1950

A study of World War II schizophrenic patients admitted to Bedford Veterans Administration Hospital from September 1, 1948 to September 1, 1949 with a service-connected neuropsychiatric disability.

Soloway, Mary
Boston University

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Boston University
A STUDY OF WORLD WAR II SCHIZOPHRENIC PATIENTS
ADMITTED TO BEDFORD VETERANS ADMINISTRATION HOSPITAL
FROM SEPTEMBER 1, 1948 TO SEPTEMBER 1, 1949 WITH A
SERVICE-CONNECTED NEUROPSYCHIATRIC DISABILITY

A Thesis

Submitted by
Mary Soloway
(B.S., Simmons College, 1936)
In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service
1950
# TABLE OF CONTENTS

## LIST OF TABLES

<table>
<thead>
<tr>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>iii</td>
</tr>
</tbody>
</table>

## Chapter

### I  Introduction

<table>
<thead>
<tr>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
</tbody>
</table>

### II  Schizophrenic Reaction with Reference to Military Service

<table>
<thead>
<tr>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
</tr>
</tbody>
</table>

**The Schizophrenic Reaction**  
**The Effect of Military Stress**

### III  Presentation of Descriptive Data

<table>
<thead>
<tr>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
</tr>
</tbody>
</table>

**Tables**  
**Discussion of Data**

### IV  Case Studies

<table>
<thead>
<tr>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
</tr>
</tbody>
</table>

### V  Summary and Conclusions

<table>
<thead>
<tr>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>55</td>
</tr>
</tbody>
</table>

**Appendix**  
**Bibliography**
<table>
<thead>
<tr>
<th>TABLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Religious Affiliations of the Twenty-five Patients</td>
<td>18</td>
</tr>
<tr>
<td>II Marital Status</td>
<td>19</td>
</tr>
<tr>
<td>III Education</td>
<td>20</td>
</tr>
<tr>
<td>IV Military Service of the Twenty-five Patients</td>
<td>20</td>
</tr>
<tr>
<td>V Place of Service</td>
<td>21</td>
</tr>
<tr>
<td>VI Length of Service</td>
<td>21</td>
</tr>
<tr>
<td>VII Occupation</td>
<td>22</td>
</tr>
<tr>
<td>VIII Ages</td>
<td>23</td>
</tr>
<tr>
<td>IX Admission Diagnosis</td>
<td>23</td>
</tr>
<tr>
<td>X Per Cent of Disability</td>
<td>24</td>
</tr>
</tbody>
</table>
Chapter I
INTRODUCTION

Purpose

This is a study of the case records of twenty-five schizophrenic patients at Bedford Veterans Administration Hospital. It was undertaken to determine if there is any possible relationship between social factors and personality traits prior to service, stress during military service and subsequent mental breakdown. The general questions which this study proposes to discuss are as follows: Will the study reveal (1) common significant elements in the family background (2) abnormal personality traits common to the group (3) psychotic or pre-psychotic behavior so apparent that these individuals should have been exempt from the situations with which they were confronted in military training and combat and (4) whether type and length of military service had a bearing on patient's illness?

Setting

Bedford Veterans Administration Hospital, established in 1928 for the care and treatment of veteran patients, is intended primarily for those patients with mental or nervous illness, but facilities are provided also for diagnosis and treatment of all types of illness. Since 1947, facilities have been available for the treatment of women patients as
well as men. Patients are accepted from eastern Massachusetts, Rhode Island, New Hampshire, Vermont, Maine and northern Connecticut.

Some form of commitment is usually required at the time of admission of the patients to the hospital, and veterans residing in Massachusetts and New Hampshire may be committed under the Massachusetts laws. Those residing in Maine, Rhode Island, Connecticut and Vermont are committed under laws of those states.

Professional standards are maintained with the advice and collaboration of a committee appointed by each of the three medical schools in Boston, namely: The Medical Schools of Harvard, Tufts and Boston University. The hospital is a teaching hospital, and facilities are provided for the training of doctors, nurses, psychologists, social service workers, as well as the permanent resident staff.

Scope

This study concerns itself with twenty-five World War II schizophrenic patients who are service connected for neuro-psychiatric disability. It includes new admissions and re-admissions, but does not include patients who at the time of admission were on trial visit status or still on the hospital books, such as patients who had returned from elopement or leave of absence. The material under discussion was taken from hospital records which cover the period from September 1,
1948 to September 1, 1949. Total admissions, thus defined, were 454 patients during the period under study. Of this number, 277 were service connected for neuropsychiatric disabilities, this including female veterans and other than World War II veterans. Of the 277 admitted, 133 were veterans of World War II. Of the 133 veterans admitted, 121 were male and 12 were female. The overwhelming majority of these 133 patients were schizophrenics.

Method

The material for this study was taken from the records of the Bedford Veterans Administration Hospital, Bedford, Massachusetts. The data obtained was from hospital records (clinical, correspondence and social service) and claims folders. These records were supplemented by personal interviews with the social workers, doctors, and nurses at the Bedford Veterans Administration Hospital active on the cases, whenever possible. Of particular value were the psychiatric social histories compiled by social service workers at this agency.

Writer selected the twenty-five patients studied by choosing every fifth male patient admitted to the hospital during the period of study who was still a patient in the hospital on November 23, 1949. By coincidence, all of the twenty-five patients selected had a schizophrenic diagnosis.

Although some statistics will be included, this will not be a statistical study. It is to be a descriptive study of
the personality development, always keeping in mind the envir-
onmental setting. A schedule was prepared which it was be-
lieved would produce the necessary information to answer the
general questions, and the material was extracted from the
twenty-five cases.

Limitations

There were certain limitations placed on the writer. In
some instances the regular records did not answer all the
questions called for in this study. As far as the record
material itself was concerned, it also must be kept in mind
that the sources, be they patients, relatives, or others,
could not in all instances be considered completely reliable.

Plan

The writer's plan for developing this study is as follows:
Chapter I will be an introduction of the thesis indicating the
purpose, setting, scope, method, and limitations. Chapter II
will cover data concerning the illness schizophrenia and its
various types. Chapter III will contain a presentation of
descriptive factors, giving an overall picture of all the cases
studied and a discussion of tables. Chapter IV will be a
presentation of case summaries. Chapter V will contain find-
ings and conclusions.
Chapter II

SCHIZOPHRENIC REACTION WITH REFERENCE TO MILITARY SERVICE

The Schizophrenic Reaction:

Mental disease, of which the schizophrenic reaction comprises the largest part, is not a disturbance in the function of a single organ, like the brain, but the maladapted, disordered psycho-biological functioning of a total organism.

The problem of schizophrenia presents to the medical profession the outstanding challenge of our day. One fifth of all hospitalized patients in this country are victims of this single disorder. The psychosis commonly takes onset in the early years of maturity and usually persists in a greater or lesser degree of severity throughout a lifetime that is not greatly shortened. Often the end is a complete disintegration of the personality. To the patient it represents separation from family and friends literally in many cases, spiritually in all cases. It casts a pall of undeserved stigma upon the family in which it strikes and no family can know itself to be exempt. In our country approximately 150,000 able-bodied citizens are annually removed from productive pursuits to be maintained at large cost in special institutions. In addition to the institutionalized population there are many schizophrenics living outside of hospitals. At best they are inoffensive incompetents and at worst they constitute a portion of the criminally insane, with hoboes, prostitutes, and other less offensively queer people falling in between.1

Schizophrenia was formerly called dementia praecox. The terms are interchangeable and are not applicable to a disease entity but to heterogeneous types of behavior tending to allied

and serious disorganizations of the personality. It is loosely subdivided into: (1) simple, (2) hebephrenic, (3) catatonic, (4) paranoid, and (5) mixed.

The catatonic type is characterized by phases of stupor or of excitement in both of which negativism and automatism are prominent features. These phases frequently alternate, perhaps with one phase changing suddenly to its opposite, although many times a given catatonic episode may present but one phase throughout its course. (...) The most frequent age of appearance is between fifteen and twenty-five. Of the various types of schizophrenia the catatonic most frequently has a somewhat acute onset and is oftenest precipitated or preceded by an emotionally disturbing experience. The prognosis for a recovery with reintegration of personality after a catatonic episode is more favorable than in the case of other types of schizophrenia, although after a period, perhaps after several episodes, there is a tendency for the catatonic type to pass over into states approaching hebephrenic or paranoid types with a permanent disorganization of the personality.

The features which are particularly apt to occupy the foreground of the paranoid type are delusions, often numerous, illogical and disregardful of reality, hallucinations, and the usual schizophrenic disturbance of associations and of affect together with negativism. The paranoid type tends to have its frank appearance at a somewhat later age than the other forms, perhaps most frequently from thirty to thirty-five. In the early stages the delusions are often limited, but later they become numerous and changeable. (...) Delusions of persecution are the most prominent in paranoid schizophrenia, but expansive and obviously wish-fulfilling ideas, hypochondriacal and depressive delusions are common. With increasing disorganization delusional beliefs become less logical.

The onset of the hebephrenic type is insidious and usually begins in early adolescence. Occasionally the onset is subacute and characterized by a depression that suggests an affective reaction. Silliness and

2 Noyes, Modern Clinical Psychiatry
3 Ibid., p. 378
incongruous or inappropriate smiling and laughter are usual. In general one may say that hallucinations are frequent, that the ideational content tends to take the form of phantasy or of fragmentary bizarre delusions rather than of elaborate or systematized beliefs. Associative processes are loose, speech is incoherent, neologisms are common and mannerisms are frequent. Regression features are prominent, wetting and soiling are common and the patient eats in a primitive, unmannerly fashion. The patient comes to lead a highly autistic life; he becomes bafflingly inaccessible and greatly introverted, while the final disintegration of personality and habits is perhaps the greatest of any of the types of schizophrenia. 4

In the simple type the most marked disturbances are of emotion, interest and activity. If hallucinations occur they are rare and fleeting while delusions never play an important role. The disorder is usually gradual in its onset and assumes the form of an insidious change of personality, the significance of which is not understood by the patient's friends. (....) Shallowness of emotions, indifference or callousness, and absence of will or drive are prominent features. (....) The patient remains uninterested in his environment and unimpressed by responsibilities. 5

If, as is the present trend of opinion, (as Noyes has written about schizophrenia) schizophrenia represents a special type of personality disorganization, a maladapted way of life manifested by one grappling unsuccessfully with environmental stresses and internal difficulties, its causes are to be found in the basic personality of the individual and the limits of his adaptive power, in the experiences which life has brought him and in the mental mechanisms and patterns of reactions by which he has attempted to deal with his special problems—faulty methods which constitute the symptoms of the disorder. 6

From this it would appear that schizophrenia is a way of adapting to life situations, and such individuals cannot deal

4 Ibid., p. 373
5 Ibid., pp. 371 and 372
with problems that occur in everyday living. Lowrey continues along this same trend.

In general, the present day point of view is that schizophrenia is a maladjustment of the total personality to the total situation. (...) The safest ground at present would be to consider schizophrenia not a definite disease based upon definite pathology, either somatic or psychic, but rather a marked personality disorganization, a type of inferior adaptation to stresses and strains, both internal and experimental. It is entirely possible that there is a special predisposition in psycho-biological constitution. (...) The essential mechanisms in schizophrenia are perhaps best described as regressions to a narcissistic, infantile type of existence.7

Hoskins also continues along these lines. He agrees that the central feature of schizophrenia is weakness of the ego, with various compensatory accompaniments, but he stresses even more than Lowrey the biological approach. He believes that the appearance of so much immaturity in the schizophrenic reaction pattern raises the question whether in the last analysis schizophrenia may represent fundamentally a failure in the maturation process—a process which may have been so weakly anchored that it can be rather readily lost.

When we reflect that heredity operates merely be passing along potentialities rather than finished integrations, the distinction between instinctual and acquired behavior becomes in some measure merely formal. The element of hereditary potentiality underlies both. Schizophrenic behavior is perhaps a joint resultant of instinctual and conditioned reactions.

7 Lawson G. Lowrey, Psychiatry for Social Workers, p. 181
Hoskins believes that the psychosis represents a failure or distortion somewhere in the course of the integrative series of the body, and the malintegration could conceivably exist at any level from the atomic to the social.

Man is depicted as the culminating phenomenon in a long process of integrative evolution. The panorama of existence embraces at one extreme the subatomic particles—the electrons, the neutrons, and the protons—and at the other the highest levels yet reached of social organization. The aggregated subatomic constituents are organized in a series of increasingly complex forms that include atoms, molecules, molecular crystals, proteins and other structural materials, protoplasm, cells, tissues, organs, organ systems, individual beings, and social groups. Emerging at the various levels are the properties of form and structure, metabolism, reproduction, life, heredity, awareness (consciousness, affect, drives and instincts, behavior patterns and empathy). These attributes in ensemble give rise to individual personalities and to social aggregates. As matter evolves into increasingly higher forms new levels of organization are imposed upon the constituent substrate units and there emerge new properties in each system thus derived. What were wholes at one level become parts at the next level. It is the peculiar new relationships of such parts that give rise to the new properties of structure and behavior. It is of especial moment to our thesis that the new emergences, at whatever level, reveals qualities that are unique and must be studied by methods appropriate to that level, though knowledge of the lower levels is necessary for the adequate understanding of the higher.

We are all so familiar with the phenomenon as a matter of personal experience that we readily overlook the astounding tour de force that nature accomplished in evolving a unified personality out of so many discrete elements. The body is a seething laboratory in which hundreds of chemical processes are going on simultaneously. It is thus a vast complex of activities at the molecular level. Each of the three thousand billion cells that make up the body carries on its own existence, assimilating its own food and oxygen, excreting its own wastes, and carrying out, in addition, its specialized functions. Thus at the cellular level also many kinds of
activities are taking place. Similarly the different organs have a variety of separate functions and the organs in turn are associated in cooperating systems. The various sorts of controlling mechanism—chemotactic, neural, hormonal, instinctual, and voluntary—come in further to complicate the picture. Yet out of this composite diversity is derived that unified totality, the individual personality. 8

In an over-all view, it can be said that the schizophrenic psychosis arises in the frustrated inadequate individuals. The general pattern of symptoms resembles the introverted type of personality. They are individuals who are inclined to give up the struggle with reality, manifesting evasive and substitute ways of meeting problems, reacting to handicaps with over-sensitiveness and tending to secure satisfactions, not from the real world, but from a world of their own making. Long before the development of the psychosis, the individuals have felt that no one understood their lonely, unhappy personality.

Among the more recent studies of the early manifestations of schizophrenia and one that comports with other similar investigations is that carried out in our Service by Cameron, who surveyed the initial symptoms in one hundred cases. Two fairly well-defined trends were seen. One of these was the gradual development of the psychosis in an individual who had from childhood been odd and aloof and who, though sane, had shown many behavior problems such as persisting enuresis, tantrums, sulking, and emotional instability. The process was often of insidious onset, the subject becoming more and more peculiar until often the appearance of frank delusions marked him as unmistakably psychotic.

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8 Hoskins, Op. Cit., pp. 65 and 66
The second trend emphasized by Cameron is a fairly abrupt appearance of manneristic behavior which may take many forms such as stupor, states of ecstasy, suicidal attempts, or bizarre exhibitionism. Often considerable confusion and inability to concentrate are seen. Outstanding among the peculiarities are withdrawal, loss of adaptive capacity, emotional dulling, and the tendency toward misinterpretations.  

The Effect of Military Stress

Comparatively late in the World War I, it was realized that it was to the best interest of the individual and the country that those individuals whose behavior would manifest psychotic and neurotic tendencies should be eliminated from the Army. Many of them proved to be inefficient soldiers. Some did not even survive the expensive training courses that were given. If they did, they soon broke down and occupied beds needed for acute surgical cases, required prolonged medical services, and were finally discharged on pension. General agreement was reached concerning the rejection of manifest psychotics but difficulties arose in eliminating potential breakdowns. When classical psychoses became overt in combat personnel, they represented failures in selection.

In those cases with histories of introverted, withdrawn personalities, occupational instability and other characteristics of the pre-psychotic personality, the military life was probably of only precipitating importance, whereas it may have played a greater role in those cases which were of primarily psychogenic etiology. If schizophrenia is a psychogenic disorder, it is a response to a frustrating and conflict-arousing situation, army life is of a

9 Ibid., p. 77
nature apt to provide this situation. Probably any disease, and psychogenic ones in particular, must be viewed as a combination of the degree of disease liability, and the extent of pathogenic and precipitating factors. Under those circumstances, it is quite possible that somebody with a minimal and normal predisposing factor might well manifest a schizophrenic psychosis, under the strain of battle fatigue or under the sexual, social and intellectual frustrations inherent in army life.

In this connection, it is interesting to note that many authors point out (Mira, most recently) that the incidence of dementia praecox in armies was never found to be greater than in the general population and hold that this tends to prove that the conditions is not psychogenic or dependent upon environmental trauma. However, this form of reasoning seems entirely fallacious if one remembers that the majority of those likely to become afflicted with dementia praecox are already ill by the time the induction age is reached and thus are in hospitals or are rejected by the examining boards. In addition, a number of people are likely to be schizophrenic and are excluded at the time of examination.

If then, after all this selection, the number of dementia praecox cases in an army still equal that of the average population, it seems to be evidence that the environmental factors indigent to army life were responsible for doubling of cases of dementia praecox. 10

War has always created situations of difficulty for individuals, and the summoning together, the training and utilization of armies have always recreated group problems of a psychological nature. War demands new adjustments from all kinds and types of people. Some of these are adaptable and well balanced and we hear little of them; others have a rather tenuous hold on life and their environment, have never made a

10 Leopold Bellak, Dementia Praecox, pp. 435 and 436
satisfactory adjustment to their own peacetime existence so that they can hardly be expected to make an easy or satisfactory adaptation to a new group life.

War forces men and women to face many new challenges to instinct; aggression, which has had to be controlled, must now be brought out, trained and used against the enemy; men must learn to kill as well as to face the prospect of being killed. Taking life involves the breaking of taboo, which is no light matter and is liable to leave behind it guilt and depression. Savages had expiatory rituals after battle but modern man, of necessity, had to find a philosophy to meet the situation. He must learn early to face and not to ignore the necessity for killing his enemy, for unless he does he may break in training and he may have a post war aftermath. Uprooted, and faced by primitive necessities which are especially alarming to many, the soldier must then go further and learn to reshape his existence in other ways. The independence and self-reliance that he had developed during childhood and adolescence have not to be given up (or so he thinks) for the implicit obedience of the disciplined soldier. He feels that he has to become a child again, dependent and as docile as he can be. In fact this is what does happen although in every army we have outgrown much of this and can utilize to the full the independence and self-reliance of the individual within the group. Nevertheless, many difficult adjustments are needed and not every basic training unit is able to provide ideal help in these adaptations. The army certainly provided problems which would be difficult enough to solve even were its human material of perfect quality.\footnote{John Rees, \textit{The Shaping of Psychiatry by War}, pp. 15 and 16.}

Once in the army, the soldier began to live and function in a social organization that had little resemblance to the one from which he came. He had to live in a nonfamilial hierarchy made up exclusively of men, and while in training, he
was subjected to hardships, physical and emotional, in which all his weaknesses came home to roost. His capacities to endure, to take the initiative, to be at once subordinate and a leader, to cooperate, to form attachments to others, to carry responsibility—all these were put to great strain. Each failure or inaptitude was registered somewhere and eventually determined the permanent place the soldier would ultimately have in the army.

Prior to military service, the soldier lived in a democracy, which meant that he had a wide range of choice regarding his activity. His personal failures did not necessarily count against him, for he could find a place where he could function within his family or outside of it. This advantage was somewhat lost in the army, and any immaturity in development became a disadvantage. It was particularly difficult for those men who had led a protected sheltered life, whose parents had assumed every responsibility for them. These men were emotionally immature and broke down early. Many a latent neurosis was precipitated long before combat conditions and the men were discharged. They were cases of arrested emotional development who had been given a rapid push into an active neurosis or psychosis, by the stress of changed conditions.

Three factors are at play in the creation of neurotic reactions to war stress: 1. The first factor is the previous personality of the soldier and his adaptability to the new situation. Any weaknesses in personality makeup will appear in the complicated social and physiologic factors involved in the war-army
situation. A latent schizophrenia may be precipitated or a manic-depressive reaction released; and incipient neurosis will acquire definite configuration, a deep hypochondriasis may be touched off, an old psycho-somatic response revived, and individual personality traits precipitated into definite form.

2. There are the reactions to danger situations in which the imminence of destruction is the paramount factor. These reactions may be conditioned to a high degree by a host of contributory factors that strengthen or weaken the tolerance for danger. Such reactions will be designated by the oldest name devised for this purpose, the traumatic neuroses. They are specific to war only because they are more frequent then than are in peacetime. 3. If the traumatic neurosis is a distinct nosologic entity, we must expect that it will in some way be incorporated into the entire personality. This of course applies only to the chronic forms, when the neurosis has had a chance to become consolidated and to exercise a polarizing influence on the adaptation of the individual. But even in subacute forms the typical manifestations of the traumatic neurosis can be engrafted upon a pre-existing psychoneurosis.12

Examination of those men who failed showed with considerable consistency, that they were predisposed in a characteristic way to the psychic damage which overtook them under the stress of military life. By predisposition, it is meant that there was a weak spot within the personality, that rendered the individual susceptible to these forces to which he was exposed during military life.

The greatest difficulty in selection is to determine the quantity of stress and the type of stress that will cause specific personality types to react adversely. The psychiatrist in selection is unable to deal with large quantities of men objectively.

12 Abram Kardiner with the collaboration of Herbert Spiegel, War Stress and Neurotic Illness, p. 29
and is unable to control the goal of his selection or the subsequent disposition of the men. He has no laboratory means of duplicating the stress to which an individual will be exposed in combat, hence the tolerance of the ego for the quantity of anxiety stimulated by combat cannot be measured. Since anxiety is a psychologically adaptive mechanism, economically necessary for survival in the presence of danger, its presence is not necessarily a handicap. In fact, individuals who are not stimulated to anxiety are predisposed to severe psychotic-like breakdowns when stress reaches their personal threshold. The subjective emotion of anxiety and its physiological concomitants force some men to fight, others to retreat. In some the anxiety reaches a stage of uneconomical and destructive influence on the ego, paralyzing in economic quantities and it evokes an adequate aggressiveness, but it persists pathologically without decrement. Thus it gradually accumulates on successive missions, resulting eventually in a breakdown.

The rapidly changing adolescent boy may maintain or improve his skills during training; but, because of the demands made on him for an unnaturally speedy maturation, he may show the first signs of emotional disturbance after he has gone through part of the training program. Hence, a boy whom the psychiatrist diagnoses as emotionally normal at the moment of selection may, on account of accidents or interpersonal difficulties, become disturbed and must subsequently be disqualified. It is apparent that, although far better psychiatric selection is necessary, superior results can only be achieved if it is accompanied by a psychiatric program for maintenance of emotional stability during the first year of extreme stress in training. Selection and maintenance are inseparable problems.13

13 Roy R. Grinker and John P. Spiegel, Men Under Stress, p. 16
Chapter III
PRESENTATION OF DESCRIPTIVE DATA

In this chapter, it is the writer's intention to present an overall picture of the twenty-five cases studied, including the pre-service period, military experience, and subsequent mental breakdown. Granted no general conclusions can be drawn from such a small group, but neither should certain trends be overlooked.

About one-half of all the patients admitted to the hospital spend some time within the first year in the most disturbed building. Patients in this building fall into three groups. Roughly, one-third of the group stay less than a month, and one-third stay up to six months before they are transferred to other buildings on the hospital grounds. The remaining third stay on indefinitely. Of the 121 male patients admitted during the year of study, 47 or 38 per cent of the patients were in the disturbed building as of November 23, 1949. Of the twenty-five patients studied, 11 or 44 per cent were patients in the disturbed building at the time of study.

In the classification of religious groups, the cases studied were divided into Roman Catholic, Protestant, and Jewish. It is probably of no particular significance that there were fourteen Roman Catholics, nine Protestants and two Jews, but it is significant in that it is a reflection of
the fact that most admissions are Catholic, because this is a Catholic area. To some extent the nationality and religious figures will depend on the geographical area from which the patients were admitted and the relative population densities of certain groups in a highly urban and metropolitan area which the hospital covers. Table I shows the religious affiliations of the twenty-five patients studied.

**TABLE I**

**RELIGIOUS AFFILIATIONS OF TWENTY-FIVE PATIENTS**

<table>
<thead>
<tr>
<th>RELIGION</th>
<th>No.</th>
<th>Per cent</th>
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<tbody>
<tr>
<td>Roman Catholic</td>
<td>14</td>
<td>56</td>
</tr>
<tr>
<td>Protestant</td>
<td>9</td>
<td>36</td>
</tr>
<tr>
<td>Jewish</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Since all of the men included in the group were of marriageable age, it is significant that of the twenty-five patients studied, twenty were single, four were married, and one, though he had been married, had been living apart from his wife.

In discussing marital status in relation to dementia praecox, Malzberg finds that the married had the minimum rate, the single the highest rate, with the divorced almost as high as the single. There are several factors here. The personality traits which are found in the pre-psychotic personality are such that the marriage rate would be lower for this group than for the general population; also, these same traits, once they assert themselves, would make it difficult for a marriage to survive. In addition to
these factors, Malzberg feels that marriage itself may have a beneficial effect upon some individuals, who might otherwise have become psychotic.

TABLE II

MARITAL STATUS

<table>
<thead>
<tr>
<th>MARITAL STATUS</th>
<th>No.</th>
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<tbody>
<tr>
<td>Single</td>
<td>20</td>
<td>80</td>
</tr>
<tr>
<td>Married</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Separated</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>100</td>
</tr>
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School progress and adjustments depend less on native intellectual endowment than is commonly supposed.

Kendig and Richmond, in a study discussed in other chapters, found that the school histories of dementia praecox patients showed low grade level, retardation, and poor quality of work. They do not conclude that there is a greater incidence of psychosis among the less educated but the dementia praecox patients show inferior learning ability even during the school years, long before the actual onset of the psychosis. Most authors agree that the relationship between education and incidence of mental disease is not one in which the lack of education is the causative factor, but that one of the characteristics of the premorbid personality is inferior learning ability, sometimes because of emotional interference.

In the cases studied, fifteen did not complete their high school education. They left school because they did not like it, or were unable to adjust to the instructors or the other

14 Bellak, Op. Cit., p. 15
15 Ibid., p. 14
schoolmates. Of the remaining ten, eight completed high school, one completed one year of college.

**TABLE III**

**EDUCATION**

<table>
<thead>
<tr>
<th>Grade Completed</th>
<th>No.</th>
<th>Per cent</th>
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<tbody>
<tr>
<td><strong>Grammar School</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7th grade</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>8th grade</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>9th grade</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>10th grade</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>High School</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st year</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>2nd year</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>3rd year</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>4th year</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td><strong>Vocational School</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>after 8th grade</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd year</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>Vocational School</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>after 9th grade</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd year</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>College</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st year</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>4th year (pre-med)</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>25</td>
<td>100</td>
</tr>
</tbody>
</table>

**TABLE IV**

**MILITARY SERVICE OF TWENTY-FIVE PATIENTS**

<table>
<thead>
<tr>
<th>Branch of Service</th>
<th>No.</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Army Air Force</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Navy</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td>Army</td>
<td>11</td>
<td>44</td>
</tr>
<tr>
<td>Coast Guard</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>25</td>
<td>100</td>
</tr>
</tbody>
</table>
TABLE V
PLACE OF SERVICE

<table>
<thead>
<tr>
<th>Area</th>
<th>No.</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic</td>
<td>12</td>
<td>48</td>
</tr>
<tr>
<td>Foreign - combat</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>non-combat</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>100</td>
</tr>
</tbody>
</table>

TABLE VI
LENGTH OF SERVICE

<table>
<thead>
<tr>
<th>Time</th>
<th>No.</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 months or less</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>6 months to 1 year</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>1 year to 2 years</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>2 years to 3 years</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td>3 years to 4 years</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>4 years to 5 years</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>100</td>
</tr>
</tbody>
</table>

Length of service does not show how long these individuals were able to adjust to military life before breakdown. Many of them had been hospitalized for many months before they were actually discharged. It is interesting to note that five patients were hospitalized within the first year of their military service. One patient was hospitalized within his fourth week of basic training. He was discharged within three months of his induction. Another was discharged within three months of induction and a third was discharged within four months.
The fourth patient to serve less than one year was discharged within ten months. This suggests that these men were not screened properly at induction. As shown in Table V, twelve of the number studied had no foreign service, and of the thirteen who did have foreign service, three were stationed in a non-combat area.

The activities of the twenty-five cases prior to service were varied. Three were students, seven were working doing skilled work, as machinists and welders, and fifteen were doing odd jobs, or working as unskilled laborers.

**TABLE VII**

**OCCUPATION**

<table>
<thead>
<tr>
<th>Type</th>
<th>No.</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Unskilled</td>
<td>15</td>
<td>60</td>
</tr>
<tr>
<td>Skilled</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>25</td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Malzberg after studying the influence of economic factors on mental health, came to the following conclusions. There is a marked difference in rates of mental disease between groups in the very low occupational brackets and those in the higher groups. Unskilled workers, one of the lowest economic groups, have the highest rate of mental disease. Social and physical selection have some influence on this rate, as do age, nativity, race, etc. The only general conclusion to which one can come is that socio-economic factors have some positive relationship to the incidence of mental disease.\(^{16}\)

\(^{16}\) Ibid., p. 12
The ages of the patients range from twenty-two to forty-four as of November 23, 1949.

### TABLE VIII

**AGES**

<table>
<thead>
<tr>
<th>Years of Age as of November 23, 1949</th>
<th>No.</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>22 years of age</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>23 &quot; of &quot;</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>24 &quot; of &quot;</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>26 &quot; of &quot;</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>27 &quot; of &quot;</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>28 &quot; of &quot;</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>29 &quot; of &quot;</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>30 &quot; of &quot;</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>31 &quot; of &quot;</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>32 &quot; of &quot;</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>33 &quot; of &quot;</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>34 &quot; of &quot;</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>39 &quot; of &quot;</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>40 &quot; of &quot;</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>43 &quot; of &quot;</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>44 &quot; of &quot;</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>25</td>
<td>100</td>
</tr>
</tbody>
</table>

### TABLE IX

**ADMISSION DIAGNOSIS**

<table>
<thead>
<tr>
<th>Classification</th>
<th>No.</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catatonic</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td>Unclassified</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Paranoic</td>
<td>11</td>
<td>44</td>
</tr>
<tr>
<td>Hebeephrenic</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Simple</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>25</td>
<td>100</td>
</tr>
</tbody>
</table>
All the patients who are being studied are service connected for neuropsychiatric disability. Periodically they are re-examined for this disability and the amount of compensation that they have been receiving is either increased or decreased depending on the decision of the adjudication board. Table X will show the per cent of disability they are receiving as of November 23, 1949.

**TABLE X**

**PER CENT OF DISABILITY**

<table>
<thead>
<tr>
<th>Per cent of Service Connected Disability</th>
<th>No.</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>30%</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>50%</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>70%</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>100%</td>
<td>22</td>
<td>88</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Chapter IV
CASE STUDIES

It is the purpose of this study to see if it will reveal (1) common significant elements in the family background, (2) abnormal personality traits common to the group, (3) psychotic or pre-psychotic behavior so apparent that these individuals should have been exempt from the situations with which they were confronted in military training and combat, and (4) whether type and length of military service had a bearing on patient's illness? The method is to present the body of case material, followed by discussion without excluding any details which are as much a part of the total diagnostic picture and relatively just as important.

The family constellation of the cases studied was broken down into three categories. They are as follows: those who came from intact homes, those who came from intact but unstable homes, and those who came from broken homes. By intact homes, is meant those homes where both parents were living together, and a so-called normal home life existed. Intact unstable homes were those homes in which both parents were living together, but there was obvious tension, nervousness, marginal living, alcoholism, poverty, a parent away from home much of the time either because of business or illness, and homes inadequate from the standpoint of unhealthy attitude or behavior of the parents. Broken homes were those in which the parents
were not living together as a result of illness, separation, divorce, or death.

It is interesting to note that of the twenty-five cases studied, twelve would be considered as having intact homes, seven came from intact unstable homes, and six came from broken homes. The first group of cases to be discussed will be those whose home life was considered as intact and stable.

CASE NO. 1

PATRICK

Thirty-one year old, white, American born, Catholic, single man entered the Navy April 3, 1942. He was discharged January 25, 1946, with a hundred per cent service connected disability for schizophrenia.

Patient was born March 2, 1918. He was one of four siblings. He has one brother and two sisters. His home life was intact, both parents were alive during his childhood and adolescence, and a so-called normal home life existed. He was always rather shy and quiet, but in spite of this was quite active in sports all during his school years. He was graduated from high school, attended a preparatory school for one year, and then was graduated from a college after taking a four-year pre-medical course. After one year at a college of osteopathy, he entered the Navy.

While in the Navy, patient served as a health officer in the South Pacific Area on the islands among the natives, and participated in medical research. He was in charge of one of the laboratories on the islands. He did not participate in combat and was not stationed in a combat area. He became ill while in the service and was hospitalized on the islands. Patient was returned to the States where he was hospitalized in Texas, and he was a patient there until the time of his discharge from the Navy. In August 1948, he was admitted to Danvers State Hospital, and was a patient there until he was transferred to Bedford V. A. Hospital on June 22, 1949. His admission diagnosis was schizophrenic reaction, simple type, incompetent.

Patient's personality development appeared normal and it
was not until he had been stationed on the islands for some time that he became ill.

CASE NO. 2

PAUL

Thirty-two year old, white, American born, Protestant, single man entered the Army March 15, 1941. He was discharged September 14, 1943 with a hundred per cent service connected disability for dementia praecox.

Patient was born September 29, 1917. He was an only child. His home was intact and a so-called normal home life existed. He was always considered rather quiet and shy. He completed high school at nineteen, and later learned the trade of grinding optical lenses. He worked for a short time before enlisting in the Army.

While in the service in this country, he became ill and was hospitalized at the Lovell General Hospital from August, 1943, until September, 1943. At that time he was discharged from the Army and was transferred to the Northampton V. A. Hospital where he was a patient until he was transferred to Bedford V. A. Hospital in September, 1944. He was a patient at Bedford until May, 1946, when he was discharged. On April 18, 1949, he was readmitted to Bedford and has been a patient ever since. His admission diagnosis at Bedford was schizophrenic reaction, catatonic, incompetent.

Patient's personality development appeared normal except that he was always considered rather quiet and shy. He did not become ill until two years and five months after he joined the armed forces.

CASE NO. 3

HOLLIS

Twenty-four year old, white, American born, Protestant, married man entered the Army November 16, 1943. He was discharged May 28, 1944 with a hundred per cent service connected disability for a mental condition.

Patient was born August 25, 1925. He was an only child and his home life was intact. A so-called normal home life
existed. His early life was normal, except that he was considered rather quiet and shy. He was graduated from high school, and worked as a clerk in a drug store for a short time before he was inducted.

He liked the army at first, but was disappointed when he failed to make A.S.T.P. After that, he disliked the army and developed symptoms which led to his hospitalization March 1944, five months after he was inducted. Patient was hospitalized at Fort Jackson, N. C. on March 24, 1944, and was discharged from the Army and transferred to Bedford on May 28, 1944. He was a patient at Bedford until November, 1944, when he was placed on Trial Visit status and was discharged from the hospital November 4, 1945. Patient was married June 7, 1948 and has been a patient at the hospital since. His admission diagnosis was schizophrenic reaction, catatonic, incompetent.

Patient’s personality development appeared normal except that he was considered rather quiet and shy. He did not become ill until five months after he was inducted into the armed forces when he was not accepted for A.S.T.P.

CASE NO. 4
GEORGE

Forty-three year old, white, American born, Catholic, single man entered the Navy, May 6, 1943. He was discharged January 29, 1945 with a hundred per cent service connected disability for schizophrenic reaction, paranoid.

Patient was born February 16, 1906. He was one of three siblings. Patient had two sisters. His home life was intact, and a so-called normal home life existed. He was always considered quiet and reserved but he made friends easily. He was a town meeting member for four terms. For the most part he avoided women, and never had any thoughts of marriage. He had gonorrhea at the age of twenty and again at twenty-four. He completed eight years of school, repeating the fourth grade, and failing the eighth grade. He worked as a laborer and shipper, changing positions but usually to better himself.

A paternal uncle had been hospitalized in a mental institution for twenty-eight years, and a sister committed suicide at forty-nine shortly after the climacterium.
Patient had no foreign service. He was hospitalized while in the service July 22, 1944 in a Naval Hospital, and was a patient until January 27, 1945 when he was discharged from the Navy and transferred to Bedford. He was discharged from Bedford after one year of Trial Visit status on March 30, 1946. Patient was readmitted to Bedford February 26, 1949 and is still a patient at the hospital. His admission diagnosis was schizophrenic reaction, paranoid, incompetent.

Family history of this patient reveals that a paternal uncle has been hospitalized for a mental condition for twenty-eight years and a sister committed suicide when she was forty-nine. Patient's personality development appeared normal except that he was quiet and reserved. He did not become ill until fourteen months after he joined the Navy.

CASE NO. 5

NORMAN

Thirty-two year old, white, American born, Jewish, single man entered the Army August 22, 1942. He was discharged January 15, 1944 with a hundred per cent service connected disability for dementia praecox, hebephrenic type.

Patient was born March 16, 1917. He was one of six siblings. He has three older brothers, and two older stepsisters by his father's first marriage. His home life was intact and a so-called normal home life existed. He was attached to his mother who pampered and spoiled him because he was the youngest in the family. He was a nervous, emotionally unstable, stubborn child. In school, he assumed the air of one who knew everything, and was called "the professor" by the other students. Prior to his entering the armed forces he worked as a clerk-typist for three years at the Watertown Arsenal.

He had no foreign service while in the Army and was first hospitalized October 1943. In January 1944 he was discharged from the Army and was transferred to Bedford where he stayed until December 1944. He was discharged from Trial Visit status from Bedford, March 7, 1945. Patient was admitted to Boston State Hospital, September 14, 1948, and was transferred to Bedford, September 23, 1948, and has been a patient at the hospital since. His admission diagnosis was schizophrenic reaction, hebephrenic, incompetent.
Patient's personality development showed that he was a stubborn child, spoiled by his mother who had pampered him because he was the youngest in the family. He was a nervous, emotionally unstable individual who assumed the air of one who knew everything in school, and was called "the Professor" by the other students.

CASE NO. 6
CHRISTOPHER

Thirty-three year old, white, American born, Protestant, married man entered the Navy August 10, 1945. He was discharged April 12, 1948 with a hundred per cent service connected disability for dementia praecox.

Patient was born July 23, 1916. He was an only child. His home life was intact and a so-called normal home life existed. His early life was normal and his adjustments were satisfactory. In school, he completed the ninth grade, and he went to vocational school where he took up the trade of machinist. In 1936, he was married. All his adjustments were satisfactory until the birth of his first and only child in 1944. His wife had had four miscarriages prior to the birth of the child in November 1944. Patient became ill and he was hospitalized at Bosworth May 3, 1945 for two and a half weeks. While at Bosworth he received electric shock treatment. Patient worked at the Navy Yard from May 1945 until August 10, 1945 when he enlisted in the Navy.

In 1946, while on the west coast awaiting overseas assignment, there was a reoccurrence of his previous disturbed behavior and he was hospitalized. He was in a Naval Hospital for about seven months and was transferred to the Taunton State Hospital July 12, 1946. From Taunton he was transferred to Cushing V. A. Hospital on January 13, 1947 where he remained as a patient until he was transferred to Bedford on December 10, 1948 for custodial care. Patient was discharged from the Navy April 12, 1948, but has continued to remain at Bedford since his admission December 10, 1948. His admission diagnosis was schizophrenic reaction, paranoid, competent.

Though patient's personality development was satisfactory during his formative years, when his wife had their first and
only child after four miscarriages his behavior became so disturbed that he required hospitalization and electric shock treatment. This hospitalization was three months before he enlisted in the Navy. In all probability the patient did not tell the examining physicians at the time of his enlistment that he had been hospitalized for a behavior disturbance, but if a check of Department of Mental Health records had been made when selectees were being inducted this man may not have been accepted for duty in the armed forces.

CASE NO. 7

CLIFFORD

Twenty-nine year old, white, American born, Protestant, single man entered the Army on July 10, 1941. He was discharged January 30, 1943 with a hundred percent service connected disability for dementia praecox, paranoid.

Patient was born February 8, 1920. He was the fourth of nine siblings. His home life was intact and a so-called normal home life existed. At the age of six, prior to entering school, he suffered a skull fracture, and had periods of amnesia from that time until he was twenty-two. He was always antisocial, did not make friends easily and had a tendency to stay home in his room listening to the radio. He was reserved, nervous, insecure, felt inferior, and did not care for girls. At the age of seventeen while at an academy he was in a skiing accident. He did not lose consciousness until after he returned to his room. He was graduated from high school at the age of twenty, and worked for a year in a defense plant prior to his entering the armed forces.

Patient was in the Air Corps and after ten months in this country was sent to Australia. He was stationed in a non-combat area and was first hospitalized in August 1942. He was transferred to this country and on January 30, 1943 was discharged from the Army and sent to Bedford from which he was discharged on elopement status December 7, 1944. He was rehospitalized November 17, 1945 in the Danville V. A. Hospital and was transferred to Bedford December 1, 1948, and has been a patient at the hospital since. His admission diagnosis was schizophrenic reaction, paranoid, incompetent.
Patient had a skull fracture at the age of six, and was in a skiing accident in 1937. He had always been a shy, insecure extremely nervous person who preferred to stay home in his own room listening to the radio. He was antisocial, and did not care for girls. Patient had amnesia from the age of six until he was twenty-two. It would appear from the above information that he was obviously not a suitable candidate for the armed forces and that evidently he had not had a thorough physical examination when he was admitted into the Army.

CASE NO. 8

JOSEPH

Twenty-nine year old, white, American born, Catholic, single man entered the Army January 5, 1943. He was discharged March 1946 with a fifty per cent service connected disability for dementia praecox. His disability has since been increased to a hundred per cent.

Patient was born February 17, 1920. He was the second of five siblings. His home life was intact and a so-called normal home life existed. At the age of five, he was struck by an automobile on the rear of the head. He was treated in a hospital for three weeks for cuts and bruises, but there was no definite history of a skull fracture. He grew up as a shy, self-conscious person who kept away from girls. He was good-natured, and extremely soft hearted. He liked to read, go to the movies, and go sail-boating. His father was a quiet home-body, and his mother was a very self-assertive person. Patient finished high school at nineteen and worked as a welder for three years before entering the Army.

He was sent overseas three months after he entered the Army and served in the Asiatic Pacific theater of operations. He served in a combat area on telephone-telegraph wire systems and communications as well as operating heavy line construction equipment. Patient was twice hospitalized while in Okinawa during the later part of 1945. In January 1946 he was evacuated to Valley Forge, and was transferred to Bedford in March, 1946. Patient was discharged from the Army March 1946, and was discharged from Bedford May 1946.
In August 1948, he was sent to the Boston Psychopathic Hospital and from there was transferred to the Boston State Hospital where he stayed for ten days and went home. On August 19, 1948, he was admitted to Bosworth and was transferred to Bedford on September 15, 1948 and has been a patient at the hospital since. His admission diagnosis was schizophrenic reaction, paranoid, incompetent.

Patient was struck on the back of the head by an automobile at the age of five, but there was no definite history of a skull fracture. He had always been shy, self-conscious and stayed away from girls. He liked to read, go to the movies and go sail-boating. His father was a quiet homebody and his mother was a very self-assertive individual.

CASE NO. 9
JOSEPH

Thirty-three year old, white, American born, Protestant, single man, entered the Army March 5, 1941. He was discharged December 4, 1944 with a thirty per cent service connected disability for psychoneurosis.

Patient was born June 22, 1916. He was one of nine siblings, and the eldest of seven sons. His home life was intact and a so-called normal home life existed. He was always shy and backward and during his childhood had difficulty mingling with other children. He always preferred being by himself. He was completely uninterested in the opposite sex. He completed nine years of grammar school, and two years of vocational school beginning work at the age of sixteen. He worked as an usher, apprentice mechanic, and finally as a motion picture projector operator assisting his father.

He was sent overseas shortly after he entered the Army and served in the Pacific in the Infantry in active combat duty from 1941 to 1944. He received mortar wounds to his head and face and was hospitalized for six months for these injuries.

After the service, patient was admitted to the Metropolitan State Hospital September 19, 1948 and was transferred to Bedford December 9, 1948. He has been a patient at the hospital since. His admission diagnosis was schizophrenic reaction, paranoid, incompetent.
Patient's home background was described as apparently normal but he had difficulty with interpersonal relationships during his childhood. He was always shy and backward and uninterested in the opposite sex. Patient received mortar wounds to his head while in the service.

CASE NO. 10
WILLIAM

Twenty-five year old, white, American born, Catholic, single man entered the Navy November 6, 1942. He was discharged September 21, 1947 with a hundred per cent connected disability for dementia praecox, simple type.

Patient was born December 20, 1924. He was one of ten siblings. His home life was intact and a so-called normal home life existed. His early life was normal except that he was always considered rather shy and quiet. He completed two years of high school, and left to enter the service at seventeen.

He was in active combat in Africa and England and spent nine months in a Naval Hospital before he was discharged. He drank a great deal while in the service and a homosexual overture precipitated his breakdown. He was in a Naval Hospital from December 1946 until July 1947.

After service he was a patient at the Westboro State Hospital from April 1, 1948 to May 11, 1948. He was admitted to the Medfield State Hospital August 2, 1948 and was transferred to Bedford on January 12, 1949 and has been a patient at the hospital since. His admission diagnosis was schizophrenic reaction, paranoid, incompetent.

CASE NO. 11
THOMAS

Twenty-four year old, white, American born, Catholic, single man entered the Army November 23, 1943. He was discharged December 18, 1945 with a hundred per cent service connected disability for schizophrenia.

Patient was born September 15, 1925. He was the fifth of seven siblings. His home life was intact and a so-called
normal home life existed. He has a history of a schizoid and introverted pre-psychotic personality. He was very shy and quiet and remained so through his childhood. He was always bashful, retiring, sensitive and retreated from any kind of social situation. He was actually afraid of girls. His hobbies were swimming and golf, and during high school he won first prize among the caddies at the local golf course. He failed to complete his senior year in high school because he was eighteen and eligible for military service. He worked as a machinist from June 1943 until November 1943 when he entered the armed forces. He was frightened and reluctant to enter military service.

He was in the infantry and then was transferred to an armored division. Patient saw a great deal of combat in the European Theater of operations. He went into France on D Day, went to Chartres, Belgium, the Siegfried Line, and into Germany where he was hospitalized for an arm injury. He was again hospitalized while in the front lines at Ardennes. It was during the Battle of the Bulge that he received a severe hip wound when a shell struck his tank. He was then hospitalized for many months. After he was returned to the states he had two hip operations. At the time of his discharge he was still on crutches. The only neuropsychiatric reference in his army record is that the patient appeared nervous and jittery after a furlough home and a neuropsychiatric consultation was requested but was later cancelled when the nervousness and tenseness disappeared. No other evidence of neuropsychiatric difficulties was found while the patient was in the hospital and until he was discharged.

After service patient was admitted to Cushing V. A. Hospital April 8, 1947 where he was a patient until he was transferred to Bedford May 9, 1949 and has been a patient since. His admission diagnosis was schizophrenic reaction, paranoid, incompetent.

Patient was always shy, quiet, sensitive and retiring from earliest childhood. He retreated from any social situations and was afraid of the opposite sex. While in uniform patient was in the infantry and an armored tank division and saw a great deal of combat in the European Theater of operations. Patient went into France on D Day and fought through to the Battle of the Bulge where he received severe hip wounds.
CASE NO. 12

DONALD

Thirty year old, white, American born, Protestant, married man entered the Army August 5, 1942. He was discharged February, 1946 with a ten per cent service connected disability for a mental condition, which has since been increased to a hundred per cent disability.

Patient was born November 29, 1919. He was the third oldest of four siblings. His home life was intact and a so-called normal home life existed. Patient's early development was not unusual except that he always felt inferior because he was relatively short in stature and was unable to compete with other bigger boys in active sports. He was described as a shy introverted personality. His mother was overprotective of him. A brother, two years older than the patient who has had asthma all his life, was a bully and always picked on the patient. The whole family always took the patient's part in all arguments. In school, because of his stature, patient was called "mouse" and later "little giant." He was a follower, keeping much to himself and always putting himself in the background because of his height. He was a good tennis player, because he felt that he could compete more evenly with others, but he never attempted other sports because of his feeling of being handicapped because of his size. He was graduated from a preparatory school in 1937, and went to Pharmacy School for one year. He worked as a photographer, and then worked as a laborer at Fort Devens until August 1942.

Patient enlisted as a private in the Air Corps, was sent to Officer Candidate School, and became a commissioned officer in one year. He became a first lieutenant and acted as an intelligence officer overseas in the North African and Italian Campaign. On April 1945, while on furlough after his return home from Europe, his mother noticed that he was withdrawn and confused. In his next assignment to a camp in Georgia, he was hospitalized because he expressed ideas of inferiority, inadequacy, persecution, and preoccupation with sexual questions. He was released December 1945 and drove his own car home where he remained on terminal leave until he was discharged February 15, 1946.

Following his discharge he entered a college and studied psychology. He was married September 8, 1946 to a fellow student. In the summer of 1947, he was hospitalized at the Worcester State Hospital. He was transferred to the Gardner State Hospital and then on October 27, 1947 he was transferred to Bedford. He was discharged from Bedford July 13, 1948.
A few weeks prior to his readmission to Bedford, his family noticed a change in his behavior and mood. Following the delivery of his wife, his symptoms became more pronounced, and he was readmitted to Bedford April 11, 1949, and has been a patient at the hospital since. His admission diagnosis was schizophrenic reaction, catatonic, incompetent.

Patient was always a shy introverted person. He felt inferior because of his stature, and was a follower. He either kept in the background or to himself. He became a commissioned officer after attending Officer Candidate School, and acted as an intelligence officer in the Italian and African campaign.

The next group of cases to be discussed are those whose homes are considered intact but unstable.

CASE NO. 13

MARTIN

Thirty-one year old, white, American born, Catholic, single man entered the Army October 16, 1942. He was discharged August 10, 1943 with a hundred per cent service connected disability for dementia praecox, hebephrenic type.

Patient was born July 29, 1918. He was one of four siblings. His home was intact unstable. The home life was inadequate from the standpoint of income, attitude and behavior of parents. Family received financial assistance from relief agencies in many instances. Patient's father, a Spanish War veteran, was a patient at the Danvers State Hospital from August 14, 1923 to September 14, 1927, and again from May 30, 1937 until 1938. His diagnosis was alcoholic, chronic, paranoid. The home was untidy and poorly furnished. There was little discipline on the part of the parents, but there was evident affection between members of the family. During infancy, patient would sleep eighteen to twenty-four hours without waking. He was always shy, reserved, withdrawn, modest and retiring. He was careless about his appearance and because of this was the butt of family jokes. He never went out with girls but had many men friends. He began school at the age of six, and completed eight grades of parochial school. Patient was considered a poor student and left school at sixteen. He had always disliked school, and looked forward to the time when he would be able to leave. His work record was poor, and
prior to joining the armed forces he worked as a salvage worker earning twelve to fifteen dollars a week. A brother was discharged from the army because of epilepsy, another brother was rejected by the draft board for unknown causes, and a sister had a police record at the age of fourteen because in the company of other children, she was soliciting men and going off in automobiles with them.

Patient had no foreign service. Eight months after he was inducted, he was hospitalized at Camp Chaffee and two months later, August 10, 1943, he was discharged from the Army and transferred to Northampton V. A. Hospital. He was transferred to Bedford October 10, 1948 and has been a patient at the hospital since. His admission diagnosis was schizophrenic reaction, hebephrenic type, incompetent.

Patient's father, a Spanish War veteran, was hospitalized twice with an alcoholic psychosis, paranoid type. Home life was inadequate from the financial standpoint and behavior and attitude of the parents. A sister had a police record at the age of fourteen for prostitution. Patient was always shy, reserved, withdrawn, modest and retiring. His school and work records were poor. In the service, he became ill eight months after he was inducted.

CASE NO. 14
PAUL

Twenty-three year old, white, American born, Catholic, single man entered the Navy September 27, 1943. He was discharged March 12, 1946 with a hundred per cent service connected disability for a mental condition.

Patient was born September 20, 1926. He is the third oldest of six living siblings. His home was intact unstable. The home life was inadequate due to years of marginal living, periods of poverty and illness. Two brothers are chronic alcoholics, another brother died at the age of twenty-four as a result of drinking. One brother does not drink, but has never been able to hold a job. Patient's mother is the dominant one in the household. Patient always had an inferiority complex. He was a truant in school, and left at the age of
fifteen. He worked at one unskilled job until he joined the Navy at seventeen.

Patient was on a light cruiser and participated in the invasion of Anzio and Southern France. His illness was precipitated by a homosexual experience with another sailor on board ship in the Mediterranean. During the service, he jumped ship and was court-martialed. He was given fifteen months imprisonment and a psychiatric examination which led to his hospitalization until he was discharged.

Patient was admitted to Bedford, after the service, on June 16, 1946. He was placed on Trial Visit status on May 20, 1947. He was hospitalized in Coral Gables from August 20, 1948 until October 7, 1948, when he was transferred to Murfreesboro, and from there was transferred to Bedford on March 5, 1949. He has been a patient at the hospital since. His admission diagnosis was schizophrenic reaction, paranoid type, incompetent.

Patient's older brother died at the age of twenty-four as a result of alcoholism. Two brothers are alcoholics, and a younger brother has never been able to hold a job. The mother is the dominant one in the household. Patient always had an inferiority complex. He was a truant in school, and left at the age of fifteen, working on an unskilled job until he joined the Navy. His family had years of marginal living, periods of poverty and illness. Patient saw active combat in Anzio, and Southern France. His illness was precipitated by a homosexual experience with another sailor on board ship in the Mediterranean.

CASE NO. 15

EDMUND

Twenty-three year old, white, American born, Protestant, single man entered the Army March 23, 1944. He was discharged March 6, 1946 with a thirty per cent service connected disability for anxiety state. This has since been changed to a hundred per cent disability.
Patient was born June 16, 1926. He is the oldest of three siblings. His home life was intact unstable. During patient's pre-adolescence his father, who was in the construction business, was away from home a good part of the time, particularly during the early years of his marriage when patient was small. Later he managed to come home week-ends. The father is a dominant, rigid, excitable man. The mother is extremely defensive about the patient. Though there is no history of marital discord, there is a suggestion of disturbed parental interpersonal relationships. Patient was very devoted to his mother. As a small child he had many temper tantrums when he couldn't have his own way. Patient was never interested in his younger siblings and rarely shared activities even with his mother who was devoted to him. He was always quiet, retiring and a backward individual. Patient was inducted March 23, 1944 while in his senior year in high school. He was placed on the enlisted reserve and called to activity in November 1944.

He was first sent to Scott Field, Illinois to study radio. When he failed to make the grade he was dropped from the course, and returned to desultory duty at Kessler Field. He was then sent to Plattsburg, New York to train as an airplane mechanic and before he finished the course the Armistice was declared and he was taken out of the course. While in uniform he was court-martialed twice, once for being late for three days for which he received thirty days in the guard house, and on another occasion he received a fifty dollar fine for failure to salute an officer. Patient has been AWOL on two occasions on both of which he had returned home. He had never been away from home previously and had been very homesick once he entered the service. He was hospitalized for one month prior to his discharge.

In September 1947, he entered Wentworth Institute and failed inconsistently. His attendance there was very irregular. In February 1948, the doctor at the rehabilitation board of the Veterans Administration suggested hospitalization for mental symptoms, and he was admitted at Bosworth March, 1948 where he was a patient for three months. On August 7, 1948, he was readmitted to Bosworth and was transferred to Bedford September 3, 1948. He has been a patient at the hospital since. His admission diagnosis was schizophrenic reaction, catatonic type, incompetent.

Patient's father, who was away on business a good part of the time when patient was small, is a rigid, excitable man. His mother was very devoted to him. As a child he had temper
tantrums when he could not have his own way. He was always a quiet, shy, retiring backward individual. He had no foreign duty, and made a very poor adjustment to military life.

CASE NO. 16

JOHN

Twenty-four year old, white, American born, Catholic, single man entered the Army August 29, 1945. He was discharged December 13, 1945 with a fifty per cent service connected disability for dementia praecox.

Patient was born June 24, 1927. He is one of seven siblings. His home life was intact unstable. During the depression the family received relief from public agencies. Once his father punished him so severely with a stick that his nose bled. His father was a very rigid, domineering individual. As a baby, the patient received considerable attention as he was a very pretty baby, and he did everything to be constantly in the limelight. When a little boy, he was bitten by a dog, and was extremely frightened. He was a quiet, shy child who was easily frightened. Whenever his mother punished him he would run away and hide. He always played by himself. He has a history of withdrawal, panic states, hallucinations and suicidal thoughts since he was twelve years old. One day when he was twelve, he came home and admitted hearing loud noises in his head. He became panic stricken with the idea that he was becoming insane or was going to die. He completed the ninth grade in school at the age of sixteen. He had repeated one grade, and just barely passed all the other grades. He attended parochial schools through the fifth grade and then attended the public schools. In June 1943, he was suspended from school in view of his poor attendance and indifference to school work. He never had any desire to take out girls. He had odd jobs for a short time after leaving school, and was unemployed for a year prior to entering the service.

He was sent to Fort McClellan for his basic training and in October 1945 he went AWOL. He was hospitalized in his fourth week of basic training, having been apprehended eighteen miles from camp. He was kept in the hospital until he was discharged.

After service he was hospitalized at Bedford March 15, 1947, and was placed on Trial Visit status September 1947. He was discharged from the hospital September 1948. He was admitted to Danvers State Hospital May 21, 1949, and was transferred
to Bedford June 22, 1949, and has been a patient at the hospital since. His admission diagnosis was schizophrenic reaction, catatonic type, incompetent.

His personality development was such that with a competent examination prior to his induction, he might not have been accepted for the armed forces. Patient had always been a shy, introverted individual, and since the age of twelve he had a history of withdrawal, panic states, hallucinations, and suicidal thoughts. He was hospitalized in his fourth week of basic training.

CASE NO. 17

PAUL

Thirty year old, white, American born, Catholic, single man entered the Navy December 15, 1942. He was discharged November 21, 1945 with a thirty per cent service connected disability for psychoneurosis, anxiety state. His disability has since been increased to one hundred per cent.

Patient was born March 28, 1909. He was the second of three siblings. He had two sisters and the children were born one year apart. His home life was intact unstable. His father, a pensioned Spanish War veteran who was unemployed much of the time, was an exact, domineering person. His mother was a cold person without affection. Patient was favored by his mother because he was the only male child, and she took him wherever she went. Discipline was inconsistent in the family as the father was very strict and the mother was very lenient. She always took the children's side in family arguments. Patient never wanted to become involved in any arguments, and when he was outside and an argument would occur, he would always run home. This was encouraged by his mother.

At the age of four he had enuresis. He was bashful, quiet, shy, sensitive, extremely obedient and anxious to please his parents. He was not interested in extra-curricular sports while at school, not interested in girls, had no outside interests and his only hobby was reading. He occasionally went to the movies and then he would take his mother as his companion. He always kept his problems to himself. He was an average student in school and completed the third year in high school. He worked for the Western Union at the age of fourteen, had
two salesman jobs, but left because "he did not have enough push." He worked as a guard in the Navy Yard for two years prior to his joining the service.

He was in combat in the Pacific and was hospitalized twice while in the service - once for two weeks in the Solomons, and then for six weeks in California where he was discharged.

After service, he was hospitalized at Cushing V. A. Hospital from September 4, 1947 to January 27, 1948 for a head injury precipitated by a drinking bout. Patient was readmitted to Cushing V. A. February 7, 1948 and was transferred to Bedford January 13, 1949. He has been a patient at the hospital since. His admission diagnosis was schizophrenic reaction, paranoid type, incompetent.

Patient's home life was poor in that there was great inconsistency in his early training. His father was a very exacting, strict, domineering person, and his mother was very lenient. She favored the patient because he was the only boy in the family, and she took him wherever she went. He was quiet, shy, sensitive, bashful, and very dependent on his mother. He had no interests in sports or in girls. He had enuresis at four, and was very anxious always to please his parents. He never wanted to become involved in an argument and would run home to avoid them. This was always encouraged by his mother. When he would occasionally go to the movies, he would always take his mother.

CASE NO. 18

MANSON

Forty-four year old, white, American born, Protestant, single man entered the Army October 23, 1942. He was discharged February 3, 1943 with a seventy per cent service connected disability for dementia praecox, paranoid type with partial social inadaptability.
Patient was born December 14, 1904. He was the younger of two siblings. He was a breach birth, and a feeding problem until he was two. He was always finicky about his food, and had stomach trouble until he was twelve years old. His sister was two years older than he. His home life was intact unstable. His father was a strict, rigid, moralistic individual, and his mother, who was very protective of him, was also very strict. She was overprotective of him and nurtured him because he was a sickly child, and he relied on her more than he should. His mother was "very careful and did not allow the patient to go with other children." Patient was very dependent on his sister. She was a "little mother to him" and fought all his battles. He was a shy, quiet, self-conscious, unhappy, peculiar child at school. He was well behaved in school, and had no interests in sports or in girls. He completed grammar school at the age of seventeen, after repeating several grades. From the age of ten, he worked on farms, peddled milk, drove trucks and had many unskilled jobs. He was often unemployed, and never worked on the same job for more than a year or two.

Patient was in the army just over three months when he was discharged.

After service, coincident with the onset of his mother's illness, patient's behavior became disturbed. His mother became ill June 1943 and died of cancer in 1944. Patient was first hospitalized at the Grafton State Hospital September 23, 1943. He was transferred to the Worcester State Hospital. He was in and out of these hospitals three times, and finally left the Worcester State Hospital in 1945. He was readmitted there January 1949. He has been a patient at the hospital since. His admission diagnosis was schizophrenic reaction, paranoid, incompetent.

Patient's home life was poor in that he had very strict, rigid parents. Patient was a breach birth, a feeding problem until he was two, and finicky about his food and had stomach trouble until he was twelve. His mother overprotected him because he was a sickly child, and he was very dependent on his sister who fought all his battles. He was quiet, shy, self-conscious, unhappy and a peculiar child in school. He had no interests or hobbies and no interest in the opposite sex.
After he completed school, he worked at unskilled jobs, and was frequently unemployed.

CASE NO. 19
JOSEPH

Twenty-eight year old, white, American born, Catholic, single man entered the Army August 14, 1942. He was discharged October 28, 1943 with a ten per cent service connected disability for psychoneurosis anxiety. This disability has since been increased to one hundred per cent.

Patient was born April 14, 1921. He is the sixth of nine siblings. The entire family is nervous and easily disturbed. His home life was intact unstable. He was a nail-biter and a "mama's boy." He was shy, quiet, and introverted preferring to be along reading in his own room. He had no friends and was not close to his family. He idealized a brother who was eleven years older than he, and was very disturbed when the brother died in an accident when the patient was sixteen. He was retarded in school and left at the age of seventeen while in his freshman year in high school. The family lived in a rural area and during patient's youth they had pigs, cows, chickens and raised vegetables. When patient left school he stayed home to take care of the work connected with this. He also worked for six months in a bowling alley and for three years as an unskilled worker in a paper mill prior to entering the armed forces. He was very disturbed over the war and at first identified himself as a conscientious objector. When he was drafted he decided to do his part because the other siblings were in the service, but he was unhappy and dissatisfied during his whole service experience.

Patient was in the ground crew of the Air Corps while in the service, and was discharged fourteen months after he was inducted after having been hospitalized for a nervous condition.

After the service he developed many psychosomatic complaints and became more seclusive. In 1948, he went to a Mental Hygiene Clinic of the Veterans Administration and after three or four sessions was hospitalized at Bosworth Hospital October 1948. He was transferred to Bedford December 1, 1948 and has been a patient there since. His admission diagnosis was schizophrenic reaction, unclassified, competent.

The family history reveals a nervous, easily disturbed family. Patient's home life was intact unstable. Patient was
shy, quiet, and introverted during his childhood, and preferred to be alone than to having the companionship of either his schoolmates or his own family. He was a nail biter and was greatly disturbed by the death of a brother whom he idealized. The brother died when patient was sixteen. When war was first declared, he was disturbed, and at first identified himself as a conscientious objector. He was unhappy and dissatisfied during his whole service experience.

The next group of cases to be discussed are those whose homes are considered broken.

CASE NO. 20

LAURI

Twenty-eight year old, white, American born, Protestant, single man entered the Coast Guard December 11, 1942. He was discharged September 7, 1945 and is now receiving a hundred per cent service connected disability for dementia praecox, catatonic type.

Patient was born December 3, 1921. His home was a broken home. His parents were separated when he was eight years old, and divorced when he was eleven. His father was unfaithful for six years before the parents separated. Patient had a half-brother by his father's first marriage, who was ten years older than he. There was never much of a relationship between the two boys, and when the parents separated, the half-brother went to live with the father. Patient cried a great deal of the time when his parents separated. He continued to visit his father throughout the years. After the parents were separated the mother did day work to support herself and the patient, and he was left alone much of the time. He was a quiet boy, preferring to be by himself though he did have some friends who apparently liked him. He was a follower rather than a leader. He exhibited some personality inadequacies when a young child, tending to withdraw from reality, and spending more than the usual amount of time by himself. He began school at six and was graduated from high school in 1940. In the year book, he was regarded as rather quiet, a good thinker, and fairly athletic, and not interested in girls. By nature
he was introverted and shy and spent most of his time with
his mother. After finishing high school, he worked in a gar-
age for a while, and gave it up because he did not like the
work. He was unemployed for a few months and for two years
did odd jobs prior to entering the armed forces.

Patient had no foreign service while in the Coast Guard.
He was stationed at various parts of the United States, mostly
in the south. He received an honorable discharge.

Following his return from the service, decided personality
changes were noticed. His behavior became so disturbed that
he was hospitalized at Bournewood from December 21, 1946 until
January 5, 1947. He was admitted to the Danvers State Hospi-
tal January 22, 1947 and was transferred to Bedford December
20, 1948 and has been a patient at the hospital since. His
admissions diagnosis was schizophrenic reaction, catatonic
type, incompetent.

A significant factor in patient's family history is his
father's instability. He had been married twice, and for six
years before his second wife left him, he had been unfaithful.
Parents were separated when patient was eight years old, and
divorced when he was eleven. He cried a great deal when the
parents separated. He was always a quiet introverted individual
who had just a few friends, and no interest in the opposite
sex. As a child, he had a tendency to withdraw from reality
spending more than the usual amount of time by himself. Patient
was a follower rather than a leader, and spent most of his
time with his mother. Following his return from the service,
personality changes were noticed.

CASE NO. 21

DENNIS

Thirty-nine year old, white, American born, Catholic,
separated from his wife and child, entered the Army August 12,
1943. He was discharged October 16, 1945 with an eighty per
cent paranoid type, with epilepsy, grand mal. His disability has since been increased to one hundred per cent.

Patient was born August 6, 1910. His was a broken home. His father was a hard working, devoted, strict individual who died of angina pectoris when patient was twelve years old. Patient is the younger of two siblings. He has an older sister. He was always considered a shy, reserved type of individual, and was very attached to his mother. She had been a patient at a State Hospital for several months before her death, which was quite a blow, came just before he went overseas. He completed his junior year in high school, and left to go to work. He held several jobs prior to entering the service, and his last job was as a laborer and sub-foreman doing maintenance work at Harvard University.

Patient went overseas July 1944. He was with the Third Army and had battle experience as an engineer in France, Belgium and Germany. While in the service, May 1945, he was hospitalized for nervousness, and was evacuated to the States as a patient and was ultimately sent to the Mason General Hospital where he remained for fourteen weeks and was given a discharge from the Army.

He was married after he returned to civilian life, on October 16, 1946 to a woman sixteen years his junior. He was hospitalized at Cushing Veterans Administration Hospital from October 1946 until November 1946 for epilepsy. The seizures first occurred after a course of insulin shock therapy had been given him at the Mason General Hospital. In 1948, he was hospitalized for seizures at the Cambridge City Hospital. In November 1948, he spent three weeks at the West Roxbury Veterans Administration Hospital for seizures and when he returned home his wife left him with their year old child. They have been legally separated, and his wife is now suing him for divorce. He was admitted to Bedford February 9, 1949 and was placed on Trial Visit status April, 1949, but was returned to the hospital June 3, 1949, and has been a patient since. His admission diagnosis was schizophrenic reaction, paranoid type, incompetent, epilepsy, grand mal.

A significant factor in the patient's history is that his mother was a patient at the Westboro State Hospital for several months before she died. Patient's father died when patient was twelve years old. Patient was considered the reserved type and was very attached to his mother whose death came just
before he went overseas. He had ten months active combat experience with the Third Army in France, Belgium and Germany. He developed epilepsy after having received insulin shock treatment.

CASE NO. 22
GEORGE

Thirty-four year old, white, American born, Catholic, married man entered the Army June 22, 1942 and was discharged December 22, 1945. He is now receiving a hundred per cent service connected disability for a nervous condition.

Patient was born October 15, 1915. His was a broken home. He was an only child. His father died when he was six months old, and a grandfather who lived with the patient and his mother died at the age of eighty when patient was four years old. His mother who had chronic asthma died after a long illness when patient was seventeen. Patient was always quiet, very serious and withdrawn. He had very few friends and only occasionally went out with them. He completed the tenth grade in school and left at the age of sixteen. He held many jobs, doing unskilled work prior to his entering the service.

He was rejected twice for poor eyesight prior to his entering the Army. Patient was stationed at Miami Beach for three weeks, did guard duty for fifteen months in Montgomery, Alabama, and spent nine months working in the Quartermaster's Corps. He was married in 1943 to a girl eight years his junior. She is feeble-minded. In May 1944, he was sent to England and was stationed there until October 1944, when he was sent to France where he stayed until he was discharged. At no time while in the service was he in danger or bombed.

Patient was first hospitalized for a nervous condition after he was discharged. He was admitted to Cushing Veterans Administration Hospital August 24, 1947 and was transferred to Bedford July 18, 1949. He has been a patient at the hospital since. His admission diagnosis was schizophrenic reaction, catatonic type, incompetent.

A noteworthy factor in the patient's family history is that his mother suffered from chronic asthma. His father died when he was six months old, and his grandfather, who had made
his home with the family died when patient was four years old. Patient was always serious, quiet, withdrawn, and had few friends.

CASE NO. 23

ALACK

Twenty-six year old, white, American born, Jewish single man entered the Army March 25, 1943 and was discharged August 19, 1943 with a thirty per cent service connected disability for neurasthenia. He is now receiving a hundred per cent disability.

Patient was born April 23, 1923. His was a broken home. He is the youngest of three siblings. His brother is seven years older than he, and his sister is five years older. Patient's mother became mentally ill when patient was a tiny baby and has been hospitalized since that time at the State Hospital for Mental Diseases at Howard, R. I. After she was hospitalized, patient was cared for by a paternal aunt until he was a year and a half, and then he was admitted to a Jewish Orphanage in R. I. His father died at this time from a stroke. Patient remained in the Orphanage until he was sixteen. His two siblings were also there. When he was sixteen, he went to live with a maternal aunt who had three daughters. He was quite unhappy living with his aunt, and between the ages of sixteen and eighteen he sold papers before and after school in order to pay his aunt for his board and room. Patient was a good-natured, friendly, affectionate child who was obedient and very sensitive. He sucked his thumb until he was ten or eleven. Though he was a sociable individual, he had a decided inferiority complex. He was moody, easily depressed and discouraged. He was graduated from high school at eighteen, and worked at the Fall River Ship Yard, first as a welding trainee and later as a welder until he enlisted in the service. While working at the Ship Yard, he was self-conscious, and felt that people were discriminating against him unjustly.

He was in the Army less than five months when he was discharged for nervousness.

After his discharge, he worked with his brother but was unable to get along because of his marked inferiority. He consulted a psychiatrist once a week for over a year in Providence. In the fall of 1948, he obtained employment in a department store and was there for two months, and again was unable to remain working because he felt that people followed
and discriminated against him. In February 1949, he enrolled at a technical school to study radio, and three weeks later began to have fainting episodes and bizarre somatic complaints. He was hospitalized in a sanitarium in Providence and was given electric shock treatment. On March 16, 1949, he was hospitalized at the Chapin Hospital, Rhode Island, and was transferred to Bedford June 7, 1949. He has been a patient at the hospital since. His admission diagnosis was dementia praecox, unclassified, incompetent.

A significant factor in the patient's family history is that his mother became mentally ill while he was an infant and she has been hospitalized in a mental institution since that time. Patient was cared for by a paternal aunt until he was a year and a half old and then was admitted to an orphanage. His father died at this time. Patient was at the orphanage until he was sixteen and then lived with a maternal aunt for two years. He had to sell morning and evening papers to pay for his board and room. He was very unhappy living with his aunt. As a child he was a sociable individual with an inferiority complex, moody, easily depressed and discouraged. He was a very sensitive child who sucked his thumb until he was ten or eleven years old. Patient had less than five months service before he was discharged for nervousness.

CASE NO. 24

RAYMOND

Twenty-seven year old, white, American born, Catholic, single man entered the Navy December 9, 1942. He was discharged April 6, 1944 with an honorable discharge. He is now receiving a hundred per cent service connected disability for a mental condition.

Patient was born March 7, 1922. His was a broken home. He is the youngest of three siblings, all male and born one
year apart. His parents were divorced when patient was four years old. Mother divorced father on grounds of non-support and interest in another woman. Family lived with patient's maternal grandparents. Patient was overly attached to his mother. He completed the ninth grade in parochial school with only fair grades. His only hobby was reading, and his only interest was to help his mother. He left school to work and support her, so that she would not have to work so hard. While working, he gave her all his money. She was "his girl friend" and he had dated once "merely to oblige the girl." Prior to his entering the service, he worked in the warehouse at Camp Devens doing unskilled work.

While in the Navy, patient saw much active combat duty. He was in the Italian invasion campaign originating in Africa. His illness began aboard ship January 1944. He was taken off the boat and sent to a naval base for thirty days and then transferred to a naval hospital for three months. He was treated for "shell shock" and was discharged from the hospital and the service the same date, April 6, 1944.

His post-service adjustment was adequate until his grandmother, of whom he was very fond, died in 1944. He became over-religious, restless, couldn't sleep and had crying spells. He was admitted to Bedford September 14, 1944 and was placed on Trial Visit status January 4, 1945, but was returned to the hospital December 17, 1945 because of a return of his previous mental picture. He was again placed on Trial Visit status on June 21, 1946 and was again returned to the hospital on March 29, 1947. On November 13, 1947, he was placed on Trial Visit status and was discharged from the hospital November 13, 1948. Because of a return of his previous mental behavior, he was admitted to the Boston State Hospital April 18, 1949, and was transferred to Bedford May 11, 1949. He has been a patient at the hospital since that time. His admission diagnosis was schizophrenic reaction, hebephrenic type, incompetent.

A significant factor in the patient's family history is that his mother divorced his father because of non-support and the latter's interest in another woman. Parents were divorced when patient was four years old. Patient was overly attached to his mother. She was "his girl friend." He left school to support her so she would not have to work so hard. He had no interest in the opposite sex, and his only hobby was reading.
Patient had one year of continuous active combat duty in the Italian invasion campaign originating in Africa.

CASE NO. 25

WILLIAM

Twenty-three year old, white, American born, Catholic, single man entered the Navy November 1943. Upon discharge October 2, 1945, he immediately re-entered and was then discharged October 19. He has a service connected disability and is now receiving a hundred per cent disability.

Patient was born September 12, 1926. He is the oldest of five siblings. He has four younger brothers. His was a broken home. His father died when he was six and the family was aided from then on by relief agencies. His was a forceps delivery. His head was badly deformed and he had a lump on his head five weeks after birth. At the age of three he had chorea. He was a nail biter, had enuresis and was a nervous child. He was troublesome in school, stubborn, a behavior problem, an attention seeker, and incompetent in his school work. He left school at the age of sixteen, worked as a dishwasher for one month, was unemployed, then worked for four months as a mechanics learner and enlisted.

While in the Navy, he participated into amphibious invasions in Europe. He was in the D Day invasion before his eighteenth birthday, and was with a demolition squadron in the Rhineland crossing. He saw combat in Sicily and in Italy. He had four and a half years of active Naval service. His illness began June 15, 1947 when he was found unconscious aboard ship. Neurological studies were found negative though patient continued to be drowsy and complained of frontal headaches. On November 6, 1947, patient was struck by an automobile and injured his leg. A neuro-psychiatric consultation was held November 26, 1947. Patient continued to sleep a great deal but was easily aroused. The consultation revealed a non-incapacitating weak dependant type of personality with emotional immaturity and incapacity. He was transferred to the Chelsea Naval Hospital on January 24, 1948 for convalescent care for his fractured leg. While at the Chelsea Naval Hospital, on April 29, 1948, he developed paranoid psychosis and was transferred to the United States Public Health Service Hospital at Fort Worth on May 10, 1948. As there was no improvement in his condition, he was discharged from the service and transferred to Bedford October 19, 1948. He has been a patient at the hospital since that time. His admission diagnosis was schizophrenic reaction, catatonic type, competent.
Patient's head was markedly deformed at birth, and he had a lump on his head five weeks after birth. At the age of three he had chorea. He was a nail biter, had enuresis, and was nervous. He was a behavior problem, stubborn, an attention seeker, troublesome and incompetent in school. His parents were divorced when he was six years old, and the family was then aided by relief agencies. Patient was in the D Day invasion before his eighteenth birthday and had four and a half years of active Naval Combat Service.
Chapter V

SUMMARY AND CONCLUSIONS

At the outset of the study, the problems presented were, "Will the study reveal (1) common significant elements in the family background, (2) abnormal personality traits common to the group, (3) psychotic or pre-psychotic behavior so apparent that these individuals should have been exempt from the situations with which they were confronted in military training and combat, and (4) did type and length of military service have a bearing on the patient's illness?"

In nineteen of the twenty-five cases studied, no significant factors in the family background were disclosed through the social histories. In six others, there were gross irregularities, which resulted in the patients not having two parent figures during their formative years. In the seven cases considered as intact unstable homes, the mother is shown as a dominant figure in the parental constellation. She is described as a strict, rigid individual, over-protective of the patient in his dealings with other members of the family, and in his dealings with life situations. One theme runs through all of the cases in which parental influences have been mentioned. The mother who has been over-protective of the patient has been very devoted to him.

In answer to the question will the study reveal abnormal personality traits common to the group, we find that in each
patient's developmental history, he was a follower rather than a leader. He was shy, quiet, insecure, antisocial, had little or no interest in the opposite sex, and as a rule had difficulty with inter-personal relationships. Many of these patients we find over-attached to the mother. We find these patients more devoted to the mother than the other siblings in the family. In all, we find a deeply rooted feeling of insecurity and the resulting inadequacy of coping with life situations. Most of these cases, according to the records, revealed a schizoid personality of long standing. These shy, reserved individuals preferred being alone rather than mixing with others. When they did have hobbies, they were solitary ones, such as reading, boating, golf, etc. It is possible that a certain proportion of these cases might have continued to make a community adjustment of varying degrees, if spared the traumatic situation of their service experience.

In three cases, we find that psychotic or pre-psychotic behavior was so apparent that these individuals should have been exempted from military service. One patient had been hospitalized for a behavior disturbance three months prior to entering the Navy. Another patient had had a skull fracture at the age of six, suffered another head injury at the age of seventeen, and had had periods of amnesia from the age of six until he was twenty-two. The patient who was hospitalized in his fourth week of basic training had had a history of withdrawal, panic states, hallucinations and suicidal thoughts.
since the age of twelve. Thus it would appear that previous medical or psychiatric histories were not made known to the examiners at the time of induction.

It is difficult to evaluate whether the type and length of military service had a bearing on the patient's illness. Of the twenty-five cases studied, ten had active continuous combat duty. These ten individuals, too, had the pre-schizoid type of personality during their formative years as did the others. Their threshold of stress was evidently higher than those men who broke down while in training, or while in this country. While it is possible that a certain proportion of these cases might have continued to make a community adjustment of varying degrees, if spared the traumatic situation of their service experience, it is impossible to ascertain whether the actual combat experience was a contributing factor or just the precipitating factor because of the pre-schizoid type of personality of all of these men.

It is interesting to note that of the ten men who had had active continuous combat duty, only two broke down on the fighting front. The others became incapacitated only after they were relieved of military stress and tension. The breakdown came when new readjustments were required. Readjustment is a traumatic experience for all. It is to be noted in all of these cases that the individuals were able to stand up under varying degrees of stress and readjustment before they became ill. For example, some of the men broke down during basic
training, others while awaiting combat, only two while in combat, and still others after discharge.

Though there is the possibility that readjustment may have been the causative factor, we must not forget that in a few of the cases, a long period of unsatisfactory adaptation preceded the breakdown. For each individual, psychological growth results from a process of gradual maturation. Biologically man is less able than any other animal to exist without prolonged support from parental figures. Over-protection, deprivation and frustration prolong this dependency beyond its usual biological duration. These factors are detrimental for the development of a strong ego which every individual needs to help him meet life situations adequately and without breakdown. Perhaps fundamentally the breakdown may be a result of a failure in the biological maturation process. During childhood these individuals did not react as the "so-called normal." They all had difficulties with inter-personal relationships. More research is needed about schizophrenia which institutionalizes so many hundreds of people yearly.

Where lies the blame that progress toward the solution of the schizophrenic problem has been so slow. No easy resolution of the difficulty is possible. The next steps that should be taken are obvious. The first is to get on with the very difficult task of enlightening the citizenry to the fact that schizophrenia is a disease and not a sin or disgrace. Were this fact adequately appreciated the social pressure for the solution of the problem would no doubt become irresistible. Another necessity is more adequate recruitment of workers in the field. Not only should a much larger number of medical students be attracted
to the field of psychiatry, but a larger proportion of the soundly trained, research-minded young physicians should be secured. The responsibility for these reforms rests primarily with the medical profession.

The final and heaviest responsibility lies upon society itself. The law of supply and demand is operative in this as in all other fields of human endeavor. Society will get approximately what it demands and is willing to pay for. Up to the present time, only a fraction of a per cent of the total funds devoted to medical research has been assigned to this, the greatest problem of all. While money alone will not solve the problem, none of the actual solutions are possible without it.

The problem is before us. Many promising leads for further research are obvious. Every baby born this year must take his chance of spending the best years of his life as a schizophrenic in a mental hospital. Society owes him a better defense.17


Approved,

Richard K. Conant
Dean
APPENDIX - SCHEDULE

1. Name
2. Date of Birth
3. Age as of November 23, 1949
4. Religion
5. Marital Status
6. Military Service and Adjustment
   Branch and Dates
   Type
   Domestic
   Foreign
   Non-combat
   Combat Area
   Combat
7. Family Constellation
   Intact
   Intact Unstable
   pre-adolescence
   adolescence
   Broken
   pre-adolescence
   adolescence
8. Pre-psychotic behavior
   pre-school age
   pre-adolescence
   adolescence
9. Activity prior to military service
   school - grade completed
   employment
   skilled
   unskilled
   duration
   unemployment
   duration
10. Hospitalization or treatment for neuropsychiatric disorder
    prior to service
    during service
    after service
11. Admission diagnosis
   competent
   incompetent

12. Compensation
   amount received at discharge
   present compensation
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