Unprocessed Trauma. Polish Medicine in the Face of Psychiatric Injury in the Era of the Great War

Joanna Urbanek

As Judith Lewis Herman has stated, 'The study of psychological trauma has a curious history – one of episodic amnesia'.[1] Medical advances with regard to recognition and treatment of this type of disturbance are closely tied to the history of armed conflict. It is commonly known that the period after the Vietnam War at the start of the 1970s, when doctors began to describe and treat post-traumatic stress syndrome among former US soldiers, was revolutionary for the development of modern diagnostics in this regard. Its symptoms are also diagnosed among victims, participants, and witnesses of not only war, but also accidents, cataclysms, and individual acts of violence. However, the history of psychology and psychiatry frequently overlooks much earlier significant achievements in this field, in the first half of the 20th century. In observing the experiences of First World War participants, erstwhile researchers correctly described disorders among them characterised by fear, whereas William Halse Rivers (1864-1922) and Pierre Janet (1859-1947) effectively formulated methods for their therapy. Nevertheless, the doctors' interest was closely tied to social reality. The 1920s and 1930s, characterised by a high level of conflict and the growth of nationalisms, were not favourable to systematic attention to the suffering of traumatised soldiers. The atmosphere at the time tended to mobilise society around national symbols, including scenes of heroic battle. An image of brazen heroes obscured the stories of real people, bearing deep psychological scars. On the other hand, the multiplicity of various types of afflictions of a neurotic and dissociative (psychotic) nature led to observations and conclusions. Only after many years, in the second half of the 20th century, did medical researchers follow them up, when study of the human psyche matured to reflection on the alarming consequences of the Second World War.

Fig. 1: William Halse Rivers, English anthropologist and psychiatrist, known for his work treating First World War soldiers who were suffering from shell shock.

First Studies of the Psychiatric Effects of Wartime Experiences in the USA and Europe

An American military physician, Jacob Mendes Da Costa (1833-1900), who at the time of the Civil War termed symptoms such as shortness of breath, perspiration, diarrhoea and chest pains as 'irritable heart', is considered to be the first to draw attention

Fig. 2: American physician Jacob Mendes Da Costa.

to the impact of wartime experiences on a soldier's nervous state.[2] His observations describe that which contemporary psychologists call combat stress.[3] Da Costa ordered the immediate withdrawal of these soldiers from the frontline and their convalescence. It is worth mentioning that his studies were known to Polish military doctors, who referred to them immediately after the First World War when they found numerous examples in their own practice. Symptoms were interpreted as a type of 'general neurosis' involving factors of a psychiatric nature. Indeed, their experiences led to conclusions on the beneficial effects of physical activity and staying at health resorts, which would significantly improve the health of patients within several months.[4]

The history of subsequent studies of wartime trauma is tied to the search for the aetiology of hysteria. This disorder was at first solely diagnosed in women. However, in 1882, Jean-Martin Charcot (1825-1893), the author of initial findings on this subject (from whom Freud drew inspiration), stated that a certain percentage of illnesses also applied to men. He thereby launched a fierce dispute among physicians that can be deemed ideological, since it concerned the axiom of inequality of the sexes from the standpoint of shape and resistance of the nervous system. It is not surprising that nervous disorders among men began to be ascribed to their particular predispositions, intellectual inferiority, or even moral depravity. Charcot's opponents included the particularly prominent German neurologist Hermann Oppenheim (1857-1919), who believed that nervous disorders were caused by damage to the nervous system. This thesis became the basis for modern studies of the brain as well as some fundamentally daunting interpretations by doctors who were seeking damage to the central nervous system in all instances of more or less significant 'nervous disorders'. Advocates of this tendency included Friedrich Schultze (1848-1934), who argued that neurosis and neuro-psychosis can be caused by even minor injuries if the illness encounters fertile ground in the form of a weak organism.[5] Clinical patients at the time were not soldiers, but workers and victims of work accidents. Their problems immediately raised scepticism and charges of simulation, which also endangered the reputation of researchers announcing the results of their studies.[6]

Researchers developed great interest in railway disasters. They were particularly spectacular in a world in which speed of movement increased many fold over the course of several decades. The complex of symptoms afflicting people suffering injuries in such accidents was termed railway-spine and subsequently railway-brain by the English surgeon John Eric Erichsen (1818-1896). He was essentially the first to describe post-traumatic stress syndrome, which was not yet formally diagnosed. However, he considered it to originate from spinal damage, and not psychological suffering from traumatic experiences.[7] This same line of research was continued by Ernst von Leyden (1832-1910), who searched for progressive inflammation of the spinal cord and meningitis among the psychiatrically ill. In his 1979 study, the German doctor declared that the symptoms described by Erichsen only applied to patients experiencing a rail collision while seated backwards to the direction of travel.[8] Only another German psychiatrist, Carl Moeli (1849-1919), concluded that the

Fig. 3: An Australian Advanced Dressing Station near Ypres, Belgium, in 1917. The wounded soldier in the lower left of the photograph has the 'thousand-yard stare' indicative of shell-shock.

symptoms described by Erichsen were unrelated to changes of an organic nature, but rather arose from psychological trauma. The above neurologists' findings repeatedly made reference to analogous disorders observed among soldiers.

There was further progress in the study of neurosis during the Russian-Japanese War. At that time, Emil Kraepelin (1856-1926) described his diagnosed so-called injury neurosis (injury hysteria) by declaring that it stemmed solely from psychiatric reasons. Another Russian physician, Grigori Shumkov, described his observed symptoms of this illness in a work called 'Aerial contusion from experiences of the war of 1904-1905'. They entailed paralysis of sensation and motor skills in one half of the body, as well as strong negative reactions to cold or heat and changes to atmospheric pressure. In contrast to Kraepelin, however, he stated that this illness was caused by

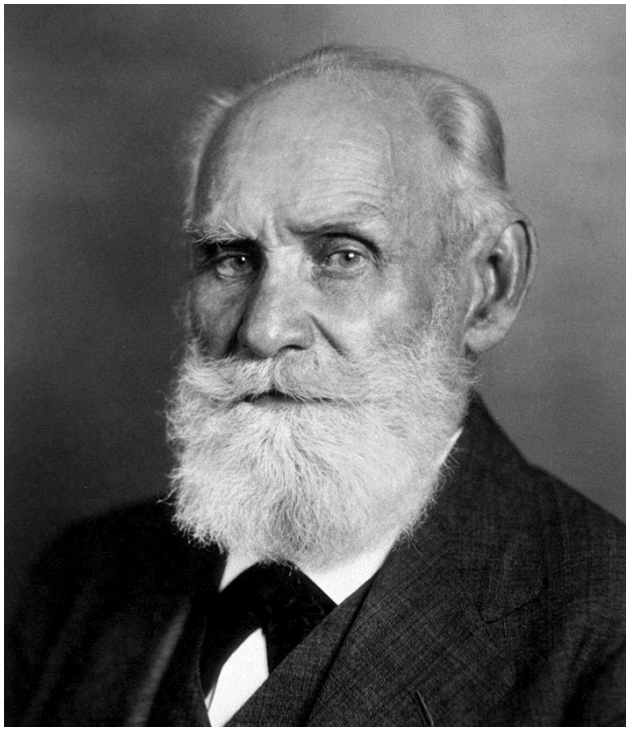


Fig. 4: The Russian physiologist Ivan Pavlov.

Fig. 5: The English physician and psychologist Charles Samuel Myers.

bullets passing in close range of a soldier's head. Studies in this direction were conducted by Ivan Pavlov (1849-1936), who experimented on sheep. He stated emphatically, however, that the claim of higher air density along the flight path of a bullet allegedly causing this illness was wrong, as no such phenomenon could be observed among animals. Working in Paris alongside the Polish psychologist Adam Cygielstrejch (1886-1935), he declared in his 1912 doctoral thesis, *Les conséquences mentales des émotions de la guerre*, that the central nervous system of a patient becomes 'poisoned' by negative psychological experiences, thus leading to psychological disorders.

The First World War marked a milestone in the history of studies on injury stress among soldiers. Numerous instances of anxiety and permanent reactions persisting after withdrawal from the frontline, various disorders, and a rapid rise in military hospitalisation produced a multitude of publications. Renowned psychiatric authorities, starting with Sigmund Freud (1856-1939), revised their positions on previously diagnosed nervous disorders.

Authors of important studies during this time included the British physician Charles Samuel Myers (1873-1946), who published an article on so-called 'shell shock' in the renowned periodical *The Lancet* in 1915.[9] He thereby made famous a term that also provided a strictly physiological clarification of psychological problems soldiers were already facing at the start of the war. His thesis was elaborated upon by Frederick Walker Mott (1853-1926).[10] Mott believed that patients' disorders arose from the rupture of blood vessels in their brains, caused by a sudden change of atmospheric pressure during artillery explosions. This was a loud voice in the dispute with advocates of the psychological aetiology of nervous disorders, which led to numerous disagreements. From that point on, doctors elaborating on Mott's claims in their work focused on a study of neurological responses. Yet they were helpless in the face of patients' psychological suffering. From the standpoint of present-day medicine, this reasoning led to the wilderness of impersonal treatment of the mentally ill. It produced a true mania of measurement and the development of hermetic, yet wildly impre-

cise, terminology. Literature from that time is now an interesting historical source showing how the advancement of military technology, including the growing importance of artillery, overwhelmed doctors unable to comprehend the impact of this machinery of death on the human organism.

There were exceptions among psychiatrists. In Britain, William Halse Rivers (1864-1922) has particular merit for rendering true assistance to patients suffering from nervous disorders. He credited his findings to a meeting with the poet Siegfried Sassoon, a war hero whose harsh experiences on the front guided him toward pacifism. Sassoon, surely suffering from the yet undiagnosed post-traumatic stress syndrome (manifested by mood swings, persistent flashbacks to the frontline and nightmares), entered a clinic run by Dr Rivers, who applied treatment based on regular conversation sessions in an atmosphere of respect and confidentiality. Rivers discovered that one of the mechanisms of war neurosis is an attempt to mentally cut off from looming stimuli associated with armed conflict.[11] In psychiatry, an analogous phenomenon of detachment by a victim of violence or accident is called disassociation. Rivers used the term 'repression', drawn from psychoanalysis. An American student of Freud, Abram Kardiner (1891-1981), sought to introduce similar methods in his practice in observing that symptoms of war neurosis essentially do not differ from hysteria diagnosed among women.[12] His studies nevertheless did not produce any broader echo in a society already focused on new peacetime problems. The subject only reappeared with another global conflict: in 1941, Kardiner published a fundamental study, *The Traumatic Neuroses of War*, providing a clinical description of what was later called post-traumatic stress syndrome, and essentially did not differ much from present-day diagnostic criteria.[13]

Observation of traumatised soldiers returning from the First World War front greatly influenced the views of Sigmund Freud himself. Initially, he thought that the source of their problems was a conflict between the peacetime attitude of a soldier and the fighting instinct. On the other hand, however, he swiftly began to observe other possible causes by noting an excessive number of stimuli to which soldiers were exposed. In his 1920 book *Beyond the Pleasure Principle*, he formulated his own theory of psychological illnesses as a disruption of the natural protection barrier of the ego that in normal circumstances controlled the death instinct (tanatos), as opposed to the life instinct (libido). He continued his reflections on war trauma in his 1926 book *Inhibition, Symptoms and Anxiety*, in which he expounded his hypothesis of fear as a basis for traumatic reactions. Perhaps commitment to his own previous findings and a desire to maintain consistency induced him to define traumatic situations in categories that he compared to the threat of castration or the loss of one's mother.[14] Freud's reflections lacked a direct link between fear and objective threat in situations facing soldiers during combat. The founder of psychoanalysis included wartime trauma in a broader context of typical psychological challenges, which, in his opinion, generally confronted mankind. As Ruth Leys notes, Freud's writing at that time was characterised by uncertainty

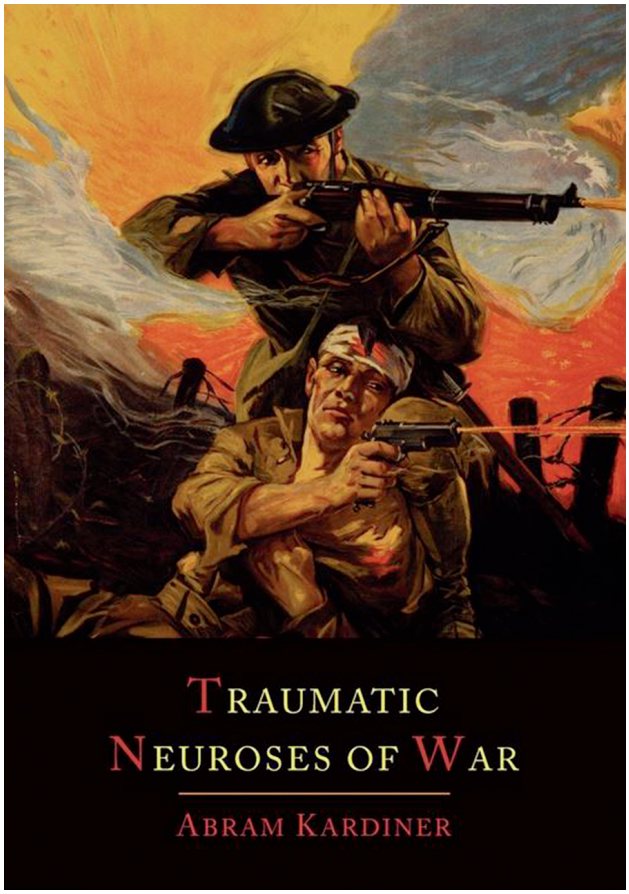


Fig. 6: Book cover of *Traumatic Neuroses of War* by Abram Kardiner, 2012 edition.

and ambivalence. After all, this was a difficult period in the personal life of the renowned psychiatrist.[15]

Other Austrian researchers of psychological wartime trauma also included Erwin Stransky (1877-1962), an opponent of Freud, who in 1918 wrote about his convictions that were supported by the already fashionable race ideology. Stransky, gaining experience in the army as a physician, described numerous individual cases in his work. They ranged from apathy to outbursts of unprecedented aggression among soldiers or collective psychotic states (hallucinations) observed in certain units, usually associated with defeat in battle.[16] Fledgling psychiatry in the first half of the 20th century did not lack an evaluative approach to patients. Causes of disorders were almost always attributed in full or in part to a patient's personality, and not to external factors. The greatest thinkers of that time succumbed to this temptation of this explanation, and 'hysteria' gained its name from the theory of its source in the womb. Such an approach left the social system intact and eliminated or 're-educated' individuals who could threaten it by speaking about abuses. The repressive side of science was primarily exposed in relation to persons lacking full legal status: women and children.

However, social transformation expanded the spectrum of doctors' interests, as well as the potential of abuses. Thus, the development of social insurance systems in Europe in the 19th and early 20th century required expertise on the state of health of compensation seekers. Patients frequently arrived with injuries to the head or spine from work accidents that caused paralysis, tremors, slurred speech or perception, or symptoms of a psychiatric nature. Many of them were diagnosed (or treated in advance) as malingerers. At times, however, the authenticity of suffering left no doubt. In order to reconcile disbelief in employer guilt with empirical observation, the term *Rentenneurose* (pension neurosis) appeared (far more bluntly coined by Polish authors as 'concupiscence neurosis'). Proponents of this approach included the German psychiatrist Adolf von Strümpell (1853-1925).

In the field of military psychiatry, analysts of disorders among soldiers were subjected to particular pressure. There was no shortage of commentary that psychological illnesses originate from moral degradation. The Canadian psychiatrist Lewis Yealland (1884-1954), during his practice in England promoted 're-education' by force: embarrassment of patients, threats, and even electrical shock as punishment. Experiences of the First World War nevertheless led to the conviction among researchers that it is possible for psychological trauma to occur without physical harm to the nervous system (fright neurosis – *Schreckneurose*). A concept prevailed that assumed both an external and internal aetiology of nervous disorders. Still under the influence of psychoanalysis, the Jewish-German academic Alexander Herzberg (1887-1944) found conflict to be the source of neurosis, which could be caused by external factors or a patient's personality.[17]

The above findings and disputes unfolded in a rapidly developing international environment of researchers, who were usually well acquainted with the findings of professional colleagues in other countries. This is evidenced by common reference to foreign medical literature. German, Austrian, French, British and Polish doctors also completed foreign internships by selecting mentors interested in a similar subject matter and centres for testing new treatment methods. Nevertheless, the arbitrary application of certain procedures, terms, and diagnoses must be emphasised. Communities of physicians supporting given interpretations and methods of treatment were akin to feuding sects – completely ignoring their competitors' contradictory results. This was possible because there was no internationally recognised register of illnesses (presently the ICD – International Statistical Classification of Diseases and Related Health Problems and DSM – the Diagnostic and Statistical Manual of Mental Disorders). Work on it lasted from the second half of the 19th century and accelerated at the end of the 1920s due to efforts of the League of Nations, although primarily causes of death were initially registered, and published statistics were incomplete. Available medical handbooks provided their authors' independent classifications and thus diverged depending on individual experiences and approaches.

Wartime Injuries and Polish Science – Research

The research interests of Polish psychologists and doctors, as well as the challenges they faced, did not

essentially deviate from global trends. Their perspective was shaped by access to foreign medical literature and training, which frequently took place in Vienna, Berlin, as well as at Russian, Swiss, or French institutions.[18] Polish doctors studied and earned their titles in the framework of systems prevailing in three countries: Austria-Hungary, Germany, and Russia. Naturally, in addition to Polish, they also employed the language of the country where they practised, usually in conjunction with French as the prevailing *lingua franca* among the educated and, more rarely, English. These factors positively affected the degree of education and medical knowledge, as did contacts between Polish doctors and the international scientific community. Together with the emergence of the Second Republic of Poland, a gradual integration of researchers ensued within a common country. Yet, they still represented various directions, knowledge, and experience, but they now published and taught in Polish while also holding regular meetings.

The First World War contributed to the development of interest in the psychiatric condition of soldiers. However, most reviewed post-war Polish publications on military psychology and psychiatry focused on the subject area of leadership and discipline. A relatively new, but very popular, area of interest in interwar Poland was psycho-technique – tools to measure the features of candidates for the military profession, particularly pilots.[19] In 1920, researchers inaugurated experimental studies at the newly founded Soldier Individualisation Department on the cognitive development of officer candidates. With time, Section IV for anthropological-psychotechnique studies was formed at the Supplementation Department.[20] Its task, above all, was control over a future leadership cadre.

During this time, the Psychological Section at the Military Knowledge Association expanded with the aim of a broader reflection on military psychology issues, including the application of psychological knowledge in times of armed conflict. The Sanitary Training Centre in Jazdów had a psychology laboratory headed by Janina Ostaszewska. Works by Stefan Baley (1885-1952), Władysław Witwicki (1878-1948), Tadeusz Kotarbiński (1886-1981), and Józef Maria Bocheński (1902-1995) were published by the Main Military Bookstore. Publications of foreign authors like Charlotte Bühler (1893-1974) and William McDougall (1871-1938) that were propagated in Poland also gained broader attention.[21]

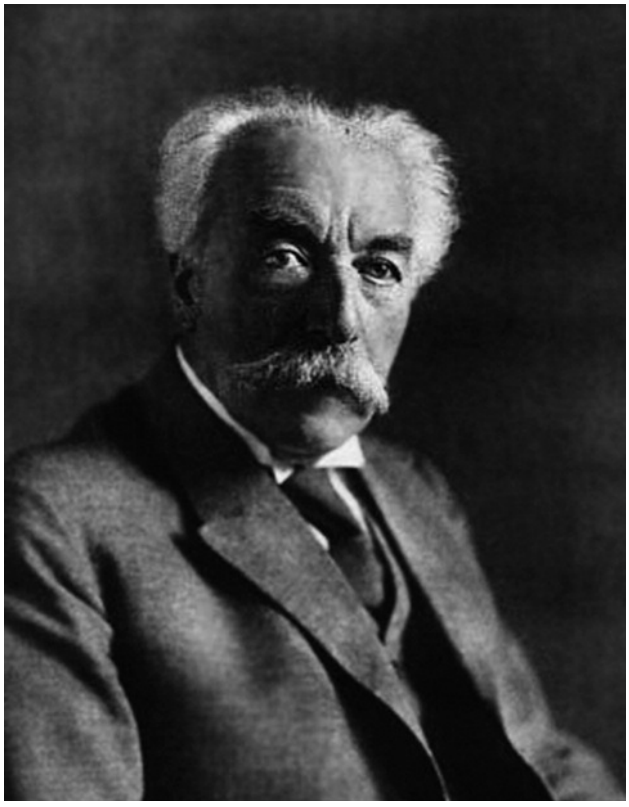


Fig. 7: The Baltic German psychiatrist Adolf von Strümpell.

The above institutions, however, had fundamental flaws. Researchers used extremely expensive equipment measuring such indices as muscle tension or heart rhythm for studies based on dubious theoretical grounds and without observing the basic methodological principles of a psychological experiment. Excitement over new reaction measurement techniques, serving to give the researcher access to the secrets of the human personality and thought, was – as mentioned above – quite typical for this period of European science. It can be called exploratory. As we know, its bitter fruit also included German experience and pseudo-medical studies tasked with confirming racial theories.

A multitude of definitions abounded in Polish academic literature, arising from the vagueness and arbitrary use of certain terms, as noted above. Doctors themselves were aware of these limitations and inadequacies in prevailing science. Stefan Borowiecki

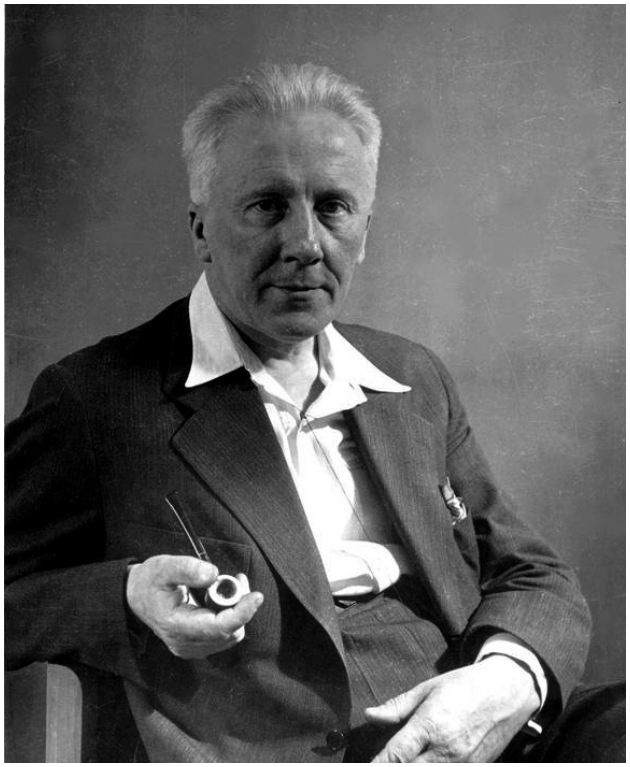


Fig. 8: The Polish psychologist Władysław Witwicki.

(1881-1937), in describing his experiences in military neurology and psychiatry during the First World War, decided to use the most voluminous and general terminology in his writings about reactive disorders.[22] He underscored the gravity of psychological shock itself in the aetiology of disorders, but also drew attention to a fact vital from the standpoint of present-day medicine, namely, that symptoms of an illness may develop with time and sometimes only manifest their entire spectrum long after the causal event. On the other hand, however, he was unable to clearly distinguish between specific features. Among states of anxiety he included psychotic (dissociative) symptoms, which, although related, belong in a different category according to present-day medicine. Therefore, his important observations, essentially leading toward the currently recognised diagnosis of post-traumatic stress, lacked clarity.

The interwar editions of the periodical *Lekarz Wojskowy* (Military Physician), from 1920 onwards, show clearly the huge amount of material that doctors contributed from their experiences with patients affected by war. The most frequently addressed issue was venereal diseases: syphilis was a plague among soldiers, and it threatened also to spread in peacetime. Another subject treated in many articles was wounds, their dressing, their complications, and prosthetics. A third significant consequence of armed conflict that emerged in Polish lands in 1920-1923 was malaria, called 'dab' in Polish literature. It peaked in 1921, when nearly 53,000 cases were registered, mainly in Polesie. Authors of texts in *Military Physician* devoted much attention to this subject. Disorders of a psychiatric and neurological nature (often classified arbitrarily) were in fourth, albeit prominent, place. Reactive neurosis (also called traumatic, reactive traumatic, etc.) was the main subject. As for arbitrary use by doctors of a complex and often empty terminology, Babiński's reference can be cited to the story of Don Quixote, who knocked on the door of an inn one night. When the keeper asked who he was hosting, so many titles were presented that the frightened innkeeper replied that he was unable to host so many outstanding guests in his humble abode.

Adam Chełmoński (1861-1924), a doctor specialising in internal medicine, head of the Infant Jesus Hospital in Warsaw, had the opportunity as a court expert to observe numerous psychologically ill patients ascribing their affliction to accidents. In a 1922 publication employing German terminology, he postulated a change of the term *Neurosis traumatica* in favour of *Schreckneurose* by arguing: 'only negative emotions are necessary to evoke any type of neurosis [...] traumatic neurosis frequently appears in such circumstances in which there is absolutely no physical injury'.[23] Chełmoński argued that bodily injuries actually protect against problems of a physical nature. Here, he cited instances of attention being drawn from pain of a psychological or existential nature by the feeling of physical ailment (flagellants). In his view, only a minuscule number of accident victims actually experienced neurosis. He also cited the prevailing opinion, especially in German and British psychiatry, that a significant role in the appearance of traumatic neurosis was played by the desire for compensation (*Rentenneurose*). It is noteworthy that in his work, which was written after the end of hostilities, he did not recall war invalids when recounting his findings in the pre-war period based on a study of

Fig. 9: Cover of the periodical *Lekarz Wojskowy* (Military Physician), April 1920.

civilian invalids, namely persons seeking a pension from the German social insurance system.

Bronisław Karbowski (1884-1940), chief physician of the 44th Kresy Riflemen Regiment, also gained his experiences with patients suffering from neurosis as a result of war. In his work, he, in turn, cited studies of the French psychiatrist André Léri (1875-1930) dating from 1918. Patients experiencing shock from explosions at close range were observed to have dilated pupils and a reduced heart rate, at times deafness/hearing hallucinations, and headaches, whereas symptoms of a psychological nature included: a slowdown in cognitive processes and muted emotions together with amnesia from the moment of explosion to the regaining of consciousness. In most cases, patients returned to full health after several days or weeks. However, in certain cases the illness became chronic by assuming forms of hysteria.[24] Typical manifestations in this regard were psychogenic paralysis of the muscles that were in a permanent state of tension, causing trembling or unnatural body curvature (victims could not walk or walked with protrusion of the upper part of the body, thus affecting posture and balance). Other symptoms, also lacking organic basis, included loss of hearing, sight, or the ability to speak. Another symptom diagnosed as hysterical was a sudden fear reaction during exposure to specific stimuli – objects or situations, at times broadening to an increasingly broader spectrum of everyday situations, so that the patient was prevented from functioning normally in society, and was certainly unable to return to military service. This symptom, in the context of its origin (front-line combat), would now be unambiguously interpreted as evidence of the hitherto still unknown post-traumatic stress syndrome.

The psychiatrist and neurologist from Poznań University, Stefan Borowiecki, in recounting Willy Hellpach's (1877-1955) findings, attributed nervous illness to disruptions caused by the need to become independent and assume responsibility. He claimed that a so-called *neurasthenia reaction* was more frequently observed in wartime among officers than rank-and-file soldiers.[25] Yet, he failed to perceive that awareness of one's own psychological state remained at a lower level among those statistically less educated. Medical care in villages from which most recruits originated certainly affected the outcome of studies. After demobilisation, they returned to their families who preferred to avoid disclosure of their state to the local populace, and they were thereby expunged from medical records.

Polish psychiatrists quite rarely perceived symptoms among their patients that are typical for a present-day diagnosis of post-traumatic stress syndrome and depression. It can be assumed that such a state of

Fig. 10: The Polish physician Bronisław Karbowski, major in the health service reserve of the Polish Army.

knowledge stemmed from a lack of awareness among patients themselves that their suffering and downturn in mood over the course of months can be classified and treated as a psychological disorder. If their state was not clearly observable, they were generally not hospitalised and continued their service. In extreme instances, they adopted a passive stance during battle and perished or deserted. Individuals displaying extremely atypical behaviour or constituting a threat to their environment came under the care of psychiatrists.

There were exceptions among researchers, those attuned to more subtle signals from patients. While practising in Austria-Hungary (Kingdom of Galicia and Lodomeria), Jan Nelken (1878-1940) stated that general apathy was at times observed among former soldiers as a result of 'traumatic experiences', which he explained as limited sensitivity for the purpose of psychological self-defence. Moreover, 'inability to rid memory of various traumatic events, usually marked by cruelty (memory hallucinations, dark states, vivid war dreams)'[26] was frequently observed. Nelken was describing the phenomenon of intrusion known in present day PTSD diagnosis. In a text published as early as August 1915, Aleksander Pański (1862-1918) (associated with Łódz and Warsaw, in the Russian Empire until 1915) also made reference to a prevailing feeling among his patients of depression caused by a series of psychological shocks on the battlefront. He wrote that 'their pessimistic mood gives rise to a weariness with life and a contempt for it, bordering on suicidal tendencies', stipulating previously, however, that new types of weaponry and the new nature of war proved to be pernicious in their effects, even to those with a strong psychological constitution.[27]

During the First World War, Polish military physicians observed a mass outbreak of certain disorders such as an epidemiological spread of so-called reactive psychoses in Austro-Hungarian partition areas in 1917 and 1918, especially in Lwów in the spring of 1917. They disappeared entirely with the collapse of the Austro-Hungarian monarchy and disintegration of military service. Symptoms of the illness usually appeared among soldiers immediately after vacation leave or several days before returning to a unit. Fits of rage, prompted by a clear loss of orientation, appeared suddenly and frequently in public places. Victims lost their sense of reality. Unease over the situation facing loved ones at home could nevertheless be discerned in uncontrolled screams ('where are my brothers – give it back – let me go – you are guilty – my dog, my dog – give me a gun – I don't want to live, don't want to live',[28] shouted a man whose two brothers were killed in action). Others fell into a stupor. Their bodies' positions recalled that adopted during hysterical outbursts, as described by Charcot. The men's behaviour was characterised by a high degree of fear. Some were also aggressive, particularly toward any officers they encountered. In Lwów, 10% of all psychiatric cases during that time manifested such symptoms.

This phenomenon began to be called 'street' or 'holiday' psychosis and it was treated with utmost suspicion. However, upon extensive analysis only 4% of patients were deemed imposters. The researcher Jan Nelken immediately drew attention to the mechanism (known among present-day psychiatrists) of 'escape into illness' – the reaction of an organism to stimuli with which the psyche is unable to cope, whereby symptoms serve to draw an individual from the true source of problems. He underscored that the afflicted who were sent to the front without assistance swiftly returned to hospital with symptoms of even greater nervous breakdown, whereas transfer to a civilian environment instilled calm.[29] In interpreting the behaviour of soldiers on leave, Nelken noted the *antizipierte Nostalgie* – 'anticipated nostalgia' described by the Austrian psychiatrist Erwin Stransky (1877-1926), a vision of return to the front from a family environment that produced such drastic resistance from the organism.[30] He noted that soldiers from the Małopolska region reacted especially strongly when sent to distant reaches, to Italy.[31] Interestingly, their psychotic thoughts did not address combat at the front itself. Usually, their subject matter revolved around a vision of death in the family, betrayal by a loved one or loss of home.

Nelken also recalled instances of mass sensual illusions that affected entire units during combat. Exhausted troops experienced collective hallucinations of a religious nature, whereby visions of divine and saintly intervention appeared in the context of waiting for help and rescue from oppression. Less spectacular, but also more frequently observed, were auditory and visual delusions of an encroaching enemy. They usually occurred at night when visibility was

Fig. 11: Medical orderlies tend to the wounded in a trench during the Battle of Flers-Courcelette, France, in mid-September 1916. The man on the left is suffering from shell shock.

limited and fear was exacerbated.[32] Such types of occurrences ended in court rooms, as soldiers were accused of simulating madness and of cowardice.

Although most researchers focused on the study of neurological responses – the discovery of disorders of a hysterical nature – or searched for genetic or inbred sources of symptoms, the clear influence of the behavioural psychology flourishing in Europe could nevertheless be observed in certain articles. Doctors therefore interpreted symptoms as a learned reaction to a stimulant. Henryk Higier (1866-1942) recalled the case of an officer who reacted with vomiting to each hostile attack, because in his first battle he had to hide at the bottom of a latrine. This trauma immediately produced a conditioned response and rendered him unfit for further military service.[33]

Attention should be given to a form of case description and treatment, which, perhaps in addition to the publications of Nelken and Pański, was characterised by a large degree of objectification of patients. Illustrations included photographs of men stripped naked for 'image' purposes or photographed during examinations or rehabilitation without respect for their dignity. Even their faces were not covered. Naked invalids were photographed when attempting to walk (independently or with attendants or equipment such as rods or crutches). To the extent that photographs in movement can be explained by the

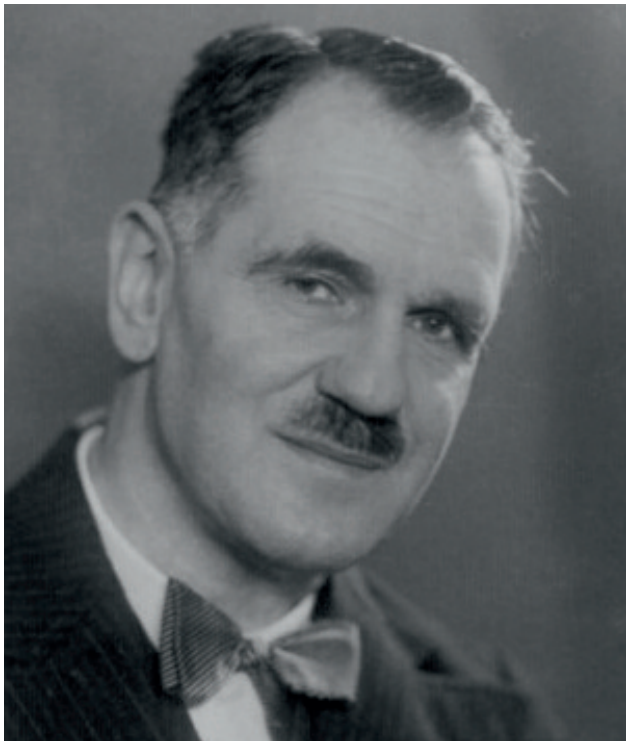
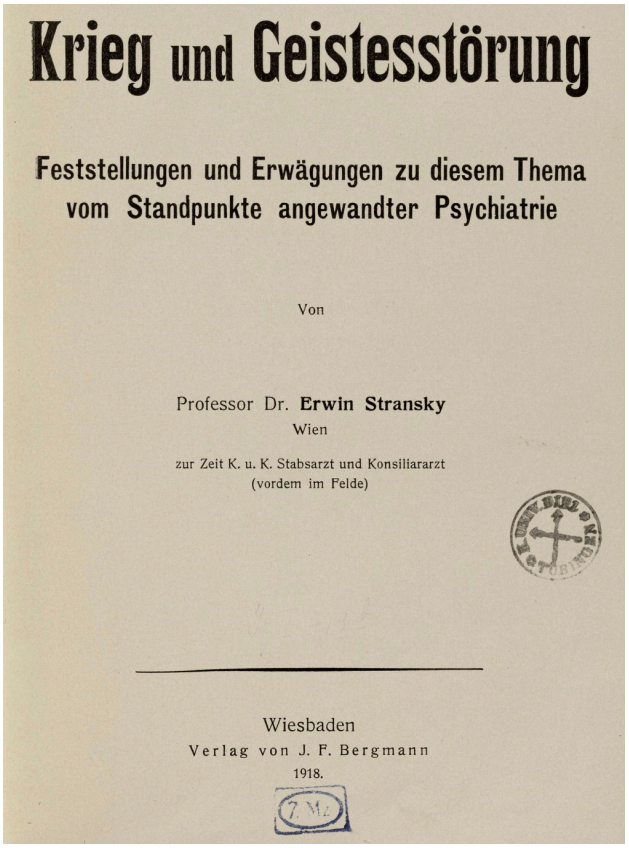


Fig. 12: The Austrian psychiatrist Erwin Stransky.

desire to show typical body position in given disorders (muscle flexion), this was completely unfounded in the case of photographs made en face in a standing position.[34] Photographs of patients were used in medical publications as engravings, similarly to illustrations and medical books or anatomic atlases. Their interpretation can be provided by Foucauld's theory of knowledge as a form of exercised power through the use of science (together with its complex terminology and authority) to regulate the life of individuals.[35] In the face of war, the health and ailments of millions of men became a public affair and a subject of great interest by state authorities. In this case, it can be argued that the humiliation of patients, including sexually, was an inseparable element of and price for medical care, as an indirect and harsh penalty for interrupting their service at the front.

Statistics and Care of Patients

Academic works from that time are devoid of any statistics that might yield an estimate of the number of patients suffering from war neurosis. Available data is very general or scant, even in the case of those hospitalised, as it concerned specific facilities in a limited time perspective. It also cannot be summarised, because researchers employed quite arbitrary terminology in their calculations. Although I have not found statistics on the period of the First World War, we nevertheless know the overall number of patients admitted to military hospitals (not civilian, where most war combatants were surely brought) on account of neurosis in years following the end of armed conflict. In 1922, this was 1,828 persons (namely, 6 per 1,000 serving in the military). This number slowly and systematically decreased with time after the end of armed conflict.[36] This data nevertheless does not reveal much about the actual prevailing psychological state of soldiers (including combatants treated in military institutions). First of all, it only covers those who were hospitalised, namely recognised cases. Secondly, we do not know what


Krieg und Geistesstörung

Feststellungen und Erwägungen zu diesem Thema vom Standpunkte angewandter Psychiatrie

Von

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1918.

Fig. 13: The publication *Krieg und Geistesstörung* (War and mental disorder) by the Austrian psychiatrist Erwin Stransky, published in 1918.

percentage of those treated suffered from disorders caused by wartime experiences and how many were new illnesses.

How were those suffering from psychological illnesses induced by warfare cared for in practice? We can only respond to this question in relation to former soldiers. Civilian victims of war were beyond the realm of reflection in medical literature and most likely received far less professional care. Sending them to a mental institution depended on their family's awareness and will. Meanwhile, soldiers were under the constant observation of colleagues and superiors, which is why atypical behaviour was more swiftly noted.

A soldier manifesting symptoms of psychiatric disorder was usually sent to a garrison hospital. If it lacked psychiatric care, he was then dispatched to one of several civilian institutions in Poland specialising in the treatment of psychological illnesses. During observation, psychiatrists also decided on the future fate of patients: ongoing hospitalisation or invalid pension. The extent to which earning capabilities were lost was specified. If it exceeded 15%, patients were given a war invalid pension. Of note here was the problematic issue of adjudication based on percentage terms. Although the state of patients, according to data from the Care Section Branch of the Ministry of Military Affairs, swiftly improved after their transfer from service to hospital conditions, it also frequently worsened after they left.[37] Soon afterwards, however, financial issues and the desire to regulate adjudication led to a stiffening of regulations. In 1923, the principle was introduced that 'the mentally ill who are not dangerous to their surroundings and whose freedom of movement in public life is minimally or not limited at all cannot be deemed completely unfit for work'. In such cases, evaluation was set at a maximum of 50% of their lost earnings capabilities. Instances of 'nervous weakening' (neurasthenia – depression) and hysteria (psychological injuries based on wartime trauma) were to be 'assessed thoroughly and re-studied' in grave instances in the belief that the patient would rapidly return to health.[38]

From 1917, Poles serving in the Austro-Hungarian Army were sent to Polish institutions, which thus possess certain data on the frequency of psychiatric trauma or of the onset of psychological illnesses among soldiers during that time. In the same year, 20 to 50 new patients arrived daily at only one neurological-psychiatric clinic at the Jagiellonian University in Cracow. This should be considered a sizable number given that it only served Poles from Galicia (the northern part of Austria-Hungary).[39]

Fig. 14: Illustration from *Przegląd Lekarski* (Medical Survey, no. 48, 1917). Soldier learning how to walk again at the neuropsychiatric clinic at Jagiellonian University in Cracow. The man is naked from the waist down to show readers the position of the patient's limbs.

Not all soldiers released due to psychiatric trauma found a place at medical facilities. If their state was deemed stable and further military service or independent functioning was no longer possible, the role of caregiver obviously rested with the family. Efforts were made to at least fundamentally regulate these actions. After the war, sections for war invalid affairs were established at County Supplementation Departments (responsible on a daily basis for the registration of further annual military service recruits) to maintain appropriate records. Their authority also included control over 'conscientious care of mentally

ill invalids taken in by families'. Unfortunately, families, inadequately informed of the rights accorded to invalids (above all, financial support) in practice frequently remained without assistance. For example, a certain Bazyli Kuryłowicz from the district of Sokółka was drafted into the Russian army in 1915. He was soon taken prisoner and returned mentally ill in 1918. Until 1922, he stayed at the expense of his family at a civilian psychiatric clinic in Tworki near Warsaw. He was then deemed completely unfit for work. Unfortunately, Kuryłowicz was deprived of a pension, because when his brother applied for it in his name – once he had been approved as the legal guardian of the invalid – it was outside the one-year deadline set for those released from the army to apply to the state for financial assistance as an invalid. This negative decision was overturned following an Administrative Court judgment, yet the family still had to fight for a fair judgment (which required financial outlays and determination), while supporting their relative with their own means. Anyone so ill that they were incapable of independent existence, especially in the settlement of complicated administrative matters, was left to themselves if they received no care from those closest to them. The Polish state made no initiative to handle their cases.[40]

The treatment of patients diagnosed with neurosis did not achieve standardisation during the 20-year interwar period. References were made to various methods aimed at 'eliminating neurotic automatisms and introducing normal cognitive mechanisms'. In serious cases, patient isolation in closed institutions was recommended together with Charcot's 'education therapy', Déjérine's persuasion method, Dubois' dialectic or corrective method, Janet's gymnastics of the will, Oppenheim's cognitive exercises, Bernheim's waking suggestions, Forel's hypnotic state, autosuggestion (Coué), reaction methods (Breuer) and shock (Liébault), characterology (Klage), Adler's psychotherapy, and Freud's psychoanalysis. The above terms conceal a quite archaic technique, as the contemporary reader may only be familiar with the latter two. Nevertheless, closer attention should be given to methods developed by the French neurologist and psychologist Pierre Janet. Like Freud, Janet felt that work with recollections was imperative to treat patients, frequently with the aid of hypnosis. He sought to rework and redefine them, thus reducing fear. A revolutionary aspect of his approach was the treatment of memory as a collection of stories whose form an individual can alter through a change of approach and training of a strong will. A similar approach can be found in the early 21st century in investigative-behavioural therapy.[41] Although Polish doctors were familiar with new psychotherapy methods, regular psychoanalysis sessions were obviously a luxury reserved only for wealthy eccentrics. I have not found any description in Polish medical literature of a case involving a war invalid subjected to such treatment, even though it cannot be excluded that such attempts were made. An analysis of Polish medical literature nevertheless reveals great interest among certain Polish psychiatrists in psychotherapy methods then practised in Europe, as opposed to antiquated yet still unfortunately adopted 're-education' methods (such as isolation and discipline). They included the strongly present psychoanalytical trend (including wildly popular hypnosis) and less invasive actions, certainly not harmful, to provide patients with a peaceful and stable environment in which they could rest and, in milder cases, gradually return to health.

In practice, the mentally ill who are capable of independent functioning at a basic level were sent to spas and baths, as warm baths were considered to calm the nervous system. Henryk Higier pointed out the effectiveness of several week-long stays in sanatoriums. He underscored that their mineral waters helped treat neurotic patients better than those to whom specific facilities were initially dedicated (e.g. Ciechocinek or Krynica were established to ease the suffering of heart patients). Thus, Higier seemingly failed to perceive the role of a change of surroundings and rest among the limited number of stimuli for treating milder cases of neurosis. He believed that this state could be improved through 'mineral salts, carbonic acid gas, radium substances[42] present in sanatorium air and water. Other Polish researchers, in accordance with observations of their foreign professional colleagues, declared the salutary role of staying at a peaceful abode, far from the dreadfulness of the front. These not very revolutionary conclusions regarding the ability of the human psyche to regenerate in accommodating conditions nevertheless led to more humane and personal relations with patients. Above all, in accordance with the golden rule of Hippocrates, they did not cause even greater harm.

Fig. 15: Scene in the tent for patients suffering from war neurosis. The American Red Cross had established a hospital for these men in the forest of Chateau Chambord, near Blois, France, 1918.

A review of methods applied toward patients admitted to specialist hospitals includes a work by Jan Piltz (1870-1930) on the subject of the neurological-psychiatric clinic at Jagiellonian University. Piltz treated patients as immature people, gently or 'harshly', in other words, from a position of authority and superiority. Hysterical outbursts (because hysteria itself was considered to be inborn and a rather indelible mental defect) were also 'treated' in Cracow through psychological violence. For example, symptoms were to quickly subside, particularly when blackmail was employed against patients by denying correspondence from families. Patients were isolated from external stimuli through denied contact with family, walks, or any correspondence. Treatments took place irrespective of patient protests, with declarations that they would continue until cured. They constituted torture in the name of misunderstood proper therapy. To the extent that professional curiosity guided the approach to exceptionally drastic methods known from abroad (intimidation, setting beds on fire to force the patients lying in them to flee), there is no indication of such brutality taking place at Polish institutions.[43]

Piltz considered that the most effective psychotherapy aimed at motivating a patient, exercising his 'strong will' and explaining reasons for his state. Like Freud, doctors considered mere understanding of the nature of topological symptoms to lead to recovery. However, in contrast to psychoanalysis (which, actually, in its classic form is still not considered in the early 21st century an effective form of help in over-

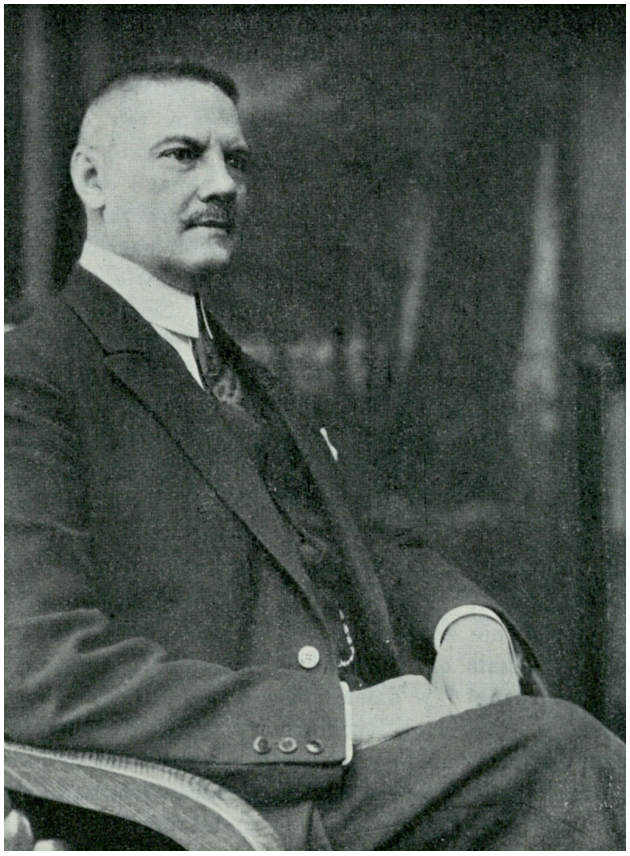

Fig. 16: The Polish neurologist and psychiatrist Jan Piltz.

coming trauma), Polish doctors took an active role in the therapeutic process without limiting themselves to merely listening, but also by offering 'suggestions' – seeking to guide a patient towards a 'correct' interpretation of an illness and attempting to strengthen the internal desire for treatment. This was not at all obvious, as they noted, in the case of neurasthenic patients (suffering from depression) and men fearing return to the front. Doctors appeared to completely misunderstand the sources of these fears. I have not found many pronouncements demonstrating an understanding of the terrifying reality of frontline service. The already repeatedly noted *Rentenneurose* was also cited in the context of no patient improvement, despite the application of all available medical treatment. Hopes of obtaining war invalid privileges connected with their condition (for example pension or a state concession for a small kiosk selling tobacco) were to effectively block patients and prevent progress in treatment[44]

Piltz also considered the use of a low-voltage electrical current (so-called Faradisation) a very effective method of eliminating symptoms diagnosed as hysterical – unnatural spasms or twisting of limbs. An electrode was applied to a twisted limb, thus forcing movement of a blocked muscle. Therefore, a patient, in unintentionally performing this movement, 're-called' how to actively perform it himself.[45] This method should not be associated with electroshock therapy (ECT).

So-called hysterics found themselves in dedicated sections at certain large institutions. An effort was made to isolate them from neurological patients (with disorders stemming from damage to the nervous system). Nevertheless, deliberate placement in general psychiatric wards, thus stimulating the desire of pensioners for a cure, served to foster arousal of the will. From today's perspective, this method must be viewed as another example of the oppressiveness of the healthcare system at that time. The scene of almost permanently institutionalised untreated schizophrenics or those afflicted with severe alcoholism, who were merely isolated from society and suppressed with psychoactive means, had to be another psychological shock repeatedly traumatising war invalids.

The problem of wartime psychiatric trauma was rarely a subject raised by state authorities. Yet, it should be noted that in Poland the problem was treated on equal terms with other health complications arising from military service. Victims were therefore eligible for a military pension, which, according to binding regulations, was dependent on the degree (percentage) of loss of earning capabilities in a civilian profession. Psychiatric illness nevertheless eluded such a simple classification, which is why more 'objective' factors were sought, more measurable than the degree of human suffering. Doctors were recommended to declare a maximum of 45% lost earning capability if a patient posed no threat to himself or his environment, and 100% if such threat was found. Usual procedures required a military commission to examine an invalid pension applicant. In the case of mentally ill patients, an opinion issued by a treatment facility sufficed. This was a convenience for applicants, but resulted in certain arbitrary treatment of patients by psychiatrists not necessarily well informed of adjudication.

Fig. 17: Jan Piltz with his staff at the neuropsychiatric clinic at Jagiellonian University in Cracow, Poland.

Conclusion

Despite the atrocities and exhausting conditions to which soldiers were subjected on front during the First World War, doctors still showed a tendency to seek weakness in the character of their patients. This approach led to stigmatisation. From the start of the 20th century, some of them more frequently turned their attention to the situational basis of psychiatric illnesses. The First World War experiences of doctors, particularly when they observed injured young and until recently fit men, contributed to a more empathetic change of approach toward psychiatric patients. Unfortunately, such an approach did not take root in Polish society during the 20-year interwar period, when the young Polish state needed a heroic vision of its most recent history. In light of serious internal problems, an unfavourable international situation, and the active promotion of militarism in the 1930s, there was a shortage of funds, interest, and time for proper care of war victims. I have focused on soldiers in this article for a reason. The experiences of millions of civilians, many among whom also surely bore psychological scars as a result of war, did not arouse the interest of Polish or foreign academics at the time. This can perhaps be explained by their utilitarian approach to these issues, which was principally an effort to maintain soldiers fit for combat and to prevent desertion.

To the extent that their real-life medical practice inspired and actually forced doctors to deal with the subject of an organism's reaction to the stress of war

during the wartime period and thereafter, subsequent researchers focused on studies of recruits and on officer training, while forgetting about the psychological consequences of war and their psychologically ill victims. The Norwegian psychiatrist Leo Eitinger (1912-1996), dealing with the psychological trauma of those rescued from the Holocaust, underscores the defensive nature of losing interest in extensive study of the psychological state of victims:

> War and victims are something the community wants to forget; a veil of oblivion is drawn over everything painful and unpleasant. We find the two sides face to face; on one side the victims who perhaps wish to forget but cannot, and the other all those strong, often unconscious motives who very intensely both wish to forget and succeed in doing so.[46]

Mechanisms blocking public sensitivity can therefore have a defensive and adaptive nature.

Finally, focus on the traumatic side of war has been undermined by a heroic narration of the dedication of thousands of frequently anonymous people, 'unknown soldiers' serving the homeland. Jay Winter, in his fundamental work on memory in the First World War, outlines the course taken by societies in Western Europe from grief (usually demonstrated individually) to the inclusion of war victims in a brave tale – heroisation. This process helped soldiers deal with nightmares, as it provided them with context and meaning. Frequently unspeakable states – fear, desperation, physical and psychological pain – were hidden from social consciousness with pride and hope of proper compensation, which frequently took the form of purely declaratory gratitude to believers. For financial and ideological reasons, Poland exceptionally lacked eagerness to commemorate the suffering of war victims. The myth of brave soldiers in Polish voluntary units (particularly Legionnaires) was rapidly conceived, while overlooking, in the collective consciousness, the hundreds of thousands mobilised in occupation armies. Their experiences were solely reduced to the real or imagined drama of fighting alongside their countrymen, but dressed in the enemy's uniforms.

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