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# Clinical research

## *From shell shock and war neurosis to posttraumatic stress disorder: a history of psychotraumatology*

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*The term posttraumatic stress disorder (PTSD) has become a household name since its first appearance in 1980 in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) published by the American Psychiatric Association. In the collective mind, this diagnosis is associated with the legacy of the Vietnam War disaster. Earlier conflicts had given birth to terms, such as "soldier's heart," "shell shock," and "war neurosis." The latter diagnosis was equivalent to the *névrose de guerre* and *Kriegsneurose* of French and German scientific literature. This article describes how the immediate and chronic consequences of psychological trauma made their way into medical literature, and how concepts of diagnosis and treatment evolved over time.*

**Keywords:** posttraumatic stress disorder; shell shock; psychotraumatology; literature; history of medicine

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### Epics and classics

Mankind's earliest literature tells us that a significant proportion of military casualties are psychological, and that witnessing death can leave chronic psychological symptoms. As we are reminded in Deuteronomy 20:1-9, military leaders have long been aware that many soldiers must be removed from the frontline because of nervous breakdown, which is often contagious:

When thou goest out to battle against thine enemies, and seest horses, and chariots, and a people more than thou . . . the officers shall say, What man is there that is fearful and fainthearted? Let him go and return unto his house, lest his brethren's heart faint as well as his heart. (King James's Version)

Mankind's first major epic, the tale of Gilgamesh, gives us explicit descriptions of both love and posttraumatic symptoms, suggesting that the latter are also part of human fundamental experience. After Gilgamesh loses his friend Enkidu, he experiences symptoms of grief, as one may expect. But after this phase of mourning, he races from place to place in panic, realizing that he too must die. This confrontation with death changed his personality. The first case of chronic mental symptoms caused by sudden fright in the battlefield is reported in the account of the battle of Marathon by Herodotus, written in 440 BC (*History*, Book VI, transl. George Rawlinson):

A strange prodigy likewise happened at this fight. Epizelus, the son of Cuphagoras, an Athenian, was in the thick of the fray, and behaving himself as a brave man should, when suddenly he was stricken with blindness, without blow of sword or dart; and this blindness continued thenceforth during the whole of his afterlife. The

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following is the account which he himself, as I have heard, gave of the matter: he said that a gigantic warrior, with a huge beard, which shaded all his shield, stood over against him; but the ghostly semblance passed him by, and slew the man at his side. Such, as I understand, was the tale which Epizelus told.

It is noteworthy that the symptoms are not caused by a physical wound, but by fright and the vision of a killed comrade, and that they persist over the years. The loss of sight has the primary benefit of blotting out the vision of danger, and the secondary benefit of procuring support and care. Frightening battle dreams are mentioned by Hippocrates (460?–377 BC), and in Lucretius' poem, *De Rerum Natura*, written in 50 BC (Book IV, transl. William Ellery Leonard):

The minds of mortals ... often in sleep will do and dare the same ... Kings take the towns by storm, succumb to capture, battle on the field, raise a wild cry as if their throats were cut even then and there. And many wrestle on and groan with pains, and fill all regions round with mighty cries and wild, as if then gnawed by fangs of panther or of lion fierce.

This text shows very vividly the emotional and behavioral reexperiencing of a battle in sleep. Besides Greco-Latin classics, old Icelandic literature gives us an example of recurring nightmares after battle: the *Gísli Súrsson Saga* tells us that the hero dreams so frequently of battle scenes that he dreads obscurity and cannot stay alone at night.

Jean Froissart (1337?–1400/01) was the most representative chronicler of the Hundred Years' War between England and France. He sojourned in 1388 at the court of Gaston Phoebus, Comte de Foix, and narrated the case of the Comte's brother, Pierre de Béarn, who could not sleep near his wife and children, because of his habit of getting up at night and seizing a sword to fight oneiric enemies. The fact that soldiers are awakened by frightening dreams in which they reexperience past battles is a common theme in classical literature, as, for instance, Mercutio's account of Queen Mab in Shakespeare's *Romeo and Juliet* (I, iv):

Sometime she driveth o'er a soldier's neck,  
And then dreams he of cutting foreign throats,  
Of breaches, ambuscadoes, Spanish blades,  
Of healths five fathom deep; and then anon  
Drums in his ear, at which he starts and wakes,  
And being thus frightened, swears a prayer or two,  
And sleeps again.

Etiologic hypotheses were put forward by army physicians during the French Revolutionary wars (1792-1800) and the Napoleonic wars (1800-1815). They had observed that soldiers collapsed into protracted stupor after shells brushed past them, although they emerged physically unscathed. This led to the description of the “*vent du boulet*” syndrome, where subjects were frightened by the wind of passage of a cannonball. The eerie sound of incoming shells was vividly described by Goethe, in his memoirs of the cannonade at the battle of Valmy in 1792<sup>1</sup> “The sound is quite strange, as if it were made up of the spinning of a top, the boiling of water, and the whistling of a bird.” In the same text, Goethe gives an account of the feelings of derealization and depersonalization induced by this frightening environment:

I could soon realize that something unusual was happening in me ... as if you were in a very hot place, and at the same time impregnated with that heat until you blended completely with the element surrounding you. Your eyes can still see with the same acuity and sharpness, but it is as if the world had put on a reddish-brown hue that makes the objects and the situation still more scary ... I had the impression that everything was being consumed by this fire ... this situation is one of the most unpleasant that you can experience.

## The dawn of modern psychiatry

The psychiatrist Pinel is often depicted as freeing the insane from their chains; in his treatise entitled *Nosographie Philosophique* (1798), he described the case of the philosopher Pascal who almost drowned in the Seine when the horses drawing his carriage bolted. During the remaining eight years of his life, Pascal had recurring dreams of a precipice on his left side and would place a chair there to prevent falling off his bed. His personality changed, and he became more apprehensive, scrupulous, withdrawn, and depressive. From his experience with patients shocked by the events and wars of the French Revolution, Pinel wrote the first precise descriptions of war neuroses—which he called “cardiorespiratory neurosis”—and acute stuporous posttraumatic states—which he called “idiotism.”

The Industrial Revolution and the introduction of steam-driven machinery were to give rise to the first civilian man-made disasters and cases of PTSD outside the battlefield. The public's imagination was struck by the first spectacular railway disasters, and physicians at the time

were puzzled by the psychological symptoms displayed by survivors. Very soon, a controversy pitted the proponents of the organic theory, according to which the mental symptoms were caused by microscopic lesions of the spine or brain (hence the names “railway spine” and “railway brain”), against those who held that emotional shock was the essential cause and that the symptoms were hysterical in nature. This controversy was to last until World War I. It seems that the first mention of the term “traumatic neurosis” dates from that time: it was the title given in 1884 by the German physician Hermann Oppenheim<sup>2</sup> to his book containing a description of 42 cases caused by railway or workplace accidents. This new diagnosis was vehemently criticized by Charcot who maintained that these cases were only forms of hysteria, neurasthenia, or hysteroneurasthenia.<sup>3</sup> After Charcot's death in 1893, the term traumatic neurosis made its way into French-language psychiatry: witness the Belgian psychiatrist Jean Crocq<sup>4</sup> who in 1896 reported 28 cases caused by railway accidents. It is at the time of Charcot's famous Tuesday's lectures that Janet (1889) and Freud (1893) discovered traumatic hysteria with all its correlates: the dissociation caused by trauma, the pathogenic role of forgotten memories, and “cathartic” treatment. This was a first glimpse of what would later be known as the unconscious.

The Russian-Japanese war (1904-5) was marked by the siege of Port Arthur and the naval battle of Tsushima. It was probably during this conflict that post-battle psychiatric symptoms were recognized for the first time as such by both doctors and military command. Russian psychiatrists—notably Avtocratov, who was in charge of a 50-bed psychiatric clearing hospital at Harbin in Manchuria—are credited with being the first to develop forward psychiatric treatment. This approach may have been a response to the difficulty of evacuating casualties over huge distances at a time when the Trans-Siberian Railway was not yet completed. Whatever the initial reason, forward treatment worked, and would again be confirmed as the best method during succeeding conflicts. The number of Russian psychiatric casualties was much larger than expected (1500 in 1904 and 2000 in 1905) and the Red Cross Society of Russia was asked to assist. The German physician Honigman served in this body, and he was the first to coin the term “war neurosis” [*Kriegsneurose*] in 1907 for what was previously called “combat hysteria” and “combat neurasthenia”; also, he stressed the similarity between these cases and those reported by Oppenheim after railway accidents.<sup>5</sup>

## World War I

World War I (WWI) was the first modern war fought with massive industrial means. This dubious distinction is also, to a lesser degree, shared by the American Civil War. In any event, WWI is certainly the period in history when “modern” warfare coincided with a “scientific” psychiatry that endeavored to define diagnostic entities as we understand them today. The role played by WWI in advancing the knowledge of psychotraumatology in European psychiatry may be compared to that of WWII and the Vietnam War in American psychiatry.

The mental distress of WWI soldiers was repeatedly described in literary autobiographies by English, German, and French authors such as Robert Graves (*Good-bye to All That*, 1929), Ernst Jünger (*In Stahlgewittern* [*Storm of Steel*], 1920), or Henri Barbusse (*Le Feu*, 1916). Jünger wrote: “The state takes away our responsibility but cannot ease our grief, we have to carry it alone and it reaches deep within our dreams.”

## Shell shock

Psychiatric casualties were reported very early in the war, in numbers that no-one had anticipated. The French physician Milian reported four cases of “battle hypnosis” following military actions in 1914.<sup>6</sup> The well-known German psychiatrist Robert Gaupp reported in 1917:

The big artillery battles of December 1914 . . . filled our hospitals with a large number of unscathed soldiers and officers presenting with mental disturbances. From then on, that number grew at a constantly increasing rate. At first, these soldiers were hospitalized with the others . . . but soon we had to open special psychiatric hospitals for them. Now, psychiatric patients make up by far the largest category in our armed forces . . . The main causes are the fright and anxiety brought about by the explosion of enemy shells and mines, and seeing maimed or dead comrades . . . The resulting symptoms are states of sudden muteness, deafness . . . general tremor, inability to stand or walk, episodes of loss of consciousness, and convulsions.<sup>7</sup>

In his review of 88 cases of mental disorder in 1915, the French psychiatrist Régis had expressed a very similar opinion about the etiological role of witnessing the horrible death of comrades: “20% only presented with a physical wound, but in all cases fright, emotional shock, and seeing maimed comrades had been a major factor.”

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The clinical picture of war neuroses differed only slightly in the two World Wars.

In the British military, patients presenting with various mental disorders resulting from combat stress were originally diagnosed as cases of shell shock, before this diagnosis was discouraged in an attempt to limit the number of cases. It is not known when the term began to be used. According to Merskey,<sup>8</sup> the first mention may be a story published in the *Times* on February 6, 1915, indicating that the War Office was arranging to send soldiers suffering from “shock” to be treated in special wards at the National Hospital for the Paralyzed and Epileptic, in Queen Square. Also in February 1915, the term shell shock was used by Charles Myers in an article in *The Lancet* to describe three soldiers suffering from “loss of memory, vision, smell, and taste.”<sup>9,10</sup> Myers reported on three patients, admitted to a hospital in Le Touquet during the early phase of the war, between November 1914 and January 1915. These patients had been shocked by shells exploding in their immediate vicinity and presented with remarkably similar symptoms. According to Myers, these cases bore a close relation to “hysteria.” The first two patients were transferred to England for further treatment after a couple of weeks (the third was still being treated in Le Touquet when the article was published). As we shall see below, these patients might not have been evacuated to the peaceful surroundings of their home country had they sustained their wounds a year later.

## **Forward treatment**

Indeed, the experience of the first war months and the unexpected large influx of psychiatric casualties led to a change in treatment approaches. The evacuation of psychiatric casualties to the rear became less systematic as the experience of the remaining war years convinced psychiatrists that treatment should be carried out near the frontline, and that evacuation only led to chronic disability. It was noticed that soldiers treated in a frontline hospital, benefiting from the emotional support of their comrades, had a high likelihood of returning to their unit, whereas those who were evacuated often showed a poor prognosis, with chronic symptoms that ultimately led to discharge from the military. Also, it was discovered that prognosis was better if the convalescing soldiers remained in the setting of the military hierarchy, rather than in a more relaxed hospital environ-

ment. Thus, by the end of 1916, evacuations became rare and patients were treated instead in forward centers, staffed by noncommissioned officers (NCOs), within hearing distance of the frontline guns and with the expectation of prompt recovery.<sup>11</sup> Treatment in the forward area (*psychiatrie de l'avant*) became the standard treatment, along with the five key principles summarized in 1917 by the American physician Thomas W. Salmon,<sup>12</sup> chief consultant in psychiatry with the American Expeditionary Forces in France: immediacy, proximity, expectancy, simplicity, and centrality. *Immediacy* meant treating as early as possible, before acute stress was succeeded by a latent period that often heralded the development of chronic symptoms; *proximity* meant treating the patient near the frontline, within hearing distance of the battle din, instead of evacuating him to the peaceful atmosphere of the rear, which he would, understandably, never wish to leave; *expectancy* referred to the positive expectation of a prompt cure, which was instilled into the patient by means of a persuasive psychotherapy; *simplicity* was the use of simple treatment means such as rest, sleep, and a practical psychotherapy that avoided exploring civilian and childhood traumas; finally, *centrality* was a coherent organization to regulate the flow of psychiatric casualties from the forward area to the rear, and a coherent therapeutic doctrine adopted by all medical personnel. Salmon's principles were discovered independently and applied universally by all warring sides; only to be forgotten, and rediscovered again, during World War II.

Among the many treatment applied to stress disorders, one was much used during WWI, and scarcely at all during WWII: the application of electrical current, also called faradization. This was probably because motor symptoms, such as tremor, paralysis, contractions, limping, or fixed postures, were common during WWI, and rare in WWII. Faradization was criticized in post-war Austria; Wagner-Jauregg—a professor of psychiatry in Vienna who was awarded a Nobel prize in 1928—was even accused of excessive cruelty in the administration of this treatment and had to appear before an investigation committee, in which Sigmund Freud had the more enviable role of testifying as an expert.<sup>13</sup> A most radical description of electrotherapy was published in 1916 by Fritz Kaufmann,<sup>14</sup> in which he explained how war neuroses could be treated in one session only by combining suggestion, authority, and steadfast application of electricity until the symptoms subsided—a form of *fight at outrance*.



### ***Concussion, fright, or malingering?***

Etiology was a controversial question that was reflected by the choice of terms: shell shock or war neurosis? Soma or psyche? The now obsolete term shell shock, harking back to the *vent du boulet* of the Napoleonic wars, implied a somatic etiology, such as microscopic brain lesions due to a vascular, meningeal, white or gray matter concussion. Other diagnoses were also used to express the belief that the cause was more an emotional stressor, rather than a physical concussion. Such diagnoses were, for instance, war neurasthenia and war psychoneurosis, in France.

Emil Kraepelin (1856–1926), without doubt one of the most influential psychiatrists of our times, wrote about his experience with war neuroses during WWI in his autobiography, published posthumously in German in 1983<sup>15</sup>:

[As early as 1917], the question of war neuroses was raised. We alienists all agreed that we should try to limit an excessively liberal granting of compensations which might lead to a sharp rise in the number of cases and claims . . . the fact that all kinds of more or less severe psychiatric symptoms could lead to a lengthy stay in a hospital, or even to a discharge from the military with a generous disability pension, had disastrous consequences. This was compounded by the population's feeling of pity for the seemingly severely ill "war-shakers" [*Kriegszitterer*], who drew attention to themselves on street corners and used to be generously rewarded. In such circumstances, the number of those who believed that a "nervous shock," or, especially, having been buried alive, entitled them to discharge and continuous support, increased dramatically.

Kraepelin's comments typify the controversies that raged at the time: (i) were the mental symptoms nothing more than malingering, with the clear objective of getting away from the frontline? Some 346 British and Commonwealth soldiers were actually shot on the orders of military command and this number certainly included soldiers suffering from acute stress disorder who walked around dazed or confused and were accused of desertion or cowardice; (ii) Did posttraumatic symptoms have pathoanatomical explanations? For instance, were they produced by a concussion of the brain or strained nerve fibers, as had been hypothesized in previous decades for the "railway spine" resulting from train accidents? (iii) A third explanation was a psy-

chological origin—in that case, was the psychological cause limited to the overwhelming fright constituting the trauma, or was it necessary to delve further into the patient's previous personality? The cases of war neurosis observed during WWI were indeed a challenge to psychoanalytical theories; it was simply unbelievable that all cases were caused by childhood traumas and it had to be admitted that psychological symptoms could be produced by recent traumas. Freud had postulated that dreams were a wish fulfillment. Not until 1920, in an address at an international congress of psychoanalysts, did he allow one exception: the case of traumatic dreams, dreams that recall recent accidents or childhood traumas. And even this turned out to be no real exception at all: Freud eventually understood traumatic dreams as fitting into his wish-fulfillment theory of dreams in that they embodied the wish to master the trauma by working it through.<sup>16</sup>

## **World War II**

A dreadful invention of WWII was the concept "total war," with the systematic targeting of civilian populations, as exemplified by the millions of deaths caused by the Holocaust, the air raids on cities to break the morale of civilian populations, and the atomic bombs dropped over Hiroshima and Nagasaki. Despite WWI, most armies were once again unprepared for the great number of psychiatric casualties and psychiatrists were often viewed as a useless burden, as exemplified by a memorandum addressed by Winston Churchill to the Lord President of the Council in December, 1942, in the following terms<sup>17</sup>:

I am sure it would be sensible to restrict as much as possible the work of these gentlemen [psychologists and psychiatrists] . . . it is very wrong to disturb large numbers of healthy, normal men and women by asking the kind of odd questions in which the psychiatrists specialize.

### ***American psychiatry***

American psychiatrists made a major contribution to the study of combat psychiatry during WWII. In *Psychiatry in a Troubled World*, William C. Menninger<sup>18</sup> shows how the lessons of WWI seemed at first to have been entirely forgotten by the American military: "during the initial battles in Africa, psychiatric casualties were sent back to base hospitals, often hundreds of miles

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from the front. Only 5% of these were able to return to duty.” As explained by Jones,<sup>19</sup> American planners, under the guidance of Harry Stack Sullivan, had believed that potential psychiatric casualties could be screened out prior to being drafted. Correspondingly, no psychiatrists were assigned to combat divisions and no provision for special psychiatric treatment units at the field army level or communications zone had been made. The principles of forward treatment were rediscovered during the North Africa campaign in 1943. Advised by the psychiatrist Frederick Hanson, Omar N. Bradley issued a directive on 26 April 1943, which established a holding period of 7 days for psychiatric patients at the 9th Evacuation Hospital, and for the first time the term “exhaustion” was prescribed as initial diagnosis for all combat psychiatric cases.<sup>20</sup> This word was chosen because it was thought to convey the least implication of neuropsychiatric disturbance. Beginning in 1943, treatment in the forward area similar to that in WWI was the rule, with the result that between 50% to 70% of psychiatric casualties were able to return to duty. Here again, the sheer number of psychiatric casualties was staggering. For the total overseas forces in 1944, admissions for wounded numbered approximately 86 per 1000 men per year, and the neuropsychiatric rate was 43 per 1000 per year.

In 1941, the first year of the war for the United States, Abram Kardiner—famous for having been analyzed by Freud himself—published a book based on his treatment of WWI veterans at Veterans Hospital No. 81 between 1922 and 1925.<sup>21</sup> In the light of the experience with WWII soldiers, Kardiner published a revised edition of his book at the end of the war.<sup>22</sup> He wrote that “the real lesson of WWI and the chronic cases was that this syndrome must be treated immediately to prevent consolidation of the neurosis into its chronic and often intractable forms.” He identified traumatic neurosis as a “physioneurosis,” thereby stressing the concomitance of somatic and psychological symptoms. Kardiner developed his own concept of the “effective ego” and he postulated that “ego contraction” was a major mechanism. Posttraumatic psychiatric symptoms in military personnel fighting in WWII were reported as early as 1945 by the American psychiatrists Grinker and Spiegel.<sup>23</sup> Their book—*Men under Stress*—is an excellent reflection of psychiatric thinking of the time; it remained a classic treatise on war psychiatry because of its detailed description of 65 clinical cases, its reference to psychoanalytical theories, and the description of cathartic treatment by

“narcosynthesis” using barbiturates. Grinker and Spiegel distinguished acute “reactions to combat” from delayed “reactions after combat.” The latter included “war neuroses,” designated by the euphemism “operational fatigue” syndrome in the Air Force. Other chronic consequences of combat included passive-dependent states, psychosomatic states, guilt and depression, aggressive and hostile reactions, and psychotic-like states.

## *European studies*

Long-lasting psychological disorders were not tolerated in the German military during WWII, and official doctrine held that it was more important to eliminate weak or degenerate elements rather than allow them to poison the national community. Interviews we conducted with Alsatian veterans who had been forcibly drafted into the Wehrmacht taught us that soldiers who had suffered acute combat stress (such as being buried under a bunker hit by a bomb) were given some form of psychological assistance soon after rescue; they were typically sent to a forward area first aid station (*Verbandsplatz*) where they received milk and chocolate and were allowed to rest. The Soviet army evolved its own system of forward treatment, under the responsibility of the unit's political (ie, morale) officer.<sup>24</sup> A look at the textbook of psychiatry published by Gurevich and Sereyskiy<sup>25</sup> in Moscow immediately after the war in 1946, at the height of Stalin's power, shows the existence of a specific diagnostic label to classify posttraumatic disorders. The authors describe the “affective shock reactions” (*affektivno-shokovye reaktsii*), a subtype of psychogenic reactions, that are observed after wartime events, earthquakes, or railway accidents; these are characterized by acute (a few days) and subchronic (a few months) symptoms. These Russian authors tended to emphasize cardiovascular and vasomotor symptoms, which reminds us of Da Costa's “irritable heart” in American Civil War soldiers. The literature on Holocaust and concentration camp survivors is too abundant to be summarized here. The best known of all the early works studying concentration camp survivors is probably the article published by Eitinger.<sup>26</sup>

In contrast to WWI, the course of symptoms over decades and their chronic nature were extensively studied in WWII survivors. For instance, in 1988, we studied<sup>27</sup> a group of French civilians living in the Alsace-Lorraine region who were conscripted into the German

army and later held in captivity in Russia. This population of Alsace-Lorraine was interesting because it was bilingual, French and German, and had cultural roots in both heritages. The analysis of 525 questionnaires showed that, after over four decades, 82% still experienced intrusive recollections and nightmares of their wartime captivity; 73% actively attempted to avoid thoughts or feelings associated with the trauma; 71% reported a foreshortened sense of the future; and nearly 40% reported survivor guilt. Beyond PTSD, these survivors from Alsace-Lorraine also suffered lasting personality changes. We believe that an aggravating factor was the fact that these individuals returned home uncelebrated, embittered, psychologically isolated, and that they were caught in a web of psychological ambiguity. They had fought in the German army against their will and under the threat of their families being deported, and were considered unreliable by the Germans. They were surprised to be treated as German soldiers upon their capture by the Soviet army. They were repatriated to a new post-war social environment in a French society that was itself plagued by the guilt of its early surrender to the Nazis, and they felt misunderstood by some of their countrymen who criticized their incorporation into the German military as a form of treason.

### The Vietnam war

During the Vietnam war, the principles of treating psychiatric casualties in the forward area were successfully applied, with a correspondingly low level of acute psychiatric casualties (11.5 per 1000 men per year). In contrast, the incidence of alcoholism and drug abuse was high. Similarly, the late and delayed effects of combat exposure in the form of PTSD were a significant source of suffering and disability among veterans in the United States. An estimated 700 000 Vietnam veterans—almost a quarter of all soldiers sent to Vietnam from 1964 to 1973—required some form of psychological help. The prevalence of delayed and chronic PTSD, in spite of the careful prevention of psychiatric casualties in Vietnam itself, was a rude awakening. Trying to explain this paradox called for new hypotheses, for instance, that PTSD might be a common form of psychiatric casualty in “low-

level” warfare.<sup>28</sup> Similar profiles had been observed in the French post-colonial wars in Indochina and Algeria.<sup>29</sup> This post-Vietnam syndrome, increasingly diagnosed in veterans in the seventies, ultimately led to the adoption of PTSD as a diagnostic category in 1980 in *DSM-III*. It seems puzzling that no such category existed in *DSM-II*, which had even abandoned the former *DSM-I* category of so-called “gross stress reaction,” when it was published in 1968, the year of the Communist Tet Offensive in Vietnam.

### Retrospect

There is currently a measure of consensus on the diagnosis and phenomenological description of PTSD, which is recognized as a specific syndrome in individuals who have experienced a major traumatic event. Most modern textbooks concur in describing this syndrome as comprising three groups of symptoms: (i) the recurrent and distressing reexperiencing of the event in dreams, thoughts, or flashbacks; (ii) emotional numbing and avoidance of stimuli reminiscent of the trauma; (iii) and a permanent state of increased arousal. The first symptoms of PTSD are often delayed and they are separated from the trauma by a latency period; however, once installed, the disorder tends to follow a chronic course and the symptoms do not abate with time. *DSM-IV*<sup>30</sup> has the merit of clearly distinguishing PTSD, a chronic syndrome, from acute stress disorder, which is short-lived and appears soon after the trauma. We tend to abusively interpret the literature of previous decades as if today's diagnostic categories had always existed. However, a clear distinction between acute stress disorder and chronic PTSD is usually lacking in previous works. Also, there was little attempt to predict the risk of developing PTSD. Providing the trauma is severe enough, most individuals will go on to develop PTSD. However, one puzzling question is that many survivors seemingly do not develop symptoms even after a severe stressor.<sup>31</sup> Likewise, the historical literature on PTSD offers few clues concerning effective treatment, once the symptoms have become chronic. The practice of forward treatment aiming to prevent the development of chronic disorders may have inspired today's psychological debriefing of disaster victims. □



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## Desde el “corazón de soldado” y la “neurosis de guerra” al trastorno de estrés postraumático: una historia del trauma psíquico

La denominación de trastorno de estrés postraumático ha sido ampliamente reconocida desde su primera aparición en 1980 en la tercera edición del Manual Diagnóstico y Estadístico de los Trastornos Mentales (DSM-III) publicado por la Asociación Psiquiátrica Americana. Para la población general este diagnóstico se asocia con el desastroso legado de la Guerra de Vietnam. Una serie de conflictos bélicos anteriores han dado origen a otras denominaciones de esta patología como: “corazón de soldado”, shock de la explosión y neurosis de guerra. Este último diagnóstico corresponde a la *névrose de guerre* y *Kriegsneurose* de la literatura científica francesa y alemana respectivamente. Este artículo describe la forma en que las consecuencias –agudas y crónicas– del trauma psíquico hicieron su aparición en la literatura médica y cómo han evolucionado los conceptos diagnósticos a lo largo del tiempo.

## Du shell shock et de la névrose de guerre à l'état de stress post-traumatique: une histoire de la psychotraumatologie

Depuis sa première apparition dans la troisième édition du Manuel Statistique et Diagnostique des Troubles Mentaux (DSM-III) publiée par l'American Psychiatric Association, la dénomination “état de stress post-traumatique” est largement reconnue. Ce diagnostic évoque immédiatement la guerre du Vietnam et les séquelles qu'elle a engendrées. Lors de conflits plus anciens, d'autres dénominations ont été utilisées telles que “cœur de soldat” “shell shock”, ainsi que des termes “névrose de guerre” et “kriegsneurose” dans la littérature scientifique française et allemande. Cet article retrace l'histoire de la description, dans la littérature médicale, des conséquences immédiates et chroniques de ces traumatismes psychologiques et l'évolution dans le temps des conceptions diagnostiques et thérapeutiques.

## REFERENCES

1. Goethe JW. Werke. Hamburger Ausgabe. Munich, Germany: Deutscher Taschenbuch Verlag; 1998:X,234. (der Ton ist wundersam genug, als wär' er zusammengesetzt aus dem Brummen des Kreisel, dem Butteln des Wassers und dem Pfeifen eines Vogels . . . konnt' ich jedoch bald bemerken, daß etwas Ungewöhnliches in mir vorgehe . . . es schien, als wäre man an einem sehr heißen Orte, und zugleich von derselben Hitze völlig durchdrungen, so daß man sich mit demselben Element, in welchem man sich befindet, vollkommen gleich fühlt. Die Augen verlieren nichts an ihrer Stärke, noch Deutlichkeit; aber es ist doch, als wenn die Welt einen braunrötlichen Ton hätte, der den Zustand sowie die Gegenstände noch apprehensiver macht . . . mir schien vielmehr alles in jener Glut verschlungen zu sein . . . Es gehört übrigens dieser Zustand unter die am wenigsten wünschenswerten).
2. Oppenheim H. *Die Traumatischen Neurosen*. 2nd ed. Berlin, Germany: Hirschwald; 1892.
3. Crocq L. *Les Traumatismes Psychiques de Guerre*. Paris, France: Odile Jacob; 1999.
4. Crocq J. *Les Névroses Traumatiques. Étude Pathogénique et Clinique*. Brussels, Belgium: H. Lamertin; 1896.
5. Ellis PS. The origins of the war neuroses. Part I. *J R Nav Med Serv*. 1984;70:168-177.
6. Milian G. L'hypnose des batailles. *Paris Med*. 1915;(2 Jan):265-270.
7. Ulrich B, Ziemann B. *Frontalltag im Ersten Weltkrieg. Wahn und Wirklichkeit*. Frankfurt, Germany: Fischer; 1994:102-103.
8. Merskey H. Post-traumatic stress disorder and shell shock—clinical section. In: Berrios GE, Porter R, eds. *A History of Clinical Psychiatry*. London, UK: The Athlone Press; 1995:490-500.
9. Myers CM. Contributions to the study of shell shock. *Lancet*. 1915;13:316-320.
10. Brown EM. Post-traumatic stress disorder and shell shock—social section. In: Berrios GE, Porter R, eds. *A History of Clinical Psychiatry*. London, UK: The Athlone Press; 1995:501-508.
11. Winter D. *Death's Men. Soldiers of the Great War*. London, UK: Allen Lane; 1978:136.
12. Salmon TW. Care and treatment of mental diseases and war neuroses (shell shock) in the British army. *Mental Hygiene*. 1917;1:509-547.
13. Eissler KR. *Freud und Wagner-Jauregg vor der Kommission zur Erhebung Militärärztlicher Pflichtverletzungen*. Vienna, Austria: Löcker Verlag; 1979.
14. Kaufmann F. Die planmäßige Heilung komplizierter psychogener Bewegungsstörungen bei Soldaten in einer Sitzung. In: *Feldärzt Beilage Münch Med Wochenschr*. 1916;63:802ff.
15. Kraepelin E. *Lebenserinnerung*. Berlin, Germany: Springer Verlag; 1983:189.
16. Freud S. *Supplements to the Theory of Dreams*. London, UK: Standard Edition; 1920;XVIII:4-5.
17. Ahrenfeldt RH. *Psychiatry in the British army in the second World War*. New York, NY: Columbia University Press; 1958:26.
18. Menninger WC. *Psychiatry in a Troubled World*. New York, NY: Macmillan; 1948.
19. Jones FD, ed. *War psychiatry. Textbook of Military Medicine*. Walter Reed Army Medical Center, Washington DC: Office of the Surgeon General USA; 1995.
20. Glass AJ. *Neuropsychiatry in World War II. Vol II. Overseas Theaters*. Washington DC: Office of the Surgeon General, Dept of the Army; 1973.
21. Kardiner A. The traumatic neuroses of war. *Psychosomatic Medicine Monograph II III*. Menasha, Wis: George Banta Publishing Company; 1941.
22. Kardiner A, Spiegel H. *War Stress and Neurotic Illness*. New York, NY: Paul B. Hoeber Inc; 1947.
23. Grinker RR, Spiegel JP. *Men Under Stress*. Philadelphia, Pa: Blakiston; 1945.
24. Gabriel R. *Soviet Military Psychiatry: The Theory and Practice of Coping With Battle Stress*. Westport, Conn: Greenwood Press; 1986:33-37.
25. Gurevich MO, Sereyskiy M Ya. *Uchebnik Psikiatrii*. Moscow, Russia: Medgiz; 1946:376-377.

26. Eitinger L. Pathology of the concentration camp syndrome. *Arch Gen Psychiatry*. 1961;5:79-87.
27. Crocq MA, Macher JP, Barros-Beck J, Rosenberg SJ, Duval F. Post-traumatic stress disorder in World War II prisoners of war from Alsace-Lorraine who survived captivity in the USSR. In: Wilson JP, Raphael B, eds. *The International Handbook of Traumatic Stress Syndromes. Stress and Coping Series*. New York, NY: Plenum Press; 1992:(chap 21):253-261.
28. Belenky G (ed). *Contemporary Studies in Combat Psychiatry*. Westport, Conn: Greenwood Press; 1987:4.
29. Crocq L, Crocq MA, Barrois C, Belenky G, Jones FD. Low-intensity combat psychiatry casualties. In: Pichot P, Berner P, eds. *Psychiatry, the State of the Art*. New York, NY: Plenum Press; 1985;6:545-550.
30. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. Washington DC: American Psychiatric Association; 1994.
31. Turner S. Place of pharmacotherapy in post-traumatic stress disorder. *Lancet*. 1999;354:1404-1405.