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## **Research and treatment of war neuroses at the Clinic for Nervous and Mental Diseases at the Jagiellonian University in Krakow before World War II in the context of psychiatry in Europe**

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### **Summary**

The aim of this article is to offer an overview of the research into diagnosis and treatment of war neuroses at the Clinic for Nervous and Mental Diseases at the Jagiellonian University in Krakow before the outbreak of World War II. It also includes a profile of the work of Prof. Jan Piltz, the then director of the Clinic, and his major scientific achievements. The publications cited in the article date in the main from the period of World War I, and comprise clinical analyses of the consequences of stress suffered at the front as well as a description of the ways in which they were treated. These are presented alongside other major findings related to war neuroses being made in Europe at the time. The article draws attention to the very modern thinking on treatment of war neuroses, far ahead of the average standards of the day, evinced by Prof. Piltz and his team. The most important innovative elements of their treatment of these conditions were the fact that they perceived the cause of the neurosis to lie in previous personality disorders in the patients, their recommendation of psychotherapy as the main method of treatment, and their emphasis on the need for further rehabilitation following the completion of the course of hospital treatment. They also paid significant attention to the importance of drawing up individual therapy plans for each patient.

**Key words:** war neurosis, PTSD, Jan Piltz, World War I

### **Introduction**

The first lecture concerning post-traumatic disorders given at the Clinic for Nervous and Mental Diseases at the Jagiellonian University was Prof. Jan Piltz's paper "Nervous and mental disorders as observed during the mobilization and the war". It was delivered at a convention of military physicians from Fortress Krakow on October 24, 1914, and published in *Przegląd lekarski* in 1915 [1].

### **Overview of profesor Jan Piltz's work**

In 1905 Jan Piltz (1870–1930) was appointed a professor at the Jagiellonian University and the first Chair of the university's merged Department of Psychiatry and Neurology. During his studies he had been assistant to Prof. A. Forel in Burghölzli, and from 1896 to Prof. E. Olivet and Prof. A. Martin in Geneva. He later worked for Prof. Bechterev in Petersburg. In 1898 Prof. A. Forel's successor, Prof. E. Bleuler, called him to Zurich and charged him with establishing the internal structure of his clinic. Recognition of his considerable organizational skills prompted the cantonal government in Vaud to appoint him to the post of deputy director of the psychiatric clinic run by Prof. E. Mahaim in Lausanne, where in 1904 Piltz obtained his doctorate in medicine. He also worked for Prof. Dejerine in Salpêtrière in Paris. In 1905 he came to Krakow on the invitation of the Medical Faculty Committee of the Jagiellonian University, charged with setting up a modern neurological and psychiatric clinic. Thanks to Prof. Piltz's efforts, the sum of fifty thousand crowns was sourced from the Galician Diet and a plot of land on what is now Botaniczna Street was obtained from Krakow city council for the construction of the clinic [2]. The Clinic for Nervous and Mental Diseases, the most modern and best designed facility in the Europe of its day, was opened in July 1914. Owing to the outbreak of World War I, however, the first civilian patients were not admitted to the clinic until 1 January 1919. During the war the newly constructed clinic housed a neurological and psychiatric ward for the Fortress Krakow military hospital [3].

Professor Piltz was twice dean of the Medical Faculty of the Jagiellonian University. His legacy includes descriptions of three pupil reflexes, which were later named after him [4, 5]. The importance of these reflexes in the international neurological literature is such that they often eclipse the significant achievements of Prof. Piltz in the field of psychiatry, e.g. in the description and treatment of post-trauma neuroses.

### **Activity of Clinic for Nervous and Mental Diseases in Krakow during World War I**

Throughout World War I Prof. Piltz and his assistants (among whom in his publications he most frequently mentioned Dr Artwiński and Dr Beaurain [6]) treated war neuroses [2]. This was the term used to describe various, usually neurotic mental disorders at the time. The common feature of these disorders was their etiology: a reaction to a mental trauma. In his first article on the mental disorders encountered in wartime, Piltz profiled the etiology of the relevant disorders as follows: 'the primary cause which provoked the sickness was a mental trauma, and partly also the physical shock suffered from an explosion in the immediate proximity of a shell, a blast of air, or from being buried by earth, without visible bodily damage' [1]. He also noticed that the circumstances of the trauma were usually accompanied by terror.

In the second half of World War I the Clinic was the main place where (in accordance with military command) soldiers from areas around Lwów [now Lviv, Ukraine], Przemyśl and Krakow were referred [6]. Mostly Poles were treated there; at first referrals

to the Clinic were made irrespective of the patient's native region, but when the war was drawing to a close, they were made according to nationality. Every other day 20–50 patients came to the Clinic, but their quick recovery times made it possible to discharge them and create new vacancies [6]. In the words of Prof. Piltz: 'Over the war years [World War I] some 11,000 soldiers suffering from nervous and mental ailments passed through the Clinic, among them about 3,000 cases of ailments in consequence of nervous shock caused by the maelstrom of war' [2]. The increase in numbers of patients with symptoms of war neuroses treated at the Clinic facilitated research into both diagnosis and treatment of such conditions, which in turn translated into numerous publications in both Polish-language and foreign-language medical journals.

### **Birth and development of war neurosis concept**

Disorders connected with combat-related stress had been observed even prior to the outbreak of World War I. The first extensive medical descriptions date from the period of the American Civil War. In the years 1861-1865 the American physician Jacob Da Costa observed dyspnea, palpitations and searing chest pains during exertion in soldiers who saw active combat [7], and gave them the name of irritable heart syndrome. In the present-day literature they are known as Da Costa's syndrome or 'soldier's heart'. Only in World War I, however, were such large numbers of soldiers seen with symptoms caused by active participation in hostilities (in the hundreds of thousands in each of the armies), which came as a surprise to the psychiatry of the day. New names emerged for the disorders, such as 'shell shock', 'trench neurosis', and the abovementioned 'war neurosis' ('nevrose de guerre'). Initially it was thought that the symptoms might have their root in both physical and mental trauma, but over the course of the war this conception was to change, putting their mental source before any others.

### **War neurosis - British psychiatry**

In 1915 the British psychiatrist Charles Myers coined the term 'shell shock' in reference to soldiers who, after experiencing the explosion of an artillery shell, felt the need to flee the battlefield, accompanied by conversion symptoms such as loss of sensory reception (vision, hearing), psychogenic paralysis, 'strange body movements', astasia, abasia, and hypersensitivity of the skin [8, 9]. Myers noted the similarity of these symptoms to those of hysteria, but had great difficulty convincing the authorities that soldiers afflicted in this way were not deserters. He attempted to assure them appropriate treatment rather than charges of desertion and sentences that often ended in execution by firing squad. Meyers believed that the defensive mechanisms of dissociation and displacement were responsible for the symptoms of shell shock. The treatment he proposed involved integrating the patient's displaced memories and restoring their consciousness [10], which was usually undertaken far from the front line.

In the same period another English physician, Arthur Hurst, claimed to be able to cure war neurosis in twenty-four hours [11, 12]. Hurst, who practised as a neurologist,

had no psychology training. In his treatment of soldiers afflicted with war neurosis at Netley Hospital, he employed above all suggestion, including hypnotic suggestion, as well as faradic treatment and bed rest. He gradually departed from the use of hypnosis, however, in view of its poor efficacy. He considered the most important element of the treatment to be ‘the creation of an atmosphere conducive to recovery’, which involved the use by the whole therapeutic team of strong suggestion that the patient would shortly be cured [12].

### **War neurosis – French psychiatry**

French psychiatry also developed its own nomenclature for the psychopathological profile observed in soldiers during World War I: ‘hypnose des batailles’ (battle hypnosis) [13], ‘l’état de distraction des grands terrifiés’ (a state of disorientation caused by extreme terror) [14]. Each of these names stressed the link between the symptoms and emotional trauma. The French psychiatrist Régis, in an overview of 88 cases of war neurosis in 1915, perceived the importance of one more etiological factor: having observed the death of comrades-in-arms [15]. The French military health service developed a different method of treating war neuroses to other European countries, siting its psychiatric units in the vicinity of the front lines. As the French neurologist Georges Guillain wrote in May 1915: ‘these illnesses [war neuroses] are eminently treatable at first (...), but the patients must not be evacuated beyond the front line; they should remain in the military zone’ [16]. In December 1916 André Léri reported that 91% of soldiers were cured, of whom ‘over 600 were cured with the help of (...) psychotherapy and sent back to the front within a few days’ [16]. He claimed to have cured three thousand soldiers within twelve months. He used faradic treatment on the body parts affected by the neurosis; he did not consider it essential, but he did feel that it accelerated treatment [14]. What he did feel was key to the cure, however, was the atmosphere of the special therapy wards for the soldiers, though this was entirely different to that described by Hurst: he emphasised the importance of military discipline, a lack of comforts, proximity to the front, and a ban on all contacts with loved ones (friends or family).

### **War neurosis – German psychiatry**

In the German army a similar psychopathological picture composed of various hysterical symptoms accompanied by apathy or intense irritability was described by Prof. Robert Gaupp [17]. He, like Myers, saw the causes in explosions of artillery shells and the mental trauma they engendered, and like Régis he also drew attention to one more circumstance: witnessing the death of comrades in arms. The increasing numbers of cases of war neuroses in the German army led to special wards being opened for these patients at the university clinics in Berlin, Munich, Heidelberg and Giessen [18]. During the first year of the war alone, more than 111,000 soldiers with symptoms of hysteria passed through military hospitals [18]. The number of soldiers affected by this problem and the need to treat them were such that the 8<sup>th</sup> congress

of German psychiatrists and neurologists in Munich in September 1916 was devoted to war neuroses. One of those who attended the congress was Prof. Jan Piltz. During the conference, Oppenheim's theory on microdamage to the nervous system as a result of the trauma was rejected in favour of a psychoanalytic concept of mental trauma, but German psychiatrists nevertheless soon began to attribute such symptoms to patients' 'weak will' and poorer qualities in their personality: cowardice, mental weakness, antisocial tendencies, and egotism [18]. It was perhaps this attitude towards patients that led to the use of the 'Kaufmann method' as the most popular. Its aim was to achieve improvement as rapidly as possible, preferably within a single session of therapy, and to send the patient back to the front [19].

Kaufmann used a range of aversion techniques on patients (electric shocks, starvation, isolation, withholding letters, locking them up in the dark), compared to which the vision of a return to the front was to be made to seem a lesser evil. But his method failed to bring the expected results, as it was characterised by a large percentage of relapses on the patients' return to active service. It also provoked huge resistance among the soldiers whom it was used to treat, and from public opinion, in view of the lack of respect for patients' dignity. In 1918 it even prompted a debate in the Reichstag, where it was dubbed 'brutal' [18]. In these circumstances, the military authorities turned to psychoanalysis as their hope. As Freud writes in his foreword to *Psychoanalysis and war neuroses*, in 1918 there were plans to establish dedicated war neurosis wards [20]. This initiative never came to fruition, however, since after the end of the war in Germany, as in the wider Europe, other matters came to the fore, and the idea was abandoned. There were, naturally, centres in Germany that used more subjective treatment methods. Fritz Mohr, who worked in Koblenz, attempted to use Freud's cathartic method [20], while Ernst Simmel employed psychoanalytic techniques in the military psychiatry unit he ran in Poznań [20, 21].

### **War neurosis – psychoanalytic approach**

The contemporary psychoanalysts, foremost among them Freud, also took an interest in war neuroses, which they treated as another source of proof that their psychoanalytic theory was correct. This was the subject of the 5<sup>th</sup> International Psychoanalysis Congress held in Budapest in September 1918. Ferenczi believed that it was the 'mass experiment' of modern-day warfare that had caused the sudden rise in psychiatric illness, so drawing attention to a previously underestimated issue: the human psyche. Psychoanalysts decisively rejected the conceptions of Oppenheim and some other psychiatrists attributing the underlying causes of the symptoms observed in war neuroses to microdamage to the central and peripheral nervous systems caused by trauma [20]. It was publications by psychoanalysts that first stressed what is now central to a PTSD diagnosis: the symptoms of recollection of the trauma. Ferenczi writes: 'hysterics suffer with recollections', and also draws attention to other symptoms typical for present-day PTSD diagnoses: anxiety, irritability and irascibility, hypersensitive perception, and nightmares directly or indirectly connected with the trauma experienced, as well as recurring waking flashbacks accompanied by anxiety [20]. Freud described war

neurosis as an inner conflict, but one that is nevertheless different than that typical of peacetime neuroses [20]. In both cases the ego is defending itself against a threat through the symptoms, but in war neurosis the threat is also external, and the symptoms are an expression of the ‘self-preservation instinct’. Jones postulated that as in every neurosis, in war neurosis there are three factors: innate predispositions, the existence of an unresolved early life conflict, and the recent traumatic situation, which seemed to have the biggest part in the development of the neurosis – a fact which surprised him [20]. The recommended treatment method for war neuroses, in view of the fact that such a large number of patients had to be treated, was ‘simplified psychoanalysis’, something that we today would call ‘short-term psychodynamic psychotherapy’. The greatest practical experience in treating war neuroses in this area was amassed by Simmel, who used a ‘combination of the cathartic method employed in hypnosis with analytic interview in a state of consciousness, as well as dream analysis both under hypnosis and without it’ [20]. He recommended that analysis be continued even after symptoms abated.

### **War neurosis – Cracovian psychiatry school**

How does the research conducted at the Krakow Clinic compare with this context? The case descriptions produced by Prof. Piltz, similarly to those originating from other World War I combat forces, were usually what current psychiatry would classify as conversional and dissociative disorders. This is no surprise because this was the dominant clinical picture of war neuroses at the beginning of the 20<sup>th</sup> century. The most common diagnoses made at the Krakow Clinic at that time were hysteric neuroses. Nowadays these occur very rarely and the most dominant diagnosis is, of course, PTSD with a typical anxiety picture. Artwiński followed Babiński’s classification of a symptom as hysteric: ‘a symptom is hysteric when it can be replicated exactly by means of suggestion and be erased by means of persuasion’ [22]. This was precisely the picture of the then dominant post-trauma symptoms presented by Prof. Piltz in his publications. He divides the psychopathological profile he observed in patients of the Clinic into neurasthenia, hysteric neurasthenia, hysteric hypochondria and hysteria [6]. Artwiński, in his article entitled ‘Hysteria in light of the war’, gave detailed descriptions of the post-traumatic symptoms observed in patients at the clinic: minor trembling, rhythmic trembling of the whole body, chiefly the legs, ‘sometimes highly bizarre compulsive bodily poses’, walking disorders, palsies and hysteric spasms [23]. The most frequent diagnoses were in the hysteric neurosis category; diagnoses of anxiety and neurasthenia (closer to PTSD) were much rarer, though they were also described by Piltz [1, 6]. Hysteric symptoms were frequently accompanied by depressive symptoms [6, 22], something which is also observed today in post-traumatic disorders. Syndromes of symptoms reminiscent of contemporary diagnoses of acute reactions to stress with typical domination of dissociative symptoms and total or partial amnesia surrounding the traumatic event and its aftermath were also observed [1]. As in typical ASD, symptoms persisted for between 2 and 10 days. Prof. Piltz believed that the differences in the symptomatic picture were

due to the differences in the stressors that caused them. He considered neurasthenic symptoms to be caused by 'overtiredness and exhaustion (...) in combination with unsatisfactory nourishment and rest, and the concurrent damaging impact of offensive moral emotions', and symptoms from the hysteric range the effect of physical and mental traumas [6]. Artwiński held a more modern opinion, stating that 'the matter of the type of [trauma] neurosis that a trauma triggers is a secondary matter (...), the quality of the trauma plays a very minor role for the mechanics of the origin of the post-trauma symptoms, at least after a certain interlude of time has elapsed from the moment of the trauma' [24].

Prof. Piltz's publications betray a great sensitivity and interest in his patients' conditions. He repeatedly noted that the incidence of simulation among his patients was negligible. This is vastly different from, for example, Kretschmer's attitude; he pointed to a significant sense of entitlement and 'a lack of good will to be cured' [25]. Kretschmer's stance was not isolated in German psychiatry, and similar opinions were to be found also in other countries.

### **Psychotherapeutic treatment model of war neurosis in Kraków**

On arrival at the Clinic the patient was placed under observation for several days, during which time not only was treatment initiated but hereditary factors were also established. The diagnosis was preceded by an interview, which was composed of two parts: 1. the whole life of the patient from his/her childhood until the onset of the illness, and 2. the onset and course of the current illness. Prof. Piltz was inclined to see the manifesting symptoms as the expression of pre-existing congenital and acquired problems, and the trauma itself as simply a trigger for the development of the symptoms. He believed that the underlying cause of neurotic symptoms is 'constitutional psychopathy', i.e. personality disorder. The traits he lists as predisposing patients for occurrence of post-trauma symptoms, such as shyness, anxiety, hypersensitivity, lack of willpower, endurance and self-control, egocentricity, and exaggerated ethical sensitivity [6], are similar to the traits in the contemporary conception of personality traits predisposing occurrence of neurotic symptoms (neurotic personality) [26]. This seems quite natural if one notes that the main disorders at this time were hysteric disorders, though it was quite a modern approach for the times. The identification of personality traits predisposing of neurosis bore no negative connotations of the moral inferiority of such patients as was the case in German psychiatry.

Piltz and his team devised a way of treating war neuroses that was similar to the methods used in other European countries, but in many respects very modern. He stressed that treatment of war neuroses should be left to specialists, i.e. psychiatrists in specially designed units. The purpose of the treatment was not only to alleviate the symptoms of the neurosis, but also to alter the personality factors that were predisposing of the occurrence of symptoms ('to exert, through appropriate treatment and handling of the patient, a certain beneficial influence on his pathological disposition, and hence on his constitutional psychopathy') [6]. He advocated an individual approach to every patient. As he wrote: 'The most effective, most important

method of treatment (...) is psychotherapy. This involves above all calming the patient down, gaining his trust, awaking his confidence in his own powers, strengthening his will power, solving and easing his pathologically affective condition, revising his pathological thought relations, and removing his pathological auto-suggestion' [6]. He contrasted psychotherapy involving direct contact with the patient against other techniques such as electrotherapy and hypnosis. 'I see the effect of electrotherapy only as a sort of suggestivity and I am far from attributing to electrical currents an autonomous effect' [6]. Similarly, he expressed a sceptical opinion on the possibility of eradicating symptoms by means of hypnosis, through direct suggestion: 'contrary to the viewpoints of the Charcot school, I have long since ceased to use the hypnotic method of putting [the patient] to sleep for hysteria.' His reason for this was that new symptoms occurred in place of the subsiding ones. He drew attention to what we would call the therapeutic relationship: 'The physician has a wide and very responsive field to act in the case of hysteria, on condition, naturally, that – next to perseverance and energy – he possesses the ability to get into the patient's psyche (...) and is creative enough to influence the unsteady and frequently perverse and cunning hysteric soul' [6]. 'If we can diminish or relieve in any other way [the symptoms], we can then make use of the moment, we congratulate the patient on his progress, we encourage him to make further attempts of his own until (...) the improvement is achieved consciously' [6]. For Artwiński, too, the therapeutic relationship, and in particular the person of the physician, was the most important factor in the treatment: 'The person (...) of the physician plays a decisive role, and the methods he uses are a secondary element' [24]. Piltz had a very modern attitude towards use of psychotherapeutic techniques in psychiatric treatment. He stressed the importance of community action, changing the patient's environment, and selection of therapeutic input on an individual basis. As early as in 1905, in a lecture he delivered to mark the opening of the Jagiellonian University's Psychiatry Faculty, he mentioned psychotherapy in the first place among psychiatric therapeutic techniques. He wrote: 'for the influence of the psyche in the genesis of many illnesses is widely recognised today, and psychotherapy nowadays plays a primary role in treating a very many sicknesses' [27]. His views, and the experiences of German physicians as reported at the Munich congress, prompted him, around 1916, to organise the first, and shortly thereafter a second specialist unit treating war neuroses – what today we would call a veterans' PTSD treatment unit. His treatment produced very good results in terms of symptom relief 'in almost all cases' [6]. He considered the most efficacious method to be 'individually applied psychotherapy', which he supplemented with exercises in speaking and walking, and electrotherapy [6]. Both Piltz and Artwiński drew attention to the mutual benefits of interactions in groups of patients with neurotic disorders, with improvement often being seen as a result of observing successful treatment of other patients [6, 24]. Piltz also stressed the role of 'follow-up treatment', with the objective of improving the patient's character and preventing relapses of the symptoms; in his units there was a policy of 'occupying the patients with work' [6].

Piltz's views were shared by his colleagues. As Artwiński mentioned: 'each of these patients requires psychoanalysis in the broad sense of the word' [24]. Even before

the end of the war, he indicated possible directions for treating and rehabilitating patients: ‘creating psychiatric colonies in the countryside’, combining treatment with work, and setting up medical centres in the community. He contrasted benefits with one-off compensation as better support in the rehabilitation process, and supported his argument with data from studies conducted in Denmark, Sweden and Switzerland. And above all ‘individual and rational treatment of war neurosis’, since ‘every soldier at the front may show symptoms, and this may be generalized in order to draw conclusions and work out solutions for after the war’ [24].

### Conclusions

It is also important to emphasise that the increase in morbidity for war neuroses connected with World War I presented the possibility for broad international discussion on their causes and treatment, in which the employees of the clinic participated. Artwiński’s articles ‘On trauma neuroses’ [“W sprawie nerwic urazowych”] and ‘Hysteria in light of the war’ [“Histeria w świetle wojny”] offer a critical review of contemporary views on the issue [23, 24]. During the war, the clinic employees had access to foreign publications and took an active part in the international exchange of experiences in the area of treating neuroses, in part through their attendance of academic symposia devoted to the matter (e.g. Prof. Piltz in Munich). This undoubtedly had an impact on the excellent outcomes of neurosis treatment achieved by the Krakow Clinic and the high academic standard of the articles its specialists published. Significantly, however, it also ensured that they retained their individual approach to patient therapy.

It was probably the great relief at the end of the war that caused interest in post-traumatic disorders to wane. This was clearly evident in psychiatry and psychoanalysis across Europe, when, after the publications on war neurosis in the early 1920s, this subject was gradually superseded by others. This was probably due in part directly to the radical decrease in the number of patients with war neuroses. Paradoxically, this confirmed Piltz’s earlier statements about the good prognosis for patients’ treatment.

Prof. Jan Piltz died prematurely as a result of post-operative complications in 1930. The next war, World War II, brought the most tragic fate to many psychiatrists in Poland. Prof. Eugeniusz Artwiński (1892–1944) became the head of the Psychiatric Clinic in Lwów [now Lviv, Ukraine], but he died before the end of the war. The next director of the Jagiellonian University clinic, Prof. Stefan Kazimierz Pieńkowski (1885–1940), pursued Prof. Piltz’s interest in conversional neuroses, but he was murdered by the Russians in Katyn in 1940 along with other doctors from the clinic: Prof. Włodzimierz Józef Godłowski (1900–1940), a professor of psychiatry at the university in Wilno [now Vilnius, Lithuania] from 1938; Assoc. Prof. Aleksander Ślącza (1893–1940); Prof. Marcin Karol Zieliński (1886–1940), a professor of psychiatry at the University in Poznań from 1938; and Col. Dr Jan Nelken (1878–1940). Dr Adam Gradziński (1902–1944) was arrested and shot by the Gestapo, and Dr Julian Dretler (1905–1944) perished during the Warsaw Uprising. These events meant that after World War II there were no doctors in the Krakow clinic with previous experience in treating war neuroses.

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