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NOSOLOGIE

Le syndrome de la guerre du Golfe vingt ans après

The Gulf War Syndrome twenty years on

Y. Auxéméry[a,*,b,c]

[a] *Service de psychiatrie et de psychologie clinique, hôpital d'instruction des armées Legouest, 27, avenue de Plantières, BP 90001, 57077 Metz cedex 3, France*
[b] *Centre de recherche psychanalyse, médecine et société, université Paris VII, EAD n° 3522, 26, rue de Paradis, 75000 Paris, France*
[c] *École du Val-de-Grâce, 1, place Alphonse-Laveran, 75005 Paris, France*

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Syndrome post-guerre ;
Vétérans ;
Critères diagnostiques ;
Méthodes épidémiologiques ;
Psychopathologie

Résumé Le syndrome de la Guerre du Golfe (S2G) semblait être un nouveau trouble qui associait une kyrielle de symptômes fonctionnels intégrant les systèmes locomoteurs, digestifs, tégumentaires et neurosensoriels. Mais malgré des investigations scientifiques très poussées, vingt ans après la fin de la guerre, aucun marqueur de souffrance physique objectif n'est retenu pour rendre compte des troubles présentés qui seront finalement attribués au stress. Les facteurs de stress ne manquaient pas pour les troupes déployées : alertes répétées d'attaques chimiques, hostilité du milieu avec ses vents de sable et ses animaux venimeux, conditions climatiques rendant difficiles de longues heures de soutien et d'observation statique, ramassage des corps et incertitude sur la durée du conflit. La tenue militaire de protection antinucléaire—bactériologique—chimique permettait un confinement certes protecteur grâce à la fermeture au monde hostile duquel viendrait la menace, mais dans le même temps, cet isolement majore la peur d'un risque hypothétique alors que les perceptions internes sont majorées et peuvent ouvrir la voie à des somatisations. Dans un tel contexte, les manifestations somatiques de l'anxiété (palpitations, sueurs, paresthésies, céphalées...) s'associent volontiers à des troubles fonctionnels somatisés auxquels peuvent encore s'adjoindre des surinterprétations de sensations corporelles selon un mécanisme d'analyse hypochondriaque. Le S2G existe bel et bien : il ne s'agit pas d'une « maladie imaginaire » mais d'un trouble psychogène impliquant un sérieux problème de santé publique qui a occasionné des dizaines de milliers de plaintes et englouti des millions de dollars. Si une souffrance psychique et psychosomatique survenant chez les vétérans est immuable au cours de l'histoire, l'expression de ces difficultés possède des spécificités en fonction du contexte culturel, politique et scientifique d'alors. Pour répondre aux souffrances humaines, une « nouvelle » entité nosographique peut se répandre dans la société en prenant l'expression épidémique d'un trouble somatisé via des mécanismes d'identification, d'imitation et de suggestion.

* Service de psychiatrie et de psychologie clinique, hôpital d'instruction des armées Legouest, 27, avenue de Plantières, BP 90001, 57077 Metz, France.
Adresse e-mail : yann.auxemery@hotmail.fr

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Epidemiological methods;
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Summary
Introduction. — After Operation Desert Storm which took place in Iraq from August 1990 to July 1991 involving a coalition of 35 countries and a 700,000 strong contingent of mainly American men, some associations of war veterans, the media and researchers described a new diagnostic entity: the Gulf War Syndrome (GWS).
Literature findings. — GWS seems to be a new disorder which associates a litany of functional symptoms integrating the musculoskeletal, digestive, tegumentary and neurosensory systems. The symptoms presented do not allow a syndrome already known to be considered and the aetiology of the clinical picture remains unexplained, an increasing cause for concern resulting from the extent of the phenomenon and its media coverage. It quickly appears that there is no consensus amongst the scientific community concerning a nosographic description of GWS: where can all these functional complaints arise from? Different aetiopathogenic hypotheses have been studied by the American administration who is attempting to incriminate exposure to multiple risks such as vaccines and their adjuvants, organophosphorous compounds, pyridostigmine (given to the troops for the preventive treatment of the former), impoverished uranium, and the toxic emanations from oil well fires. But despite extremely in-depth scientific investigations, 10 years after the end of the war, no objective marker of physical suffering has been retained to account for the disorders presented. It would appear that the former soldiers are in even better objective health than the civil population whereas their subjective level of health remains low. Within this symptomatic population, some authors have begun to notice that the psychological disorders appear and persist associating: asthenia, fatigability, mood decline, sleep disorders, cognitive disorders and post-traumatic stress disorder (PTSD). Within the nosological framework, does GWS cause functional disorders or somatisation? Finally, 20 years after the end of the fighting, only PTSD has been causally attributed to military deployment.
Clinical findings. — Certain functional symptoms of GWS occur during the latent phase of a future reexperiencing syndrome, latent phase which is the locus of nonspecific symptoms. The psychotraumatised subject does not express himself spontaneously and waits to be invited to do so: if the social context does not allow this expression, the suffering can remain lodged in a few parts of the body. How can the inexpressible part of the trauma be recounted, particularly if the social context does not allow it? For civil society, calling into question ''the somatic word'' of veterans is difficult: why were they sent to face these hardships? What could we learn from these soldiers we do not wish to listen to: the horror of the war, the aggressive impulse of men, and the confrontation with death? Another obstacle to this reflection is the reference to stress as a prevalent aetiopathogenic model of the psychological trauma. A model like this, considering that PTSD is a normal reaction to an abnormal situation, finally discredits the subject and society and disempowers them by freezing them in a passive status of victim.
Discussion. — However, as GWS affects approximately a quarter of subjects deployed, it is not very likely that all these symptoms are caused by a psychotraumatic reaction. Many veterans suffering from GWS have themselves rejected the diagnosis of PTSD, arguing that they do not suffer repetition nightmares. What the veterans rightly tell us here is that the notions of stress and trauma cannot strictly be superimposed. A subject may have been intensely stressed without ever establishing traumatic flashbacks and likewise; a psychological trauma can be experienced without stress and without fear but in a moment of terror. This clarification is in line with the first criterion of the DSM-IV-TR which necessarily integrates the objective and subjective dimensions as determinants of PTSD. Yet, scientific studies relating to GWS are struggling to establish opposition or continuity links between the objective external exposure (smoke from petrol wells, impoverished uranium, biological agents, chemicals) and the share of inner emotion albeit reactive and characterised by a subjective stress. There were no lack of stress factors for the troops deployed: repeated alerts of chemical attacks, hostility of the environment with its sandstorms and venomous animals, climatic conditions making long hours of backup and static observation difficult, collecting bodies, lack of knowledge of the precise geography of their movements and uncertainty of the duration of the conflict. The military anti-nuclear—bacteriological—chemical uniform admittedly provided protective confinement, shutting out the hostile world from which the threat would come but, at the same time, this isolation increases the fear of a hypothetical risk whilst the internal perceptions are increased and can open the way to future somatisations. In a context like this, the somatic manifestations of anxiety (palpitations, sweating, paresthesia...) are willingly associated with somatised functional disorders to which can also be assigned over-interpretations of bodily feelings according to a hypochondriacal mechanism. The selective attention to somatic perceptions in the absence of mentalisations, the request for reassurance reiterated and the excessive use of the treatment system will be diagnostic indices of these symptoms caused by the stress. Rather