The general treatment of the war neuroses, summed up, was the following: Rest when indicated, persuasion, suggestion, work, and psychological reeducation. In dealing with the cases fresh from the line, after one's experience with the older cases, it was most striking how much more suggestible the former were seen to be. Hysterical symptoms that might require hours of treatment in a base hospital could frequently be cleared up by suggestive therapy in a few minutes in a fresh case. It was the policy of the hospital not to transfer cases deemed unsuitable for immediate front-line service to Base Hospital No. 117 as long as gross objective, hysterical symptoms persisted. This suggestibility worked both ways, and unless the therapeutic side was pressed the symptoms tended to become rapidly fixed. But the advantage was with the physician.

Upsetting battle dreams were likewise easier to clear up in the fresh cases. These battle dreams were among the few symptoms that seemed to be as marked in the fresh neuroses as in those longer from the line, and they were the most common complaint. (They were frequent in fresh wounded cases as well.) Some patients would stay awake night after night to avoid them. Usually simply explaining the dream mechanism and urging the patient to ventilate and mentally assimilate his affect-charged battle experiences rather than "to keep them out of the mind" during waking hours was quite sufficient therapy; very rarely were hypnotics required.

One of the most valuable assets in the treatment of the neuroses was the creation of a ward atmosphere of cure. The patients were quite observant of one another, and a cured case which they had seen from the beginning was a most useful asset. Once the atmosphere of cure was created a part of the therapy became automatic. The ward atmosphere depended almost entirely on the ward surgeon, and it was most striking how quickly the efficiency of the doctor was reflected in the therapeutic results of his ward. Certain members of the staff had had the advantage of training at Base Hospital No. 117 under the stimulating influence of the medical director there.

In every soldier probably there was some degree of mental conflict between, on the one hand, the instinct of self-preservation and, on the other hand, the more socialized "carry-on" urge and desire for social esteem, with regard to front-line service. There were three possibilities: First, the "carry-on" driving force predominated, which was the condition of the normal soldier, and of not a few neurotic individuals. Secondly, if the "carry-on" force was weak or absent, a neurosis might not develop because the conflicting forces were too unequal and there was little tendency to symptom fixation. These were the fear cases, and certain of them were very honest individuals in their "I can't stand the gaff" attitude. Thirdly, when the two opposing forces were approximately evenly balanced, a soldier might perform his duties fairly well until some environmental factor, such as a shell explosion, upsetting emotional experience, fatigue, or minor trauma, disturbed that balance in favor of self-preservation, and a neuroses developed. The symptoms of the neurotic, while out of proportion to the more immediate upsetting event, were usually not out of harmony with it; for example, the relationship between a slight hip trauma and a subsequent functionally paralyzed leg; between a somewhat thin concussion experience and a headache and tremor, or, perhaps, deafness;

between an upsetting emotional experience and the development of an anxiety state, etc.

Undoubtedly many soldiers carried on after the same sort of experiences as sent most of the neurotics to hospitals. The cumulative effect of these upsetting experiences must have been large and in time might break men of good balance and make-up. A number of cases held on until their divisions were relieved from the line and then snapped when the sustaining power of action was removed.

Life itself being represented by a series of adjustments and compromises between the individual and his environment, the war neuroses furnished no exception. At one extreme was the pure concussion group, and allied to this were the cases in which trauma and exhaustion played the most prominent part; at the other extreme were the fear cases, in which the personal element predominated. Between these extremes fell the bulk of the neuroses, the environmental and personal factors participating in varying proportions, seizing and fixing on the most available experience, as shell explosion, fatigue, trauma, upsetting emotional event (killed comrades, etc.).

Neurotic symptoms were quite natural after many of these experiences, and consciousness probably played a very minor part, if any, in their incipiency. But into the maintenance of the neuroses, the conscious factor entered to a greater extent. Any doubt as to this was removed by the decidedly ameliorating effect of the armistice on the majority of the cases. The fear-group cases were largely conscious of the difficulty all the way through, but these were not cases of malingering, because there was no conscious simulation. There may have been a degree of malingering in some of the neuroses, but pure malingering undoubtedly was rare.

In civilian cases of neuroses, along with changing the patient's attitude toward himself, it is nearly always possible to modify the environment in which the neurosis arose. The problem of the war neuroses was simpler and more difficult—simpler to the extent that the conflicting forces were less obscure, and more difficult in that the aim of treatment was to enable the patient to be sent back to the same precipitating environment, i. e., the front line. The soldier's neurosis was his reaction and adjustment to an unbearable situation, and it had a double-barrelled potency: To get him out of the situation and keep him out of it. This last factor probably accounted for the tendency later to symptom fixation, and this was the more immediate therapeutic problem. A simple mechanistic explanation of the neuroses was helpful to the patient. But more valuable from a therapeutic standpoint was the effect of a definite attitude on the part of the ward surgeon that the goal of treatment of the war neuroses was return to duty.

There were three avenues for the disposal of patients from the army neurological hospital: Return to duty; transfer to Base Hospital No. 117, the special base hospital for the neuroses; and transfer of the medical, mental, and surgical cases to other hospitals where more appropriate care and supervision could be given them.

The primary function of the hospital was to return as many cases as possible to duty with their divisions, and in as short a time as possible. The average

duty case was in condition to go back within 10 days, although there were exceptions. It is impossible to estimate from the length of stay in the hospital the time required for recovery because most of the recovered cases would have to wait over in the hospital, sometimes for several weeks, until a particular division could be reached. The hospital received most of its cases from the north and east of Verdun, and the delay in return to duty was more marked when the divisions moved from sector to sector. Just before the armistice was signed, arrangements were made to return the duty cases to corps replacement camps rather than to their divisions, and this facilitated matters greatly.

The question of return to duty was complicated by the possibility of relapse. On the 532 cases returned to duty, 15 cases were known to have come back to the hospital with relapses; none of them lasted more than one day under fire. Soon after the opening of the hospital 22 cases were returned to duty in one group and within 24 hours 11 of them (included in the above 15) were sent back with an assortment of hysterical symptoms. They had spent the night in a village that was heavily shelled. This experience made one more cautious in the selection of line-duty cases. When a division was in a large area and participation in heavy fighting followed recoveries were more durable.

The relapses were all cases of hysteria and hyperemotivity (fear), and these were the two groups that presented the main problem in selection for duty. With the exception of certain of the concussion cases, there was in the general attitude of the patients in the hospital a distinct absence of any keenness of desire to return to front-line service. The question before the hospital staff with nearly half of the hysteria and fear cases was: Which is wiser from the standpoint of army efficiency, to send these men back to the front line on the chance that they will carry on or to send them to Base Hospital No. 117 to be reclassified as labor troops? One's first impulse was to carry out the former alternative, especially if one were dealing with a plain case of fear. There was another point of view to consider, however, and that was the line officer's. Even if the hysterical and fear cases were not contagious in the front line, the chances were that they would not be individually dependable. There were exceptions, of course. Furthermore, at a time when every available bit of transportation was needed for wounded men, a seat in an ambulance for a relapsed nervous case seemed rather superfluous.

Before troops went into the front line for the first time it was a hazardous proposition to predict which individuals would develop "shell shock." Men who had been visibly "on edge" often carried on well, and vice versa. The front line itself was the only test. There was a history of neuropathic make-up or neuropathic stock in about 40 per cent of the cases of war neuroses admitted. In 100 case records selected at random the family history was positive in 38 and the personal history in 40. Much depends on the criterion for the term neuropathic. This 40 per cent included the cases with any definite history of nervous or mental anomalies whatever in stock or make-up. Certain of the ward surgeons went into this question carefully, others more casually; so the 40 per cent is only an approximation.

The average American soldier's attitude toward "shell shock" had a large proportion of tolerance and curiosity in it. An attempt was made to abolish

the term. Although this could be done in official communications, it was manifestly impossible in ordinary speech. Much more profitable was the dissemination of information among the troops as to just what "shell shock" meant. The divisional variation in the number of such cases was very striking—it occurred in inverse ratio to the morale. Among the patients themselves there were two main attitudes. The first was to this effect: "You're a long time getting it; but once you get it, it's got you"; and the second: "It's easy to get and easy to get over." The majority of them agreed on one point—they were unfitted for future front-line service. This attitude was one of the main problems to combat in the neuropsychiatric hospitals.