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Mutilation and Disfiguration (France)

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This article explores the issue of suffering through two distinct categories of those mutilated during the Great War: amputees, who were the most numerous, and the disfigured, who were the most emblematic of the violence inflicted on the body. Amputees were subjected to pain, a phenomenon largely buried in the family circle and denied by the medical world. This pain occurred within one's core or absent member and amputees used a variety of words to refer to the magnitude of the perceived sensations. Many of amputees became addicted to morphine. Amputees and the disfigured also faced the difficulty of identifying and accepting a face that appeared no longer his in addition to refiguring relationships with others who expressed feelings such as repulsion, disgust, fear or pity towards the afflicted.

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Introduction

At the end of the war, Europe counted more than 10 million [dead](#) or missing. The number of the wounded soldiers is unknown. In the French case, there were more than 3.5 million documented wounded, suggesting an actual figure of 2,800,000 men, that is 40 percent of all mobilized men. Half were wounded twice, more than 100,000 were wounded three or four times. Many had their bodies mutilated. The statistical data on mutilation should be approached with caution: the number of amputees (one or several limbs) varies from 70,000 to 700,000.

The disabled belong to the landscape of the post-war years in Europe. Their presence in the street recalled and sometimes revealed the violence of the war. Placed in front of the victory march on 14 July 1919, disabled veterans were a testament to the recognition of a French nation in defense of which many had experienced physical suffering.

This march also “heroized” injuries/disability and, in a sense, valorized the disabled veteran. A delegation of “broken faces” (*gueules cassées*) had also been invited by [Georges Clemenceau \(1841-1929\)](#) to attend the signing of the [Treaty of Versailles](#). These men were located such that all participants in the ceremony would have to pass in front of them. Their presence was intended to leave a mark and, particularly for the German participants, to denounce German “barbarism” during the war.

After the war, specialty organizations for specific disabilities began to appear. The first, “The Union of the Broken Faces” (*l'Union des Blessés de la Face*) was created in 1921; others such as “The Amputee” (*L'Amputé*), “The Cranial Wounded” (*Le blessé crânien*) or “The Eyes Wounded” (*Le blessé aux yeux*) followed. Many associations were very short-lived, as in the case of the “Wounded and sick of the Kidney victims of the War” (*Blessés et malades du rein victimes de la guerre*) which did not exist for more than one year. Still the wave of founding associations continued until the middle of the 1930s, fragmented by type of mutilation, by political allegiance and by geographical location.

An overview study of the associations does not give much insight into the intimate life of the disabled veteran. What do we know about his return home, his family, his rehabilitation (or not) to the civil life, the acceptance (or not) of his disability by himself and by others? In fact, only a few elements can help us understand the discourses of the disabled veteran: the discourses and appropriation of those discourses within the associations and the discourse of the medical establishment. Though the question of pain and suffering involves almost all of the war disabled, this article will only discuss it in relation to amputees as this category concerns the largest number of disabled and as the pain of the amputees appears with such acuteness and diversity.

We can study suffering through the example of another category of disabled men, those who were wounded in a most human part of their body, the face. The “broken faces” of the Great War were exposed to a double violence: the first is that of the difficulty becoming identified with a face which has lost its identity function; the second is tied to relational dynamics with those both known and unknown and the construction of a new ritual of interaction.

How and in what way did forms of the exclusion of the “broken faces” develop during and after the war? Did the creation of an association of “men without faces,” in specialized hospitals during the war and then in the post-war era in 1921, allow these men to escape marginalization? In what way was the association of “broken faces” also a proponent of exclusion?

The history of disability and disabled veterans is recent area of study. In the French case, the works of [Antoine Prost](#) on the associative movement and Jean-François Montès on the legal aspect of the mutilated have opened the way. A comparative history insistent on the body, on the traumatism, on care-taking, on the intimacy of return to civilian life and on the rehabilitation of the body has still only been approached tentatively. It is a difficult subject to address primarily because of the considerable amount of archival documents but today it is an essential one.^[1]

Pain

“Every history is a family history,” affirmed the American historian [Jay Winter](#). Thus, I will begin with the health history of my great-uncle, [Lucien Froidure \(1895-1967\)](#). Injured on the left leg by a bullet on 10 October 1916 at Sailly-Saillissel, during the famous [battle of the Somme](#), his history extends beyond the war. His leg was partially amputated several times and finally disarticulated. Beginning with the first days after the last amputation, he felt a pain in his “ghost limb” in form of paroxysmal attack. His disability prevented him from returning to work as a mechanic so he became watchmaker. He married a single mother and acknowledged her child. “It’s for his pension that she married with him,”^[2] said one of Lucien’s sisters. The five children born after the marriage were recognized by Lucien; only one was legitimate.

Up until his death in May 1967, the pain occurred each month and lasted a period of two to five days. It was in isolation in the garage of his house that he waited out his attacks of pain. Indeed, the attacks appear to have been completely negated by his wife and children, for whom the pain was normal. As I prepared this work about the pain of amputees, I put some questions about Lucien to his sister, his nephew and to one of his sons, which brought Lucien’s story to light. This story had been buried in the family circle. Silence reigned and the humiliation was never mentioned. But, Lucien’s story touches on the essential themes of this article: the return home of the amputee veteran, his rehabilitation, his pain, his relation to the amputation and the acceptance (or not) of his disability.

Reading the bulletins of the association of amputees like “The Amputee” (“*L’Amputé*”) or “The National Federation of the Great Disabled” (“*La Fédération nationale des Plus grands invalids*”) it is clear that they too were inclined to silence. In fact, pain is only treated in these periodicals with regard to a claim, including pensions or jobs. Pain was also not expressed in intimate relationships and, in this sense, pain remained a family taboo, sparking the problem of the non-receipt of pain. The amputees explained, “We speak only when we know that we will be heard.”^[3] The apparent refusal to hear is maintained in the medical discourse which was, in part, inclined to deny or ignore the pain and to attribute it to hallucinatory or psychological phenomena. The denial of pain has undoubtedly

helped to entrench amputees in silence: it is easier to deny the pain than answer to it.

On the other hand, there was also a feeling of compassion for the amputees. Their condition required constant care and often spouses played the role of a [nurse](#). Spouses assisted the amputee in his pain, though sometimes they induced an attack by knocking against the stump during the night or by varying the “mood.” To some degree, spouses recognized the pain of their amputee husbands, claiming, “No one can endure what he endured” or, “You can’t imagine what he has suffered.”^[4]

The physician [René Leriche \(1879-1955\)](#), who was considered the “father” of the question of the amputee’s pain, wrote in 1937: “The poor men are often very difficult patients because they are more irritable or more irascible.”^[5] Some witnesses close to the pain of the amputee also suggest a form of permanent internalization of the pain: “You could not hide his pain but you could not do anything about it, the pain attacks had become a habit and we did not speak about them.”^[6]

The question of the pain of amputees in the medical context was restricted to only a few physicians in [France](#) after the war and remained on the margins of medical discourse. The word “unfortunate” was used very frequently in physicians’ accounts of these particular patients.^[7] This lack of interest is correlated with the inability of the medical world to provide answers for this segment of disabled, fueling the silence.

Words for Pain

During consultations with physicians, amputees attempted to define the pain that they felt. Physicians reported the use of a range of words such as: tingling, numbness, throbbing, painful launches, thrill, crush injuries, wag, tear, crash, burn, feeling expansion, feeling contracture, burning, bite, twist, tension, contraction, pinch, cut, electric shock and shake.

According to some specialists, the sensations perceived in post-traumatic pain corresponded to those perceived during the trauma itself as if the perception of pain had been perpetuated since the time of injury. It is very important to underscore the association between pain and memory. Besides the words used by the disabled themselves, physicians used certain words to describe the different types of manifestations of pain amputees felt, in particular: convulsions, epilepsy, shaking, vibrations, spasms, chorea, neuritis, radiation, painful stump, ghost pain, pains and paresthesia.

The variety of words listed above, including those reported in the medical discourse, demonstrates the extent of the pain, but also the difficulty of understanding its various manifestations. The pain, to some extent, appears to have been drowned out by words.^[8]

Forms of Pain (Amputees)

Regardless of the words amputees used to describe their pain, some form of pain was experienced by almost all (Leriche mentions a figure of 98 to 99 percent).^[9] The following section will detail the

variety of sensations experienced by those who lost limbs during and after the war.

First, there is the “illusion of the presence of the amputated limb,” also called “hallucinosis” or, in the words of [Weir Mitchell \(1829-1914\)](#), the American physician who observed the phenomenon in amputees during the American Civil War, the “phantom limb.” In this case, the mutilated becomes convinced of the presence of the amputated limb whose outline appears momentarily blurred. The amputee is not able to acknowledge the alteration of his body schema. According to a study by Doctor [Anatole Sliosberg \(1905-?\)](#), of 170 amputees during the Great War, the “presence” of the haunting absence of a limb cut off the immediacy of the amputation: “The subject is surprised to learn his mutilation so clearly were the contours of the phantom limb drawn.”^[10] The psychiatrist [Jean Lhermitte \(1877-1959\)](#) noted about the “illusion of the perception” that “any subject to which a member has been brutally cut off, either because of a trauma incurred or an operation, is made aware of this mutilation through the sight of an alternate appearance.”^[11]

Therefore, 95 percent of amputees saw a phantom limb appear during the first year after the amputation, two thirds of whom saw one appear immediately after surgery. For other amputees, perception of the phantom limb occurs much later. However, in all cases, the sensation of the phantom limb was the same. The phantom limb could produce sensations without pain. Physicians most frequently were told of feelings of shortening: the sensation that the phantom limb was shortened in comparison to the existing correlating limb with its end adjoining the stump. Physicians reported cases of “ghost hands” at the stump of an amputated arm. More rarely, the amputee signaled to the physicians a progressive shortening of his ghost limb in the years following the amputation limb and that the sensation of phantom limb slowly disappeared. This occurs for the most part in the case of upper limb amputations. Physicians have highlighted the influence of prosthesis in this phenomenon: in fact, most of upper limb amputees (arm or forearm) refused to wear their prosthesis. It is the absence of intermediate segments between the stump and the end of the ghost limb that would have aroused the feeling of shortening and then the disappearance of the phantom sensations. In the case of lower-limb amputees, prosthesis, necessary for movement, could replace the phantom limb itself.^[12]

Amputees also described to their doctors a feeling of mobility in the phantom limb. Indeed, in some cases, the phantom limb seemed to be the seat of involuntary movements, such as the opening or the closing of the hand, the flexion or the extension of the elbow and, in some subjects, the performance of all the movements attributed to the existing limb.^[13]

Amputees also experienced the illusion of pain in the absent limb,” also called “algehallucinosis.”^[14] The onset of pain in the phantom limb manifested in many different ways despite the feeling of the constant presence of the phantom limb for most patients. According to Doctor Sliosberg, pain emerged in almost half the cases in the early days following the amputation.^[15] In a third of the cases, the pain came a year later, even if the amputee had accepted his mutilation and taken on an active life. In this case, the pain arose suddenly in the form of a “paroxysmal” attack. Sliosberg

insisted on one point: “The earlier the onset, the more amputation that was done in the early days after the trauma, and vice versa.”^[16]

The stump was another location of pain, which was similar to that of epilepsy, convulsions or spasms. The stump contracted with a clonic or tonic movement. In the first case, which was the most frequently observed, the amputee’s pain ranged between thrill and seizure, affecting all muscles of the stump with an extreme violence. This manifested mainly in lower-limb amputees, especially during bowel movements of coitus or ejaculation. The pains were of such intensity that they sometimes caused syncope. In the second case – tonic epilepsy – the stump stiffened (“erection of stump”) so painfully for a period ranging from a few seconds to several hours.

Nearly half of amputees suffered pain both in the stump and in the phantom limb. The “quality” of stump did not seem to have any bearing on the pain experienced by the amputee.^[17]

Pain Management

The physician Émile Foucher admitted in his work the medical field’s incapacity to deal with the issue of pain. He wrote: “The question of treatment remained, truly agonizing over the sufferings of the unfortunate who were entrusted to us. We must note, to our confusion, that we felt disarmed by a question as tenacious as amputation.”^[18] Surgeons attempted re-amputation but without result. René Leriche spoke against re-amputations: “We don’t re-amputate, even if the stump is not correct. A re-amputation recreates the same pain and makes it even more difficult to care for.”^[19]

Painkillers, including aspirin which “they consumed in astonishing amounts”^[20] according Sliosberg, were heavily prescribed: pyrethane, nealgyl, sedatives, or vitamin B1 coupled with physiotherapy, radiotherapy or ionization. “These methods fail or even aggravate the situation,”^[21] explained the same author. The surgeon Leriche highlighted the use of morphine and its consequences: severe constipation (lasting eight to ten days) and addiction or dependence, with the alternative being sometimes suicide. Leriche wrote: “We must not let them become morphinomen: the amputee with an addiction to morphine is incurable. Sooner or later, he will reoffend. Believe me, I cared for forty of them.”^[22]

Suffering

For those with disfigured faces, the pain of surgical reconstruction was combined with the mental distress of disfigurement. In specialized clinics in France, the “broken faces” tried to resurrect themselves. The injured inhabited immense rooms with the disfigured “always in package” as one nurse wrote. The injured discovered a world where everyone was disfigured, where all had instead of a face “a nameless thing, a monstrous pile of shredded flesh, of dressings, of pus, of bundled fever,”^[23] as one wrote in “*La Greffe Générale*”, the bulletin of the association *l’Union des Blessés de*

la Face. This was a fundamental step in the building of a new identity for the “broken faces.” Discovering the new face in the mirror was experienced less individually than collectively, as the wounded now belonged to a group of stigmatized men, their faces ravaged by war, seemingly inhuman.

Disfigurement had the effect of disintegration on the personality, causing deep emotional imbalances and disordered, schizoid behavior (withdrawal), which is also a form of self-exclusion. The psychological defense mechanisms constructed to reduce the anxiety caused by the awareness of their new appearance and the difficulties of integrating their new environment, invited the disfigured to withdraw. However, withdrawal was not a universal occurrence which strongly depended on the personality of the wounded. As two French psychiatrists, Alliez and Robion, wrote in the *Annales Medico-Psychologiques* in 1969, “extroverted personalities whose activities are directed towards the outside are less affected by disfigurement than people already naturally inclined to withdraw and isolate and that a facial wound provides an additional reason for their anxiety in confronting others and the outside world.”^[24]

Another infrequent form of reaction to this type of extreme disfigurement was suicide. These cases were rare as the hospital environment insulated the “broken faces” from the difficulties and animosities of the outside world. Still, some disfigured affirmed that they would prefer to die than live with this disability because it was an attack on their dignity as men: “We returned home disfigured. Remember, comrades, those painful hours, especially for the most wounded of us, who sometimes came to curse the fate that had made them stay alive.”^[25] Though no monthly reports from the surgeons at the maxillofacial centers mentioned a case of suicide, there surely were attempts.”

Family Contact

One of the most difficult tasks of medical staff was to prepare the disfigured for his first meeting with his family. Reconnecting could be done in the hospital or outside with permission or when the disfigured returned home permanently. Wherever it took place, this first meeting with intimates constituted the first real relationship since the soldier’s disfigurement.

Intimate and family relationships played a part in the reconstruction of the identity of the disfigured. The possibility of rejection was high so medical staff introduced contact slowly. This is why medical staff, especially surgeons, did not appreciate family visits synonymous with foreign aggression and capable of disturbing the protective world of the hospital. A painful meeting could immerse the “broken face” in anxiety and all the benefits of restorative treatment could disappear. The family could also offer protection and help the disfigured to overcome his terrible ordeal. If the first meeting went well, the disfigured could begin to desire “to get out” and live.

Outside the Hospital to Self-Exclusion?

At the end of the Great War, disfigured men were a constant presence in the streets exhibiting the

impact of the brutality of war. These men with “broken faces” peopled the devastated landscape. In some cases, the facially wounded pleaded to be recognized for their heroic behavior during the war. In this sense, the horrible mutilation could provide a feeling of pride. The French surgeons Pons and Lartigau wrote in 1966: “It is rare to observe in the disfigured of war a feeling of inferiority. Better, some of them refused a surgical restoration. This category of wounded seems to find in their scars of their wounds a valorization of their personality.”^[26]

Nevertheless, the disfigured were relentlessly subjected to the subjectivity of the gaze of others. These “terrifying masks” attracted inevitable attention. The sight of the “broken faces” aroused feelings of fascination and sympathy, mingled with fear, pity or disgust. The mutilated appeared as otherworldly beings. The feelings of revulsion or fear they aroused constantly reminded the disfigured of what had become of him and the significance of his different appearance. One explained: “In our outing, we perceived in the eyes of women, looks of pity, only pity. However, it’s difficult for a young man, 20 years, to inspire anything else.”^[27] We noticed here the fear of not being able to expect a normal emotional life, to be loved by a woman.

From the large amount of data on the French “broken faces” of 1914-1918, we can prove that many of them married and integrated back into the family circle. This suggests that some were able to accept their disability. Still, the difficulties of returning to civilian life as a whole were much more difficult to overcome.

The Union of the “Brothers of Suffering” (“L’Union des “frères de souffrance”)

An answer to the moral and physical distress of the disfigured men outside of the hospital after the war was found in the formation of the “Union of the Wounded of Face” (*l’Union des Blessés de la face*) in 1921, the first association created based on type of injury. The main objectives set by Colonel [Yves Picot \(1862-1938\)](#), the president of the association were “to improve materially the lot of our poor comrades, to help and support them in the moral crises they have to confront but we also raise ourselves morally by practicing the feelings of the most sincere and pure fraternity.”^[28]

One of the Union’s most important projects was the acquisition of a house able to accommodate the poorest of the disfigured. The “house of broken faces” was inaugurated in 1927 in the castle of Moussy-le-Vieux, near Paris. Refusing uselessness, residents occupied themselves by working the castle’s farm. The development of a farm also demonstrates the strength of the myth of return to the land and perhaps reveals a desire to live in isolation.

The residents ventured outside the castle most often in groups. Socializing revolved around banquets, general meetings and walks in the park. A small portion of the “broken faces” stayed permanently in Moussy but all of the members of the association came regularly to the castle, alone, after a surgical operation or accompanied by their families. All these measures helped to make Moussy a world apart, a transposition of the fraternity born in the specialized medical centers during the war. The acquisition of a new home in 1934, Le Coudon in the Var in the South of France,

answered the new needs of the disfigured, as Moussy-le-Vieux was no longer sufficient accommodation.

The death of Colonel Picot before the Second World War marked a turning point in the history of the association of the broken faces. A feeling of failure increased by the arrival of new contingents of the disfigured from the Second World War, Indochina and Algeria who swelled the ranks of the family of the disfigured. The “broken faces” of the Great War continued to constitute the dominant group of this community of men. Yet, the younger generations considered the first generation too rigid and too dominating, contributing to a new form of marginalization within the community.

Conclusion

We have focused here on two aspects of disability: pain and suffering for two separate categories of disabled of the Great War, amputees and the disfigured, “*les gueules cassées*.” However, these same questions apply to many others categories of disabled such as those with a wounded abdomen or skull and also those wounded psychically in the cataclysm of World War One.

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Notes

1. ↑ See the work of Marjorie Gerhardt (University of Exeter) concerning the experience of the “broken faces” in Britain, [Fiona Reid](#) (University of South Wales), Susanne Mitchl (University of Mainz) on the German experience in the style of Sabine Kienitz or Pieter Verstraete (University of Louvain) concerning amputees. Many other questions regarding disability remain to be investigated by historians.
2. ↑ Interview with Léone Froidure, one of Lucien Froidure’s sisters, September 1998.
3. ↑ Interview with Dr. Pierre Tajfel, head of the anti-depression center at CHU Versailles, October 1999. I hope he finds here an expression of my gratitude for his agreement to place his experience and competence at my disposal. It is equally important for me to thank Dr. George Labouret together with the Association of the Great Disabled and in particular his General Secretary Mr. Leclerc for their very kind attention.
4. ↑ Interview with Dr. Tajfel, October 1999.
5. ↑ Leriche, René: *Chirurgie de la douleur*, Paris 1937, p. 167.
6. ↑ Interview with Karl Froidure, Lucien Froidure’s son.
7. ↑ See in particular, the work of Foucher, Sliosberg or Leriche.
8. ↑ Delaporte, Sophie: “Le corps et la parole des mutilés de la grande guerre”, in: *Guerres Mondiales et Conflits Contemporains* 1/205 (2002), pp. 5-14.

9. † Leriche, cited in Aboulafia, Elie: Contribution à l'étude de la douleur chez les amputés, thèse de médecine n°2147, Geneva 1953, p.8.
10. † Sliosberg, Anatole: Les algies des amputés, Paris 1948, p. 9.
11. † Lhermitte, Jean: Image de notre corps, Paris 1939, p. 158.
12. † Delaporte, "Le corps et la parole des mutilés de la grande guerre", pp. 5-14.
13. † Delaporte, "Le corps et la parole des mutilés de la grande guerre", pp. 5-14.
14. † Leriche, René: Chirurgie de la douleur, Paris 1937, p. 170.
15. † Sliosberg, Les algies des amputés 1948.
16. † Sliosberg, Les algies des amputés 1948, p. 29.
17. † A study done on amputees in which nearly 85 percent were combattants from 1939-1945, 16 percent from 1946-1961 and 1.1 percent from 1914-1918 yields some comparative elements: 55 percent experienced pain in the stump, 17 percent in the phantom limb and 27 percent in the stump and the phantom limb at the same time. See: Féodoroff, V.: Etude de la douleur chez les amputés traumatiques, victimes de guerre (176 observations), thèse de médecine, Paris 1990.
18. † Foucher, Émile: Contribution à l'étude de la douleur et des spasmes d'origine névritique dans les moignons d'amputations, thèse de médecine n°235, Paris 1920, p. 130.
19. † Leriche, La chirurgie de la douleur 1937, pp. 167-186.
20. † Sliosberg, Les algies des amputés 1948, p. 87.
21. † Ibid.
22. † Leriche, La chirurgie de la douleur 1937, p. 81.
23. † Stenay, Marcel-G: "Leur Rire", in: La Greffe générale 6 (1 April 1918), p. 3, online:<http://gallica.bnf.fr/ark:/12148/bpt6k1040901s/f3.image> (retrieved: 22 January 2015).
24. † Alliez, J. / Robion, M.: "Aspects psychopathologiques de la défiguration. Leur relation avec la dysmorphobie" in : Annales Medico-Psychologiques 4/2 (1969), pp. 479-494.
25. † Bulletin de l'Union des Blessés de la face, March 1951, p. 1.
26. † Pons, J. / Lartigau, G. / Vauterin, C.: Problèmes psychologiques chez les défigurés. In: Revue française d'odonto-stomatologie 13/3 (1966), p. 406.
27. † Bulletin de l'Union des Blessés de la face, 1953, 3 trim., p. 8.
28. † Bulletin de l'Union des Blessés de la face, booklet 1921-1981, p. 5.

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