identity and become a member of a team with the only reward being his identification with that of the team . . . (and) the leadership of the unit . . . Psychologically the leader is well recognized as representing the strong father figure who is interested in the individual . . . Many soldiers freely admitted that it was chiefly because of their feelings of loyalty and devotion to their associates (and leaders) that enabled them to go on...Their individual civilian-life conscience was displaced by a group conscience, which served both in a positive and negative fashion. Positively it gave them permission to kill, a behavior antithetical to their entire life ethics and training. Only through group permission and approval could they do it and even then it was often very difficult (pp. 200-201).

The training experience also provided a means for dampening the stresses of combat— the pain, exhaustion, and fear (Smith, 1981) by idealizing the war effort .

As in the aforementioned description of the training experience of combatants during World War II, some Vietnam combatants also found that decreased self-autonomy in the service of group cohesiveness eventually led to an enhanced sense of loyalty, pride, direction, and a more solidified personal identity. For example, a Vietnam veteran described the following:

I gave up the old ways that I believed about myself and my world after returning from Vietnam. I used to be half-hearted about being an American. I went through hell over there, but now I believe much more in the value of life and I'm as loyal an American as you'll ever find.

Yet for those veterans who have continued to idealize being a part of a "successful" military effort, they have frequently been unable to reflect on the individual meaning of their military experiences from both positive and negative points of view. As a result, they have remained fixed—attitudinally, cognitively, and emotionally to those ages (18, 19, and 20) when they experienced combat. Smith (1981) has referred to this as a "sealing-over process".:

> In sealing over, one does not need to examine individual aspects of the experience but broadly binds the experience-unitarily with the overarching rationale symbolized by the flag, the medals, the parades, and the movies. (p. 53). For the veterans (of Word War 11) who are now older and much more sophisticated. . . the sealing-over process froze their experiences and perceptions. . thus remaining untouched by later learning. . . "

This process of sealing over was equivalent to fixation in a state of regression and it achieved an essential purpose—the sanction of the war efforts for young trainees and combatants, which Smith described as follows:

Like hot wax which can permeate each strand of a ball of loose ends of string, so too, in sealing over, sanction permeates the loose ends of experience, giving them meaning and bending them into a unit, immune from the demands of having to be integrated with the view of self and the world, prior to the event." (p.42).

In contrast to World War II veterans, an excessive number of Vietnam veterans had negative experiences and negative outcomes. They suffered from pathological regressions resulting in identity diffusion, identity "splitting" (Brende, 1983) and pathological identifications with "the aggressors," at described by Shatan (1974) as follows:

> . . .the classic slogan of identification with the aggressor is "if you can't beat 'em, join 'em . . . When the 'induction phase' of counter guerrilla training succeeds, the soldier...undergoes a psychological regression during which his character is restructured into a combat personality. . .The trainee surrenders his personal identity to the corporate identity of his military legion . . . He adopts the paranoid stance of combat as his new reality principle. . . "

As an example of the aforementioned description, a veteran described his induction into military service as a process of giving up a civilian identity with moral standards for a combat identity without moral standards.

> They expected me to give up my old self in order to become a Marine. When I went into the service I cared about people, but when I came out I became a big bad Marine that killed people.

The War Experience

War has evoked basic survival modes of functioning, characterized by the presence of primitive or even subhuman defensive behavior, called biogenetic or, more commonly, phylogenetic regression. Phylogenetic regression has referred to the archaic racial heritage of man (Bailey, 1978)—representing the evolutionary carryover of primitive behaviors described by MacLean (1949; 1958; 1962; 1973)—as emanating from subcortical centers whose functions have meant to insure survival, originating from reptilian (brain stem) and mammalian (limbic system) brains. These subcortical centers have been involved in the direct expression of primitive aggression, and sexuality, as a means of fostering basic survival.

Phylogenetic regression in human beings, has been typified by territoriality, retaliation toward competitors, primitive group socialization, and blind submission to the leader of the "pack," characteristic also of animal behavior. Lorenz (1963) has described the phenomenon of "fighting like a cornered rat," a metaphor of subhuman behavior which has characterized the desperate struggle of a fighter or group of fighters who know that losing is equal to dying. Thus basic survival behavior in animals has often been equated with killing or being killed, which has also been typical of the combat veteran.

Furthermore, "animal like behavior," such as the aggressively protective behavior observed in Vietnam veterans (Brende, 1983), has also been observed in "mother hens" protecting their young (Lorenz, 1963). For example, a Vietnam veteran described the following: "A neighbor threatened my son and when I heard about it, I went over to his house, knocked on his door and when he came to the door, stuck a .45 in his mouth and said, "If you ever do that to my son again, I'll blow your f..... head off. " Other veterans have said "I'll kill anyone who threatens my family. They are a part me and no one will threaten them."

Lorenz's description of territoriality in animals may partly explain why foreign armies have often failed to win, described as follows:

> If we know the territorial centers of two conflicting animals. . .we can predict, from the place of encounter, which one will win: the one that is nearer home. " p. 28)

Finally, Vietnam veterans' descriptions of their combat experiences have I been characterized by language descriptive of a phylogenetic regression, as follows:

> When I was in Vietnam, I felt like an animal. I lived by the law of the jungle. It was kill or be killed. I learned that I had to kill to survive and I enjoyed it. The enemy weren't really human anyway. We called them gooks and slant-eyes. Hey weren't much higher than animals.

The experience of "fused" primitive aggression and sexuality, typical of limbic system arousal characterizing phylogenetic regression, was sometime subjectively experienced as a powerful "high"—even "addicting." As one veteran said, "the 'adrenalin high' I experienced in 'Nam was even better heroin." Consequently, combatants found pleasure from killing when it was associated with invincibility and omnipotent fantasies as described by one veteran:

> We were high, during the Tet offensive, with killing. You can't talk guys out of firing when they are all hyped up. They were so hyped up that they kept shooting all night long after we stopped their advance. We killed about 300 to 400 V.C. right inside the compound . . . stacked up their bodies the next day and torched them. The guys were so hyped up they wouldn't stop shooting. The only thing to do was to let them get exhausted, take them back to the rear, and give them food, drink, and women for a couple of days and then let them sleep. I'd get a whole villa for myself for 500 piastras a day, get drunk, eat, screw women for a couple a days. I'd take on as many as four at a time. This was the way we wound down. We were kill crazy and had to get it out of our system. The sex was important and we were very aggressive sexually."

REGRESSION AND POST-TRAUMATIC SYMPTOMS

The experience of military training and war often resulted in phylogenetic regressions to more primitive, archaic behaviors enhancing the likelihood of survival during life threatening, combat experiences. But unfortunately, for some Vietnam veterans, such behaviors recurred many years later in the form of aggressiveness, dehumanizing sexuality, risk-taking behavior, and impulsiveness, symptomatic of severe character pathology (Brende, 1983). They have often described their frequent tendency to automatically "fall back" on the use of primitive aggression typical of the combatant, as in the following example of a veteran wounded in a bar fight:

> A guy shot me in the leg and I won't feel complete until he's dead. I have dreams about killing hire all the time. I know that if I ever see him again, I won't be able to control myself.

Others have "regressed" to similar pleasurable fantasies during the course of hospital treatment as follows:

> I've had dreams of wiping out the entire hospital staff. I've killed before and liked it. And I can do it again. When you have 60 men under you and can kill anyone you like, that's a great feeling of power. There's nothing like it. I could get together all

the Vietnam veterans around here and we could wipe out the staff if we had to.

Vietnam veterans have suffered from chronic or acute regressive symptoms related to their frequently found character pathology. Such symptomatic patterns have reflected ego boundary changes in the form of diffusion rigidity, or ego boundary disintegrations, described more completely as follows:

Ego Boundary Diffusion

Diffusion of ego boundaries has been described as resulting in either reenactment of the symbiotic stage of development (Mahler & Fure, 1968), or to a counterphobic fusion with an aggressor, whereby "differentiation of self from non-self is abolished and self object representations refuse. Here we find idealized, ecstatic merged states and terrifying, aggressive merged states" (Kernberg, 1980 p. 109).

Idealized relationship states in young trainees and combatants have sometimes been associated with the internalization of idealized persons and ideologies which became parts of the self (Meissner, 1971). The resulting diffusion of ego boundaries taking place during such internalization has been described as a process whereby "object cathexis and identification are indistinguishable" (Meissner, 1970, p. 579). This process enabled war combatants to "fuse" with their comrades whereby they became part of an effective fighting team, as described by a Vietnam veteran:

> I felt like my buddies were like my right and left hands. . .we know how each other thought and were able to cover for each other in a jam.

Such experiences were relished by those who described having no closer relationships in their lives beyond those made with "army buddies." Unfortunately, for those who have been unable to reestablish such close relationships, other means have been attempted to foster "idealized regressions" to ecstatic states. Thus the heavy drug or alcohol use among Vietnam veterans has perhaps also been an attempt to recreate idealized, regressive, fused states, similar to that which Spotts & Shoutz (1982) have described as the substance-induced infantile regression and merger with the "idealized primal mother." In this way veterans have temporarily suppressed the anxiety and fear associated with post-traumatic symptoms— particularly the persistent feelings of detachment and isolation.

In some combatants diffusion of ego boundaries has been associated with significant character changes following the incorporation of their war experiences— "embracing the ever-presentness of death...like a new introject" (Shatan, 1974). Such pathological identifications with violence and death, have given rise to the formation of "killer-victim selves," and subsequent destructive and self-destructive behavior (Brende, 1983).

Ego Boundary Rigidity

The combatants' need to control awareness of fear and regression to a state of helplessness has led to rigidification of ego boundaries. This was commonly achieved via the formation of omnipotent character defenses (Brende, 1983) which provided adaptive counterphobic and aggressive defenses for combat conditions described by one Vietnam as follows:

> I was never afraid. As a matter of fact, when I was hunting Charlie I felt invincible. And after a good kill I felt really high."

Such omnipotent traits often persisted after returning to civilian life veterans were unable to loosen rigid boundaries and regress as normally occurs during meaningful interpersonal relationships—particularly expressions of love and interdependency. This combination of omnipotence and emotional detachment has been described by a Vietnam veteran who maintained a rigidly dominant, unemotional relationship with his wife:

> I can't tell my wife I love her. I can't express any feelings. I believe that a mar doesn't ever cry. I could never reveal such a weakness to my wife. I'd die first.

The problem with emotional detachment has been described by Wilson (1977) as an ego boundary rigidification which made "it particularly difficult to successfully (and empathically) fuse ego boundaries with others . . . to express emotion, especially affection and warmth....

Regression and Ego-Boundary Disintegration

For some combatants, regression was associated with acute episodes of ego disintegration—experienced as extremely terrifying states of dyscontrol and psychotic-like behavior (Menninger, Mayman & Pruyser, 1963). Such catastrophic "schizophrenic" reactions have been described in combat during World War II:

> In World War II, every soldier who underwent a particular battlefield experience developed schizophrenic symptoms . . . The soldier was under fire and in danger of being killed . . . if the situation lasted for several days, every single soldier appeared classically schizophrenic when the shooting stopped. . . If thee were reasonable healthy before this trauma they recovered spontaneously with rest." (Karon & Bandenbos, 1981, p. 43).

Episodes of ego boundary disintegration—described as regressions to chaotic identifications Jacobson, 1954)—have occurred as post-traumatic flashbacks and aggressive outbursts in Vietnam veterans. These symptoms, associated with the emergence of "killer-victim" identifications (Brende, 1983) have resulted from the breakdown of rigid ego boundaries, sometimes during states of dissociation, described as follows:

> These six teenagers made obscene gestures from their car. I took them on one at a time. It was like I was back in Vietnam, fighting the enemy all over again.

Another veteran described waking up from a nightmare in which he relived the death of his closest friend while in Vietnam, while "regressing" to being on patrol in the jungles of 'Nam which he described as follows:

> I was out on a search and destroy mission—I had to kill the gooks or they would kill me. When I woke up I was wandering around the streets of the neighborhood, all muddy with my clothes torn up from crawling through the surrounding woods.

Disintegrative regressions have also had more tragic outcomes. For example, a veteran of both Korean and Vietnam combat, who tried to carry on a normal civilian life, described the following regression while in a state of disassociation:

> Ever since I returned from overseas, something had changed inside of me. Something was locked up within me. It got loose one night when I was at a dance and saw a another guy trying to make it with my wife on the dance floor. The next thing I remember was waking up the next day in a jail cell and they told me that I had gone out on that dance floor and stabbed the guy 27 times. I didn't remember anything about what had happened and now I'm afraid of what I might do again if I ever get mad. (Brende, 1984.)

A regression to primitive aggressive and sexual behavior has been described (Bain, 1980), wherein an isolated, Vietnam veteran distorted reality and misperceived a Vietnamese girl to be a V.C. agent. He took her up to an empty apartment to interrogate her and violently raped and killed her, later "awakening" while wandering the streets in a dreamlike, fugue state. Unfortunately, Vietnam veterans with pathological ego-boundary changes have a subliminal awareness of the threat of impending ego-boundary disintegrations which preclude their acceptance of helplessness and vulnerability. Consequently they avoid situations which induce feelings of vulnerability for fear of losing control, becoming, "psychotic," and killing themselves or others.

REGRESSION AND RECOVERY

While regression has most often been viewed as a pathologic phenomenon, causing disintegration of ego boundaries and a return to primitive behaviors and defensive patterns, it has also been described as pal of a recovery, restorative, or integrative process. Regression may then foster integration-referred to as: "regression in the service of the ego" (Kris, 195 or "adaptive regression" (Hartman, 1939). This kind of regressive experience has been associated with ego-boundary flexibility, dissolution of ego boundaries occurring during meditative or religious experiences (Brende

Rinsley, 1979), or positive ego boundary transcendence as described b persons "in love" (Kernberg, 1977).

Perhaps one of the earliest theorists to conceive of the restorative capacities of regression was Carl Jung. To quote Jung: "In the darkness of the unconscious a treasure lies hidden ... It is these inherent possibilities a 'spiritual' or 'symbolic' life and of progress which form the ultimate, though unconscious, goal of regression" Jung, 1976, p. 330). Thus, from a Jungian perspective, integrative regression "contains the seed of new psychic health bringing up those images or symbols, which, functioning as energy transformers, are capable of changing the direction of the psychic process again into a progressive one" (Jacobi, 1951, p. 75). Rather than representing a pathological return to primitive modes of functioning, integrative regression is conceived of having restorative capacities which facilitate higher levels of psychic integration and wholeness; "going one step backwards in order to b able to take two steps forward" (Fromm, 1977).

Fromm (1977) has contrasted the adaptive regression characterized by a state of ego receptivity to pathological regression, characterized by a state of ego passivity. In the adaptive state, the ego copes creatively while in pathological state, the ego assumes a defensive stance. "When the ego is passive, the person accedes to the demand ... from the instincts, the superego or the external world ... (and) the individual submits ... (helplessly), feels overwhelmed and cannot act all... characteristic (of) catastrophic reactions" (Fromm, 1977, p. 375). Thus, critical elements of integrative regression include the following:
(I) that the ego boundary can be "discovered";
(2) that the regression is mere temporary and "reversible"; and
(3) that the ego can remain intact while journeys into deeper levels of the unconscious (Blanck, & Blanck, 1974).
When regression fosters psychic growth, recovery, or renewal, I "patient" necessarily possesses a healthy ego which can temporarily "let E 67

of defenses against past memories or archaic images within the unconscious: facing memories and images directly to achieve integration and to progress to higher levels of psychic functioning.

Thus the goal of treatment is to enhance the veteran's inner receptivity to an adaptive or integrative regression, achieved only when pathological ego boundaries can give way to flexibility, pathological omnipotent traits can give way to the acceptance of helplessness, victimizing behavior can give way to expressions of guilt and grief, and fragmentation of identity can give way to an integration of "split-off" aspects of the self. However, this receptivity is likely to occur only within the presence of a stabilizing environment, protective persons, and effective therapeutic relationships. Kernberg (1980) has defined three components of the ideal therapeutic situation as follows: (1) The holding function of the therapist, described by Winnicott (1958) as the "good enough mother"; (2) the emotional availability of the therapist at times of disintegrative regression; and (3) the capacity of the therapist to respect the patient's autonomy and eventual separation/individuation.

REGRESSIVE EXPERIENCES AND TREATMENT PHASES

Early Treatment Phases and Disrupting Regressiue Experiences

Early phases of individual and group therapy are often marked by fluctuating behavioral symptoms and threats of disintegrative regression, manifestations of either overcontrol or undercontrol (Horowitz, 1976; Smith, 1981). For example, overcontrol is manifested by emotional detachment, denial, and omnipotent counterdependence, undercontrol is manifested by symptoms generally thought of as regressive, such as intrusive and repetitive thoughts, images, dreams, aggressive outbursts, and reeenactments of traumatic events, previously described as resulting from the breakdown of rigid ego boundaries.

The emergence of regressive symptoms during early phases of short-term group therapy has been reportedly managed by providing a cognitive framework by which veterans can better understand their symptoms (Parson, 1981), discussing positive experiences at the end of group therapy sessions and having the group members participate in physical activities between therapy sessions. These measures have effectively controlled regressive symptoms. In some cases, meditation and hypnosis have also been used to enhance the experience of relaxation and self-control (Brende & Benedict, 1980; Parson, 1981). However, regressive techniques attempted during this time have often threatened some veterans with the dissolution of unstable ego boundaries and stimulated anxiety. For example, group members were asked to "regress" during the seventh group session of a short-term group treatment by closing their eyes, "visualizing" a past unpleasant experience, and modifying it to achieve a positive outcome. However, only one of eight group members was able to accomplish it. The veteran who succeeded, described the following:

> "I found myself in my imagination visiting my mother. We had a conversation and it wasn't upsetting like I expected it to be. It turned out well. We talked together and I gave up all the anger that I had been carrying around toward her for a long time."

The other seven veterans either avoided the attempted visualization or became quite anxious.

The use of a regressive technique during early phases of individual therapy may also precipitate a disintegrative regression (Brende & McCann, 1984), as described in the following case:

> A hospitalized combat veteran with a history of substance abuse and posttraumatic symptoms entered individual therapy upon being discharged from the hospital. During the fourth session, the veteran expressed a desire to relive and "abreact" emotions related to a profoundly traumatic event that he had experienced shortly after arriving in Vietnam. He was asked to relax and attempt guided imagery which then led to his "reliving the traumatic event." He revivified his best friend blown up in front of him and then his experience of remaining trapped under the dead body

for several hours. In spite of the use of cognitive reconstructuring techniques and support to help him resolve his survival guilt, the veteran subsequently had a vivid nightmare associated with terrifying feelings of vulnerability. He began to drink excessively following which he had a dissociative episode and found himself reliving the fear of being in the jungles of Vietnam. Supportive therapeutic techniques effectively stabilized this regressive episode .

When regressive techniques, including meditation and hypnosis, have been initially used to provide a means for relaxation and control of anxiety, they have reportedly stirred up apprehension after persistent use (Brende & Rinsley, 1979; Brende & Benedict, 1980). For example, meditation used regularly has been found to lift repressive barriers (Glueck & Stroebel, 1975), thus evoking increased dreaming and recollection of past memories, likely to increase anxiety levels in Vietnam veterans—particularly during early phases of treatment. For example, a veteran in treatment with one of the authors (JB) had become a proficient meditator, but after three months of use, reported that he was having excessive numbers of unpleasant dreams and memories that interfered with his ability to work and consequently, had to reduce the amount time that he spent on meditation (Brende & Benedict, 1980).

Later Treatment Phases—Utilization of Regressive Techniques

While the initial phases of therapy have been characterized by the management of regressive symptoms, interpretations and confrontation of counterdependent behavior, later phases of therapy have frequently focused on the encouragement of regression. This includes the use of techniques which encourage reliving the past in order to achieve a "healing recapitulation" 'Figley, 1979) via therapeutic revivification (Brende, 1981) or hypnotic age regression (Schneck, 1956; Weitzenhoffer, 1953) when possible. The patient's capacity to benefit from such regressive experiences is predicated on the presence of healthy ego boundaries and the ability to maintain awareness of e present time and the therapist's presence (Gill, 1948; Schneck, 1956, 1960; Kline, 1959). The reliving of unresolved past traumatic events becomes a controlled regressive experience rather than an uncontrolled repetitive flashback—fostered by a therapeutic modality, which can provide a means to achieve free access to past experiences necessary for more complete lf-awareness and sense of identity (Reiff & Scheerer, 1959).

Parson (1981) has described the second phase of therapy as a prelude for the use of regressive techniques. It is a time when the therapist "gently cracks the all with which the vet has surrounded himself. " Relaxation techniques, and meditation have been used to facilitate this process by lifting repressive barriers (Carrington & Ephron,1978).

Parson (1981) has also described the succeeding or third phase of therapy as "in vivo affective revival phase" during which time treatment facilitates controlled regressive pathway to the traumatic experience ... possible (when) the veteran (can) withstand the possible 'fragmenting' effects of controlled regressive ego activity in response to the ego-lulling impact of Citation, relaxation and hypnotherapy" (p. 35)

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When regression fosters psychic growth, recovery, or renewal, the "patient" necessarily possesses a healthy ego which can temporarily "let -go-of" defenses against past memories or archaic images within the unconscious: facing memories and images directly to achieve integration and to progress to higher levels of psychic functioning.

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Hypnotherapy, when properly integrated into the therapeutic process, has been effective as a means of facilitating revivification or therapeutic reliving of painful memories, completion of grief work (Spiegel, 1981), and integration of dissociated aspects of the self (Brende & Benedict, 1980).

Integration of abreacted traumatic experiences is possible when combined with "working-through," as has been described during analytically oriented psychotherapy with borderline and narcissistic patients (Chessick, 1977). The "working-through" process is essential as revealed in the following example:

> A Vietnam veteran, after one and one-half years of therapy, including numerous abreactive sessions, began to have awareness that he had blocked a memory related to the death of a close buddy. Relaxation techniques were attempted to recovery the memory which presumably was associated with guilt-ridden destructive behavior. For several weeks following this session, the veteran had homicidal and suicidal ideation and fear of losing control over aggressive impulses. Further therapeutic work with this patient helped him resolve guilt related to his buddy's death.

Regression and Character Pathology

Veterans suffering from serious character pathology have benefited from a lengthy therapeutic process (Brende, 1982). However, patients with characterological symptoms have often resisted the use of regressive techniques which threaten self-control (Brende & McCann, 1984). Consequently, therapeutic interventions have initially been geared toward clarifying resistances to dependency on the therapist, described as follows:

> A Vietnam combat veteran, hospitalized with post-traumatic symptoms, including characterological manifestations of borderline personality disorder (Brende, 1983), expressed his counter-dependent attitude toward the therapist during the early months of therapy by coming late to sessions and devaluing therapy as a waste of time. It soon became apparent that his counter-dependency and devaluation of therapy and the therapist were linked to experienced in Vietnam were he felt devalued, betrayed and abandoned by persons in authority. The therapeutic intervention clarified the relationship between those experiences of devaluation, betrayal and his counter-dependent attitudes in therapy.
>
> During the next therapy session, the veteran was able to reveal prior frightening experiences of nearly being killed. However, his revelation of fear and helplessness immediately evoked expressions of counter-dependent rage toward all 'helpers' during the next session. Treatment subsequently processed when the therapist clarified the presence of rage and helplessness in the form of vacillating ego states related to unresolved abandonment feelings - as has been described ruing the treatment of borderline patients (Masterson, 1976; Masterson & Rinsley,

1975).

The patient's vacillating behavioral changes reflected periodic regressions and changing ego boundaries - in part, a result of increasing degrees of helplessness and dependency on the therapist and the treatment process. Such regressions, occurring in semi-controlled fashion, have often facilitated an increasing capacity for trusting the therapist.

Borderline character traits (Brende, 1983) and serious self disorders (Parson, 1981) have been modified when veterans' resistance to depending on therapists has given way to "therapeutic symbiosis" (Searles, 19782) and idealized transference (Frick & Bogart, 1982)—necessary for the realignment of ego boundaries occurring during recovery (Brende & McCann, 1984).

The therapist's failure to complete the work of breaking through persistent resistance to dependency may manifest itself through unresolved victimization (Brende, 1983) as a symptomatic displacement for unacceptable helplessness. For example:

> A Vietnam veteran completed three years of therapy including several hypnotherapy sessions, but continued to have brief lapses of concentration, headaches, fatigue, dizzy spells and vision disturbances alternating with angry outbursts—problems which were associated with the nonacceptance of his own helplessness. Finally, he revealed the feelings associated with his regressive symptoms, "I feel helpless, but it's a rotten bad feeling. I find it hard to be helped by anyone else and I can't stand to have someone give me a hand or drive my car for me. I want to take care of myself!"

In yet another example of victimization symptoms, a Vietnam veteran with significant character pathology began to accept his dependency on his individual and group therapists after two years of therapy, yet feared their ability to respond to his overwhelming dependency needs. As a way of testing their capacity to take responsibility for him, he developed regressive symptoms of victimization, mainly in the form of nightmares wherein he was shot and killed. Then he would wake up either in a cold sweat or in a state of disorientation and became aggressive because he did not trust the other hospital personnel, nor accept their help. At such times, he requested that one or the other of his therapists be called on to intervene as he developed exaggerated fears of being abandoned by the staff. The interventions provided by his therapists were to be available to support him, acknowledge his fear of increasing dependency, as well as his terror about abandonment or rejection. Thus he gradually accepted his state of helplessness and enhanced the trusting relationship with his therapists.

Veterans who resist hypnosis may suffer from the fairly common fear of vulnerability, which often arises whenever lying down or going to sleep at night. For example, a Vietnam veteran who, after three and one-half years of therapy, still complained of the fear of sleeping, was hypnotized and relived a frightening experience when he had to

lie on the ground absolutely still and without sound for three days in order to keep from being discovered by enemy soldiers. He came out of the trance state describing the following feeling: "I feel I didn't want to wake up. And it's just like when I'm afraid to go to sleep at night. I'm afraid to wake up for fear I'll discover someone is going to kill me."

Finally, the resistance to going into a trance state may be regaled to the fear of unleashing hidden rage. Particularly in patients whose aggression is a predominant symptom, age regression to combat is potentially frightening. However, when character resistance is adequately resolved, hypnotic age regression can be an effective therapeutic modality. For example, a Vietnam veteran whose symptoms included emotional detachment, "killer" fantasies, and counterdependent omnipotence continued to suffer from traumatic dreams, alienation and fear of losing control over his aggression. After two and one-half years of therapy, he agreed to being hypnotized to uncover the origin of his symptoms. During the hypnotic regression, he relived the death of a close buddy for whose death he had felt responsible. He became aware of previously unacknowledged anger toward him. As a result of the revivification and subsequent working-through of the guilt and grief feelings, he found relief from the traumatic dreams, alienation and aggressive outbursts.

Summary

Regression, both during and following combat, has had several meanings, but in general has meant a descent to diminished autonomy and more primitive defensive modes of functioning. Regression was encouraged during military training as it fostered the surrender of individual autonomy to leaders and to the collective team efforts of the military unit. Individuals came to accept their diminished autonomy and increased dependency on comrades. However, if close comrades were killed or injured during combat, survivors were left intensely vulnerable and prone to pathologically regressive behavior.

Regression during war time was phylogenetic in nature to primitive survival behavior. Vietnam veterans often described their combat experiences as a day-by-day survival with a "kill or be killed" philosophy. Unfortunately, their experiences fostered dehumanizing aspects of regression so that the idealization of fighting for the good of the "motherland" was replaced by the degradation of killing for the sake of killing. As Vietnam veterans increasingly became victimized by the dehumanization of their war experiences, their regressions became more pathological and associated with identifications with aggressors. The resulting serious identity changes caused ceaseless problems following their return to civilian life where they often suffered from serious posttraumatic character pathology.

Post-traumatic symptoms, often described as regressive attempts to return to the primitive survival behaviors of Vietnam, have also been attempts to repeat and change prior experiences of failure or loss. The treatment of such symptoms has generally occurred in phases, with management of regressive symptoms initially important for the control of destructive and self-destructive behavior during the first

phase. Following the development of a stable and trusting therapeutic relationship, later phases of therapy have utilized specific regressive techniques as a means of achieving "healing recapitulation. "

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