EMERGENCY TREATMENT AT THE FRONT

Stationed, as the division neuropsychiatrists were, in combat areas, all their work being confined to field hospitals, where patients were held only from 3 to 10 days, depending upon military operations, the experience of these officers with the treatment and final outcome of the cases was limited chiefly to the milder forms of the neuroses. The more obstinate and chronic cases, of necessity, were evacuated to the rear areas.

To the treatment hospital at the front the neuropsychiatric patient was sent after he had taken the first important step on the road to recovery. At least no one was sent there until a determined effort had been made to convince him that he could be cured. Of course, there was necessarily a constant and fairly large residuum of refractory cases, but these were not permitted to negative the atmosphere of optimism which existed. Although situated in the field within the range of artillery fire, and subject to the military necessity of moving at an hour's notice, it was still possible to approximate suitable hospital conditions. The first difficulty which presented was the lack of nurses. The group of enlisted men who were selected had in the beginning nothing more than the doubtful merit of curiosity concerning the "shell-shocked" soldiers. Until it was possible to inculcate a certain degree of nursing morale it was necessary to deal with them from the point of view of military discipline. Certain orders were given, and failure to obey them was considered a punishable infraction of a military command. The few simple rules and suggestions utilized at first (in one division) are here quoted:

RULES FOR PSYCHONEUROSIS WARDS

1. Each patient on admission to have a hot drink.
2. Each patient to have three full meals a day unless otherwise ordered.
3. Do not discuss the symptoms with the patient.
4. Be firm and optimistic in all your dealings with these patients.
5. No one is permitted in these wards unless assigned for duty.
6. The rapid cure of these patients depends on food, sleep, exercise, and the hopeful attitude of those who come in contact with them.

From such an elementary beginning there gradually developed among the enlisted men, who acted as nurses, a high degree of interest and efficiency and a generalized and successful effort to intelligently maintain certain therapeutic principles without which success would not have been possible.

Classification was an important function of this hospital. Generally speaking there was an effort to keep the mild cases in one tent, the more severe in another, the physical problems separate, and the recovered awaiting return to the front apart from the others. Soldiers with obstinate symptoms were segregated.

The physical needs of the patients were constantly borne in mind. Hot, abundant meals were provided; exercise, amusements, and work were utilized, not haphazard fashion, but with a certain object in mind.

One finds in current reports on the therapy of war neuroses indefinite allusions to an intangible and mysterious therapeutic influence termed "atmosphere." By this is meant, presumably, the general feeling and understanding which existed among all those who came into medical contact with the war neu-

roses, and which sought to provide an urge or incentive for the soldier to return to his duty on the firing line. This was necessarily developed at every point in the American Expeditionary Forces where nervous and mental casualties were grouped for treatment. However, it should not have been permitted to remain at a vague and undefined stage, nor should its growth and direction have been left to mere chance. As a matter of fact, it was a thing which could be deliberately created and shaped into a definite and valuable therapeutic agent. As employed in the type of hospitals under consideration, it was separated roughly into positive and negative elements, the first being concerned with the advantages of returning to the front, and the second with the disadvantages of evacuation to the rear. Constantly, and in every conceivable fashion, were emphasized the glory and traditions of the division, of the regiment, and of the company, and the very important part which each soldier played in contributing his share. Further, the personal relation which so frequently existed between officer and soldier was in a sense filial, just as the intimate feeling between man and man was fraternal. In the field with combat troops, where close association under dangerous conditions made for the relaxation of certain features of rigid military discipline, such as ordinarily obtains in a cantonment, or camp, and also erased social barriers, it is exceedingly probable that what might be termed an artificial familial instinct was often developed and replaced in a measure the one of which the individual was at least temporarily deprived. This factor, too, could be utilized as a powerful means for obtaining a healthy therapeutic atmosphere.

On the other hand, evacuation to the rear was painted in gloomy colors. The patients came to realize that leaving the division, or unit, meant probably the opportunity forever lost of having a part in its present victories and consequently in future honors and rewards. It involved a total separation from the paternal officer and brother soldier, and finally becoming that most unhappy of mortals, a lone casual. It was in a sense a desertion, since it left comrades to "carry on" alone. It would be impossible to enumerate all the methods employed to foster and stimulate such impressions. The following sample will serve: Informal talks to groups of soldiers, the announcing and publishing of bulletins recounting the gallant advance of this or that unit, or the exploits of some well-known officer, or soldier, of the division, the reading and discussing of citations which had been received, rumors of a big offensive which was imminent, or of a well-earned rest which soon would be officially ordered, and the relating of incidents and episodes, "gossip" with a personal flavor which had come back by word of mouth from the front. No incidental opportunity was neglected. For instance, during the Meuse-Argonne operation, columns of German prisoners frequently passed the tents. The patients were urged to view the procession, always a stirring event, which often succeeded in evoking an exhibition of satisfaction and even patriotic fervor. It is doubtful whether anyone who has not been an actual witness can appreciate the value of even such simple measures. The whole plan was far from being an uncertain proposition which could be expected to appear and act spontaneously, but was based on an estimate of what emotions and feelings were to be activated and what degree of stimulation was needed to gain the desired object.

It is difficult to understand why such a personal and concrete thing as the attitude of the psychiatrist toward each of his patients had to be is so often described in such general terms. It was by far the most important feature of practically any form of treatment. Taking its cue chiefly from personality and intellectual capacity, it had to be rapidly defined in the mind of the physician so as to meet the needs of the individual under consideration. Further, frequently it had to be varied from time to time in the same case. It affected every phase of treatment, often dictating the mode in which specific symptoms were removed, modifying the explanation of the neurosis and governing the methods utilized in the final rehabilitation of the soldier before his return to the front.

The particular methods of treatment utilized may be roughly divided into those which were applied to all the patients, or to fairly large groups, and those which had an individual application. The former is largely dependent for its effect on the creation and maintenance of the right kind of military atmosphere, which seeks to produce and encourage a desire to return to the front. In this respect the following observations may be of interest: A certain type of soldier, often of a moderately high intellectual grade, not infrequently presented a curious psychological paradox as the time for his return to the front approached. He had made a good symptomatic recovery, had a considerable degree of insight into the mechanism of his neurosis, may have expressed a wish to go back to his regiment, and yet found a marked difficulty in taking the final step. This was not due to the fact that he was distinctly unwilling to return to duty, for he would have been as much or even more troubled by a decision which would have evacuated him to the rear. Apparently, there was in these cases a temporary volitional paresis. This condition was observed in a small percentage of all the neuroses. Experiments along the lines of logical reasoning and appeal to the individual had little result, and it was decided to try the effect of another plan. When a sufficiently large group had been collected, they were gathered together in a tent and given an informal talk, which was little more than an effort to reach and sway the emotions. Beginning with a recital of the situation at the front with reference to the division, and particularly to the various units which were represented by the soldiers present, it emphasized the acute need for every available man, and the fact that comrades were suffering because of their absence, and finally came to a climax by a dramatic request for volunteers for immediate service. The result was always highly gratifying, and the spontaneous enthusiasm showed that these men were actuated by something more than mere deference to the wishes of an officer. In another group of patients who had made a fairly good symptomatic recovery, or who persistently retained a few insignificant symptoms, the question of volitionally withheld cooperation arose. Two courses were open. The power of the military machine might be invoked to force action, reducing the matter to a choice between front line duty or court-martial. Such a procedure was not employed. Its permanent value is not only questionable, but it is open to objections on ethical grounds. However, it had to be recognized that the problem was no longer strictly a medical one. Without using undue severity and with no trace of malice, such men soon found that an invisible barrier had

been erected between them and the other patients. They were denied certain privileges and had to do most of the distasteful work, such as policing the grounds, digging latrines, etc. No one was permitted to impugn their motives, yet on every side they were confronted by a questioning attitude. Always the opportunity was afforded, and was indirectly encouraged, to talk over the situation with one of the physicians; always there was the invitation and the temptation to change their status to a happier and more honorable one. About 90 per cent of this group were eventually reached by such a simple method.

For the attack on individual symptoms resort was had to various forms of suggestion which have been described in detail by various authors. Whenever there was a choice between two methods, the simpler was always preferred. Complicated procedures seemed unnecessary. Often nothing more elaborate than passive relaxation of flexion and tension plus appropriate suggestion was needed to remove tremors; indeed, many of them disappeared spontaneously. If a paralysis responded at all to passive movement which gradually became active by the imperceptible withdrawal of the assisting hands of the physician, electricity was not employed. If an hysterical deprivation could be reached by suggestive persuasion or argument, such "tricks" by means of the stethoscope, tongue depressor, mirror, etc., as were in vogue were avoided. There were, of course, times when a degree of mystification was necessary, but it was never the first resort and was usually reserved for more refractory symptoms. Hypnotism was never used. As a preliminary to the consideration of the individual symptoms, there was an estimate of how much of the symptom was real and how much was only apparent. A change of position to one making for greater physical comfort, the removal of constricting clothing or of an external source of irritation, a hot drink, and a reassuring word or two were sometimes in themselves sufficient to decrease materially the range of tremors, to improve an exaggerated posture or movement, or to reveal a seeming paralysis as only a paresis. The amount of amnesia, particularly, always appeared greater than it really was. Before any intensive attempt was made to treat it as a symptom its extent was carefully gauged. A simple and brief series of questions and answers often strikingly diminished its proportions. The selection of a route to gain access to any sign or symptom which presented in a patient was much influenced by the attitude which the psychiatrist had decided on as best suited to meet his needs as an individual.

When more refractory symptoms were to be dealt with, that which seemed the most obvious thing to do was attempted first. Strict segregation had a wholesome effect on obstinate tremors or convulsive movements. Every advantage was taken of possible modifications of classification. A patient with a persistent difficulty would be placed for a short time in the midst of a small group of recovered soldiers awaiting transportation to the front. Occasionally some one who had made a particularly striking recovery was kept for a few days as a sort of hospital "pet" for the sake of the effect on difficult cases. He was taken into the confidence of the psychiatrist and instructed as to what was expected of him. Now and then a "chronic" patient was made to observe the removal of some symptom in a recent case. Sometimes the physician planned to have his conversation and opinions overheard by this or that