Selected Papers.

THE "INSTINCT-DISTORTION," OR "WAR NEUROSIS."*

BY DONALD E. CORE, M.D., MANCH., M.R.C.P., LOND.,
Honorary Assistant Physician, Manchester Royal Infirmary; Physician, Ancoats Hospital; Captain, R.A.M.C.T.F.

In a paper published some little time ago¹ it was pointed out that functional nervous disorders could be divided into two groups, according as to whether they were or were not determined by environment. Hysteria, and the neurosis about to be considered, belong to the former of these two groups, both being influenced by environment, while neurasthenia or the functional nerve disorder brought about by exposure of the nerve cells to prolonged poisoning by micro-organismal products, and certain of the reflex neuroses, belong to the latter.

The group of cases now to be considered resembles the hysterias in that environment plays a dominant part in their formation, but they differ from them in two respects: (1) in hysteria the rôle of environment is indirect, whereas in these cases it is direct; (2) hysterical phenomena are based on a physiological reaction, while the group under consideration is not so based; the phenomena are pathological and subserve no useful function in the shielding of the conscious mind from unpleasantness. For all practical purposes it is a product of modern warfare; it occurs in people correctly adapted for the requirements of civilized life when such people have been, for a length of time that varies with the individual, made to live in the utterly abnormal environment produced by the war. A functional breakdown of the kind to be described is liable to happen to everyone under these conditions, the variable element being the length of time that elapses before the symptoms become manifest.

THE PRIMARY INSTINCTS.

Our normal behaviour under conditions of civilized life is to a great extent the result of the development, inhibition, and combinations of the primary instincts among each other. McDougall describes seven such instincts:

The instinct to run away under the emotion of fear.
The instinct to fight under the emotion of anger.
The instinct of repulsion under the emotion of disgust.
The instinct of curiosity under the emotion of wonder.
The instinct of self-abasement under the emotion of subjection.
The instinct of self-assertion under the emotion of elation.
and The Parental Instinct under the emotion of tenderness.

These instincts should not be looked upon as hard-and-fast and rigidly defined from each other. Nor can we imagine that in an ideally primitive organism such instincts exist in a state of elemental purity; it is almost certain that they have evolved from a functionally undifferentiated nervous system, and that their development has been determined by environment. Generally speaking, the environment in which animal and vegetable life has developed through the ages has been the same for all forms—an environment of ceaseless stress and strain, of unending activity and competition; therefore all animal life met with on this planet manifests the presence of some or all of these instincts, their combinations and associations. But they are essentially labile, and their relative strengths depend on the minor differences in the conditions of life brought to bear upon any genus or species. But in that these instincts have developed from some undifferentiated form of nerve activity, the reactions manifested when for any cause the normal play of emotion and conation is disturbed need not be distinct and specific for each instinct involved. As a matter of fact, there is, I think, a tendency for certain of these instincts to show their "resentment" under such circumstances in a characteristic manner; but this is no more than a tendency, and need not necessarily obtain.

Now, if we consider the above seven primary instincts, we see that in that their relative strengths are the result of our customary environment, and are, in such strengths, useful for our customary environment; then, given a sudden and sufficiently radical alteration in our surroundings, the developed instincts in their relative powers may be utterly inefficient for the fresh environment. Modern civilization tends to the safety of the individual without any very great trouble on his part, and the emotions of fear, anger, and repulsion are not, in such a state, called very frequently into action—at any rate, with any great intensity of tone. Much of the nerve force associated

* Reprinted from the *Lancet* of Aug. 10, 1913.

with these emotions is transferred to other conative activities, with results that are useful to the individual as long as he is living under the conditions of civilized life to which he is accustomed.

THE EMOTIONS IN WARFARE.

But under the conditions of modern warfare the emotions of fear and disgust particularly are called into frequent and violent activity. And not only is there a sudden and intense evocation of unaccustomed emotions, but the end-results and conative aspects of such emotions, so far from being given free play, are expressly forbidden, both by the idealistic conceptions acquired during childhood and early life and by vigorous punishment from fellow-men. Thus in modern warfare men are daily put into positions of imminent danger; the danger to life under certain conditions of military duty may be so great as to render death a practical certainty. In such situations men, if they are normally constituted, experience fear, and, under ideal conditions of such a position, would run away. As it is, self-respect and military discipline prevent this normal end-result, and such men proceed to fight in direct disobedience to their instinct. The helpful influence of the emotion of savage anger against their adversaries is not felt with any intensity. The disgust at the unaccustomed sights and sounds of conflict is not allowed to manifest itself in the normal way by repulsion, so that under these conditions three of the most powerful instinctive activities are distorted.

How utterly abnormal from the biological standpoint such a situation is may be inferred if we take analogous cases in the lower animal world and imagine a rabbit confronted by a hungry fox. If we further imagine the rabbit to be an idealist he might be tempted, for abstract reasons, to fight the fox, and the result would be obvious, and from the point of view of natural selection, wise. Such a situation between two such animals is inconceivable, but if in place of abstract reasons the rabbit was fighting in defence of its young, then, whatever the result, the incident would be natural and the animal would probably fight more efficiently.

If we consider the above seven primary instincts we see that they are divisible into two

groups, members of each reinforcing each other and antagonizing those of the other group. Into one of these groups fall the emotions of fear, disgust, and self-abasement, with their associated impulses; into the other anger, self-assertion, wonder, and tenderness felt for offspring. A sense of inferiority combined with disgust reinforces the feeling of fear and renders the impulse to fly more powerful; whereas fear may be diminished by anger, a sense of superiority, and especially by the activity of the tender emotion. Unfortunately the tendency of modern warfare is to give play to the emotions of the first group without developing those of the second, and also to produce emotional tone without allowing the associated impulses to come into action. The elaborate inculcation of a hatred for the enemy and of a conviction that he is fighting in defence of his hearth and home are undoubtedly useful in lessening the destructive emotions of the first group in the case of the fighting man.

In that the occurrence of any emotion should normally be followed by the actual occurrence of its associated impulse, suppression of the appropriate conative aspect is directly harmful to the proper functioning of the nervous system, and is liable to be followed by functional disorders of this system.

In the case of the production of hysterical symptoms as opposed to those of the functional disorder we are now considering, it was stated that the etiological value of the exploding shell and of the collapsing trench lay in the fact that they reinduced an emotional tone which had been at one time in the life of the patient associated with some particular incident that he had seen, or heard, or experienced. In the type of functional disorder that we are dealing with now, the exploding shell and the falling trench also are important etiological factors, but they bring about their effects in a different way; they act as the "last straw on the camel's back," and simply complete the degree of fear that is necessary to make the symptoms obtrusive. In the former case these factors act as the triggers of a specially adjusted mechanism; in the latter as the final blows in the disrupting of the normal mental mechanism.

SYMPTOMATOLOGY.

The symptomatology of the "war neurosis" differs from that of the hysterics in that it con-

forms to one type. In hysterical conditions of the pure or protective form there is found a cutting away from the consciousness of the patient all impulses coming from a region of the body which has been concerned in the transmission of unpleasant impressions; in the suggestion hysterias the diversity of symptoms and symptom groups is only limited by the limitations of the particular patient's powers of association, but in the war neurosis the diversity of symptoms is reduced; they conform to the various motor manifestations of fright, and are divisible into two groups.

In the first of these the fright manifestations are those associated with flight: pallor of the face with a rapidly beating heart and staring eyes, sometimes to the extent of exophthalmos; dilatation of the pupils and muscular excitability, spasm or tremor. Such symptoms in their essence are physiologically useful in that they put the animal into a state of preparedness for the obtaining of a desired objective—immediate removal from a given neighborhood—and this is the group that is most often met with in this form of functional nerve disorder, some or all of them. When all are present the impression on an observer of utter fright is irresistible, but in actual practice all of them are not present in the majority of cases, and then the rôle of the suppressed emotion may escape attention.

In the second group the fright manifestations are those associated with the "crouching" instinct met with in certain of the lower animals, a process which keeps such animals perfectly stationary in situations of intense and imminent danger so as to avoid attracting the attention of an enemy. Here, in addition to the tachycardia, sweating, and dilatation of the pupils, there are inability to walk, or even to move the legs at all for this purpose; occasional attacks in which the patient for a short time cannot voluntarily move any part of his body; and inability to make a noise, aphonia, whispering speech, or its modification, stammering.

THE ELEMENT OF FEAR.

These somatic signs are indicative of a "choked up" conative aspect at, and leading up to, the time of their occurrence. Now, although it is true that normally the conative aspect of an instinct follows after the emotional, nevertheless it is a fact that the per-

formance of appropriate actions tends to the production of the associated emotion. Thus, bracing the trunk muscles, clenching the hands, and setting the teeth will induce a feeling of anger; and it is to be expected that the presence of the symptoms mentioned above would reproduce the emotion of fear. This is always the case, and it is the presence of this emotion that is the deciding factor in the diagnosis of the war neurosis. These patients always at one time or another experience fear.

In the early, untreated, and acute cases the fear may be obvious and openly expressed; in addition to looking terrified, the patient is terrified, and he is terrified waking and asleep. As he improves the fear leaves him in his waking hours and is confined to his dreams, and the importance of a history of terror-dreams can hardly be overrated.

Much has been written lately on the subject of dreams and dream interpretation, and much of what has been written seems to me to be of the nature of a very elaborate structure built on very slight foundations. We do not know enough of the psychology of thought to justify detailed interpretation of dream incidents, but the emotion that is evoked by these incidents not only illuminates the general trend of the dream, but also gives important information as to what particular emotion has been excited and, if not actually suppressed, not been allowed free play during the waking hours.

The progress of a patient suffering from the war neurosis is best estimated by the intensity of the terror-dreams. In the earliest phase, when fear is felt during the waking hours, there may be a difficulty in getting to sleep at all on this account. Later, when he does sleep his rest is fragmentary, and is broken by the distress caused by his dreams. The fear-content of the dreams is so intense that it wakes him with a jerk, often with a cry; he lies for a time unable to move and sweating freely. He then drops off to sleep again, and the same behaviour is repeated throughout the night.

This phase gives way to one in which the patient on waking in the morning remembers with considerable distress the dreams that he has had, terrifying in themselves, but not sufficiently intense to wake him up. Or if he does wake up in this stage there is no free sweating.

In the third stage towards recovery the

dreams do not come every night; several nights of refreshing sleep are obtained, and only now and again does he experience the dreams; in this stage he is not awakened at all by them. It is instructive, however, to notice that in this stage, if he is touched while asleep, he wakes with a start and in distress. If in the course of treatment the patient relapses, the dreams revert to the early types, but not, in the majority of cases, with sufficient intensity to wake him.

As these patients improve, the element of fear disappears from their waking life and in the course of time from their dreams. But in the vast majority of cases the somatic symptoms—tremor, stammering, and so forth—remain, and in such cases the final phase of the disorder has been entered, the stage of habit. The habit stage is of importance, for not only is it the stage of greatest duration, but it tends to perpetuate the condition by bringing about relapses. If while under treatment anything occurs to upset a patient's confidence in the methods of treatment he is receiving, if the conviction that he is going to recover is weakened from any cause, then his mind becomes, so to speak, sensitive to his symptoms, and in that these are the result of fear they work backwards and reproduce the emotion, as mentioned above; but the emotional intensity is rarely as intense as in the earliest phases of the condition.

These two stages of war neurosis, the emotional and the habitual, are characteristic, and their differentiation is important from the point of view of complete recovery. A patient in the first stage is ill and requires hospital treatment, whereas one in the second stage is merely inconvenienced, and very often hospital treatment is the direct opponent to complete recovery.

ANOTHER TYPE OF CASE.

In Mesopotamia and in India during the first half of 1916 quite another type, from the point of view of symptoms, of functional nervous derangement was met with. This form was characterized by evident mental dullness as far as events happening round the patient were concerned. Such patients would answer questions correctly but briefly; they took no interest in any subject under discussion and never volunteered any remarks; they were per-

fectedly content to lie quietly and passively; they neither read nor wrote. When given any information bearing upon their interests they either took no notice at all or dismissed the subject with some indifferent remark. Their mental state was one of inertia; there were no positive signs, and to anyone who did not know anything of the antecedents of a particular patient he would seem just rather a surly and uninterested person. Yet in the course of their convalescence they proved themselves rather the reverse.

Such patients were those who had been in Mesopotamia some time, and who had experienced the distressing monotony that a prolonged residence in that country impresses upon most people. In the early days of the campaign, everything there was characterised by this deadness—country, climate, occupation, and food. I cannot help thinking that the condition of intellectual inertia produced is the result of this utter absence of interest—is, in fact, the result of an abeyance of the emotion of wonder in the instinct of curiosity. Patients in this condition recovered quickly when sent away from the country, recovery in many cases being associated with a period of irritability.

THE SEX INSTINCT.

In view of the mass of literature, constructive and destructive, that has been published during recent years on the part played by the sex instinct in the production of functional nervous derangements, it may be advisable to discuss briefly its potency or otherwise as such a factor in the light of the evidence gained from the multitude of functional disorders that have been recently observed.

In that sexual activity is an instinct with emotional, receptive, and conative aspects, it may reasonably be supposed to be a possible source of an instinct-distortion neurosis, and in my opinion it is such a source in a limited number of cases. Its *modus operandi* is strictly analogous to that of the flight and repulsion instinct; that is, it produces a neurosis when there is an intense emotional activity with obstructed conative activity. In other words, it is not excessive sexuality nor perverted sexuality that produces the neurosis; it is compulsory abstinence from sexual activity. Given that a man with strong sexual tendencies be

forced to live in an environment where he is unable to gratify them, however healthy they may be, then such a man may in the course of time manifest an instinct-distortion neurosis. I do not think that there is any need to postulate the existence of "repressed complexes" or other subtleties; a man in this position may masturbate or fall into homosexual practices, or, what is still more important, he may fear the possibility of such a happening. The end result is the same; he worries himself ceaselessly over his condition and ultimately develops mental depression. Such men frequently tend to struggle against this depression and to overcompensate in the direction of high spirits, and their neurosis takes this form—cheerfulness and high spirits with periods of intense depression—and such patients require careful watching, for they not infrequently resort to suicide.

Of course, in the case of men and women of an hysterical type the primary incident may be of a sexual nature, but this is not in any way essential, nor is it, in my opinion, at all frequent, at any rate in this country. The sex neurosis works through the medium of worry, and it is difficult, I think, for some of us to realize how intense this worry may be. Such cases may be suitably called "isolation" neuroses, for it seems probable that in addition to enforced sexual abstinence the factor of loneliness plays a part.

The sex instinct is most emphatically not of primary importance in the production of the war neurosis.

CAUSATION.

It will thus be seen that the war neurosis as described above differs entirely in its mode of origin from hysteria. The latter condition clinically is the result of an improper suppression of a tendency that is inherent in every one of us and which is determined by our position in the scale of evolution; it is manifested as a result of an emotional activity which is normal as far as the emotion is concerned. The former is the result of an improper strain on the emotions themselves, leading to a wrongful emotional tone and to distortion of the bodily mechanism which is associated with the conative aspect proper to the emotion concerned. To use an analogy, there is all the difference between the two conditions that there is be-

tween the emptying of a reservoir by raising the sluices in the dam and by smashing the sluices or the dam itself.

The actual method by means of which emotional activity becomes manifest as somatic phenomena is an interesting problem that does not concern us here; the work of Cannon and others indicates the sympathetic nervous system and certain of the ductless glands as important connecting links. It is important, I think, to exclude from the pathology of "shell shock" (which is a term generically applied to certain hysterical and instinct-distortion phenomena, and which is about as applicable to either as "cold" or "chill" would be to all varieties of inflammation of the lungs) any lesion which gives rise to organic clinical signs. Cases in which, after death, hemorrhages and compression lesions are found are better called "shell disease," after the principle that distinguishes caisson disease. The different functional disorders included at present under the name of shell shock should be sharply separated from those in which organic lesions can be diagnosed during life.

In this way, then, a shell exploding so close to a man that the violent alterations in the air-pressure brings about cerebrospinal hemorrhages and other disruptive effects would produce "shell disease," whereas the explosion that completes the measure of emotional stress in the manner described above, and which brings into eminence a condition that has long been incubating, produces "shell shock," so-called. In the presence of signs of organic disease shell shock should not be diagnosed, but shell disease. Of course, there are bound to be cases in which the diagnosis between the two conditions is of extreme difficulty, but from the point of view of both prognosis and treatment it is well to go on the principle of diagnosing shell shock only when a thorough examination reveals no signs of organic disease, and shell disease when such signs are present.

DIAGNOSIS.

The diagnosis of the instinct-distortion, or war neurosis, is, as a rule, easy. In the absence of signs of organic disease it may be made in the case of any patient who shows symptoms of nerve irritability and in whom, at one time or another, the element of fear is present. In the event of such symptoms ex-

isting in a patient who shows no signs of fear, either in his waking hours or in his dreams, one of two conditions may be present—the war neurosis in the late or habit stage, in which there will be a history of terror-dreams at the beginning of the illness; or a suggestion-hysteria, in which case no such history is obtainable. Naturally, leading questions should not be asked; the patient should merely be asked if he sleeps well, or if he slept well at the time of onset of the breakdown.

It sometimes happens, though not in my experience very commonly, that an instinct-distortion neurosis and a pure hysteria exist in the same patient.*

I recently saw a young soldier, a private, who was under treatment for herpes zoster. The condition affected the left side of the chest in the area of the fourth dorsal segment. While under treatment he quite casually mentioned that he had been recently suffering from what he called “attacks,” after he had been in bed for a little time and when he was going off to sleep. In these attacks, which lasted only for a minute or so, he lost his sight, and all power of making a noise; he was absolutely unable to move a limb; he came to himself sweating, and, as he described it, “sick with fright.”

The emotional tone of the incident, the inability to move or to make a sound were quite characteristic of the instinct-distortion neurosis, the symptoms conforming to those of the second group mentioned above, but the temporary blindness was difficult to account for on the grounds of an instinct-distortion neurosis.

Looking through some past notes of the case, however, the following entry was found: “The patient states that what worried him most when in Flanders were the horrible sights, to which, unlike most of his companions, he could never get accustomed.” The amaurosis, in fact, was the result of a pure or protective hysteria, and the condition of the patient was due to the existence of the two types of functional nerve disorder.

The actual determining cause of the attacks was the sensation of his heart beating as he became drowsy; the trouble did not arise until

he began trying to lie on the left, or herpetic side. The condition of the nervous system was quite slight and readily passed away; he had not been invalidated for it; but in the event of his not having had herpes zoster when he did, it would be a matter of interest as to which functional derangement, the hysterical or the instinct neurosis, would have become obtrusive first. Probably the hysterical, in which case he would have been invalidated for blindness.

The above case is of interest in that it indicates the lines along which an approach to the diagnosis should be made. Any particular symptom should be investigated from the standpoint of its being or not being, as the case may be, useful to the individual as a means of escape from his enemies, or of its being a derivative of such a useful manifestation. Thus, inability to move or to make a noise is obviously useful to the hare when trying to avoid attracting attention, but blindness is not, for it would militate against the final rush when the animal realized that attention had been attracted; it would prevent this realization to a great extent. Therefore the blindness could not form part of the instinct-distortion neurosis, and further examination into the attitude of the mind of the individual to his surroundings in the fighting line will ultimately bring into prominence some association with sight—either, as in the case just mentioned, distressing sights, or, if these are not complained about, some childish association in which the eyes played a part.

TREATMENT.

The treatment of the instinct-distortion neurosis is, in its essence, simpler than that of the hysterias, and more satisfactory. This, of course, follows from the fact that in the latter conditions symptoms are treated, while the underlying condition remains; the patient is hysterical to the end of his life. In the former, however, the harmony of the nervous system can be, and as a rule is, fairly easily restored, the difficulty experienced in practice being the persistence of certain symptoms as habits, and even these are more readily removed than would at first sight appear probable. In the course of time, when all ideas of the war as an imminent factor have disappeared, the more troublesome of these symptoms will be done away with owing to their very obtrusive-

* As a general rule, in a hysterical individual the hysteria symptoms manifest themselves before the emotion neuroses have had time to develop; this is, of course, intelligible on the theory that the hysterical person develops his condition to protect his consciousness from emotional distress. The instinct-distortion neurosis may be colored by a suggestion hysteria, but in such a case the greater includes the less, and the case should be looked upon as an instinct-distortion neurosis.

ness, while the less troublesome will persist only as long as they do not interfere with the patient as a useful individual in the surroundings in which he works.

Treatment falls necessarily into two groups according as to whether the patient is or is not ill. These two groups correspond fairly accurately to the phases mentioned above, the active or terror phase of the illness and the habit phase.

There are two fundamentally important principles in treatment that should always be kept in mind. The first is that the patient must be removed as quickly as possible from the environment which was responsible for the condition—he ought to be taken right away from any focus of fighting; and the second is that from the very beginning he ought to have it impressed upon him that he is going to get completely cured. The removal from the combatant atmosphere is so obvious and so usual that its importance as a method of treatment as well as the light it throws on the origin of the condition is in danger of being overlooked.

When such a patient has arrived at the "ultimate base" wherein the remainder of his treatment is to be effected, if he is still in the active stage he should be kept for the most part in bed and in a ward that is quiet. It is inadvisable that he should be alone; I think that a ward with two other patients in it forms the best environment. Here he should stay until he is able to sleep without being waked up frequently by his dreams. In the early stages, when he is unable to sleep at all, I have found the best results with trional, 10 gr., with or without aspirin, and diminished gradually as the tendency to sleep improves. During this period it is well to make him realize that he has power over his legs by making him take a few steps every day in the ward, but as long as he is definitely "ill" with his condition he ought to spend most of his time in bed. He should be seen frequently by the medical officer in charge and should be constantly reassured as to his complete curability and encouraged to look upon himself as improving from day to day.

As the sleep improves and the dreams lessen in intensity he should be made to leave the ward for a short time each day and mix with the other patients, and then the more detailed

treatment may be instituted. It will be found that patients manifest one, some, or all of the following disabilities; speech defects, tremors, disorders of gait, mental depression, irritability of the sympathetic nervous system.

As regards *speech defects*, the principle of treatment may be summed up in the words, "careful and painstaking reëducation." At the Seymour Park Military Hospital in Manchester we have been fortunate enough to obtain the assistance of the officials of the Institute for the Deaf and Dumb in the treatment of cases of disordered speech, and the results have convinced me that these patients are the most readily curable of all. Definite classes are formed, and the men are shown the position of the lips in the articulation of the vowels and their compounds. They are taught breathing exercises, are made to read aloud, and are discouraged from speaking to fellow-patients while they stammer. The result in the majority of cases is little short of marvellous, but, as in all cases of the instinct-distortion neurosis, treatment must be painstaking and to a large extent individual, and a very considerable degree of patience is required.

Similarly, in the treatment of *disorders of gait*. In the event of there being complete inability to move the legs at all, the patient should be made to sit on the edge of the bed and "feel the floor with his feet." Often enough this produces clonic spasms of the legs and the patient at first can practice only for short periods at a time, but if he is made to practise regularly and is systematically encouraged these spasms lessen, and he then begins to apply pressure to the floor with the feet. He should then be supported and made to stand, and to take a step or two; in the course of a very short time with support he will be able to get over the ground easily. The support should then be lessened, and it is well to remember that it is very much more easy to err by keeping the support, orderly, crutches, or stick, too long than not long enough. As soon as the patient can move fairly well when supported by an orderly he should be given crutches, and when he realizes that he can manage these, he should be made to give them up and take to a stick. The same principle is repeated with the stick; he should discard it as soon as he is able to use it with comfort. During the orderly, crutch, and

stick stages he should be made to take exercises of precision over a track marked out on the floor. Two lines are painted on the floor about three feet apart, and foot-marks are indicated between them; the patient is told to walk between the lines, putting his feet on the marks. The proper use of the thigh and leg muscles should be insisted upon. These exercises may be associated with the use of a treadle machine.

Tremors also should be treated with exercises of precision. The coarse, clonic spasms of the early stages of the condition readily subside as improvement in walking is attained—and the less the patient's attention is drawn to the hands and arms in this stage the better. In the stage of the fine tremors he should be made to use his hands and arms in the way that best appeals to his interest; he should be made to construct models with a set of child's bricks or, in the later stages, with some of the "Meccano" outfits. Or he may be encouraged to manipulate chessmen or to do crochet work. The extent of useful exercises for tremors in the later stages is very nearly endless, and it requires only a little imagination on the part of the medical officer, sister, or nurse to suit a patient's requirements and, in addition, to make the exercises interesting. At the same time, these exercises should be carefully watched; any tendency on the patient's part to look upon them as a means of getting through the day apart from any therapeutic value must be checked; also, as soon as he has become proficient at one set of such exercises he should be given another and more delicate set. And when all signs of mental disturbance have disappeared and he realizes that he can do useful work with his hands, then the sooner he is discharged from the hospital atmosphere into some form of civil employment the better.

An interesting symptom-group that occurs in certain of the patients suffering from this form of neurosis is *mental depression*, and often enough this becomes obvious only in the later stages of the disorder. Such depression may be due to the troublesome nature of the symptoms for which, primarily, a patient is undergoing treatment; in such a case it subsides as the symptoms improve and requires no special treatment. In other cases it is present in the absence of any obtrusive somatic symptoms,

and then treatment should proceed along two lines—"therapeutic conversations" and employment. Therapeutic conversations should always be added to whatever form of treatment any patient with the instinct-distortion neurosis is receiving, but when there is well-marked mental depression they become of paramount importance. In such conversations, as far as possible, the "doctor and patient" atmosphere should be avoided, and in most cases in my experience psycho-analytic methods are not needed. The patient should be treated in a friendly manner, and in the course of time definitely asked what is troubling him. If sufficient tact has been used I find that there is usually very little difficulty in getting him to say what is on his mind; often enough, unfortunately, the cause of the depression is perfectly reasonable, and as far as medical treatment is concerned is not removable. And of all the causes domestic worries are the most potent. In other cases the depression is the result of disabling symptoms that are irremovable. In one case I saw profound depression was caused by gross nystagmus, apparently the result of hemorrhages round the fourth ventricle and aqueduct; the case was one of shell disease. Depression caused by obtrusive symptoms is best treated by giving the patient occupation in experimental workshops; work which is not specially interfered with by his condition is chosen for him, and he is encouraged to make himself proficient in it. The more he is made to realize that he is not utterly disabled the more the depression lessens, but in some cases we have to admit that the depression is justified.

The *tachycardia* and other signs of irritability of the sympathetic nervous system are best treated by graduated exercises. It is an unfortunate fact that patients suffering in this way are extremely difficult subjects to convince that there is no organic disease of the heart; in the mind of the average patient palpitation, praecordial pain, and giddiness are incontrovertible signs of "heart disease." Such patients are best treated in hospitals specialized for heart conditions, in which the whole atmosphere of the patient is directed towards his realization that his symptoms are in no way dangerous, and that by training they will cease to hinder his activities in after life.

NOMENCLATURE.

In conclusion, it may be permissible perhaps to discuss the nomenclature of this condition, the instinct-distortion neurosis. The usual name, shell shock, is unfortunate, because it covers cases that are hysterical as well as those that are not, but which are the results of a strained emotional activity. But shell shock covers neither of these conditions completely; the most characteristic cases of the instinct-distortion neurosis may give no history of shell shock. On the other hand, what soldier patient that has been in the front line for any time has not been in the sphere of bursting shells? The name "shell disease" is applicable, for it is the direct disruptive effect of the explosion that produces the lesions of that condition, but shell shock, as a name applied to functional nervous breakdown in soldiers, cannot be justified.

Exposure to the sights and sounds of the modern battlefield may bring on hysteria manifestations or symptoms of the instinct-distortion neurosis. This latter name is clumsy, and "war neurosis" is too general a name to be applied to this disorder.* The more specific name "terror-neurosis" is perhaps a little invidious at the present time, and I would suggest calling the condition described in the foregoing pages "dysthymia" (*δυσ*, impeded; *θυμός*, emotion).

We could then sum up the state of affairs as regards the factor of the exploding shell thus: The neuroses usually met with as results of the present war are hysteria and dysthymia. Neither is exclusively the result of the war, but of the two, dysthymia is the nearer approach to a specific war neurosis. In neither need there be a history of a bursting shell or a collapsing trench; such a history may be present in both. The bursting shell and the collapsing trench have no specific value in the determination of these neuroses; they possess an adjuvant value only, and this value may be obvious or masked. Only in "shell disease," where there are demonstrable organic lesions, have these factors any specific value, and the resulting condition is not functional.

* I have recently seen a most characteristic example of this neurosis in a woman, resulting from physical fear of being confined. The neurosis became evident shortly after marriage and became acute during pregnancy.

REFERENCES.

¹ The Lancet, 1918, i, 365.

Book Reviews.

Vagatonia: A Clinical Study in Vegetative Neurology. By DR. HANS EPPINGER AND DR. LEO HESS. Translated by WALTER MAX KRAUS, A.M., M.D., AND SMITH ELY JELLIFFE, M.D., Ph.D (Second Edition. Nervous and Mental Disease Monograph Series, No. 20. 8vo. pp. 93. New York: Nervous and Mental Disease Publishing Company. 1917.

This book, while not a large one, consists of a clinical study of the vegetative functions of the nervous system. While the influence upon this portion of the nervous system from the secretions of the endocrinous glands is still largely an unknown field, yet the disturbances of organ functions in various nervous diseases are so frequent and varying that a new point of view of the origin and meaning of these disturbances cannot help being stimulative. This book gives evidence of wide reading and study, and as one of the best studies in this portion of the field of neurology which has its chief bearings in the wider field of internal medicine, of which neurology is an important part, deserves careful reading by all serious students of internal medicine.

Study of Organ Inferiority and Its Psychological Compensation. By DR. ALFRED ADLER. Nervous and Mental Disease Monograph Series, No. 24. 8vo. pp. 86. New York: Nervous and Mental Disease Publishing Company. 1916.

The author has here presented a theory of the inferiority of an organ, or organs, from various causes, which he considers as due to a variety of factors,—heredity and others, which have a large influence in determining the development of a great number of organic diseases, tuberculosis and other infectious diseases, carcinoma, and disturbances of function. Then he considers the effect of compensation of this original inferiority in various ways, with especial stress upon the psychic effect, both in the direction of repression and the development of psychoneuroses, and of compensation in psychological directions. He finds in his studies in particular confirmation of Freud's theories of the origin of psychoneuroses.

While the arguments are stated broadly, and the clinical cases adduced in support of these views are given in outline only, and seem far from convincing, the book is suggestive, though it can hardly be considered as even proving much which favors the Freudian theories of the psychoneuroses.