A STUDY OF HYSTERIA, BASED MAINLY ON CLINICAL MATERIAL OBSERVED IN THE U. S. ARMY HOSPITAL FOR WAR NEUROSES AT PLATTSBURG BARRACKS, N. Y.

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INTRODUCTORY REMARKS

It has been repeatedly observed that the apparent incidence of nervous and mental disorders in armies in times of peace is higher than in civil populations. The causes which combine to produce this general result are probably many and varied. To a certain extent, however, this statistical showing is to be ascribed not indeed to higher incidence, but to the fact that the exactions of military life bring to light constitutional weaknesses which, under other conditions, pass unobserved.

In times of war the apparent incidence is further and enormously increased, especially through the development of psychoneuroses; and thus the world war of 1914-1918 furnished experiences which brought into great relief certain neuropsychiatric problems.

War neuroses have their counterparts in peace times and in civilian life—particularly in the so-called traumatic neuroses and in hysteria. The war, however, created an unprecedented opportunity of observing such cases in large numbers and under conditions forcing into view their underlying psychic mechanisms.

The main object of this paper is to report in condensed and convenient form some of the material observed in the U. S. Army Hospital for War Neuroses at Plattsburg Barracks, N. Y., together with an analysis of it in the light, not only of my own experience, but also of published experience of others, and of pre-war conceptions of psychoneuroses.

PURELY FUNCTIONAL AND MENTAL NATURE OF HYSTERIA

My experience has led but to a full confirmation of the long prevailing view of physicians that *hysteria is purely functional in its nature*. Hysterical manifestations not infrequently fasten themselves to a wound or a scar; often they are attributed by the patients to such physical factors as shell shock without wound, or to being buried in débris, becoming exhausted from continuous marching with heavy equipment, etc. An analysis of the cases, however, readily reveals the fact that *the mechanisms underlying hysterical symptoms are purely mental* and that the physical factors apparently involved operate not as such but through their psychic accompaniments, such as fright, disgust, rebellious feeling, suggestion, etc.

A striking instance of hysterical symptoms arising through suggestion originating in a trivial wound or scar is that in the case of B., Co. C., 23d Inf., who was admitted by transfer from Base Hospital No. 8, Savenay, France, on Oct. 15, 1918. He had a flat circular scar, about the size of a five-cent piece, on the outer side of the right leg. This scar marked the site of a superficial shrapnel wound sustained on the Verdun front on March 18, 1918. The fragment penetrated only the clothing and lodged in the soft tissues of the leg so superficially that another soldier was able to pry it out with the point of his penknife; iodine and bandage from a first-aid packet were applied and the patient sought no treatment by a medical officer. In about three weeks the wound healed completely. A few days later he developed "shell shock" with paralysis of both legs which eventually left a limping gait due to weakness of the right leg and an area of hypoaesthesia most marked around the scar but in a lesser degree extending from the knee to within an inch of the ankle on the outer one-third of the circumference of the leg. Shortly after the armistice the patient recovered and on Dec. 12, 1918, he was returned to duty.

The view that the mechanisms underlying hysterical symptoms are purely mental is held almost unanimously by those of experience.

Möbius,¹ M. Lewandowsky² and Imboden³ may be cited as random examples.

1. Jelliffe, S. E.: Hysteria, in *Modern Medicine*, edited by Osler and McCrae, Philadelphia, P. Blakiston's Son & Co. 5:655.

2. Lewandowsky, M.: Erfahrungen über Behandlung nervenverletzter und nervenkranker Soldaten, *Deutsch. med. Wchnschr.*, Dec. 30, 1915.

3. Imboden, K.: Das Neurosenproblem im Lichte der Kriegsneurologie, *Cor.-Bl. f. Schweiz. Aerzte* 47:1098 (Aug. 25) 1917; abstr., *J. A. M. A.* 69: 1305 (Oct. 13) 1917.

Although there is almost complete unanimity on the point of hysteria being a purely mental disorder, there is considerable divergence of views as to its exact nature and as to the mechanisms underlying its manifestations. Most of the current conceptions were formulated prior to the war. A brief restatement may be permitted.

Charcot's conception was that of a disease entity. This conception led to a preoccupation with symptomatology, differential diagnosis, clinical definition, and largely remained on a descriptive level.

Möbius saw in hysteria not a disease entity but a biologic trait characterized by a special type of reaction. "For him every one was more or less hysterical. Every one has hysterical small coin in the bank of his personality."⁴

Janet's contribution consists essentially in the theory of subconscious mental processes. An idea or a group of ideas may operate somewhere beneath the threshold of consciousness. For him "Hysteria is a form of mental depression, characterized by the retraction of the field of personal consciousness and by a tendency to the disassociation and the emancipation of systems of ideas and of functions which by their synthesis constitute the personality."⁵

Further progress in the analysis of hysterical mechanisms is due to Freud.⁶ He attempts an explanation of the phenomenon of splitting or doubling of personality to which Janet has called attention. Ideas or complexes of ideas are lodged in the region of the subconscious not at random but by a purposeful functional process, which he terms *repression*, by reason of being charged with painful affect. The important part played by affect in the etiology of hysteria had, of course, long been sensed and had been insisted on in particular by Binswanger. Freud's experience has led him, moreover, to assume the universality of a *sexual origin* of the repressed complexes underlying hysterical manifestations.

The final principle of the Breuer-Freud hypothesis is the principle of *conversion*. The strangulated affect, the unreacted-to emotion, belonging to the disassociated state which has been repressed, finds its way into bodily innervation, thus producing the motor phenomena of hysteria. In this way the strong idea is weakened by being robbed of its affect—the real object of conversion.⁷

4. Jelliffe, S. E.: Hysteria, p. 656.

5. Quoted by S. E. Jelliffe (Footnote 1).

6. Freud, S.: Selected Papers on Hysteria and Other Psychoneuroses, English translation by A. A. Brill, New York, Nerv. and Ment. Dis. Pub. Co.

7. White, W. A.: Current Conceptions of Hysteria, Interstate M. J. January, 1910.

There remains to be mentioned the contribution of Babinski,⁸ which has largely dominated the French schools not only in pre-war years but even through the war, having apparently survived the light of the great mass of newly added experiences.

The essence of Babinski's contribution consists in an attempt to isolate from the heterogeneous mass of material traditionally thrown together under the heading of hysteria the elements of which it is composed. An application of more careful diagnostic technic has enabled him to eliminate organic cases, emotional disorders and reflex disorders, leaving behind a more restricted hysteria to which he has applied the newly-coined term *pithiatism*. For him *hysteria, in this restricted sense, consists in manifestations which are brought into existence by the influence of suggestion and the cure of which takes place by persuasion*.

Perhaps the most significant point insisted on by Babinski is the necessity for distinguishing true hysteria from simulation, especially where the latter manifests itself in characteristically hysterical phenomena—paralyses, contractures, anesthesia, etc. The result of treatment by persuasion here becomes the basis of the differentiation: If persuasion fails to cure, the case is not hysteria but simulation.

The question may properly be raised, *How do the facts, which have been observed in the course of our experience, square with current pre-war theories?*

A study of the Plattsburg material seems to indicate the following:

1. Hysterical phenomena are a special group of manifestations arising on a basis of neuropathic constitution.
2. Neuropathic heredity is probably the essential factor in the etiology.
3. The frequent occurrence of dissimilar heredity and, in the patients themselves, of neuropathic traits not specifically hysterical, points to a relationship of some sort between hysteria and other manifestations of neuropathic constitution.
4. The hysterical tendency varies widely in degree and shades off toward normal constitution by gradual transition. Thus, in some cases the tendency becomes manifest in childhood and continues to be so through life under ordinary conditions, while in other cases it remains latent until brought to light by some extraordinary condition on removal of which it lapses again into latency.

In other words, this material leads away from Charcot's conception of hysteria as a disease entity and rather toward that of Möbius,

8. Babinski: *Démembrement de l'hystérie traditionnelle. Pithiatisme*, Semaine méd., Jan. 6, 1909; Babinski and Froment: *Hystérie, pithiatisme et troubles reflexes*, Collection Horizon, Paris, 1916.

which regards clinical hysteria merely as exaggerated manifestation of a common biologic trait. These views are based mainly on data which have been summarized in Tables 1-6.

ANALYSIS OF TWO SELECTED GROUPS OF CASES OF HYSTERIA

These data arise from two selected groups of cases of hysteria. Group 1 consists of fifty patients in whom hysteria existed prior to enlistment and was not incurred in line of duty; patients disposed of by discharge on certificate of disability. Group 2 consists of fifty patients in whom no evidence of the existence of hysterical manifestations prior to enlistment could be obtained; in these patients the condition was, therefore, considered in line of duty; all of them eventually recovered and returned to duty. Naturally, the more pronounced cases are those of Group 1.

Table 1 shows neuropathic heredity in a high percentage of cases in both groups, but in a higher percentage in Group 1 than in Group 2.

TABLE 1.—NEUROPATHIC HEREDITY

	Group 1, per Cent.	Group 2, per Cent.
Family history positive for neuropathic heredity.....	76	52
Family history negative for neuropathic heredity.....	24	46
Family history unascertained.....	—	2

Table 2 shows in detail the various neuropathic conditions recorded in the family histories of hysteria patients. It demonstrates the fact of dissimilar heredity and the greater prevalence of the various neuropathic conditions represented therein in the families of patients in Group 1 than in those of Group 2.

TABLE 2.—NEUROPATHIC CONDITIONS IN FAMILY HISTORIES
OF HYSTERIA PATIENTS

	Number of Cases	
	Group 1	Group 2
Epilepsy	14	5
Fainting spells	11	2
Sick headaches	8	6
Insanity	10	6
Feeble-mindedness	—	1
Alcoholism	7	10
Criminalism, eccentricities, temperamental anomalies.....	15	6
Other nervous diseases (nervousness, breakdown, etc.).....	42	36
Total.....	107	72

Table 3 shows social maladjustments prior to enlistment. These consist in poor progress in school, poor showing in work (frequent aimless changes of occupation, low earnings, long periods of idleness,

etc.), intemperance, criminalism, domestic maladjustments, etc. The table shows that the percentage of social maladjustment is much higher in Group 1 than in Group 2.

TABLE 3.—SOCIAL MALADJUSTMENTS PRIOR TO ENLISTMENT

	Group 1, per Cent.	Group 2, per Cent.
History positive as to social maladjustment.....	62	40
History negative as to social maladjustment.....	38	56
History unascertained	—	4

Table 4 shows in detail the various items of social maladjustment, giving, for the two groups respectively, the number of instances of each item. There are more items of maladjustment than cases of maladjustment, in both groups, as in many cases there is a record of more than one item. But it should be noted that the excess of items of maladjustment in Group 1 as compared with Group 2 is out of proportion to the excess of cases of maladjustment. We find, indeed, that while cases of maladjustment in Group 1 as compared with Group 2 are in the proportion of 155:100, items of maladjustment are as 227:100.

A further analysis of the data shows that 86 per cent. of the cases in Group 1 and 68 per cent. of those in Group 2 present either neuro-pathic heredity, or a history of social maladjustment, or both.

In other words, the data indicate that Group 1 is characterized not only by a greater percentage of cases of defective constitutional make-up, but also that the defectiveness is of a graver sort in the average cases in that group: it becomes manifest at an earlier age and is more persistent and more general.

TABLE 4.—ITEMS OF SOCIAL MALADJUSTMENT

	Number of Instances	
	Group 1	Group 2
Poor progress in school	24	9
Poor showing in work.....	13	2
Intemperance	8	9
Criminalism	4	2
Other maladjustments (domestic, etc.).....	10	4
Totals.....	59	26

Thus I find in these data an explanation for their maladjustment to the military régime and for variation in degree of such maladjustment. Turning now to the military record of these soldiers I find that the data afford a rough measure of such maladjustment, i. e., something more than a mere impression.

It will be seen from Table 5 that the great majority of the men in Group 1 did not enlist voluntarily but were drafted, while the opposite is true of the men in Group 2; also that a greater number of the men in Group 1 are known to have claimed exemption from the draft. It will be understood, of course, that in none of the cases had any claim for exemption been found valid by the draft boards.

TABLE 5.—MANNER OF ENTRANCE INTO MILITARY SERVICE

	Group 1	Group 2
Enlisted voluntarily	11	32
Drafted	39	17
Unascertained	—	1
Claimed exemption from draft.....	5	2
Did not claim exemption.....	19	37
Unascertained	26	11

The principal manifestation of hysteria is invalidism of one sort or another without organic basis. However, all the cases in the two groups under consideration were ambulant cases. Though presenting, perhaps, a limping gait, a tic, a tremor, a contracture, a paralyzed arm, aphonia, a stooped-over position, or, on occasion, fainting spells or even violent convulsions, the symptoms were disabling only as regards drilling, hiking or duty of any kind, but not as regards taking a leisurely constitutional, attending an entertainment, visiting lady friends in town, being absent without leave or eating three meals a day.

In the light of these considerations, the amount of time spent in a hospital by an hysterical patient acquires a special significance as throwing a side light on the degree of constitutional defect present in a given case.

In Table 6 the cases of both groups have been divided according to the fraction of time spent in hospitals since entering the army. It will be seen that the men in both groups spent a strikingly large part of the time in hospitals, but that those in Group 1 did so to a far greater extent than those in Group 2. The majority of the men in Group 1 rendered little or no service in the emergency, proving themselves instead but an added burden and expense to the government.

TABLE 6.—FRACTION OF TIME SPENT IN HOSPITALS SINCE ENTERING MILITARY SERVICE

	Number of Cases	
	Group 1	Group 2
Less than two-fifths.....	9	25
From two-fifths to three-fifths.....	16	13
From three-fifths to four-fifths.....	13	8
Over four-fifths	12	3
Unascertained	—	1

The data exhibited in Tables 5 and 6 afford some hint as to the motives which actuate hysterical conduct; a discussion of these motives follows later.

As further evidence of the constitutional defect underlying hysteria may be mentioned its very frequent association with other constitutional disorders, such as constitutional psychopathic states, epilepsy, alcoholism, and especially mental deficiency. As regards the latter condition alone, our psychologic department reported the results of intelligence tests as indicating that no less than 31 per cent. of the patients with hysteria were under 10 years in mental age.

ETIOLOGIC MECHANISM OF HYSTERIA

The constitutional basis of hysteria being granted, the question still remains, What are the immediate factors at work in the etiologic mechanism; or, more specifically, In what way are disabling manifestations produced and maintained?

The patients themselves, especially the more feeble-minded and ignorant among them, are apt to attribute their disabilities to trivial and inadequate causes. Good examples are:

Tonsillectomy producing aphonia; malaria producing aphonia; a cold producing aphonia; measles producing aphonia; herniotomy producing a limping gait; astasia-abasia caused by a 2-mile hike; "shell-shock" producing paralysis of both legs; stooped-over position, so-called *campocormia*, produced by a slight blow on the groin and later aggravated by an operation for varicocele; typhoid and paratyphoid protective inoculation causing hemiplegia and hemianesthesia; sudden monoplegia with anesthesia affecting one arm, produced by "a stroke" without known cause; violent convulsions produced by attempt to obtain blood for Wassermann reaction test from vein in arm.

It is obvious that these alleged causes hardly deserve consideration; they are, at most, occasions out of which have arisen suggestions in part determining the particular symptomatology, rather than true causes. The causes assigned by medical officers are, as a rule, of a different order. In the early months of the war physical and psychic factors were mentioned more or less indiscriminately:

Cases of nervous and mental shock were found to be due sometimes to the bursting of heavy shell near the man, to his burial under earth and debris, or to the effects of noxious gases; in other cases to nervous exhaustion due to sleeplessness, fear, anxiety or other prolonged strain.⁹

The symptoms are always referable to the strain of active service. Sniping is important, the ghastly sights of carnage are still more responsible, but the intensest strain is high explosive shell fire.¹⁰

9. Turner, W. A.: Cases of Nervous and Mental Shock Observed in the Base Hospitals in France, *Brit. M. J.*, May 15, 1915.

10. Forsyth, D.: Functional Nerve Disease and the Shock of Battle, *Lancet*, Dec. 25, 1915.

Campbell names three etiologic factors in these neuroses—the noise of the exploding shells, the violent atmospheric concussion, and the fear caused by the terrifying war conditions.¹¹

Myers divides mutism into two groups according to causes—physical and psychic. His impression is that the two groups occur with equal frequency.¹²

Gradually, as the distinction became clear between true cerebral concussion and psychoneuroses, the view gained ground that physical factors, as such, played no part in the etiology of psychoneuroses.

Bonhöffer noted that many symptoms of war neuroses were such as fright itself may directly induce. Karplus found that while physical traumata were often present, they were also at times absent.¹³

The explosion has not only physical effects, but also a psychic one, which consists in an emotional shock. In certain cases this *emotional shock* dominates the situation to the point of being alone responsible for the neuro-psychic symptoms which a hasty and superficial consideration at first placed in relation to cerebral concussion; and it is because both give rise to an emotional shock that the explosion of a shell and a terrifying sight find expression in the same syndrome.¹⁴

ACUTE EMOTIONAL DISORDERS TO BE DISTINGUISHED FROM HYSTERIA

In studying the etiology of war neuroses it would seem important to distinguish the acute emotional disorders observed at the front from hysteria. This distinction has been, perhaps, most clearly drawn by Léry who had opportunities of seeing cases at the front, in field hospitals and in neuropsychiatric centers in the interior. According to this author, it is a mistake to think that hysterical manifestations are an integral and necessary part of the emotional syndrome. They can appear independently of all emotion; and the emotional syndrome has nothing in common with hysteria.

It seems that the psychic factors to which war neuroses in general are attributed—fright caused by danger from projectiles, horrifying sights, etc.—play a part only in the acute emotional syndrome; hysterical phenomena are not directly produced by them. On this point there is unanimous agreement among those who have had opportunities of observing cases at the front.

It is a remarkable fact that hysterical manifestations never appear except when a patient is in a place of security: in a trench, a dugout, a first-aid sta-

11. Campbell, H.: War Neuroses, Practitioner, London, May, 1916.

12. Myers, C. S.: Contributions to the Study of Shell Shock (IV), Lancet, Sept. 9, 1916.

13. Birnbaum, K.: Kriegsneurosen und -psychosen auf Grund der gegenwärtigen Kriegsbeobachtungen; erste Zusammenstellung vom Kriegsbeginn bis Mitte März, 1915, Ztschr. f. d. gesamte Neurologie u. Psychiatrie, 1915; reviewed by August Hoch in New York State Hosp. Bull. 8:287, 1915.

14. Rogues de Fursac, J.: Traumatic and Emotional Psychoses; So-Called Shell Shock, Transl. by A. J. Rosanoff, Am. J. Insan. 75:19 (July) 1918.

tion. Moreover, they disappear, as by magic, either when security is diminished, as by the dugout being shelled, or when the ambulance is in sight for the evacuation of the wounded. Often they appear during the period of artillery action in preparation for an attack; but never has an hysterical convulsion or paralysis been seen in the open, on the battlefield, under exposure to a barrage—a fact which seems to us of major interest for the understanding of the pathogenesis of hysterical disorders.¹⁵

Psychoneurotic affections need not follow directly on the causative emotional disturbance, but an incubation period of varying length may intervene. In the firing line psychoneuroses are rare. But once he is out of danger, the psychopath, no longer dominated by instinct, is a prey to any abnormal mental and neurotic states that conditions or events, present or previous, may arouse in him. These manifest themselves in contractures, paralyzes, tremors, convulsive fits, etc.¹⁶

Those disorders which develop at the front and are the direct expression of violent emotion are never of long duration; they last scarcely more than a day or two; the intensity of their manifestations subsides rapidly and almost all patients can be returned to the front within a few days. Many, it is true, have to be kept in the field hospital as long as a week or ten days, but this is generally due not to persistence of the emotional disorder proper, but to the physical exhaustion from overexposure, overexertion, lack of sleep, lack of food, etc., which usually accompanies it.

Capt. William Brown reports that of 200 nervous and mental cases which passed through his hands in December, 1916, 34 per cent. were evacuated to the base after seven days' treatment, and 66 per cent. returned to duty on the firing line after the same average period of treatment.¹⁷

The immense majority of cases of emotional disorder return to the front, cured, without ever reaching the zone of the interior.¹⁸

The recovery in cases of uncomplicated emotional disorder is usually complete. Of course a tendency toward recurrency remains. In some cases it can be demonstrated, according to some observers, that a heightened emotional susceptibility has been produced.

To becoming accustomed to emotions, which fortunately is the rule, there is opposed a certain "anaphylaxis" toward emotions; but in the genesis of such anaphylaxis, it should be stated, one is obliged to go back to a certain degree of predisposition which is more or less constitutional.¹⁹

15. Léry, A.: *Commotions et émotions de Guerre*, Paris, 1918; reviewed by A. J. Rosanoff in *Arch. Neurol. & Psychiat.* **1**:273 (Jan.) 1919.

16. Molinari, G.: *Nosografia delle psiconeurosi di guerra*, *Riforma med.*, Naples **33**:898 (Sept. 15) 1917.

17. Salmon, T. W.: *The Care and Treatment of Mental Diseases and War Neuroses ("Shell Shock") in the British Army*, New York, The National Committee for Mental Hygiene, 1917.

18. Léry, A.: *Commotions et émotions de Guerre*, Paris, 1918; reviewed in *Arch. Neurol. & Psychiat.* **1**:273 (Jan.) 1919.

19. Léry, A.: *Commotions et Emotions de Guerre*, Paris, 1918.

The psychoneurotic symptoms which persist and which force the evacuation of cases to the rear (save possibly those seen in the rare cases of "emotional anaphylaxis"), and more particularly hysterical symptoms, are, thus, evidently to be regarded not as direct products of emotional shock but as arising, after the lapse of a greater or lesser interval of time, by a different psychic mechanism.

ILLICIT MOTIVE AS FACTOR IN ETIOLOGY

I come now to the consideration of a factor which, though seldom frankly avowed by patients and seldom definitely established by clinical investigation in individual cases of hysteria, yet has made itself clearly apparent to many observers in all armies. Speaking for myself and with special reference to my experience in this hospital, I would say that this factor has obtruded itself on my attention until I have come to regard it as the mainspring of hysterical conduct.

This factor consists in a *concealed, illicit, morally untenable motive*.

The motive is not always the same, but it is always characterized by the above mentioned qualities. Its most frequent variations are:

1. To evade the law of conscription.
2. To procure, on reporting for physical examination at a training camp, rejection for physical unfitness.
3. To evade dangerous, disagreeable or difficult duty, or to evade all duty.
4. To procure the ease and privileges of hospital care.
5. To procure discharge on certificate of disability.
6. To procure compensation for disability.

As stated above, not I alone, but also other observers, in all armies, have been impressed with this factor in the mental mechanism of hysteria and have more or less clearly formulated their impression.

The psychological basis of the war neuroses (like that of the neuroses in civil life) is an elaboration, with endless variations, of one central theme: escape from an intolerable situation in real life to one made tolerable by the neurosis.²⁰

As long as war is in progress and return to the front is imminent the patient prefers (unconsciously at least) to retain his disability rather than to face the perils and discomforts of trench life.²¹

Speaking in particular of refractory hysterical phenomena, Léri says: "In all cases they originate not in emotion, but in reflection, when emotion no longer exists; they originate in the idea of retirement on pension with its double benefit of further removal from danger and pecuniary indemnity."²²

20. Salmon, T. W.: *The Care and Treatment of Mental Diseases and War Neuroses ("Shell Shock") in the British Army*, New York, The National Committee for Mental Hygiene, 1917.

21. MacCurdy, J. T.: *War Neuroses*, *Psychiat. Bull.*, July, 1917.

22. Léri, A.: *Commotions et émotions de Guerre*, Paris, 1918.

The "wish" is certainly a strong etiologic factor in these functional conditions. This is shown by the fact that, with injuries which *a priori* render a soldier unfit for further active service, they are very rarely found.²³

The motivation of psychogenic neuroses consists of a subconscious wish to escape the events which produced them—a "recourse to neurosis," at least in so far as the picture is dominated by hysteria and whenever there has been an internal conflict. In fright neuroses there is no such motivation.²⁴

Henneberg does not expect much from psychotherapy for soldiers who have been at the front. The men have no wish to recover and be sent back.²⁵

In the individual case direct evidence of illicit motive is seldom available. This, however, is in the nature of things and is not surprising. Yet not infrequently patients make unguarded remarks which amount almost to a confession. These are some examples:

1. A soldier was asked, How old were you when you were drafted? "I was within ten days of being 32 years of age. They beat me to it by ten days." (H., Hqs. Co., Classification Camp, A. E. F., France.)

2. Q. If you were as much disabled when you were drafted as you are now, why did you not claim exemption? A. "It was no use. Our local board took in everybody regardless. You'd have to be dead to get exemption." (P., 51 Co., 159 Depot Brigade, Camp Taylor, Ky.)

3. A soldier had a violent hysterical convulsion on the veranda in front of the window of the office of the senior member of the disability board. After about twenty minutes of violent commotion, he arose and came, weeping, into the office: "Oh, Major, did you see me have that spell?" Yes, I did. "Oh, Major, don't give me an S. C. D." (Surgeon's certificate of disability for discharge). I am afraid I shall have to. "Very well, sir, it's up to you; you are the head of the board." (F., 2 Tank Co., A. E. F., France.)

4. One soldier simply declared, "I am a case of constitutional inferiority; a good many doctors said that; the local board had no business to draft me into the army; it is the duty of the medical officers to rectify the mistake; it is their duty to discharge me." (M., 50 Co., 159 Depot Brigade, Camp Taylor, Ky.)

The avowed intention was almost always to serve the country and even die for it; but "Captain ——— in Base Hospital ——— told me I was not fit for the army. If I am not fit for duty, then why don't you give me my discharge?" This argument, in one form or another, was very common among those whose motive it was to secure discharge on certificate of disability.

That illicit motive, and it alone, and not shell concussion, war strain, emotional shock, etc., is the factor which actuates hysterical conduct is further shown by three groups of observations.

23. Lewandowsky, M.: Erfahrungen über Behandlung nervenverletzter und nervenkranker Soldaten, Deutsch. med. Wchnschr., Dec. 30, 1915.

24. Saaler, B.: Ueber nervöse und psychische Krankheiten in ihren Beziehungen zum Kriegsdienst, Berl. klin. Wchnschr., Dec. 25, 1916.

25. Zeehandelaar, I.: Nederl. Tijdschr. v. Geneesk. 2:41 (July 1) 1916; abstr., J. A. M. A. 67:890 (Sept. 16) 1916.

In the first place are to be mentioned the cases of hysteria arising in training camps in this country. In every National Army cantonment many cases came to light often on the day of reporting for military duty, more often early in the course of training—at any rate before any “war strain” could possibly have made itself felt. These cases presented all the manifestations of hysteria which, when seen in overseas cases, have so often been attributed to “shell shock.”

In the second place is the striking fact that among prisoners of war who have been, like other soldiers, exposed to shell fire, strain, etc., scarcely any cases of hysteria or other psychoneuroses have been observed.

Mörchen found only five cases of war neuroses among the 40,000 war prisoners at the Darmstadt prisoners' camp. There is every reason to assume that they had been subjected to the same kind of mechanical and emotional stress as the German soldiers, among whom hysteric nervous disturbances were so common. Lust,²⁶ reviewing 20,000 war prisoners, found the war neuroses rare among both military and civilian persons.

Victims of war neuroses usually are not taken from among the wounded, contrary to Oppenheim's statement. They seldom occur among prisoners even when they have been shocked severely. Prisoners are actuated by one great desire; to remain well so that when they are exchanged they may return home in good health.²⁷

In the third place is the very common experience of quick and complete recovery from hysterical symptoms on evacuation to a base hospital, followed by a return of the symptoms in the same or even a greater degree of intensity or by development of new symptoms on any prospect arising of again being sent to duty. Many of the overseas patients have furnished such a history. The relapse has generally occurred either on the way from the hospital to a reclassification camp or shortly after arrival there. Sometimes no cause is given for the relapse; at other times a trivial cause.

1. “The very day I came to the replacement camp from the nerve hospital, I was made so nervous by the men shouting and knocking their mess kits against the wall that I could not speak my name and shook all over.” (B., Co. C, 23 Inf.)

2. “I was sent from Base Hospital No. 34 to the replacement camp and on the following day assigned to duty. That evening as I stood on a barrel looking in through the window at a Y. M. C. A. entertainment, a gasoline engine a short distance away made a sharp noise. This frightened me greatly; I began to shake violently and got off the barrel on which I was standing.” He was ordered to remain in quarters by a medical officer; the following day he was no better and remained in bed; on the day after, still being no better,

26. Lust, F.: *Kriegsneurosen und -gefangene*, München. med. Wchnschr. **63**:1829 (Dec. 26) 1916; abstr., J. A. M. A. **68**:667 (Feb. 24) 1917.

27. Gaupp, R.: J. A. M. A. **68**:647 (Feb. 24) 1917.

he had to be readmitted in Camp Hospital No. 26. After two weeks in the hospital his nervousness continued and he was transferred to Base Hospital No. 8, thence to be returned to the United States (M., Co. C, 28 Inf.).

Others have recorded similar observations.

Severe types that exhibit well-marked symptoms after six months do not recover in the army. A considerable proportion of those who "recover" in hospital break down again at their depots or command depots.²⁸

In the case of very slight affections, to the casual observer the patients seemed well and ready for action. But the whole state of affairs was altered as soon as the physician suggested that they begin active service again. Reassuring suggestions, that had hitherto been very effective, were no longer of any avail. The patient leaves the hospital at once; at the railroad station acute symptoms appear; and, on arriving at his regiment, nothing remains to be done but return him to the hospital. In some patients, the acute symptoms reappear even before they start to rejoin their regiments. In all such cases, there seems to be the one predominating etiologic factor—fear and horror at the thought of returning to the front.²⁹

The extremely logical and extremely brutal method introduced by Kaufmann, consisting in strong electric shocks with loud staccato military commands to do certain exercises, has realized some surprising cures, but time has shown that relapses are liable to follow on the slightest provocation.³⁰

If it is true, as stated above, that the essential element of etiology in hysteria, aside from inborn predisposition, is the existence of a concealed, illicit, morally untenable motive, it is not difficult to explain why the war has produced so many cases: It created situations in which men's natures have suddenly come to be subjected to the acid test of demand for greater personal sacrifice. It was inevitable that natures deficient in physical stamina, courage and moral inspiration should become actuated by ignoble motives.

Although it has been said that special conditions of modern warfare are responsible for the great number of psychoneuroses and that in previous wars no such effects had been observed, the fact is that, under other names, in various forms, invalidism without organic basis undoubtedly existed in abundance in all wars.

It was early discovered that when men left the field for medical treatment, they were lost for the campaign, if not for the war. The aggregate absent from the two armies (on the Potomac and in Washington), which should have been united at Antietam, was 101,756. The total in action was but 87,164. Many of those absent by authority are those who have got off either sick or wounded, or under pretense of sickness or wounds, and having origi-

28. Ballard, E. F.: Some Notes on Battle Psychoneuroses, *J. Ment. Sc.*, July, 1917.

29. Gaupp, R.: *Hysterie und Kriegsdienst*, München med. Wchnschr., March 16, 1915.

30. Imboden, K.: Das Neurosenproblem im Lichte der Kriegsneurologie, *Cor.-Bl. f. schweiz. Aerzte* **47**:1098 (Aug. 25) 1917; abstr. *J. A. M. A.* **69**:1305 (Oct. 13) 1917.

nally pretext of authority are still reported absent by authority. (From General McClellan's letter to the President under date of July 15, 1862): "The reduced condition of the old regiments . . . points to the necessity of earnest endeavor to collect all the absent officers and men belonging to these organizations. I suggest that every hospital . . . be inspected within the month of October by, if necessary, scores of officers detailed for the purpose, to ferret out the old soldiers hidden away therein. Such an inspection would produce more fruit in one week than the recruiting service can in three months. And finally, I would suggest to the War Department . . . the arrest of deserters. Convalescent soldiers leave hospitals, and have done so for the past year, and return home habitually. It is the experience of every army commander that not more than a tenth of the soldiers who are left behind sick ever rejoin." (From General McClellan's letter to the President under date of Sept. 28, 1862): "Malingers soon become adepts in feigning all manner of diseases. By June, 1862, impositions became so frequent, that discharges for rheumatism had to be prohibited in orders. Any soldier who had once returned to his village, or his home, could at any moment procure his discharge, provided a physician "in good standing" would honestly or corruptly sign a certificate. The number of men discharged in 1862, by means of the combined agencies referred to, approximated 100,000 men. The immediate effect of those discharges was to reduce all the regiments in the field to mere skeletons; their permanent effect can be seen today in the system of pensions. The total amount paid in 1903 for pensions and the expense of maintenance during the fiscal year was \$141,752,870.50.³¹

The above abridged quotations, all of which pertain to the Union Army in the Civil War, show that what we now call war neuroses were not only present then but that they constituted an evil of even greater magnitude, relatively, than in the world war of 1914-1918.

PSYCHIC MECHANISMS UNDERLYING CURES

The point of view advanced here with reference to the mechanism of hysteria is borne out not only by the conditions under which the disabling symptoms arise, but also by the conditions under which they disappear.

The factors to which patients themselves attribute their cures are apt to be, like the causes they assign for their troubles, trivial and inadequate. The following are typical examples:

1. "I was cured by a miracle of the Lord." (D., 72d Co., 159 Depot Brigade, Camp Taylor, Ky. Case of hemiplegia and hemianesthesia.)

2. "Captain N. lifted up a little bone in my ear that had got out of place and from that moment I could hear as good as ever." (S., Hqs. Co. 39 Inf. Deafness was complete and bilateral; manipulation was limited to left ear.)

3. "Captain K. gave me electrical treatment, and after the second treatment I was all cured up." (N., Co. E, 155 Inf. Labored gait due to contractures at both knees in position of partial flexion.)

4. "Captain H. cured me in less than five minutes with hypnotism." (T., Co. I, 372 Inf. Case of tremor of head, trunk and upper and lower extremities,

31. Upton, Emory: *The Military Policy of the United States*, Ed. 4, Washington, D. C., 1917.

grotesque gait, high-pitched voice, explosive utterance, tendency to repeat each word or phrase in conversation three or four times rapidly.)

5. "I ate at first one half of an apple; on offering the other half to a patient friend, he refusing it, I said right out, surprising myself, 'I will eat it myself.' I think the apple and the massage did it; therefore I will eat apples forever, they being my lucky fruit." (W., Co. D, 310 Lab. Bn. Case of aphonia.)

6. "In the hospital in France I lay helpless in bed, unable to move or even sit up. The ward surgeon said I might never be able to get up and walk again. Then I prayed the most earnest prayer I ever prayed in my life. On the following day I got out of bed, just tumbled out; from then on grew gradually better; at first was able to crawl around on the floor, then walk about on crutches. Started for the United States on July 1. On board ship used two canes in walking instead of crutches. At the Embarkation Hospital in Newport News, Va., I no longer used crutches or canes and have used none since." (S., T-7, 23 Eng.)

Turning now to the attitude of medical officers regarding cures of hysterical manifestations, I find a striking general tendency to ignore mental mechanisms underlying pathogenesis and course. Only external aspects of hysteria as a rule receive consideration. The preoccupation seems to be with description of manifestations, charting of areas of anesthesia, differentiation from various organic affections, etc. The first object is generally diagnosis; when that is established no further investigation of mental mechanism is attempted. The next step is treatment—again without reference to the mental situation; and cures are attributed to this or that therapeutic method, every method having its advocates and opponents:

Work and interest in extraneous life are the best cure for such cases.³² In the way of treatment complete physical and mental rest are essential for both neurasthenia and shell shock.³³

Massage and electricity should be avoided in hysterical cases.³⁴ That this (faradic current) is an indirect method of suggestion no one can deny; but the important point is that the procedure is efficacious, uniformly efficacious, quickly efficacious. It need only be tried to demonstrate its almost infallible action.³⁵

The results of this treatment (chloroform anesthesia combined with suggestion) have been so satisfactory that I desire to give some account of the details of the same in this brief note.³⁶ The author disapproves of the use of an anesthetic for curing deaf-mutism.³⁷

32. Turner, W. A.: Cases of Nervous and Mental Shock Observed in the Base Hospitals in France, *Brit. M. J.*, May 15, 1915.

33. Hurst, A. F.: *Functional Nervous Disorders, Medical Diseases of the War*, London and New York, Longmans, Greene & Co., 1917.

34. Campbell, H.: *War Neuroses, Practitioner* 96:501 (May) 1916.

35. Chavigny, P.: *Psychiatrie aux armées; thérapeutique et médecine légale*, Paris méd., Jan. 1, 1916.

36. Milligan, E. T. C.: *Method of Treatment of Shell Shock*, *Brit. M. J.* 2:73 (July 15) 1916.

37. Russell, C. K.: *Study of Certain Psychogenetic Conditions among Soldiers*, *Canad. M. A. J.*, August, 1917.

The treatment par excellence is hypnotic suggestion.³⁸ Nonne calls attention to the advantages of hypnotic suggestion. Cures are frequent and rapid.³⁹ As to hypnotism, no more need be said than that its use is prohibited in military hospitals.⁴⁰ Psychic treatment without hypnosis is recommended.⁴¹ It is striking to note how frequently hypnosis is condemned as inadequate or actually deleterious.⁴²

If further treatment is required, psycho-analysis is necessary, and the problem now becomes an everyday neurosis, the incidents of the war merely being the most recent in a life-time of mental strains.⁴³ However helpful psycho-analysis may be in time of peace, in time of war such methods appear unnecessary and undesirable.⁴⁴

PARTICULAR METHOD OF THERAPY OF COMPARATIVELY LITTLE IMPORTANCE

I am able to report from my own experience that the particular method of therapy employed is a matter of comparatively little importance. The mechanism of cure readily reveals itself when studied in the light of the above discussed mechanism of etiology. One or more of the following factors are frequently seen to be operative in cures:

1. An attitude on the part of medical officers impressing patients in such a way as to preclude any hope of successful imposition.
2. Demonstration of the unreal nature of the disability.
3. Strict discipline as opposed to sympathy, doddling or humoring.
4. Painful or otherwise disagreeable features of treatment.
5. Removal of motive actuating the symptoms by change in situation.

These factors deserve somewhat detailed discussion. The first mentioned factor is all important for the prevention of hysterical manifestations and for their suppression in the earliest stages. The frequency of hysterical manifestations arising at the front has been observed to vary extremely according to the local atmosphere created by medical officers.

For instance, in the army in which we had the direction of the neurological center, we have had the satisfaction of seeing the number of "nervous seizures"

38. Eder, M. D.: *War Shock; the Psychoneuroses in War; Psychology and Treatment*, Philadelphia, P. Blakiston's Son & Co., 1917.

39. Berlin Letter, J. A. M. A. **66**:440 (Feb. 5) 1916.

40. Chavigny, P.: *Psychiatrie aux armées; thérapeutique et médecine légale*, Paris méd., Jan. 1, 1916.

41. Babinoﬀ, Y. K.: *Injuries to the Nervous System Caused by the War*, Russk. Vrach, Petrograd, 1915.

42. *Functional Psychic Disturbances in the Light of the War*, editorial, Med. Rec., Aug. 26, 1916.

43. Forsyth, D.: *Functional Nerve Disease and the Shock of Battle*, Lancet, Dec. 25, 1915.

44. *War and Psychoanalysis*, editorial, New York M. J., Dec. 23, 1916.

diminish from the time the rumor was spread—through soldiers who had returned to their organizations without permission—that with us “the seizures were not in good repute and were regarded rather with disfavor.” As to mutisms and deaf-mutisms, we have seen them arise in certain armies in the form of veritable little epidemics, whereas in others they were almost unknown.⁴⁵

As to the second factor—demonstration of the unreal nature of the disability—it is plainly operative in the cures of aphonia and mutism by means of general anesthesia and by the “ball method,” and in the cures of paralyses, especially of the lower extremities, by means of strong electrical stimulation. Patients dread being detected in the act of simulation and therefore yield to the “treatment” rather than allow it to appear too clearly that they are able to phonate, talk or move their limbs, and yet will not do so. Under the circumstances, to fall in with the purpose of the doctors and declare themselves cured becomes for the patients the best way out of an extremely awkward and even dangerous situation.

The administration of ether for the cure of functional deafness and functional loss of voice has always in our hands proved satisfactory. It is essential that the loss of consciousness be slight, and that the patient be suddenly roused so as to realize that he is speaking or hearing.⁴⁶

A number of interesting case histories are cited to show the use of the “ball method” for curing aphonia. This method consists in introducing a ball into the larynx to cause temporary suffocation and thus produce a reflex restoring functioning power to the adductors. The method should be applied as soon as the patient has recuperated from the shock that caused the aphonia. Usually one short sitting only is necessary. The author feels that some cases of this kind are led to prolong their trouble by the desire to get as much war indemnity as possible.⁴⁷

The principle involved in the cures of paralyses and anesthetics by electricity likewise consists in surprising or forcing the patient into betraying by an involuntary movement the functional integrity of both motion and sensation in the affected limb.

The third factor—strict discipline—is unanimously insisted on by all who have had cases of war hysteria to treat, although they have so widely disagreed on other points. This factor is related to the first and supplements it by impressing on patients not only the hopelessness of imposing deception on medical officers, but also the certainty of every attempt to derive advantage from being “sick” being promptly met by measures of discipline.

45. Léry, A.: *Commotions et émotions de Guerre*, Paris, 1918.

46. Bruce, A. N.: *The Treatment of Functional Blindness and Functional Loss of Voice*, *Rev. of Neurol. & Psychiat.*, May, 1916.

47. Muck, O.: *Weitere Heilungen von Stimmverlust im Kriege*, München. med. Wchnschr. **63**:1466 (Oct. 10) 1916.

The fourth factor—painful or otherwise disagreeable features of treatment—very often succeeds where other methods have failed. It would seem hardly necessary to go into discussion of the mental mechanism of this factor; obviously it works by directly combating the motive by which the symptoms are produced—that of securing relief from dangers and hardships—and by substituting a new motive and a more immediately urgent one—that of getting “cured” and thereby escaping the painful treatment.

F. Kaufmann⁴⁸ is the accredited author of a system of treatment which even some of his fellow countrymen have considered inhuman. . . . Kaufmann worked out a system of combined suggestion and painful electrical shock, aiming at a drastic cure in one sitting. The germ of this principle dated from 1903, when, as an assistant to Erb, he observed the beneficial effects of remorseless electrical treatment in a case of hysterical muscular contraction. His system includes the four following principal features:

1. Preliminary suggestion, consisting not only of the stock methods of suggestion, but also the “atmosphere” of a hospital in which successful cures are numerous.

2. Powerful electrical shocks supplemented by vigorous “word suggestion.” As a rule, the sinusoidal current of a pantostat was preferred to the faradic current. It was combined with the galvanic current when there were symptoms of hysterical anesthesia. Some idea of the patients’ sensations may be gathered from the term *Ueberrumpelung* (unexpected attack) used in the author’s description.

3. Maintenance of an atmosphere of strict military discipline.

4. Masterfulness and pertinacity were essential; it might take hours before the desired effect was obtained, but with perseverance and the exertion of the physician’s whole personality success was ultimately achieved. . . . After the ordeal the patient should be kept in hospital a few weeks to diminish chances of relapse.

Prof. Otto Schultze⁴⁹ admits that this system has been stigmatized as inhuman, but does not, he thinks, inflict pain very different from that of a woman in labor. At his hospital he found Kaufmann’s system vastly superior to others.⁵⁰

Similar success has been attained in the treatment of refractory cases of hysteria by some neurologists in France by a method of painful electric shock, so-called “*méthode du torpillage*” (Vincent, Rimbaud, Trenel).

Myers found that in many cases these sensory disorders clear up spontaneously. Sometimes he saw marked improvement during an examination (a hypalgesia and hypesthesia completely disappeared after several *deep* pricks which the patient felt).⁵¹

48. Kaufmann, F.: München. med. Wchnschr., May 30, 1916.

49. Schultze, O.: Münch. med. Wchnschr., 63:1349 (Sept. 19) 1916.

50. Disciplinary Treatment of Shell Shock (Notes from German and Austrian Journals), Brit. M. J., Dec. 23, 1916.

51. Myers, C. S.: Contributions to the Study of Shell Shock, Lancet, Feb. 13, 1915; Jan. 8, March 18, and Sept. 6, 1916; abstr., Psychiat. Bull., July, 1917.

Some patients recover from their symptoms when the surgeons decide to undertake an operation. Some recover on being "bullied," threatened with courtmartial (S., 4th Co., B. S., S. C.), etc. "A few recovered their speech spontaneously, and a few did so after being harshly reprimanded and isolated from other patients."⁵²

On the introduction of Wassermann tests as a routine procedure for all cases, many of our hysterical patients objected, and finally resorted to violent seizures in the laboratory. They created great disturbance, knocked the furniture about, broke glassware, and had to be held by several men. The situation was quickly controlled by the use of a whiff of ammonia "to revive" them. The patients claimed to have lost consciousness during the seizures; yet seizures have been seen to stop more than once when the chief of laboratory merely called out loudly, "Sergeant, bring the ammonia bottle!"

SPONTANEOUS CURES

Perhaps the most significant factor in the mechanism of cures is the one last mentioned in the enumeration—that of removal of motive actuating the symptoms by change in situation.

The patients which were sent to the Plattsburg hospital from overseas were for the most part those which had proved most refractory to treatment in hospital in France. Yet a great many of them had recovered spontaneously at the time they reached Plattsburg; and there was an outbreak of spontaneous cures following the signing of the armistice. Physicians who had succeeded in gaining a real insight into the mechanism of war hysteria had forseen this outcome long before it happened. The following was written in 1915:

There exists at the present time a factor by which the prognosis of emotional war psychoses is radically biased: it is the war itself. The prospect of returning to the front constitutes, for many of the emotionally unstable, an obstacle to recovery of such power that it is impossible to say if it alone might not suffice to keep up the neuro-psychic symptoms and to impart to the disease the appearance of chronicity which has been noted in some cases. The fate of these patients will not be settled until peace has been signed.⁵³

CIRCUMSTANCES CONTRIBUTING TO PREVALENCE OF HYSTERIA

That a desire to evade dangerous or difficult duty or all military duty should be prevalent in time of war is not surprising; but that it should so frequently lead to hysterical manifestations, i. e., invalidism without organic basis, requires some explanation.

52. Myers, C. S.: Contributions to the Study of Shell Shock.

53. Rogues de Fursac, J.: Traumatic and Emotional Psychoses. So-called Shell Shock, *Am. J. Insan.*, July, 1918. (English translation by A. J. Rosanoff.)

In this connection should be mentioned first of all the well-known gullibility of the medical profession. Draft evaders seem to know that they need but to complain of a disability to gain the support of duly authorized medical officers. While to laymen the scheme of these patients is often clearly apparent, the tendency of medical men is to overlook or ignore underlying motives and mental mechanisms and to allow themselves to be imposed on. Far-fetched theories are propounded even by leaders in the profession. The following examples will suffice:

Dr. Grasset suggests as an explanation of the psychology of deaf-mutism that these patients probably think that they have died, as the only thing which unites such a patient to existence is the preservation of his sensibility and sense of movement.⁵⁴

I believe this mutism is due primarily to an inhibitory functional paralysis of the voluntary cerebral nervous centers which control the management of the breath and direct its mode of escape through the glottis, mouth and nostrils.⁵⁵

The disturbance affects the highest cortical levels, the middle levels with the subconscious mechanisms for everyday activities, the motor centers in the cord with their issue in the final common path, and the muscles themselves, and often also the afferent paths and the receptive apparatus for localization and the components of deep sensibility. . . . The disorder of voluntary movement may be explained by an overaction of the cerebellum, or by want of counteraction of the cerebellum owing to the impulse from the cerebrum being in abeyance.⁵⁶

Continuous suppression or re-suppression, attended by continuous over-stimulation of the instinct to action, brings about a stage of chronic hyper-excitability, resulting in physiological over-activity of the censor.⁵⁷

May not paralysis, contracture, tremor, anesthesia, etc., be due to inhibition, or to exhaustion caused by excessive stimulation of the sense organs or nervous system, or to a molecular disturbance of some kind produced by vibrations in the equilibrium of the nerve cells?⁵⁸

A double origin is postulable—a central and a peripheral genetic modus, i. e., psychic concussion and injury of the peripheral nerves. A violent impulse from external stimuli causes a functional disturbance of the delicate mechanism of the psychic centers, shown in (1) faulty distribution of motor impulses,

54. Grasset, Joseph: Clinical Lecture on the Psychoneuroses of War, Med. Press and Circ., June 9 and 16, 1915; abstr. by H. Butts in U. S. Naval Med. Bull., January, 1916.

55. Mott, F. W.: Psychic Mechanism of the Voice in Relation to the Emotions, Brit. M. J., Dec. 11, 1915.

56. Clarke, J. M.: Some Neuroses of the War, Bristol Med.-Chir. J., July, 1916; abstr. by H. J. Norman, J. Ment. Sc., January, 1917.

57. Ballard, E. F.: Some Notes on Battle Psychoneuroses, J. Ment. Sc., July, 1917.

58. Sollier, P., and Chartier, M.: La commotion par explosifs et ses conséquences sure le système nerveux, Paris méd., Oct. 23, 1915.

(2) hypo-innervation, (3) hyper-innervation, causing tremors, tonic and clonic spasms, etc., instead of single muscle actions.⁵⁹

The patient was a soldier who in August, 1916, became mute after the explosion of a grenade close to him. He was kept for forty days in a military hospital where various therapeutic measures were tried without success. He was discharged while still dumb, with ninety days' convalescence leave. He was arrested as a deserter perhaps because, when still suffering from the effect of the shock, he had left his regiment, and was condemned to imprisonment. He was sent to another hospital and on admission he was completely speechless, but his hearing was normal. He was placed under anesthesia and recovered speech; at first it was monosyllabic, but after a course of vocal exercises it became normal. In answering questions he stammered a little—a defect he had not had before his injury. That he was not a malingerer was shown by a certificate from the principal officer of the hospital where he had first been under observation that the condition was caused by an injury received in the service. . . . Chiadini said he could not believe that through the elective action of chloroform and ether on the lipoid substances of the brain, that organ suddenly passed from a state of inhibition to a normal extrinsication of thought with correct expression in words. . . . In all cases he believed that the centers of motor and sensory speech and their relation one with the other and with the periphery were intact; but one of the two centers was separated from the ideative center, and therefore from the whole of the remaining cortex; there was therefore an interruption of the association fibers going from the whole cortex to each of the speech centers.⁶⁰

Undoubtedly the situation which makes it so easy for any shirker to evade duty by developing functional disability is not entirely due to gullibility of the medical profession. It is partly due to the difficult position in which medical officers are placed by military law.

It is one thing to convince oneself that in a given case there is no organic disease and only functional disability motivated by desire to evade duty or gain government compensation, and it is another thing to furnish such legal evidence as would convict a soldier of malingering in a court of law. Yet a medical officer has no other alternative than that of either designating the disability by some respectable name, such as "hysteria" or "psychoneurosis," or making a diagnosis of malingering and thereby being placed in a position of having to prove criminal intent on the part of the soldier.

The result is that, while every medical officer in the army has witnessed cases of malingering, the diagnosis of malingering is scarcely ever made. The present writer, for instance, during twenty months' service in Camp Upton and Plattsburg, witnessed many dozens of cases that he and other officers regarded as cases of deliberately

59. Oppenheim, H.: *Der Krieg und die Traumatischen Neurosen*, Berl. klin. Wehnschr., March 15, 1915.

60. Pansera, Guisepppe, and Chiadini: *Un caso di mutismo da shock nervoso*, Policlinico, Rome, Dec. 10, 1916.

feigned disability, yet in only one of them—to be described farther on—was an official diagnosis of malingering made, it having proved possible to get conviction on that charge before General Court Martial.

RELATIONSHIP BETWEEN HYSTERIA AND MALINGERING

This brings us to the question of the relationship between hysteria and malingering. Here it should be noted that opinions differ as to when a diagnosis of hysteria should be made and when one of malingering. Yet even those who hold diametrically opposite views are agreed that there is a close similarity in the clinical manifestations of the two conditions and great difficulty in establishing the differentiation in practice. The quotations which follow are from writers both on hysteria and malingering.

Quite the most difficult problem, however, is to differentiate a conversion hysteria from malingering.⁶¹

Cases of malingering are by no means always easy to diagnose, for there is no sharp dividing line between downright malingering, mere exaggeration, subconscious malingering, and actual disease; each class merges into the next.⁶²

A most important function to be performed by a psychiatric service is the detection of true malingerers as distinguished from those soldiers who, because of psychopathic or neurotic conditions, may show almost identical indications and yet not be guilty of simulation.⁶³

The subconscious influence of desires and wishes can often be demonstrated. The pathologic fraud, closely related to the hysteric, is sometimes found, and it is easy to understand why he appears more frequently in times of war than of peace.⁶⁴

This multiform neurosis (hysteria) is not chosen by malingerers, but, more than any other disease, it renders the diagnosis of malingering extremely complicated and difficult.⁶⁵

Appreciating the fact that the diagnosis and subsequent treatment of hysteria, neurasthenia, and malingering is made difficult by the merging of symptoms common to any two or all three of the conditions, the author cites illustrative cases giving the psychology of each in an attempt to clear the atmosphere.⁶⁶

Nothing resembles malingering more than hysteria; nothing hysteria more than malingering. . . . We may examine an hysterical person and a malingerer—using exactly the same tests—and get precisely the same results in one case as in the other. The finer the methods that we employ to test the genuineness of their complaints, the reality of their objective phenomena, the

61. MacCurdy, J. T.: *War Neuroses*, Psychiat. Bull., July, 1917.

62. Campbell, H.: *War Neuroses*, Practitioner, London, May, 1916.

63. Chavigny, P.: *Psychiatrie et médecine legale aux armées*, Paris méd., July 17, 1915.

64. Bonhöffer, K.: *Erfahrungen über Epilepsie und Verwandtes im Feldzuge*, Monatschr. f. Psychiat. u. Neurol., July-August, 1915.

65. Bailey, Pearce: *Malingering in U. S. Troops*, Mil. Surgeon, March and April, 1918.

66. Lumsden, T.: *Psychology of Malingering and Functional Neuroses in Peace and War*, *Lancet* 2:860 (Nov. 18) 1916; abstr. by D. G. Sutton, U. S. Nav. M. Bull., April, 1917.

more do they—in hysterical individuals—yield results which in a non-hysterical person would be held as proof of positive deceit.⁶⁷

The motives which I have found as constituting the mainspring of hysterical conduct are the same as those which students of malingering have uniformly reported as actuating their cases. Thus, Colonel Bailey⁶⁸ mentions, among others, the following motives in malingering: (a) to evade service, (b) to avoid duty, (c) to obtain exemption from punishment, (d) to obtain transfers.

Colonel Ford writes as follows: "Malingering is practiced to avoid unpleasant or dangerous duty, to secure hospital care and service, to make as much trouble as possible for those in authority, and to outwit them if possible. The chief causes are avoidance of danger and quest of a pension. . . . A successful malingerer promptly has a host of imitators."⁶⁹

Jones and Llewellyn mention the following motives of malingering: (a) monetary gain, (b) to evade punishment, (c) to evade duty or responsibility, (d) to evade or escape military service. And they note the following manifestations: pain, hyperesthesia, anesthesia, analgesia, limping gait, tremor, contractures, paralysis, epileptiform seizures, amaurosis or amblyopia, contractions of the visual field, deafness, aphonia, stuttering, mutism, deaf-mutism,⁷⁰ etc. Colonel Bailey mentions similar manifestations.⁷¹

In the case of legally established malingering which has come under my own observation the manifestations were typical of hysteria: shuffling, labored gait, stocking anesthesia, weakness, pain in legs and tremor. The case would, indeed, have passed for one of hysteria, had not the patient procured a fraudulent roentgen-ray plate. He had fastened a piece of bone to the sole of his foot with a strip of adhesive plaster which made it appear on the roentgen-ray plate as a detached piece of bone in the metatarsal region, an easily exposed deception. He was tried before General Court Martial, found guilty and given twenty years.

DISTINCTION BETWEEN HYSTERIA AND MALINGERING

The question thus arises, What is the distinction between malingering and hysteria? A search through the literature reveals but one point to which the differentiation is fastened almost unanimously, namely,

67. Jones, A. B., and Llewellyn, L. J.: *Malingering*, Philadelphia, P. Blakiston's Son & Co., 1918, pp. 117 and 118.

68. Bailey, Pearce: *Malingering in U. S. Troops*, Mil. Surgeon, March and April, 1918.

69. Ford, J. H.: *Details of Military Medical Administration*, Chapter on Malingering, Philadelphia, P. Blakiston's Son & Co., 1918, p. 531.

70. Jones, A. B., and Llewellyn, L. J.: *Malingering*, p. 12.

71. Bailey, Pearce: *Malingering in U. S. Troops*, Mil. Surgeon, March and April, 1918.

the *conscious or unconscious quality of the motivation*. Yet even on this point writers have shown much inconsistency; for it is generally admitted that even malingering may be "subconscious" or "unconscious."

The cardinal point of difference is that the malingerer simulates a disease or a symptom which he has not in order to deceive others. He does this consciously. . . . He lies and knows that he lies. The hysteric deceives himself by a mechanism of which he is unaware and which is beyond his power consciously to control.⁷²

It may require a rather exhaustive study to determine whether the symptoms are produced on the basis of a conscious or an unconscious wish, which is essentially the difference in etiology between malingering and hysteria.⁷³

All hysterical manifestations are of the nature of unconscious psychical reactions, just as voluntary acts are conscious psychical reactions.⁷⁴

Exaggeration, either conscious or unconscious, is the most common form of malingering.⁷⁵

Malingering, as well as lying and deceit, far from being a form of conduct deliberately and consciously selected by an individual for the purpose of gaining a certain known end, is in the great majority of instances wholly determined by unconscious motives, by instinctive biologic forces over which the individual has little or no control.⁷⁶

It is not always true that malingering is an acutely conscious reaction, as it is often beyond the awareness of the individual, occurring in the subconscious.⁷⁷

It is strange that so futile a consideration, one so obviously belonging to the domain of metaphysics and not science, as the question of degree of consciousness of a mental process, should become the preoccupation of scientific men and should be chosen as a criterion of clinical diagnosis!

Everyone who has given the matter any thought must be aware of the great difficulty of defining to oneself the motivations of even the simplest volitional processes. Such self analysis requires special skill and training in introspection; and even under the best conditions the data that thus become available can perhaps never become a part of the material of science, being serviceable only as *leads* to problems in psychology.

72. Salmon, T. W.: *The Care and Treatment of Mental Diseases and War Neuroses ("Shell Shock") in the British Army*, New York, The National Committee for Mental Hygiene, 1917.

73. MacCurdy, J. T.: *War Neuroses*, Psychiat. Bull., July, 1917.

74. Jones, A. B., and Llewellyn, L. J.: *Malingering*, p. 117.

75. Jones, A. B., and Llewellyn, L. J.: *Malingering*, p. 59.

76. Glueck, B.: *The Malingerer; a Clinical Study*, Internat. Clin. **3**: S. 25, 1915.

77. Sheehan, R.: *Malingering in Mental Disease*, U. S. Nav. M. Bull. **10**: 646 (October) 1916.

One may, indeed, have an illusion of lucidity of consciousness; but he needs only to attempt a *formulation in language* of the results of his introspection to convince himself of the darkness within.

When we are dealing with weak-minded, ignorant, emotionally unstable, morally defective individuals, such as hysterics and malingerers; and when, moreover, the question is one of "conscious," "coconscious," "preconscious," "foreconscious," "subconscious," or "unconscious" *deception*, it is all the more amazing that a criterion, which is, in the first place, vague, and, in the second place, purely subjective, should seriously occupy the professional mind as a guide in practical work.

But there is more to add to the confusion. A case, it is said, may begin with conscious deception and end with unconscious self-deception; or vice versa; or there may be a mixture of unconscious and conscious simulation (i. e., hysteria complicated with malingering); or there may be a condition half-way between conscious and unconscious simulation.

M. Gilbert Ballet points out that a man may begin by shamming, and, as the result of auto-suggestion, end by developing the condition simulated, thus becoming the victim of his own chicanery.⁷⁸

Hysteria, when prolonged for months, is very apt to have malingering grafted on it, and what was at first a purely psychological disturbance of function may ultimately be perpetuated mainly by the intention to deceive.⁷⁹

One has to recognize the fact that a genuine hysterical person may for purposes of gain resort to simulation.⁸⁰

This condition (so-called guard house back or camptocormia), in which the back is held stiffly forward or laterally, is frequent in our army. . . . It is generally regarded as midway between malingering and hysteria.⁸¹

While it is in the nature of things that the motives actuating hysterical conduct should be, for the most part, concealed, this fact can by no means be regarded as proof of their being beyond the awareness of the patients. Occasionally they are either confessed or detected in other ways which show their clearly conscious nature, as in the following cases:

1. "To be honest about it, if I could get out of the army I would like it; now that's the truth. My half brother has a big farm, about seven or eight hundred acres of land and his wife is sick; and he has been at me to come and live with him, sort of look after his farming, his horses, and so on." (S., 7 Truck Co., 23 Eng. Case of hysteria characterized by pains in head and back, dizziness, amnesia, paralysis of legs, stammering, weakness, fatigability; cured by "the most earnest prayer.")

78. Campbell, H.: War Neuroses, Practitioner, London 96:501 (May) 1916.

79. Harris, W.: Nerve Injuries and Shock (Oxford War Primers), New York, Oxford University Press, 1915.

80. Jones, A. B., and Llewellyn, L. J.: Malingering, p. 129.

81. Bailey, Pearce: Malingering in U. S. Troops, Mil. Surgeon, March and April, 1918.

2. "I know I never worked hard in my life. If you've want to discharge me I could work in an ammunition factory or something like that. I could go home then and be near my girl; I know I'd be more contented then. I might as well tell you the truth; no use of me lying." (D., 301 Co., Q. M. C. Case of hysteria characterized by limping gait, attacks of excitement.)

3. "About 6 o'clock on the night of April 12, on my way to the watch post—well, I can't say that I was blown up because I heard no explosion, and did not see the trench cave in, and had no blood drawn on me except a slight scratch on my back—I became unconscious, but I do not know the cause of my unconsciousness. When I came to I found myself between 30 and 40 feet in front of the trench in no-man's land. I managed to crawl back into the trench by using my hands and arms: I could not use my legs, as I had lost the use of both of them completely." The following version was later obtained by correspondence from First-Lieutenant Harold P. Gibson, 23 Inf., A. E. F.: "On April 12, 1918, while I with B. (the patient) and Corporal Hiller, both of my platoon, was inspecting outposts, B. suddenly stopped, fell against the side of a trench and told me he had no control over both his legs. He had to be carried to the battalion first-aid station and was then evacuated. B. had, during all the time that I knew him, been troubled with the arches of both feet." (B., Co. C, 23 Inf. Case of hysterical paraplegia, areas of anesthesia, violent tremors, globus, etc.)

Among other points of differentiation between hysteria and malinger which have been suggested are: 1. Result of treatment by persuasion, i. e., if persuasion fails to cure the case is not hysteria but malingering (Babinski). 2. A desire to be cured speaks for hysteria; the opposite indicates malingering. 3. The malingerer dreads examination; the hysteric welcomes it. 4. Hysterical manifestations bear the stamp of a certain genuineness which those of malingering lack. These points merit somewhat detailed discussion.

As regards result of treatment by persuasion, it is very generally recognized that in many cases which are by all diagnosed as typical hysteria persuasion fails to cure—so-called refractory hysterics. In other cases, also refractory, a cure is, indeed, obtained by persuasion but only when it is reinforced with painful electrical treatment (Kaufmann method, "torpillage"), ammonia, isolation and liquid diet, threat of operation, threat of court martial, etc.

It is true, of course, that many cases of hysteria have readily yielded to persuasion; but the conditions under which that has happened should be taken into account. When the danger was removed of being returned to the front, especially, as already stated, after the signing of the armistice, many cases were not only easily "persuaded," but were cured by any method that happened to be tried, though they had previously proved refractory. The cure in these cases is obviously to be attributed not so much to persuasion as to the removal of the danger. Some patients have remained refractory even since the signing of the armistice; in these cases the actuating motive is to gain government compensation; that is the reason why the "persuasion" that has cured thousands of others is doing them no good.

Moreover, proved malingering has also in many cases yielded to persuasion, while other cases have proved refractory; in other words, the experience with malingering, in that respect, has been exactly like the experience with hysteria. I would cite, in this connection, the observations of Sicard.⁸²

In six cases the deception was detected by the mild method (*méthode douce*). This consists in appealing to the pride of the patients, avoiding all suggestion of reproach, all criticism in public, and, above all, any accusation of malingering before a third party. We take them aside, and make them realize the unworthiness of their conduct. We appeal to their patriotism and prescribe an electric treatment to serve as pretext for a rapid cure. We have had, from some at least, expressions of real regret and remorse for their actions. These men were returned to the army. Two of them have written to us since and are giving good service at the front.

But other malingerers, those of fixation as a whole, remain inflexible. They exhibit an impervious obstinacy. One feels that all persuasion is useless, that every appeal to their better nature, to their moral sense, is vain. There is no worse deafness than that which is resolved not to hear. The only recourse is threat (*la manière forte*) of court-martial, or at least of appearance before court-martial.

The author describes in a note an interesting case of malingering in which a soldier terminated a period of ten months without a spoken word by a well-acted seizure in which speech and hearing supposedly returned to him. He confessed his trick later in a letter, but promised to atone for it by his future conduct—a promise which he is keeping.

Babinski's differentiating test of cure by persuasion is based on his general conception, according to which the essential feature of the hysterical personality is abnormal suggestibility. But a close scrutiny of the facts does not support this conception. An equally plausible case might be made out for abnormal *lack* of suggestibility.

Under certain conditions the hysteric is, indeed, remarkably receptive to *certain* suggestions; but he is at the same time refractory to others. When he has to play sick in order to avoid dangerous duty he will not only be readily influenced by suggestions unwittingly made by the examining physician in testing for disorders of sensation, etc., but will actually seek suggestion by observing cases of real disease and will develop by autosuggestion such symptoms as he may imagine to be appropriate for a "dead nerve," "stoppage of circulation," etc. At the same time he is apt to resist any suggestion of cure.

But a time comes when, on removal of danger, the situation changes. What was previously a life-saving disability now becomes a nuisance. Although many are, in the new situation, cured spontaneously, others feel that a sudden cure without treatment would but betray the false nature of the trouble. Nothing is more natural than that they should

82. Sicard, J. A.: *Simulateurs sourds-muets*, Paris méd., Oct. 23, 1915.

again seek the cooperation of our gullible profession to assist them in making a seemingly and plausible exit from an awkward situation. And so after taking electricity, hypnosis, reeducation, vocal exercises or what not, accompanied by "suggestion," they are pronounced cured; this carries with it not only relief from no longer serviceable disability, such as mutism, paralysis, contracture, etc., but also, by implication, added certification by duly constituted medical authority that a disease had existed.

Turning now to the next point of differentiation, according to which a desire to be cured speaks for hysteria, while the opposite indicates malingering, I have to say that no generalization in this respect can be made which would hold true for all cases of hysteria; everything depends on special features in a given case and on special circumstances.

Every practitioner knows the service a nervous illness often is to a patient in dealing with relatives, over whose head the patient holds it almost as a threat; this process may be consciously or unconsciously carried out. Under such circumstances the patient's deep-rooted objection to getting better may defy all therapeutic measures.⁸³

I have seen cases in which stubborn resistance to treatment gave way, following the signing of the armistice, to an impatient longing to get well. The following is a good example: "Oct. 7, 1918, electro- and hydro-therapeutic treatment discontinued because patient resists everything done for him and is sure nothing will help him. October 14, no improvement. October 24, no improvement. November 8, no improvement. November 18, transferred to Plattsburg."—(From the clinical record at Walter Reed General Hospital.) "This complete paralysis of the leg had continued for several months in spite of all efforts in one of the best French hospitals to effect a cure. He had been given some of their most drastic electrical treatment without obtaining any response. His desire to get well has been so great that after hearing another patient remark that he had been able to walk after falling down a flight of stairs, he tried a like cure on himself by throwing himself down a flight of stairs. In the first treatment, combined faradic-galvanic current, applied to the left foot, we were able to develop some voluntary motion. After the third treatment he was able to walk without crutches. In the course of about two more weeks (Jan. 3, 1919) he was discharged, cured."—(Report of Capt. Claude D. Kellam, M. C., chief of physiotherapy department, U. S. Army General Hospital No. 30, Plattsburg Barracks, N. Y. Case is that of S., Co. I, 103 Inf.)

The next alleged differentiating point, according to which the malingerer dreads examination, while the hysteric welcomes it, is, as far as my experience is concerned, untrustworthy. In the case of malingering cited above the patient at all times willingly submitted to neurologic examinations in which the areas of anesthesia were repeatedly mapped out, etc. Under similar conditions hysterics, too, welcome examination.

83. Jones, Ernest: *Papers on Psycho-Analysis*, New York, William Wood & Co., 1918, p. 354.

But I have many times seen hysterics cease to cooperate and become resistive to examination on a suspicion arising in their minds that the object of the examination is to test the genuineness of the symptoms. This was especially noted in cases of convulsions, in which the patients by turning away, biting, struggling, and fighting resisted an examination of the pupils, knee jerks, plantar reflexes, etc.

The last mentioned differentiating point, according to which hysterical manifestations bear the stamp of a certain genuineness which those of malingering lack, is also not to be relied on. All that can be said is that in both hysteria and malingering one meets with various degrees of adroitness in simulation, various degrees of determination and persistence.

Macdonald tells of a man, feigning epilepsy, who during a fit suffered without flinching knives thrust under his nails, the insufflation of irritating powders into his eyes, and one day fell 30 feet to convince the expert, though finally he acknowledged his deceit.⁸⁴

To sum up: my own experience, much discussion with other medical officers, and a study of the literature on the subject under consideration, all lead me to the conclusion that *what some have described under the name of hysteria and what others have described under the name of malingering are one and the same thing*. The difference seems to be entirely one of viewpoint.

"Hysteria" is an expression which would stress a medical viewpoint. "Malingering" is one which would stress a legal viewpoint.

SEX FACTORS—INTRAPSYCHIC CONFLICTS

There remain two other point in connection with hysteria which merit discussion in the light of the war experiences: (1) the part played by sex, (2) the theory of intrapsychic conflicts.

Although Freud's views as to the exact part played by sex factors in hysteria have undergone considerable modification from the time of his original formulation nearly twenty-five years ago, even in his recent formulations the sex element is regarded as essential in the etiologic mechanism. The hysterical symptom corresponds to the return to a manner of sexual gratification which was real in infantile life and which has since been repressed. The hysterical symptom can assume the representation of various unconscious non-sexual impulses but cannot dispense with a sexual significance.⁸⁵

It seems quite probable that, in relation to a certain variety of material, the idea of the universality of sex factors is well founded. The sphere of sex, under ordinary conditions, might even *a priori* be

84. Jones, A. B., and Llewellyn, L. J.: Malingering, p. 48.

85. Freud, S.: *Sammlung kleiner Schriften zur Neurosenlehre*, 2nd Ser., 1909, pp. 142, 143, 150; cited by Pfister, O.: *The Psychoanalytic Method*, New York, Moffart Yard & Co., 1917; transl. by C. R. Payne.

regarded as the main if not the sole source of "concealed, illicit, morally untenable motives" postulated by me as the mainspring of hysterical conduct. But the war experience has shown even to loyal adherents of Freud that hysterical manifestations can be actuated by motives other than sexual.

Psychoanalysts in civilian practice claim that the individualistic tendencies in question are preponderantly related to the sex instinct. In war, however, this does not seem to be the case, these latter tendencies coming into play, apparently, only as a complication.⁸⁶

The psychoneuroses of peace time are usually the result of mental conflicts between repressed instinctive tendencies and the demands of civilized life. The instinct most often involved is the sexual. In the psychoneuroses of war time, however, we find that the conflict is usually between the soldier's ego instincts (particularly that of self-preservation) and the demands of military service.⁸⁷

Even in peace times, neurologists have seen but too often hysterical manifestations ("traumatic neuroses") arise on the basis of exaggerated claims for indemnity, sick benefit, accident insurance, workmen's compensation, etc., without the intervention of sex motives.

It seems, therefore, justifiable to conclude that an illicit motive is an essential part of the mental mechanism of hysteria; but such motive need not be of a sexual nature, although undoubtedly it very often is.

In most other respects, what I have seen of hysteria in the course of my war experience bears out Freud's conception of its underlying mechanisms more fully than any other pre-war conception. I would cite here the well formulated presentation by Ernest Jones:

Neuroses are not diseases or accidents that happen to a person, as the French school of psychopathology maintains, but are phenomena produced and brought about by some tendency in the person's mind, and for specific purposes. Freud distinguishes three classes of motives that operate in this way, one essential, the other two not. The indispensable one is an unconscious desire to obtain pleasure by gratifying in the imagination some repressed and disassociated impulse, a motive, therefore, arising in the part of the mind that is not in harmony with the ego-ideal. A second motive is to achieve some end in the outer world; for instance, sympathy from an unkind husband, which the person finds easier to do by means of a neurosis than in other ways. The third set of motives has the same purpose as the last, but may be distinguished from it in that they concern the making use of an already existing neurosis rather than the helping to bring one about.⁸⁸

Turning now to the subject of intrapsychic conflicts, it will be remembered that the manifestations of hysteria are regarded by some as a

86. MacCurdy, J. T.: War Neuroses, *Psychiat. Bull.*, July, 1917.

87. Payne, C. R.: Special Report on the Applications of Psychoanalysis to War Neuroses at U. S. Army General Hospital No. 30, Plattsburg Barracks, N. Y.

88. Jones, E.: *Papers on Psycho-Analysis*, p. 573.

sort of compromise resulting from a conflict between repressed, sub-conscious wishes and the patient's conscious tendencies representing the better part of his "split-up personality."

Flight or desertion is rendered impossible by ideals of duty, patriotism, and honor, by the reactions acquired by training or imposed by discipline and by herd reactions. Malingering is a military crime and is not at the disposal of those governed by higher ethical conceptions. Nevertheless, the conflict between a simple and direct expression in flight of the instinct of self-preservation and such factors demands some sort of compromise.⁸⁹

The manifestation of abnormally repressed mental processes is to be understood only by consideration of the action of intrapsychical conflict. . . . The energy finds an outlet in some somatic manifestation, a process Freud terms "conversion." This is the characteristic mechanism underlying hysterical troubles, where a given bodily symptom, such as a tremor or an aphonia, is the expression of a repressed mental complex.⁹⁰

I can confirm, from such observations as I have been able to make, the existence of a conflict. But it has seemed to me to be, for the most part if not entirely, a conflict rather between the patients' desire to shirk, loaf, avoid exposure to danger, gain unearned compensation, etc., and pressure from external sources the object of which might be to expose their motives and the unreal nature of their disability, to bring on them the opprobrium of their comrades, to render them liable to legal prosecution, etc.

In other words, I was unable, in the great majority of cases, to detect any pricking of conscience, evidence of regret at being a burden rather than a help to their country in its great emergency, any struggle between nobler and baser parts of self, but rather a general lack of evidence of the existence of a nobler self in these cases.

This brings us to the subject of the hysterical personality.

THE HYSTERICAL PERSONALITY

I have already endeavored to show that hysteria is but one of a number of varieties contained in the large group of neuropathic constitutions. The family and personal histories of hysterics indicate some sort of relationship to the constitutional psychoses, epilepsy, mental deficiency, constitutional psychopathic states, etc. But the hysterical personality can be more specifically defined. Its essential feature, it seems to me, consists in a *character defect*. In the moral side of our nature three motivating principles can be distinguished, each of which actuates our conduct in a measure which differs in different individuals.

89. Salmon, T. W.: The Care and Treatment of Mental Diseases and War Neuroses ("Shell Shock") in the British Army, New York, The National Committee for Mental Hygiene, 1917, p. 30.

90. Jones, E.: Papers on Psycho-Analysis, p. 23.

The first of these may be termed pure or esthetic morality; it is represented in the saying "It is better to be right than to be president." No considerations of selfish advantage, of mere catering to popular taste or demand, are here permitted to enter. A person actuated by this principle turns away from thoughts of deception, theft, dishonesty, or any other moral filth, just as he might, from inherent esthetic repulsion, turn away from a foul smell.

The second principle may be termed prudent morality; it is represented in the saying "Honesty is the best policy." Unlike the case of the first principle, here considerations of selfishness and personal ambition not only are permitted to enter, but are the basis of doctrine. A person actuated by this principle turns away from wrongdoing not from an esthetic aversion, but because of a conviction that, in the long run at least, it does not pay.

The third principle, imposed morality, has its roots in the deterrent force of such measures of redress, retaliation, or protection as are available to individuals and society in dealings with wrongdoers. A person actuated by this principle has no esthetic aversion to wrongdoing; and he regards the maxim of prudence with cynicism. His preoccupation is, mainly, how to escape detection, conviction and punishment. If he refrains from wrongdoing, it is only when the risk involved is too great and too immediate.

I could not better define the hysterical personality, as I have observed it, than by saying that it is characterized by total lack of the first principle; that it is at best actuated by the second principle; and that it is, in its typical manifestations, actuated entirely by the third principle; i. e., in so far as its conduct has any moral quality at all.

This places the hysterical individual in close relation to the criminal. Yet a certain difference may be pointed out. Most hysterics are characterized by a trait which is foreign to many criminals: indolence.

A desire to lead a parasitic existence, to be a burden on relatives, employers, the government, to live on a pension and do no work, is characteristic of many of these patients. They would, and often do, steal anything conveniently within reach, lie, cheat, make work and trouble for others, wantonly destroy government property, but they haven't the enterprise or energy that some criminals have of planning and carrying out an embezzlement or a burglary or a train robbery: That is too much like work.

This description may seem to some much overdrawn. I would, therefore, again note that the above described traits of hysterical personality exist in all degrees. Between the man of highest integrity, actuated only by the purest motives of unselfish service, and the one who utterly lacks all moral compunction and is constantly preoccupied

with motives of shirking and of organizing a parasitic existence, there are many shades of transition.

It should, moreover, be borne in mind that the material observed in the Plattsburg Hospital, on which this study is based, represents, by selection, the most refractory cases of hysteria met with in the army. The reader will recall that of 100 so-called concussion and nervous cases received at triages near the front, sixty-five were returned to duty within a few days and thirty-five were sent to army neurological hospitals. Of the latter, twenty were later also returned to duty and fifteen sent to Base Hospital No. 117, at La Fauche, in the Service of Supplies. Eventually fourteen of even this group were returned to duty and but one sent back to the United States.⁹¹

My comments refer particularly (a) to this 1 per cent. of cases, weeded out from amongst all concussion and nervous cases on the basis of their stubborn resistance to treatment and total unfitness for duty and, (b) to a small number of still more flagrant cases that had arisen in the domestic cantonments. To what extent generalization from my conclusions might be valid is, of course, another question.

The statistical analysis, in the beginning of this section, of two selected groups of cases of hysteria, demonstrates differences in degree. Analyses of individual cases present such differences even more strikingly.

One man, for instance, gives up a well paying position and enlists voluntarily in the Signal Corps with the hope of "helping in the war and at the same time maybe learning something," though determined to avoid, if possible, combatant duty or exposure to any danger. Following an unexpected order to prepare for embarkation for overseas he develops violent coarse tremors and fainting attacks which persist until his transfer is arranged to the medical department with assignment to duty in the Plattsburg hospital. Thereupon, being assured of the removal of the danger of exposure to submarine attack, etc., he makes a prompt and complete recovery, and renders daily extremely valuable and conscientious service as office assistant. (R., Co. G, 321 F. S. Bn.)

In contrast with this case may be cited that of a man who became inspired with the idea of utilizing this rare opportunity of securing a life pension. With that in mind he enlists and two weeks afterward develops, from an alleged injury due to being struck in the groin by a case which he was carrying, a stooped over position, so-called camptocormia. Shortly afterward he is operated on for varicocele, and this aggravates his disability. Thereafter he spends over fifteen months, i. e., the remainder of his "service" in the army, in hospitals or on furloughs for his health, does no work, makes all kinds of trouble for the authorities, declares he can never be cured, demands discharge on certificate of disability: "If the government is afraid of a little compensation, I don't think it is treating the soldier boys very fair." (S., 4th Co., B. S., S. C.)

91. Editorial, *Mental Hygiene*, January, 1919.

NEW DESIGNATION SUGGESTED FOR HYSTERIA

From all that has been said above, the reader can almost surmise the view to which the war experience has led me. I feel, on the one hand, that the practice of camouflaging the true nature of the conditions here dealt with by means of such euphemisms as hysteria, war neurosis, concussion neurosis, traumatic neurosis, shell shock, etc., and thus, through implied authoritative professional support, imparting to them a stamp of respectability, is bad in every way. On the other hand, in view of the fact that, whether conscious or unconscious, simulation of disease occurs on a basis of inborn neuropathic constitution, it cannot be encompassed within the simple formula of malingering, i. e., crime, the responsibility for which is entirely on the patient. I would banish from medical classification the above named terms and others like them and designate the cases in question *constitutional psychopathic state, simulation*.

NEURASTHENIA

The cases classed under the heading of neurasthenia may be roughly divided into two groups which are superficially very similar to each other but which, on closer study, may be found to present wholly different psychic mechanisms.

The first of these is characterized by depression, discouragement, difficulty of concentration, feeling of inadequacy, and psychomotor retardation—in other words, it is a condition apparently allied to the manic-depressive psychoses.

The second is characterized by vague general hypochondriasis with purely subjective symptoms, and may often be shown to be motivated exactly in the manner of the above discussed hysterical manifestations. It is, to my mind, but a special type of hysteria or simulated disease. It is apt to be seen in persons presenting the same sort of character defect as that which underlies common hysteria, but endowed with better intelligence, of better education, more polished and diplomatic, more suitable and plausible. Thus I find it relatively more frequent in commissioned officers than in enlisted men.

My experience has amply shown that the possession of native intelligence far above the average and good educational and social opportunities are not incompatible with gross lack in moral sentiment. The following cases are cited for illustration.

1. An officer who had been under suspicion and surveillance was later reported in France for what seemed to be pro-German propaganda. He had stated that enormous supplies had been abandoned by the Allies to the Germans in the spring of 1918; that the French troops had become utterly demoralized; that he had been directed to place time bombs for the destruction of the supplies of the Allies in the event of further advance by the Germans; that the fall of Paris was only a matter of days; that the Germans had a tremen-

dously powerful new explosive, etc. He was placed under arrest on June 5, 1918; later, following examination by a psychiatrist, he was declared not fully responsible and returned to the United States as a nervous patient (K., A. S. S. C.).

2. An officer who gave a history of fainting spells and other epileptiform manifestations which, he said, began after he had been gassed in France, showed nothing on examination. Aside from his history there was no evidence of epilepsy and no record of his having been observed in seizures of any kind. Shortly following his admission to this hospital, papers were received showing that he had been charged with a serious offense in France and had disappeared for a time. His whereabouts were for a time unknown, but he appeared in Field Hospital No. 6, later placed in Class "D" by medical officers and returned to the United States (R., 4 Eng.).

STRIKING CASE DEMONSTRATING THE REMARKABLE STABILITY OF A NORMAL NEUROPSYCHIC CONSTITUTION

On Nov. 18, 1918, a group of men, survivors of the torpedoed transport *Ticonderoga*, were admitted to the Plattsburg Hospital. It would seem that nothing that happened in the war was more exhausting, horrifying, depressing, and nerve racking than the experience of the men on the *Ticonderoga*. The abridged account furnished by one of these men is herewith submitted. This case is instructive in that it shows what remarkable stability a normal mental constitution has and how inadequate etiologically, in the absence of a neuropathic predisposition, are the factors to which so often psychoses and neuroses are attributed.

H., white, aged 18; previous history negative; enlisted July 15, 1918, and sailed for overseas Sept. 18, 1918. The transport was shelled, torpedoed, and sunk on Sept. 30.

At about 5 o'clock in the morning, patient was in his bunk with all his clothes on but his blouse and shoes; he was suddenly awakened by the bell signal "to life boats" and by the noise of constant shelling. He slipped on his blouse, shoes and life preserver; as he reached the deck he saw one shell knock the 3-inch gun off the platform and kill the gun crew; he was knocked down by the jar though not hurt or rendered unconscious; started toward the upper deck, the shelling going on all the time; one shell exploded about 10 or 15 feet from him; this time he was rendered unconscious and, on coming to about five minutes later, found himself in a narrow passageway into which he had been thrown. He had a violent headache, was gasping for breath, shaking violently all over, and found that his hands, arms and body had been sprayed with minute particles from the exploding shell, which were so hot that his clothing was charred or burned through where they struck. For about an hour he assisted in preparing the life-boat for lowering, loading it with blankets, etc., the shelling going on all the time. The submarine was seen about 200 yards away; the bridge had been partly blown down; shells were seen striking various parts of the ship and throwing up and killing men; some life boats which had been lowered were struck by shells and sunk; others were dumped on account of being lowered in a hurry; wounded men were all over the deck, and many, both wounded and not wounded, were in the water;

one man had had his nose shot off and received a gash in the back of his head; he approached the patient and asked that he kill him. There was a good deal of shrieking and groaning, although most noises were drowned in the noise of constantly exploding shells. Then a big blaze was seen over what was left of the bridge and all men were ordered to fight the fire on the bridge. The shelling stopped for about twenty minutes but started again from the other side. While lowering their life boat a shell killed the paymaster, a sergeant, a private, and some others who were standing there waiting to get in. No other life boat succeeded in getting away and only one raft. In the meantime the *Ticonderoga* was struck by two torpedoes and finally sank, carrying with it the wounded on board.

When they began rowing away with their life-boat there were twenty men in it. In a few minutes they saw the submarine coming toward them. The captain (Capt. M., ranking as Lieut.-Com. in U. S. Navy) said, "Well, we shall die like men!" (He had been severely wounded in both legs, with face bleeding, and part of the time unconscious; later at times delirious.) At the same time they rowed toward the submarine and soon came alongside of it. One of the submarine officers asked them first, in broken English, if they were armed; one ensign and one soldier were then taken on board the submarine; in the meantime the life-boat was tied by a tow rope to the stern of the submarine; then the submarine submerged, but fortunately the knot became untied and the life-boat was left afloat with eighteen men in it, of whom five had been wounded. They floated around all day; at about 3 o'clock in the afternoon sighted a raft, and toward 5 o'clock came near enough to it to throw a rope to the men on it; there were ten men on the raft, some of them wounded; they had no water or rations. Five of the men from the raft succeeded in getting into the life-boat; it was not considered safe to permit any more to come in. They planned then to tow the raft so as to have the men near enough to give them rations, but the raft slipped away, and they lost sight of it. One of the wounded men in the life-boat died that evening and his body was thrown overboard. The first two days and nights it was rather rough and it rained; it kept two men busy all the time baling. The canvas covering the boat had to be held down at the gunwale to prevent being swamped by a wave; the sail that had been put up had to be held by a rope and managed as was necessary. Two of the severely wounded men lay in the bottom of the boat and got a little sleep; but the remaining men got no sleep whatever in the four days and three nights.

During the first night the patient and several of the others kept vomiting small quantities of greenish liquid. Nobody seemed hungry, and they ate nothing until the afternoon of the second day, about 3 o'clock, when they had one apricot, one small hard-tack, and some apricot juice mixed with water—only a tablespoonful of that mixture to each man. Everybody was thirsty, but only small quantities of water were given out, and those only at meal times. The third and fourth days they had one meal each, same as above and, in addition, one-fourth of a thin slice of bologna. All the time they were shaking with chilliness and were sopping wet. The fourth day, however, was much calmer, sunny and warm, and they got dried out and warmed up. At noon on the fourth day they sighted a ship (*The Moorish Prince*) in the distance and at 3 o'clock they were taken on board.

The patient suffered from headache, great weakness, shook all over, and had pain in the back from cramped position; he was also famished and extremely thirsty. The others were in the same condition. They got some

whisky, were cautiously fed and were placed in warm bunks. The patient's sleep was disturbed by dreams of shelling, etc., and he would start suddenly; also every noise, especially the boat whistle, would wake him with a start; although he was able to be up and around, he lay in his bunk the greater part of the time.

On Sunday, October 6, their fourth day on the freighter, H., with others, was transferred at sea to a British transport and reached New York on October 10. He was taken to the U. S. Army Debarkation Hospital at Ellis Island, New York City; after two nights there the patient was transferred to Camp Merritt, N. J. He complained of headaches daily, nervous shakiness, bad dreams and being readily startled by noises. On November 17, he was transferred to the Plattsburg hospital.

Physical Examination on Admission.—His height was 67½ inches, his weight 139 pounds in ordinary clothing. (His usual weight is 150 pounds.) The patient stated that he tires easily. He had rather pronounced tremor of hands and eyelids. (Two days later the tremor was greatly reduced.) The grips were equal but rather weak. Findings otherwise were negative.

Mental Examination.—"I feel quite well now; I still have headaches, but not very often. At times I have a feeling of longing and worry due to the fact of being away from home and facing death as I did and not having seen my people. The dreams that I have now are only like those I used to have before. I am not fit for full duty, but could do light duty and I think I would be able to work up to full duty before long." His attitude and manner were entirely normal. The patient asked for his clothes and to be given something to do. He adapted himself well to the hospital routine; presented no emotional disturbance, disorder of flow of thought, oddities, hallucinations or delusions. Orientation, memory, grasp on general information were intact. He was unable to recall any dream.

PSYCHO-ANALYSIS IN WAR NEUROSES

The Plattsburg hospital has been fortunate in having on its medical staff an able exponent of psycho-analysis, Dr. Charles R. Payne. The report submitted by him contains conclusions which are worth noting:

Psychoneuroses of war differ from those of peace in: (1) the conflict involves the ego instincts rather than the sexual; (2) in the war psychoneuroses the conflict is much nearer the surface of consciousness. Psychoanalysis is not practicable in treating cases of war psychoneuroses among private soldiers for three reasons: (1) too much time required; (2) patients during war lack real desire to get well; (3) majority of patients are not of sufficiently high intelligence to be suitable for psychoanalysis. Psychoanalysis is of great value in treating psychoneuroses among officer patients.

LESSONS FOR CIVILIAN PRACTICE

War neuroses and malingering in the army have their counterparts in civilian life—hysteria and the so-called traumatic neuroses. The problem of "traumatic neuroses" is very likely to grow to vast proportions with the progress of legislation for workmen's compensation, accident insurance, sick benefit funds, etc. It would seem that the interests of society, insurance organizations, public service corporations,

etc., should be protected by amending legislation so that, while providing fully for compensation in cases of actual injury or disease, it should render the subject of purely functional, mental, simulated disability or disease entitled to no indemnity but only to examination and treatment in a hospital for a limited period of time.⁹² The removal of temptation would result in greatly lessening the incidence of simulated disability or disease.

SUMMARY

1. Hysteria is purely functional in its nature and the mechanisms underlying its manifestations are entirely mental.

2. By way of preliminary to the discussion of my own experience a brief restatement is offered of pre-war current conceptions of hysteria.

3. An analysis of two selected groups of cases of hysteria is offered—fifty cases in each group. This analysis leads to the following conclusions: (*a*) Hysterical phenomena are a special group of manifestations arising on a basis of neuropathic constitution. (*b*) Neuropathic heredity is probably the essential factor in the etiology. (*c*) The frequent occurrence of dissimilar heredity and, in the patients themselves, or neuropathic traits not specifically hysterical, points to a relationship of some sort between hysteria and other manifestations of neuropathic constitution. (*d*) The hysterical tendency varies widely in degree and shades off toward normal constitution by gradual transition.

4. Causes to which patients attribute their hysterical symptoms are obviously and absurdly inadequate; they are, at most, occasions out of which have arisen suggestions in part determining the particular symptomatology.

5. Various causes assigned by medical officers are enumerated. With the progress of the war, the view gained ground that physical factors, as such, played no part in the etiology of hysteria.

6. In studying the etiology of war neuroses, it is important to distinguish the acute emotional disorders observed at the front from hysteria.

92. Recently the head of the medical department of the French army requested the advice of the Société de Neurologie de Paris concerning the proper medicomilitary disposition of cases of hysteria still under military jurisdiction. The answer was threefold, the third part being: "In general, purely hysterical manifestations entitle one to no recompense. Exceptionally, a percentage of disability may be allowed somewhere between zero and 20 per cent., but in no cases shall the latter figure be exceeded" (Rev. neurol., 1919, No. 3). From this it would appear that the opinion of the members of this learned society does not much differ from mine.

7. According to Léri, it is a mistake to think that hysterical manifestations are an integral and necessary part of the emotional syndrome; they can appear independently of all emotion; and the emotional syndrome has nothing in common with hysteria.

8. Psychic factors to which war neuroses in general have been attributed—fright caused by danger from projectiles, horrifying sights, etc.—play a part only in the acute emotional syndrome; hysterical phenomena are not directly produced by them.

9. Those disorders which developed at the front and are the direct expression of violent emotion are never of long duration; the intensity of their manifestations subsides rapidly and almost all cases can be returned to the front within a few days.

10. Speaking with special reference to my experience, the main-spring of hysterical conduct consists in a concealed, illicit, morally untenable motive.

11. Its most frequent variations are: (*a*) To evade the law of conscription, (*b*) to procure, on reporting for physical examination at a training camp, rejection for physical unfitness, (*c*) to evade dangerous, disagreeable, or difficult duty, or to evade all duty, (*d*) to procure the ease and privileges of hospital care, (*e*) to procure discharge on certificate of disability, (*f*) to procure compensation for disability.

12. That illicit motive and it alone is the factor which actuates hysterical conduct, is further shown by the following three groups of facts: (*a*) Many cases have arisen in National Army cantonments in this country very early in the course of training. (*b*) Among prisoners of war who have been, like other soldiers, exposed to shell fire, strain, etc., scarcely any cases of hysteria or other psychoneuroses have been observed. (*c*) Very often quick and complete recovery from hysterical, symptoms, having occurred on evacuation to a base hospital, is followed by a return of the symptoms in the same or even a greater degree of intensity, or by development of new symptoms, on any prospect arising of being sent again to duty.

13. Statements which have been made to the effect that war neuroses had not been observed in previous wars in such large numbers are probably not in accord with facts.

14. The factors to which patients themselves attribute cures are apt to be, like the causes they assign for their troubles, trivial and inadequate.

15. Among medical officers there is a striking general tendency to ignore mental mechanisms; cures are attributed to this or that therapeutic method, every method having its advocates and opponents.

16. According to my experience, the particular method of therapy is a matter of comparatively little importance.

17. In cures the following factors are frequently seen to be operative: (*a*) Medical officers impressing patients in such a way as to preclude any hope of successful imposition, (*b*) demonstration of the unreal nature of the disability, (*c*) strict discipline as opposed to sympathy, coddling, or humoring, (*d*) painful or otherwise disagreeable treatment, (*e*) removal of motive by change of situation.

18. Many spontaneous cures occurred, in previously refractory cases en route to the United States and later on the signing of the armistice.

19. Among circumstances contributing to the prevalence of war hysteria is gullibility of the medical profession.

20. As opposed to laymen, the tendency of medical men is to overlook or ignore underlying motives and mental mechanisms and to allow themselves to be imposed on in the crudest fashion.

21. Military law places medical officers in a difficult position. They must either designate the disability by some respectable name, such as hysteria or psychoneurosis, or make a diagnosis of malingering and have to prove criminal intent.

22. All are agreed as to there being a close similarity in the clinical manifestations of hysteria and malingering and as to there being great difficulty in practice of establishing the differentiation.

23. The motives which I have found to be the mainspring of hysterical conduct are the same as those which students of malingering have reported as actuating their subjects.

24. In the one case of malingering which has come under my own observation the manifestations were typical of hysteria.

25. A search through the literature reveals but one point to which the differentiation is generally fastened; namely, conscious or unconscious quality of the motivation.

26. It is strange that so futile a consideration, one so obviously belonging to the domain of metaphysics and not science, as the question of degree of consciousness of a mental process, should become the preoccupation of scientific men and should be chosen as a criterion of clinical diagnosis!

27. Further phases of confusion of hysteria and malingering.

28. Among other suggested points of differentiation between hysteria and malingering are: (*a*) Result of treatment by persuasion, i. e., if persuasion fails to cure the case is not hysteria but malingering (Babinski). (*b*) A desire to be cured speaks for hysteria; the opposite indicates malingering. (*c*) The malingeringer dreads examination; the hysteric welcomes it. (*d*) Hysterical manifestations bear the stamp of a certain genuineness which those of malingering lack.

29. In my experience differentiation based on any of these points is not possible.

30. My own experience and study lead me to the conclusion that what some have described under the name of hysteria and what others have described under the name of malingering are one and the same thing. The difference seems to be entirely one of point of view.

31. War experience has shown that hysterical manifestations can be actuated by motives other than sexual.

32. In most other respects, what I have seen of hysteria in the course of war experience bears out Freud's conception of its underlying mental mechanisms better than any other pre-war conception.

33. The essential feature of the hysterical personality seems to consist in a character defect.

34. I would banish from medical classification such euphemisms as "hysteria," "shell shock," "traumatic neurosis," etc.; and would also banish the expression "malingering" with its implication of crime for which the responsibility is entirely on the patient.

35. I would designate, instead, the cases in question by the term *constitutional psychopathic state, simulation*.

36. The cases classed under the heading of neurasthenia may be roughly divided into two groups. The first represents a condition allied to the manic-depressive psychoses; the second is characterized by vague general hypochondriasis, may often be shown to be motivated exactly in the manner of ordinary hysterical manifestations, and is, to my mind, but a special type of hysteria or simulation.

37. My experience has amply shown that the possession of native intelligence far above the average and good educational and social opportunities are not incompatible with hysterical character defect and with gross lack of moral sentiment.

38. Judging from the narrative of survivors of a torpedoed transport it would seem that nothing that happened in the war was more exhausting, horrifying, depressing and nerve racking than their experience.

39. These cases show what remarkable stability a normal neuro-psychic constitution has and how inadequate etiologically, in the absence of a neuropathic predisposition, are the factors to which psychoses and psychoneuroses are so often attributed.

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