Chapter 1
The Nature of Shell-shock

A French doctor has said, "Il n'y a pas de maladies." (*There are no sicknesses, there are only sick people*)

Whatever the validity of this statement, it is undoubtedly true of the nerve-stricken soldier. Every case is a case by itself, and as such it must be considered by anyone, be he layman or doctor, who is interested in its nature and treatment. For the troubles displayed in the many disorders classed under the official title shell-shock are extraordinarily numerous and different, and their removal necessitates a similarly varied repertoire of "opening moves" on the part of the physician.

Although the term shell-shock has been applied to a group of affections, many of which cannot strictly be designated as "shock," and into the causation of which the effect of the explosion of shells is merely one of many exciting factors, this term has now come to possess a more or less definite significance in official documents and in current conversation. It is for this reason that we have chosen to use it rather than the more satisfactory, but less widely employed term, "War- Strain." The reader will, therefore, understand that whenever the term shell-shock appears in these pages, it is to be understood as a popular but inadequate title for all those mental effects of war experience which are sufficient to incapacitate a man from the performance of his military duties. The term is vague; perhaps its use implies too much; but this is not altogether a dis- advantage, for never in the history of mankind have the stresses and strains laid upon body and mind been so great or so numerous as in the present war. We may therefore expect to find many cases which present not a single disease, not even a mixture, but a chemical compound of diseases, so to speak. In civil life, we often meet with cases of nervous breakdown uncomplicated by any gross physical injury. We are scarcely likely, for example, to meet it complicated by gas poisoning and a bullet wound. Yet such combinations as these - or worse - are to he met with in the hospitals every day.

This is perhaps an opportune place to point out a significant popular misunderstanding concerning the nature of such maladies as we shall discuss in this chapter. A common way of describing the condition of a man sent back with "shock" is to say that he has "lost his reason" or "lost his senses." As a rule, this is a singularly inapt description of such a condition. Whatever may be the state of mind of the patient immediately after the mine explosion, the burial in the dug-out, the sight and sound of his lacerated comrades, or other appalling experiences which finally incapacitate him for service in the firing line, it is true to say that by the time of his arrival in a hospital

in England his reason and his senses are usually not lost but functioning with painful efficiency.

His reason tells him quite correctly, and far too often for his personal comfort, that had he not given, or failed to carry out, a particular order, certain disastrous and memory-haunting results might not have happened. It tells him, quite convincingly, that in his present state he is not as other men are. Again, the patient reasons, quite logically, but often from false premises, that since he is showing certain symptoms which he has always been taught to associate with "madmen," he is mad too, or on the way to insanity. If nobody is available to receive this man's confidence, to knock away the false foundations of his belief, to bring the whole structure of his nightmare clattering about his ears, and finally, to help 'him to rebuild for himself (not merely to reconstruct for him) a new and enlightened outlook on his future - in short, if he is left alone, told to "cheer up" or unwisely isolated, it may be his reason, rather than the lack of it, which will prove to be his enemy. And nobody who has observed the hyperaesthesia to noises and light in the nerve-hospital, nobody who has seen the effects upon the patients of a coal dropping unexpectedly out of the fire, will have much respect for the phrase, "lost his senses." There exist, of course, cases of functional blindness, deafness, cutaneous anaesthesia and the rest, but the majority of the nerve patients show none of these disorders and recovery from them is often rapid.

In a word, it is not in the intellectual but in the *emotional* sphere that we must look for terms to describe these conditions. These disturbances are characterised by instability and exaggeration of emotion rather than by ineffective or impaired reason. *(This subject has been lucidly discussed by C. Burt, "Psychology and the Emotions," School Hygiene, May, 1916,)*And as we shall see later, in the re-education of the patient, the physician is compelled continually to take this fact into account.

As we have pointed out, every nerve-stricken soldier presents a case by itself. Slavish adherence by the physician to one of the classical names or labels used in diagnosis usually spells failure. The patient must be approached *without prejudice*, and the doctor who wishes to be of real help to him must make up his mind to examine and ponder over the sufferer's mental wounds with as much, nay, even more care and expenditure of time than would be given to physical injuries. A mere cursory inspection in the course of the formal ward visit is a solemn farce, if it pretends to be a serious attempt to cure the mentally afflicted.

A man, standing at "attention" by the side of his bed. surrounded by his comrades and faced by. the medical officer, the military sister, and perhaps even by other members of the staff may volunteer the information that he is sleeping badly. But this imposing procession and cloud of witnesses is scarcely conducive to the production of any further evidence as to the cause of his insomnia. For of those causes even pre-war

experience makes it possible to assert that their name is legion, and their character often of an exceedingly intimate and private nature.

The formal visiting of patients in the wards, while adequate for the care of physical injuries (which, can be subsequently attended to by trained nurses and sisters) and necessary for administrative and disciplinary purposes, is insufficient for "mental cases." It is with this fact in mind that the military authorities have instituted special hospitals in which more detailed attention may be given to the latter class of patients. In these institutions the soldier may have private interviews with his medical officer, and the history of the trouble can be unravelled in conversation. *1t is only in this way that any scientific insight into a case of mental disorder can be obtained.*

A short time spent in such interviews, or even the perusal, by the uninitiated, of the papers already published in the Lancet, British Medical Journal, and else where, (such as for instance, D. Forsyth, Lancet, Dec. 25th, 1915 p. 1399; C. S. Myers, Lancet, Mar. 18th, p. 6o8; R. G. Rows, .Brit. Med. J., Mar. 25th, 1916, P. 441; G. Elliot Smith, Lancet, April 15th and 22nd, 1916; H. Wiltshire, Lancet, June 17th, 1916.) will convince one of the immense complexity of these unusual mental conditions, and moreover, of the absolute necessity of obtaining and understanding the patient's past history, before and during the war. A dozen cases sent back from the front as shell-shock may prove to possess not a single feature in common - except the fact of the shell explosion. And this, as has been pointed out, may be but the "last straw." The patient often discloses in the first interview this fact that he was displaying all his present symptoms before the arrival of the particular shell which laid him out.

It is now possible to attempt a brief sketch of the typical conditions which give rise to some of the chief varieties of shell-shock. Let us take a common case; that of the patient who is returned to this country, figuring in the casualty lists under the terse and business-like military formula, "shock, shell."

For various reasons, which the reader will easily supply, we choose to present a composite picture of the history of such a soldier. Not all the conditions described here need necessarily have operated in any one case taken at random, but we shall err, if at all, on the side of understatement. The correctness of the description may be checked by a reference to the papers already mentioned.

We must first try to conceive the experiences of the soldier before the occurrence of the knock-out blow, so far as they bear on his present condition. Let us suppose that his period of training has made hint physically and mentally fitter than he had ever been before, that no military causes of anxiety or fear, such as the experience or the anticipation of being torpedoed on the outward voyage, have operated to any noteworthy extent in his case. He enters the trenches in first-class condition. The

duration of his stay there, provided he is not wounded, or attacked by any bodily illness, will depend from that time forward upon the nature, duration, intensity and frequency of the emotion-exciting causes, and upon himself. By that all-inclusive word "himself" we mean to signify chiefly his temperament, disposition and character. It must be remembered that one of the greatest sources of break-down under such circumstances is intense and frequently repeated emotion· By this is meant not only experiences of fear or of sympathy with suffering comrades, in short, those conditions the manifestations of which might cause the man in the trenches to be spoken of as "emotional," but also other mental states associated with general excitement, anxiety, remorse for major or minor errors, anger, elation, depression and that complex but very real state, the fear of being afraid. (The more definite terms of technical psychology are not used here, as it is considered wiser to employ popular language.)

The soldier may be subjected to intense emotional stimuli of this kind for days or weeks without relief. And whereas to the mental sufferer in civil life sleep often is vouchsafed, "setting him on his feet" to continue, more or less effectively, the struggle next day, to the soldier sleep may be impossible, not necessarily because of his excited mental state, but simply from the lack of opportunity or the disturbances going on about him. In course of time his loss of sleep from external causes may easily set up bodily and mental excitability, which in its turn acts as a further cause of insomnia. The usual mental conditions associated with loss of sleep then rapidly supervene: pains and unpleasant organic sensations, hyperaesthesia, irritability, emotional instability, inability to fix the attention successfully upon important matters for any length of time, loss of the power of inhibition and self-control.

These symptoms, troublesome enough in civil life, become positively dangerous to the man in the trenches, especially if he is in a position of responsibility. In that case his standing as officer or NCO. merely adds to his mental distress. Bodily hardship, such as exposure to cold and wet, hunger, and the irritation from vermin, obviously aggravates the disorders we have described.

We must not suppose, however, that the man who is experiencing some or all of these mental and bodily conditions is at this period necessarily displaying any obvious *outward* signs of his trouble. There may he no tremor, no twitchings, no loss of control of the facial or vocal muscles which would indicate his state even to his neighbours. He may, for a long time, "consume his own smoke." And during this process he may even appear to his comrades to be steadier and more contemptuous of danger than before. Dr. Forsyth (*op cit., p. 1210*) has cited some dramatic incidents, in which officers who imagined that their instinctive fear was becoming apparent to the men under their .command took unnecessary risks in order to impress these men with the idea that they were not afraid.

It must be understood that this suppression of the external manifestations of an emotion such as fear is but a partial dominance of the bodily concomitants of that emotion. The only changes which can usually be controlled by the will are those of the voluntary or skeletal muscular system, not those of the involuntary or visceral mechanism. While no signs of fear can yet be detected in the face, the body, limbs or voice, these disturbances of the respiratory, circulatory, digestive and excretory systems may be present in a very unpleasant degree, probably even intensified because the nervous energy is denied other channels of outlet.

The suppression of fear and other strong emotions is not demanded only of men in the trenches. It is constantly expected in ordinary society. But the experience of the war has brought two facts prominently before us. First, before this epoch of trench warfare very few people have been called upon to suppress fear continually for a very long period of time. Secondly, men feel fear in different ways and in very various degrees.

The first fact accounts for the collapse, under the long continued strain of trench warfare, of men who have shown themselves repeatedly to be brave and trustworthy. They may have felt intense emotions, obviously not of fear alone, for a long time without displaying any signs of them. But suppression of emotion is a very exhausting process. As Bacon says, "We know diseases of stoppings and suffocations are the most dangerous in the body; and it is not much otherwise in the mind."

The second fact mentioned above is of great importance in the consideration of our problem. There are undoubtedly men who seem to be immune to fear of the dangers of warfare. But to them we scarcely apply the adjective "brave." The brave man is one, who, feeling fear, either overcomes it or refuses to allow its effects to prevent the execution of his duty.

Other emotional states however, besides fear, arise and require suppression. The tendency to feel sympathetic pain or distress at harrowing sights and sounds, disgust or nausea at the happenings in the trenches, the "jumpy" tension in face of unknown dangers such as mines - all these, like fear, are or have been biologically useful under natural conditions and, like it, are deeply and innately rooted in man. But the unnatural conditions of modern warfare make it necessary that they shall be held in check for extraordinarily long periods of time.

The impossibility of regarding modern methods of warfare in the same light as natural and primitive means of fighting appears very clearly when we consider the instinctive and emotional factors involved in the two sets of circumstances. In natural fighting, face to face with his antagonist, and armed only with his hand or with some primitive weapon for close fighting, the uppermost instinct in a healthy man would naturally be that of pugnacity, with its accompanying emotion of anger. The effect of every blow

would be visible, and the intense excitement aroused in the relatively short contest would tend to obliterate the action of other instincts such as that of flight, with its emotion of fear. But in trench warfare the conditions are different. A man has seldom a personal enemy whom he can see and upon whom he can observe the effects of his attacks. His anger cannot be directed intensely night and day against a trench full of unseen men in the same way in which, it can be provoked by an attack upon him by an individual. And frequently the assaults made upon him nowadays are impersonal, undiscriminating and unpredictable, as in the case of heavy shelling. One natural way is forbidden him in which he might give vent to his pent-up emotion, by rushing out and charging the enemy. He is thus attacked from within and without. The noise of the bursting shells, the premonitory sounds of approaching missiles during exciting periods of waiting, and the sight of those injured in his vicinity whom he cannot help, all assail him, while at the same time he may be fighting desperately with himself. Finally, he may collapse when a shell bursts near him, though he need not necessarily have been injured by actual contact with particles of the bursting missile, earth thrown up by its impact, or gases emanating from its explosion. He may or may not be rendered unconscious at the time. He is removed from the trenches with loss of consciousness or in a dazed or delirious condition with twitchings, tremblings or absence of muscular power.

Upon recovery of consciousness, which may take place after periods varying between a few minutes and a few weeks, the immediate disorders of sensation, emotion, intellect, and movement, are often very severe. It may be presumed that at the beginning of the war they must have appeared far more serious to most of the doctors who saw them in their early stages than they would now. This speculation is suggested by the evidence of the case-sheets sent with the men from France in the early period of the campaign. Such diagnoses as "delusional insanity," and other similar terms taken from the current classifications of advanced conditions of insanity, appear very frequently as descriptions of cases which on arrival in England had almost entirely lost every sign of mental unusualness. In fact, one of the most cheering aspects of work amongst this type of case has been the rapidity with which men who have presented quite alarming symp- toms have subsequently recovered.

It may seem almost unnecessary to enumerate the bizarre phenomena which constitute the immediate results of shellshock, for our newspapers have naturally seized upon such unusual details and have made the most of their opportunities in this direction. But the reader will obtain a clearer idea of the facts if they are catalogued once more.

The most obvious phenomena are undoubtedly the disturbances of sensation and movement. A soldier may be struck blind, deaf or dumb by a bursting shell: in rare cases he may exhibit all three disorders simultaneously or even successively. It should be added that these troubles often vanish after a short space of time, as suddenly and

dramatically as they appeared. Thus one of the blinded soldier survivors of the *Hesperian* recovered his sight on being thrown into the water, Other blind patients have had their sight restored under the action of hypnosis. Mutism is often conquered by the shock of a violent emotion, produced accidentally or purposely. Examples of such "shocking" events taken at random from our experience were the sight of another patient slipping from the arms of an orderly, the "going under " chloroform, the application of a faradic current to the neck, the announcement at a "picture house" of Rumania's entry into the war (this cured two cases simultaneously), and the sight of the antics of our most popular film comedian. The latter agency cured a case of functional deaf-mutism, the patient's first auditory sensations being the sound of his own laugh.

The muscular system may be affected in an equally striking manner. Contractures often occur in which a man's fist may be immovably clenched for months; or his back may be bent almost at right angles to his lower limbs, there being in neither case any bodily change discoverable by the neurologist which can account for such a condition. These contractures, though curable, often prove very obstinate, and at present their nature remains somewhat of a mystery. Other distressing and long continued disturbances take the form of muscular twitchings and tremors or loss of power in the limbs.

Not every nerve-case, however, presents such striking and objective signs as those which we have just been describing. The *subjective* disturbances, which are apt to go undiscovered in a cursory examination of the patient, are frequently more serious than the objective, and are experienced by thousands of patients who to the mere casual observer may present no more signs of abnormality than a slight tremor, a stammer, or a depressed or excited expression. These afflictions: loss of memory, insomnia, terrifying dreams, pains, emotional instability, diminution of self-confidence and self-control, attacks of unconsciousness or of changed consciousness sometimes accompanied by convulsive movements resembling those characteristic of epileptic fits, incapacity to understand any but the simplest matters, obsessive thoughts, usually of the gloomiest and most painful kind, even in some cases hallucinations and incipient delusions - make life for some of their victims a veritable hell. Such patients may have recovered from sensory or motor disturbances and yet may suffer from any or all of these afflictions as a residuum from the original "shock- complex;" they may suffer from them as a complication of the discomfort attending upon a wound or an illness, or, on the other hand, they my have no overt bodily disorder: their malady then being usually given the simple but all-inclusive (and blessed) description "neurasthenia."

Now the happiness and welfare of such men obviously is bound up to no small extent with the character of the hospital or hospitals (for the plural number is commonly to

be used in writing the history of these patients) to which they are sent. In the general military hospitals the medical officers have neither the time nor, in many cases, the special knowledge, necessary to deal with cases of this kind. Such patients may recover of themselves without any treatment, but a large number of them tend to get worse, and if they are left without attention their symptoms are apt to become stereotyped into definite delusions and hallucinations. Moreover, in a general ward such men may become a constant source of disturbance and annoyance to other patients and to the nurses. One of the symptoms of their illness is a morbid irritability; they tend to become upset and to take offence at the merest trifles - and this leads to trouble with patients, nurses, and the medical officers responsible for discipline. But if special consideration is shown them by the nurses the other patients are apt to misunderstand it and even to complain of favouritism. In other words, when mixed with wound cases in a general hospital, these nervous patients are apt to be regarded as a nuisance - which is bad for them and for the proper working of the hospital. Another consideration, too, is that the subjection of such men to irksome regulations of military discipline, and the usual penalties for infringing them, is often so potent a factor in producing disturbances as to, be quite fatal to any hope of amelioration.

These considerations have led the military authorities to establish special hospitals for nerve-cases. (For particulars of these hospitals, see W. Aldren Turner's Report, *Lancet*, May 27th, 1916 p. 1073.) In such institutions the patients can be nursed and attended to by a staff which, being used to the idiosyncrasies of such illnesses can make conditions more suitable to them.

A man's particular nervous malady is likely to be of common occurrence in the nerve-hospital; it does not render him conspicuous, and therefore an object of fussy solicitude, galling pity, or suspicious contempt, as is too often the case in other institutions. If unwounded, he need not suffer the taunt of "having nothing to show" as his reason for staying in hospital. Further, while in the special hospital, more importance is attached to some of the patient's symptoms, less disturbance is produced by others. The occurrence of a "fit" is viewed by the rest of the men in this class of hospital in a truer perspective, and the patient does not find himself a "nine-day wonder", as he so easily may do in a small auxiliary hospital full of straightforward wound cases. Up to this point we have discussed the various troubles subsumed under the term shell-shock in what may be termed its initial and middle stages. In the middle stage, the patient having recovered from the severe and acute symptoms constituting the former phase, is left with a motley residuum of troubles, the chief of which we have enumerated on pages 12, 13. In distinguishing between this middle stage and that which follows it, we may perhaps ask the reader to assist us by recalling the difference between a mechanical mixture, and a chemical compound. In the former, the ingredients of the mixture remain unaltered and unaffected by the proximity of other

substances, as for example when sugar is mixed with sand. In the compound, on the other hand, chemical action and reaction occur between the components so that not one of the substances is immediately recognisable in the complex, as for example when carbon, hydrogen and oxygen combine to form alcohol, which resembles none of them.

Now it would be distorting the facts of mind to suggest that while the third stage of shell-shock is a compound (as it undoubtedly is) the middle stage is a mixture. For the very essence of mind is its compound nature. But what we wish to point out is that in this middle stage the abnormalities have had very little time to react upon each other, with the result that there is some resemblance to a state of mixture, the phenomena existing temporarily side by side, so to speak. In this stage a patient may be troubled simultaneously by several unusual mental occurrences, such as terrifying dreams during very light sleep, loss of memory for certain periods of his past, and inability to understand or to carry out complex orders. For a short time in his "bowled- over" state he may be worried by the separate attacks, of these various troubles at different periods of the day and he may be too overwhelmed to try to understand or to attempt to see relations between them. This state of mind, in which the patient is still his "old self," though a somewhat overturned self, resembles the mechanical mixture in our illustration. The reader may obtain some idea of this condition if he recalls any one day in his own experience when "everything seemed to go wrong"; when at one moment he was turning to face this difficulty, at another, that, but still retained to a great extent his usual attitude towards the world.

As has been pointed out, however, the state of "mechanical mixture" is utterly alien to the normal mind, which tends rapidly to interpret, in the light of its own experience, and to integrate as far as possible, its events, however incongruous they may be. The mind cannot, for any length of time, allow a new experience to remain strange or undigested. It must gather in and assimilate that event to the systematised complex which we call its own past experience. It follows that the ultimate result upon any particular mind of a new experience, if it be of a personally significant nature, will depend almost entirely upon the past history of that mind. Thus for example the question whether the patient can or cannot satisfactorily stand up to his new troubles will be determined not only by his disposition, temperament and character, but also by his previous personal experience.

It is thus obvious to anyone who gives the matter any serious consideration, that the manifestation of a severe psychical shock must necessarily be determined in a large measure by the nature of the mind upon which the injury falls. It would he idle to pretend therefore, that, in diagnosis, the story of the patient's past experience can be left out of account, for the manifestation of the injury will obviously depend largely upon the individual patient's "mental make-up."

Faced by the existence of a number of unusual mental phenomena the patient will inevitably succeed in time in inventing for himself, explanations of their coexistence. This "rationalisation," as it is called, is a perfectly normal process which is constantly going on in every individual, yet it plays a great part in complicating the mental disorders of the middle stage, and thereby intensifying the patient's ultimate distress. For instance, he may not be more than temporarily disturbed by the unusual experiences we have mentioned if they assail him separately (or seeking conscious and rational grounds for actions (and beliefs) whose motives are largely unconscious and perhaps irrational.). But, given time, he will soon begin to connect their appearances, and will argue to himself that these phenomena, can have only one meaning.. that he is mad or rapidly becoming so. And in this completely erroneous procedure he will be aided and abetted, not only by his own ignorance of the relation of mental normality to abnormality, but also by the general tendency of the uneducated to class everything unusual in the mental sphere as "mad." Once he is convinced that he is in this state he may easily lose all hope of getting better, thereby increasing enormously the gravity of his case. Completely illogical, but to him entirely satisfactory explanations of his condition will then multiply.

As we have mentioned, this rationalisation is no unusual phenomenon in ordinary life. It will be clear to anyone who gives the question a moment's thought that few of the non-scientific beliefs held by even a highly educated person have ever been logically reasoned out from fundamental principles. In fact such principles frequently cannot be reached, for she very good reason that they have never been consciously conceived by the individual. One's views on religion, politics, or the relations and rights of the sexes may exhibit in their outer casings a semblance of rational structure. their core, however, is not reason but emotion. As James expresses it:-

"In its inner nature, belief or the sense of reality is a sort of feeling more allied to the emotions than to anything else . . . reality means simply relation to our emotional and active life. This is the only sense which the word ever has in the mouths of practical men. . . . Whenever an object so appeals to us that we turn to it, accept it, fill our mind with it, or practically take account of it, so far it is real for us and we believe it. Whenever, on the contrary, we ignore it, fail to consider it or act upon it, despise it, reject it, forget it, so far it is unreal for us and is disbelieved. . . . Whatever things have intimate and continuous connection with my life are things whose reality I cannot doubt."

Few people, however, realise this truth so clearly, or express it so lucidly, as Professor James. Often we believe that we are logically convinced when in reality we have been convinced first, and have invented reasons for our conviction afterwards. But many of our beliefs and attitudes have been implanted in us in childhood. or early youth by processes which could not by the wildest stretch @of imagination be called

logical. And not the least important of those beliefs are those held by the average. Briton with regard to insanity. (The opinions of Dr. Bedford Pierce upon this matter are highly important. *British Medical Journal*, January 8th, 1916)

For the patient, then, his mental troubles, having intimate and continuous connection with his life, become very real indeed. But the longer he is left alone to "cheer up," the longer he broods over his troubles in isolation, the longer he is allowed to build theories upon his inadequate and inaccurate data, the more intimately and continuously connected with his life will the abnormalities become. They may come to be so integrated with each other that his very personality becomes tinged. Then he is no longer a normal person battling with his separate enemies, but one who has made terms, and those often disastrous ones, with his closely allied foes. An attempt to cure him at this stage will then necessitate the analysis of a highly complex compound, while in the early and middle stages merely the attack upon separated elements is necessary.

We are concerned at present with the facts of shell- shock, but this is perhaps a suitable place in which to deal with an opinion about this set of phenomena, which is not uncommon, especially perhaps in people above military age. That judgment, expressed sometimes bluntly, but oftener in a more subtle fashion, is that shock or neurasthenia are polite names for nothing else but "funk" It is not easy to take a dispassionate view of this question, but to persons holding this opinion the following points are worthy of consideration.

First, the most severe and distressing symptoms occur to a. surprising extent in the case of those patients whose past history shows that, far from possessing even the normal quota of timidity, they had been noted for their "dare-devilry" and had been specially chosen as despatch-riders, snipers and stretcher-bearers in the firing line. Secondly, it is not uncommon for patients to ask to he sent back to duty because they feel that they have been too long with nothing to do, while it is quite obvious to the doctor that they are as yet unfit to bear any great strain. Thirdly, the seasoned regular, officer or NCO., as well as the young soldier of only a few months' service may display precisely the same symptoms as those we have described. (Our personal experience has been of privates and noncommissioned officers only, but there is no *a priori* reason for supposing that these remarks do not apply to the commissioned ranks. It has been found that in the French Army the cases of neurasthenia amongst officers have been very numerous) Such men have frequently been in the army for many years, and have fought on previous occasions with great success. Their strength of mind and body has been demonstrated over and over again, yet at last they have broken down. And they manifest the greatest concern at their unusual symptoms.

It will be readily granted, of course, that there exist among the nerve patients returned from the front cases in which there is genuine fear of the war, arising from memories of the experiences which they have undergone. Even this state of mind, however, is usually expressed by the patient in some such phrase as "I don't want to go back, but I'll go quite willingly if I'm ordered to." It should not be forgotten, moreover, that not a small number of instances are known in which these men prove to have made repeated attempts at enlistment after having been rejected several times, or even discharged from the army, changing their medical examiner until they have succeeded. One case, presenting a great number of the symptoms of shell-shock in a very intense form, including, beside the ordinary neurasthenic troubles, blindness, deafness, and mutism at successive times, was that of a man who had been discharged from the army as medically unfit and had re-enlisted.

Two cases may be quoted here in illustration of some of these assertions:

The first is that of a non-commissioned officer who went through the initial eleven months of the war in France and Flanders, was subjected to every kind of strain, physical, mental and moral, which that stricken field provided; and in addition was wounded twice, gassed twice, and buried under a house, on all five occasions being treated in the field ambulance and then returning to the trenches. After all this experience he had not qualified for sick leave, but was granted five days ordinary leave to return home, apparently in a good state of health. After reaching England and while waiting for a train in the railway station, he suddenly collapsed, became unconscious, and for months afterwards was the subject of severe neurasthenia. Apparently at the front the excitement, the sense of responsibility and especially the example that he felt he should set his men, seem to have kept him right. These stimuli removed, he broke down. The whole of his trouble seemed to be due to the dread lest on his return to the front, the added responsibilities which would fall upon his shoulders (because most of his own officers had been killed and there would be new men to replace them) might be too much for him. His intelligence seemed (to himself) to have become numbed by his experiences, and he became conscious of the unreliability of his memory and of his inability to understand not only complex orders, but, as he put it "even the, newspapers." It was this that excited in him the dread lest he should be incompetent to discharge adequately the duties which would fall upon him. There was nothing of malingering or shirking in his case. There was no fear of physical injuries or of returning to the front; on the contrary, he was anxious to go back. His fear lest the possibility of his failure would be bad for his platoon was wholly due to that admirable sentiment of regimental loyalty, which comes out so strikingly in the nervous troubles of the non- commissioned officer.

This class of case demands a great deal of patient and sympathetic attention before the real cause of the trouble is elicited, and then months of re-education may be required to build up anew the man's confidence in himself.

The second case is that of a soldier who had suffered from severe shock symptoms and had recovered. In conversation with the medical officer the soldier expressed his willingness, and even his desire, to return to the front, in full knowledge of the fact that the officer's report in that sense would lead to his being sent back to fight. That night the patient was awakened by a terrifying dream, the true significance of which was certainly not adequately appreciated by him. Although he dreamt that he was afraid to go back to the front, apparently he did not realise that he was actually afraid - i.e., that the dream had any meaning. On examination it proved to be a detailed forecast of the imaginary incidents of his return to his regiment, and of his attempt to commit suicide when ordered to go to France. Here was a man who of his own initiative had asked his doctor to certify him as ready to go back, yet in his sleep the train of thought, started by the discussion of the possibility of his return working subconsciously, had stirred up images of what this implied, and reinstated emotions of so terrifying a nature that in his dream he preferred suicide to facing the ordeal again.

It may perhaps be allowable to quote in this connection the view of a German neurologist, Professor Gaupp, on the "shock-cases" ("Hysterie und Kriegsdienst" (Hysteria and War Service), *Munchener Medizische Wochenschrift*, March 16th, 1915.) which have been sent back from the German front. At the same time it is important to remind 'our readers that Gaupp is writing of a conscript army, the authorities in which are certainly not notorious for lenity to the individual; further, that up to the time of writing the present chapter, all the "shock" patients in Great Britain have been men who voluntarily elected to serve their country, the majority of them having enlisted in the earliest stages of the war. In discussing cases where nervous trouble, uncontrollable in nature and intensity, had led to the patients being kept in German hospitals for months, it was sometimes found that the mental foundation which was a causal factor of these troubles was a more or less conscious anxiety concerning the possibility of a return to the front.

"There is no justification," says Gaupp, "for calling every instance of this a case of malingering or simulation. There are quite capable men of irreproachable character whose nervous system is positively unfitted for the hardships and horrors of war. They have enthusiasm and the best of intentions but these cease to inspire them when the horrors and terrors come. Their inner strength rapidly decreases, and it only requires an acute storm to break upon the nervous system (such as the explosion of a shell or the death of comrades) for their self-control to vanish completely. Then automatically their condition changes into what is popularly called "hysteria." The exhausted mind then feels that it is no longer master of the situation, and therefore takes refuge in

disease. At first, as a rule, obvious signs of terror and anxiety (trembling, twitching, etc.) manifest themselves; if these are cured there still remain chronic symptoms of hypochondria and despondency. Time, however, has its effect in many of these cases."

If a patient comes into the hands of a physician before the processes of rationalisation and systematisation have become established, the medical officer should be able to meets difficulties, and help him correctly to interpret his unusual experiences by explaining to him their origin and nature.

" The application of discreet sympathy and tact by a physician who endeavours to discover something of the man's past mental history may be able to reassure a patient upon his particular trouble with the happiest of results. To a man quite unacquainted with text-books or speculation on psychology there can be no darker mystery than the working of other people's minds. To such a man the natural conclusion is that his own mental processes are universal and normal. But if, as a result of some nerve-shattering experience of warfare his mind suddenly develops a trick which was quite unknown to him before, though this development may be far from abnormal to the troubled patient it may seem to be an unquestionable symptom of madness"

Many of the cases in which a patient has merely needed reassuring have been of this type. A short and very simple explanation of some elementary facts of psychology is often sufficient to bring about an immense change in the man's condition, which has led to his curing himself. And this is the ideal method of cure. It may seem that an inordinate amount of space has been denoted to the demonstration of a simple truth, that mental, like bodily disorder, should be treated early, or complications may ensue. But there are reasons for giving so much prominence to this aspect of the subject. The chief is that in our own country, mental disorder is seldom treated in its early stages. Nearly all our elaborate public machinery for dealing with this distressing form of illness is devised, and in practice is available, only for the advanced cases. This war has shown clearly a truth which, of course, was already known before to many doctors, but never adequately appreciated by the general public, that a case of advanced mental disorder may pass not only through various milder stages on its way, but that if intercepted at these earlier stages, it may frequently be cured with ease.

Another point which should be emphasised is this: shell-shock involves no *new* symptoms or disorders. Every one was known beforehand in civil life. If by any stretch of the imagination we could speak of a specific variety of disease called shell-shock, it would be new only in its unusually great number of ingredients. And the most gratifying truth of all is that even this hydra-headed monster, if caught young, can he destroyed. From the fact that shell-shock includes no new disorders the important inference may be drawn that the medical lessons taught by the war must not

be forgotten when peace comes. The civilian should be offered the facilities for cure which have proved such a blessing to the war-stricken soldier.