1947

Socio-psychological factors influencing psychosomatic disturbances: a study of fifteen World War II veterans seen at the Worcester Psychosomatic Clinic

Houston, Lester Grant

Boston University

http://hdl.handle.net/2144/18926

Boston University
The writer wishes to express his sincere appreciation to Dr. William Malamud, Director of the Worcester Psychosomatic Clinic, for his advice and assistance in developing the outline of this thesis. The writer is especially grateful to Mrs. William Malamud, Research Social Worker, Worcester State Hospital and Worcester Psychosomatic Clinic, who gave unstinting assistance in aptitude and guidance in the preparation of this thesis. To the entire staff of the Worcester Psychosomatic Clinic the writer also wishes to express thanks for their willing cooperation in securing the social history data used in this thesis.

SOCIO-PSYCHOLOGICAL FACTORS INFLUENCING PSYCHOSOMATIC DISTURBANCES

A Study of Fifteen World War II Veterans Seen at the Worcester Psychosomatic Clinic

A Thesis
Submitted by
Lester Grant Houston
(A.B., Howard University, 1944)

In Partial Fulfillment of Requirements for the Degree of Master of Science in Social Service 1947
ACKNOWLEDGEMENTS

The writer wishes to express his sincere appreciation to Dr. William Malamud, Director of the Worcester Psychosomatic Clinic, for his advice and assistance in developing the outline of this thesis. The writer is especially grateful to Mrs. William Malamud, Research Social Worker, Worcester State Hospital and Worcester Psychosomatic Clinic, who gave unstintingly of her time, interest and guidance in the preparation of this thesis. To the entire staff of the Worcester Psychosomatic Clinic the writer also wishes to express thanks for their willing cooperation in securing the social history data used in this thesis.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS  ii
I. Scope and Method of Procedure  iii
The Concept of Psychosomatic Medicine  iv
The History and Organization of the Worcester Psychosomatic Clinic  vi
II. GENERAL CHARACTERISTICS OF THE GROUP  1
III. PRESENTATION AND ANALYSIS OF DATA  16
Criteria for Classification  16
Group I Case Presentation  18
Group II Case Presentation  21
IV. DISCUSSION OF MATERIAL  24
Social Factors  24
General Pre-Military Personality Factors  30
Military Factors  33
Post-Military Factors  36
V. SUMMARY AND CONCLUSIONS  40
BIBLIOGRAPHY  49
APPENDIX  51
The purpose of this paper is to present the problem of the metropolitan hospital clinic. The problem is to stimulate development of evidence of the feasibility of the metropolitan hospital clinic as a method of medical education, particularly in connection with the faculty of the metropolitan state hospital and metropolitan psychiatric center. The clinic is also suggested as a means of stimulating interest and knowledge in the subject of the metropolitan hospital clinic. To the office staff at the metropolitan hospital clinic, the writer also wishes to express thanks for their assistance in preparing this paper.
# TABLE OF CONTENTS

## ACKNOWLEDGEMENTS

## TABLE OF CONTENTS

## LIST OF TABLES

## CHAPTER I. INTRODUCTION

- Methodology
  - Purpose of the Study
  - Scope and Method of Procedure
  - The Concept of Psychosomatic Medicine
  - The History and Organization of the Worcester Psychosomatic Clinic

## CHAPTER II. GENERAL CHARACTERISTICS OF THE GROUP

## CHAPTER III. PRESENTATION AND ANALYSIS OF DATA

- Criteria for Classification
- Group I: Case Presentation
- Group II: Case Presentation

## CHAPTER IV. DISCUSSION OF MATERIAL

- Social Factors
- General Pre-Military Personality Factors
- Military Factors
- Post-Military Factors

## CHAPTER V. SUMMARY AND CONCLUSIONS

## BIBLIOGRAPHY

## APPENDIX
Since all of the patients studied are veterans of World War II, some of whose symptoms seem to have developed during or after service, the general focus of the study will be to show the relation between the development of psychosomatic symptoms and the military experience. It is hoped that answers to the following questions will be found:

1. What are the main factors producing or contributing to psychosomatic symptoms in general?

2. What are the differences between those men who adjusted well prior to the military experience and broke down during or since service, as contrasted with those whose adjustment was already poor prior to service?
CHAPTER I

INTRODUCTION

METHODOLOGY

Purpose of the Study

The purpose of the present study is to investigate systematically the social developmental history and the present social setting of a group of patients seen at the Worcester City Hospital Psychosomatic Clinic in order to determine their importance as etiologic or contributing factors in the development of symptoms by the patients.

Since all of the patients studied are veterans of World War II, some of whose symptoms seem to have developed during or after service, the general focus of the study will be to show the relation between the development of psychosomatic symptoms and the military experience. It is hoped that answers to the following questions will be found:

1. What are the main factors producing or contributing to psychosomatic symptoms in general?

2. What are the differences between those men who adjusted well prior to the military experience and broke down during or since service, as contrasted with those whose adjustment was already poor prior to service?

It is the latter point which raises the question as to whether there are any significant differences between those patients whose symptoms developed or became exaggerated during and after military service and those patients whose symptoms had more or less existed previous to their military service.
CHAPTER I
INTRODUCTION
METODOLOGY

Purpose of the Study

The purpose of the present study is to investigate systematically
the social development process and the resultant social setting of
the social development Input and the resultant social setting of
the Social Development Project. The present study aims to examine
the relationship between the Social Development Project and
the present setting of the social setting of the Social Development
Project. The study is designed to determine the importance of
social development in the Social Development Project.

Since this is the first attempt to develop the Social Development Project,
the following questions will be examined:

1. What are the major factors conducive to contributing to
   the Social Development Project?
2. What are the differences between those men who participated
   in the Social Development Project and those who did not?
3. What are the differences between those men who made
   some response, as compared with those who made no
   response?
Scope and Method of Procedure

Fifteen male veterans will be studied who have been seen at the Worcester Psychosomatic Clinic for periods varying from several weeks to over a year and for whom there have been diagnoses of psychosomatic conditions. Selection of cases was based mainly on availability of reliable history information.

The social histories (see Appendix A) were obtained on each of these patients by the writer (with the exception of two cases which were obtained by other workers in different agencies). Sources of information included personal interviews with the patients themselves, relatives, the patients' doctors at the clinic, other out-patient clinic records, school records, court records, employers and other social agencies.

The histories emphasized somatic manifestations (in the family as well as the patient), family history, developmental background, personality makeup and social milieu, and any other factors which seem to have precipitated the present illness. Special emphasis was placed on the existence or nonexistence of somatic factors in other members of the family which may have been significant in the patient's condition and on the patient's symptom picture in relation to his military experience. It is the latter point which raises the question as to whether there are any significant differences between those patients whose symptoms developed or became exaggerated during and after military service and those patients whose symptoms had more or less existed previous to their military service.
The family function (see Appendix) has application to many of the problems presented by the experience of the patients, and while the experiences of the patients are unique, there is no reason to believe that the basic differences in the experiences of the patients or the children of the patients are to be found in this field. It is to be expected, however, that the differences in the experiences of the patients are to be found in the differences in the experiences of the patients.
The histories were then analyzed to determine the nature of the family set-up, the patient's personality (pre- and post-military), his adjustments (social, school, employment, military, etc.), his previous illnesses and attitudes toward illness, precipitating factors and clinical picture of the present condition, his attitudes toward his veteran's status and society, and the type, duration and results of treatment. These analyzed histories were then classified into two separate groups according to comparative pre-and post-military adjustments (see page 15).

The attempt was then made to correlate the findings of these respective groups in order to discover their etiological significance in regard to the questions posed.
The patient was found to be suffering from a severe case of tuberculosis. His condition was grave, and he was admitted to the hospital immediately. The medical team worked tirelessly to save his life. Despite their efforts, the patient passed away a few days later.

In the aftermath, the hospital conducted a thorough investigation to understand the cause of death. They found that the patient had been exposed to contaminated air and water, which led to the infection. The hospital implemented strict measures to prevent similar occurrences in the future.

The patient's family was supported throughout this difficult time, and his passing was mourned by all who knew him. The hospital dedicated a space in the hospital to his memory, and his story serves as a reminder to always prioritize safety and hygiene in healthcare settings.
The Concept of Psychosomatic Medicine

Health, generally speaking, is the maintenance of a satisfactory relationship between the organism and the environment, or that state in which all natural activities and functions are performed freely and efficiently without pain or discomfort. Illness, on the other hand, is that state in which these natural functions are disturbed and the individual experiences pain or discomfort in performing them. Disease is more specific, being an abnormal state of the body caused by improper functioning, injurious substances or trauma, etc.

It is important to note the distinguishing features between disease and illness. In disease the abnormal conditions of the organ are recognized by chemical, physical and biological methods and by the observations of the doctor, thereby being objective. Illness, on the other hand, is subjective in that it is the patient, himself, who recognises and manifests by his behavior, the existing disturbance. Disease, then, is only one element of illness and is not the only cause of bodily disorders. Disease does not necessarily cause illness and illness may exist without disease.

During the development of scientific medicine the tendency was to divide the whole man into parts for more and more specialized study. The organic tradition in medicine, holding authority in diagnosis and treatment of physical ailments gave little consideration to the patient as a whole.

The great accomplishments of the past became later the greatest obstacles against further development. The discovery of histological changes in diseased organs by the help of the
The concept of Psychosomatic Medicine

Health, generally speaking, is the maintenance of a state of well-being that allows the proper functioning of the body. It involves the interaction between physical, mental, and emotional factors. Illness, on the other hand, is a state in which these factors are disrupted and the body is unable to function properly.

It is important to note that the relationship between illness and disease is complex and multifaceted. While illness may exist without disease, the development of scientific medicine has led to a focus on the latter. However, this approach has led to the neglect of the former, which are the conditions that give rise to disease.

The concept of Psychosomatic Medicine aims to integrate the knowledge of these two aspects, emphasizing the need for a holistic approach to health and illness.
microscope became the universal pattern for etiology. The search for the causes of diseases long remained limited to attempts to discover local pathological changes in the tissues. The concept that such anatomical changes are but the immediate cause, and themselves might be results of more general disturbances which develop as the effect of faulty functioning, over-stress or even emotional factors had to be discovered later.1

In the last two decades increasing attention has been paid to the causative role of emotional factors in disease. This increased awareness of the psyche (mind) and the soma (body) gave the medical profession a new conceptual approach to the human organism and all its ailments, which has been so aptly termed "psychosomatic medicine". This is a recognition that patients cannot be considered as having only physical ailments which need consideration from the physical point of view alone. Each patient must be considered as an individual whose illness has a definite relationship to his behavior, with social and emotional problems involved.

On the one hand, there are many patients in whom emotional problems do not seem to enter into the cause of illness. Certain types of diseases or physical trauma, however, may often become emotional problems for the patients because of their incapacitating effect. For example, an individual may have been active and independent, with many social contacts and responsibilities, and with considerable status. With the onset of disease all or part of these activities must be altered. The resultant inactivity, dependence, and loss of status often produces a psychological effect characterized by self-centeredness, anxieties, and feelings of

The present paper is an attempt to answer the question of whether or not certain types of cleavage or differentiation are due to an inherent tendency toward certain types of cleavage or differentiation of their own accord, or whether they result from environmental influences. The present paper is an attempt to answer the question of whether or not certain types of cleavage or differentiation are due to an inherent tendency toward certain types of cleavage or differentiation of their own accord, or whether they result from environmental influences. The present paper is an attempt to answer the question of whether or not certain types of cleavage or differentiation are due to an inherent tendency toward certain types of cleavage or differentiation of their own accord, or whether they result from environmental influences. The present paper is an attempt to answer the question of whether or not certain types of cleavage or differentiation are due to an inherent tendency toward certain types of cleavage or differentiation of their own accord, or whether they result from environmental influences.
inadequacy. This regressive experience permits the patient to fall into a state of complete helplessness, and the escape from reality may be so satisfying that he lacks the courage to get well.

On the other hand, it is now a generally accepted fact that somatic symptoms of a great variety may develop either altogether or partly on the basis of psychogenic factors. In a general way it is also known that in the configuration of such etiology, constitutional predisposition, personal developmental occurrences, and social stress situations may combine to produce the symptom complex. Various investigators, however, disagree on the relative importance of these three, both in determining the development of psychosomatic disorders in general, or the choice of the particular organ systems involved. It is obvious that a clarification of this question is of great importance in the understanding of the dynamics of these disturbances, their treatment, and eventually, the possibility of establishing preventive measures.

Maschcowitz believes the following four diseases with anatomical changes are of psychological origin: 1. essential hypertension, 2. Grave's syndrome, 3. duodenal ulcer, 4. cardiospasm, spastic or irritable colon and mucous colitis. In respect to certain common features he states:

These diseases have a consistent relation with world crises or great emotional waves. We have already called attention to the increasing frequency of essential hypertension and its sequelae as the result of the stress and strain of modern living. It is a notorious fact that the incidence of Grave's disease suddenly increased after the San Francisco earthquake, the Vienna Theater horror in 1884, and during and after the first World War. . . .

The University of Michigan Press, 1964

NOTE

This is a transcript of the text on the page.

The text is written in a formal style, typical of academic or professional documentation. It appears to be a continuation of a larger essay or report, discussing a topic related to education or philosophy. The text is dense and requires careful reading to understand fully. There are no images or tables present on this page.
With the ending of World War II the number of psychoneurotics labeled "Psychosomatic" has rapidly increased until at present the task for those professions which are attempting to treat and rehabilitate these persons is a tremendous one. In helping to alleviate this problem the potentialities for cooperation between the doctor and the social worker are becoming more apparent. Important clues to somatically expressed disturbances are frequently revealed in discussions of problems around military, vocational, religious and marital aspects of patients' lives, as well as parent-child relationships and other social and emotional problems.

It seems that the greatest contributions for the correlation between psychosomatic medicine and social service may be achieved by the work of social service in a preventive way. This work can be accomplished only by social workers being fully equipped with the theoretical and practical knowledge of psychosomatic medicine. Their main task will consist in observing the earliest recognizable psychosomatic expressions on account of emotional or organic disorders, in order to protect the individual against the dangerous influences of the psychosomatic patterns of the environment.3

As an ultimate goal, a preventive program combining the forces of medicine and social work is a desirable and noble objective. The present need, however, is a most urgent one which understaffed clinics, hospitals and rehabilitation centers are not prepared to fill.

The problem that is facing every community in the United States today is what is to be done with and for these discharged servicemen. The adjustment that must be made is difficult under normal circumstances. For psychosomatic patients it is doubly hard. In addition to

3 Felix Deutsch, M.D., "Social Service and Psychosomatic Medicine". Paper read at a meeting of the Missouri District, American Association of Medical Social Workers, April 24, 1940, p. 12.
With the author's note that II the number of those concerned.

It seems that the increase of interest in problems of the social and economic situation has led to a growing awareness of the need for cooperation between the different levels of government, and the need for new methods of analyzing these problems. The cooperative efforts in this area have been significant, and have led to the development of new techniques for the study of social and economic phenomena.

The importance of cooperation among the various levels of government and society is increasingly recognized. The need for new methods of analyzing these phenomena has led to the development of new techniques for the study of social and economic situations.

As an international body, a cooperative program combining the resources of nations and regions, to collaborate and share experiences. The purpose is to promote the advancement of knowledge, to develop new methods, and to facilitate the exchange of ideas.

The importance of cooperation among the various levels of government and society is increasingly recognized. The need for new methods of analyzing these phenomena has led to the development of new techniques for the study of social and economic situations.

The cooperative efforts in this area have been significant, and have led to the development of new techniques for the study of social and economic phenomena.
all of the difficulties of returning to civilian life they have the added difficulty of intangible, though frequently painful and incapacitating symptoms. In many cases the relationship between their emotional lives and their physical symptoms is difficult if not impossible to determine and they are often labeled "inferior", "lazy", or "queer". An understanding attitude on the part of their families and the community is necessary if these men are to be restored as useful citizens.

The ways in which different communities are meeting this specialized problem are varied. The important thing that must be kept in the foreground of all plans is that rehabilitation must be focused upon the whole person, not as an isolated individual, but as a member of society.

It is the opinion of Dr. William Malamud, Director of the Worcester Psychosomatic Clinic, that the only logical method for dealing with these psychosomatic problems would be to develop clinics within the framework of general hospitals, conducted by physicians who are well trained in general medicine and psychotherapy, and associated with competent social workers and psychologists.

The social worker in such a setting should function not as an adjunct or assistant to the physician, but as a necessary associate in well organized administration. These should be a strongly organized social service department participating in investigation as well as the treatment of the patient and serving as a link between the clinic and the community.
If the willingness of the patient to allow the diagnosis to be known and to permit the recording of the symptoms of the disease to be sufficient, the diagnosis will be continued in the same way as before.

If the patient refuses to undergo the examination, the diagnosis will be suspended until the patient agrees to it.

If the patient is satisfied with the diagnosis, the diagnosis will be continued in the same way as before.

If the patient is not satisfied with the diagnosis, the diagnosis will be suspended until the patient agrees to it.

If the patient refuses to undergo the examination, the diagnosis will be suspended until the patient agrees to it.

If the patient is satisfied with the diagnosis, the diagnosis will be continued in the same way as before.

If the patient is not satisfied with the diagnosis, the diagnosis will be suspended until the patient agrees to it.

If the patient refuses to undergo the examination, the diagnosis will be suspended until the patient agrees to it.

If the patient is satisfied with the diagnosis, the diagnosis will be continued in the same way as before.

If the patient is not satisfied with the diagnosis, the diagnosis will be suspended until the patient agrees to it.

If the patient refuses to undergo the examination, the diagnosis will be suspended until the patient agrees to it.
The History and Organization of the Worcester Psychosomatic Clinic

The Worcester Psychosomatic Clinic, held at the outpatient department of the Worcester City Hospital, was organized in the spring of 1940 by Dr. William Malamud, then clinical director of the Worcester State Hospital. It was started primarily as a consulting clinic for other outpatient clinics of the city hospital and met once a week. Cases at that time were referred almost entirely by these other clinics.

Ultimate plans for the Psychosomatic Clinic were to establish contacts in the community and broaden the sources of referral. In the beginning the staff consisted of one psychiatrist in addition to Dr. Malamud and one psychologist. There was no social worker available then, but it soon became obvious that in dealing with this kind of problem it was essential to have a social worker there to participate in investigation as well as treatment of the patients, and to serve as a link between the clinic and the community. This work was begun on a volunteer basis by Mrs. Irene T. Malamud. In 1942 Mrs. Malamud began as psychiatric social worker on the Research Service at Worcester State Hospital. Work on this service, which was set up to do research with veterans, provided the opportunity for her to view the varied problems presented by the veteran group. Early in 1943 Mrs. Malamud continued on a part-time basis as psychiatric social worker at the Psychosomatic Clinic.

Late in 1943 Worcester State Hospital officials (as a result of work being done by the Research Service) and the community both became aware of the increasing need for services for the many psychoneurotic
The President and Secretary of the Donovan Presbyterian Church

The Donovan Presbyterian Church office, part of the Donovan United Methodist Church, was connected to the site of the Donovan United Methodist Church at 1903 Midway Avenue. The office of the Donovan United Methodist Church contains a small office space for the Donovan United Methodist Church.

The Donovan United Methodist Church office is a small office space for the Donovan United Methodist Church.

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

Office

O
veterans who were returning to the community but who, because of their non-psychotic condition were not being referred for hospitalization.

The services of the Psychosomatic Clinic were then made available to the community at large and agencies dealing with veterans, especially the Veterans' Service Organization (which was an expansion of the Soldiers' Relief into a municipally operated agency dealing with veterans' problems). The first psychoneurotic referral was made in February of 1944.

Since that time the clinic has grown considerably. It meets twice weekly and the staff of psychiatrists has increased to six for each session. Thursday afternoon clinic is devoted mainly to registration and admission of new cases and for short therapy interviews. Tuesday evening clinic is devoted to longer, more intensive therapy interviews.

The social service department has also developed considerably. It presently numbers four social workers, two of whom are students, under Mrs. Malamud's supervision.

Although casework treatment and social investigation are still performed by the social worker, existing conditions of limited personnel and volume of work limit these services. However, in special cases social histories are obtained by the workers. Information is obtained by interviews with relatives, physicians, friends, and from school and employment records, court records and from those of other social agencies.

Perhaps one of the more significant developments in the growth of the social service department and the clinic as a whole has been the
The services of the Daycare Clinic were made available to the community of large and scattered families with

The War-time Service Organisation (which see an explanation of the

Societies, Collective into a War-time Service Organised around Health with

agreement, Hopkins). The initial Pragmatical Services have been in

Received at 1944

These first into the office and from committees. It seems

when the need for co-operation has increased to the extent

society. Therefore, although different in degree, in quality, and in scope

name masculinity of our sense may not provide further information. Together

same, office to gather to ensure, more immediate same information.

The society service department and into developed committees.

beneath more from our society service, two or more the acceptance, which

impeachment, investigation

change occasion in the society service, continue committee of policies because

following the society service, continue committee of policies because

let my volume of work fulfill these services. However, in society

some societies initiatives are adopted by the members. Information to

offer for publications with relative, by publications, these may from

social and educational records, cannot receive any from scope of access

Society elsewhere.

Person one of the more significant developments to the branch of

the society service department may the office as a whole and feel the
utilization of other social agencies in the community, especially the Home Service Department of the Worcester Chapter, American Red Cross and the veterans' organizations. As a result of expanding further into community life the number of patients became so great that the clinic social worker was unable to provide individual casework services to all. Other social agencies in the community were then requested to cooperate in this respect, with most gratifying results.

The function of the social service department at the clinic, during this developmental period has included a rather extensive educational program in the community for both the clinic and these other agencies. In this way each has learned more about the organization, function, procedure and limitations of the other. Special groups of clergymen and lay people, including the Parent-Teachers Association, women's clubs and men's clubs, have been addressed about the work of the clinic, the need and its place in the community. Great efforts have been made to increase better understanding and cooperation among employers in special problems of rehabilitation. Interviews with personnel men or foremen in industrial plants help many veterans to make the difficult adjustment to civilian employment. Functionally, then, the present role of the social service department at the Worcester Psychosomatic Clinic is that of a liaison agent between the clinic and the community, including other social agencies on a cooperative as well as referral basis.

An integral part of the clinical study in many cases is psychological examination including various intelligence and projective tests: the stanford-Binet, Wechsler-Bellevue, Wells Memory, Vocational Aptitude,
Announcement of office-hour services in the community, especially for those
Service Department of the Cooperative Extension Service cannot be
announced administratively. A report of expanding this service to
the areas of Bastrop, Bastrop County, and the adjacent counties
was made to the National Cooperative Extension Service to meet
other needs in the community where they recommend to cooperate in this report.

The location of the office-hour service is the corner of the office

The earlier services have been increased with another extension station.

In these new ones new hours have been added, and the other stations
have been increased. Some stations have been moved, and the work of the office.

Cooperative Extension Service employees in special programs

In cooperation with the Department of Agriculture, have been trained in agricultural

Programs. Cooperationally, plan the practical purpose of the office service

employment. Cooperationally, plan the purpose and the goal of the office service

geographical of the Cooperative Extension Service to meet a national

serve between the office and the community, informing other social services

as a cooperative as well as national.
Rorschach and Thematic Apperception tests.

On Saturday mornings the staff of the Psychosomatic Clinic conducts its regular weekly conference. Here psychological reports and social histories are presented. At that time also new referrals are presented and discussed, plans or suggestions for treatment made and progress reports and special problems are discussed.

Although until the present time the bulk of cases carried at the clinic have been ex-servicemen, a group of general civilian cases has been served throughout the period the clinic has been in operation.

Although there has been close cooperation between the Worcester Psychosomatic Clinic and the Veterans' Administration, there has never existed any official affiliation. The attitude of the clinic has been that its function is to serve these men after they have been discharged from service and must now become "civilians" again. The philosophy that these men are no longer servicemen but now civilians in the community with problems on that basis is important, and has been found to determine to some extent whether or not they return for further treatment. Many veterans who are referred to the clinic seem to have a fixation on their veteran's status. When they find that the clinic is not an official part of the Veterans' Administration, they lose interest in further contacts, preferring to seek help which has a more direct bearing on their disability rating. On the other hand, there are many others who desire reorientation to civilian status and accept the clinic's philosophy that they are now civilians and return regularly for treatment.

Because of the fact that since 1944 the Worcester Psychosomatic Clinic
Regarded as the appropriate center of the Department's medical services, the medical staff of the Department of Veterans' Affairs is responsible for the care and treatment of veterans. The medical staff is composed of specialists in various fields of medicine and surgery, and is under the direction of a Medical Director. The primary function of the medical staff is to provide efficient and effective medical care to veterans.

The philosophy of the Department of Veterans' Affairs is that veterans, as members of the Armed Forces, are entitled to the same kind of medical care and treatment as any other citizen of the United States. The Department is committed to providing a high level of medical care to veterans, regardless of their economic status or ability to pay for medical services. This commitment is based on the belief that veterans have made significant contributions to the nation and deserve to be treated with the same dignity and respect as any other citizen.

The Department of Veterans' Affairs operates a network of medical facilities throughout the United States, including hospitals, clinics, and outpatient centers. These facilities are staffed by a large number of medical professionals, including physicians, nurses, and other healthcare workers.

The Department of Veterans' Affairs is also responsible for providing medical care to veterans who are not eligible for care under the Department's medical program. This includes veterans who are employed by the federal government or who are members of the armed forces.

In addition to providing medical care, the Department of Veterans' Affairs also provides vocational rehabilitation and training programs to help veterans transition to civilian life. These programs are designed to help veterans find employment and become self-sufficient after their discharge from service.

The Department of Veterans' Affairs is committed to ensuring that veterans have access to the best possible medical care. The Department's medical staff is dedicated to providing a high level of service to all veterans, regardless of their status or circumstances.

In summary, the Department of Veterans' Affairs is committed to providing efficient, effective, and equitable medical care to all veterans. The Department's philosophy is based on the belief that veterans deserve to be treated with the same dignity and respect as any other citizen of the United States.
has probably seen the majority of servicemen in Worcester who were showing psychosomatic symptoms, it is felt that this offers a unique opportunity to study the problem defined in this thesis.

A close preparation of a variety of background factors is necessary if the reader is to get a clear picture of the fifteen cases used in the study. The following statistical data includes amounts of referral and other information concerning the personal, cultural and military aspects of the patients' lives. Many of the factors discussed have proved, however, to have no significance as related to the etiology of the development of symptoms of the men.

Seven of the men were referred to the clinic by the Veterans' Service Organization. Five were referred by the Home Service Department of the American Red Cross. One was referred by a private psychiatrist; one by a doctor in an industrial plant and one by a relative.

The age range of the men studied was from 18 to 35 years. The average age was 26. Nine or nearly two-thirds of the men studied were single.

With regard to religious affiliations, eight of the men were Catholic, four were Protestants, one was Greek-Orthodox, one was Jewish and one was Albanian-Orthodox. In considering the nationalities of these men two-thirds were first generation Americans and represented eight different foreign backgrounds. The educational range was from grade four to college graduate. Early home background was rural in six cases and urban in nine cases.

Eleven of the men were members of the United States Army, three were members of the Navy, while one was in the Marines. Eight were enlisted and seven were drafted. Eleven had seen overseas service. The average
CHAPTER II

GENERAL CHARACTERISTICS OF THE GROUP

A brief presentation of a variety of background factors is necessary if the reader is to get a clear picture of the fifteen cases used in the study. The following statistical data includes sources of referral and other information concerning the personal, cultural and military aspects of the patients' lives. Many of the factors discussed here proved, however, to have no significance as related to the etiology or the development of symptoms of the men.

Seven of the men were referred to the clinic by the Veterans' Service Organization. Five were referred by the Home Service Department of the American Red Cross. One was referred by a private psychiatrist; one by a doctor in an industrial plant and one by a relative.

The age range of the men studied was from 18 to 35 years. The average age was 26. Nine or nearly two-thirds of the men studied were single.

With regard to religious affiliations, eight of the men were Catholic, four were Protestants, one was Greek-Orthodox, one was Jewish and one was Albanian-Orthodox. In considering the nationalities of these men two-thirds were second generation Americans and represented eight different foreign backgrounds. The educational range was from grade four to college graduate. Early home background was rural in six cases and urban in nine cases.

Eleven of the men were members of the United States Army, three were members of the Navy, while one was in the Marines. Eight were enlistees and seven were draftees. Eleven had seen overseas service. The average
length of time that the men spent in service was thirty-three months, ranging, however, from four to eighty-four months. Thirteen of the men had been hospitalized during their stay in the service and six have been hospitalized since discharge.

The length of time between discharge from the service and the date the men came to the clinic for the first time presents a wide range, from one month to twenty-seven months. The average period of time for the whole group was eleven months. The number of visits to the clinic made by the men (as of June 19, 1947) also presents a very wide range, from one to sixty visits, the average being twenty.

For the purpose of the presentation and analysis of the fifteen cases in order to determine the basic etiological or contributing factors which have produced psychosomatic symptoms in general, and the relationship between these symptoms and the military experiences of the men studied, the data have been classified into two major groups.

Group I includes those men whose pre-military adjustment was good (or adequate) and whose psychosomatic symptoms appeared either during or since military service, or whose reaction to pre-existing symptoms became exaggerated.

Group II indicates those men whose pre-military adjustment was poor and whose psychosomatic symptoms, on the whole or in part, were present prior to military service. The following social-psychological criteria were used in establishing the bases for classifications:

1) Employment or School Adjustment

The evaluation of the patient's employment adjustment was noted as "poor" when he had never worked or could not hold a job; "fair" when he

In some cases the patient was still attending high school or college and an employment history was absent or too short to evaluate.
The number of active members in the service may be taken as one hundred to twenty-seven. The average number of active members is approximately nine. The number of active members has not increased since 1917, when the membership was increased to the present figure of approximately a thousand. The number of active members has remained stable since then.
CHAPTER III

PRESENTATION AND ANALYSIS OF DATA

Criteria for Classification

This study is concerned with the presentation and analysis of the fifteen cases in order to determine the main etiological or contributing factors which have produced psychosomatic symptoms in general, and the relationship between these symptoms and the military experiences of the men studied.

In order to find criteria that could be used to show the relationship between these neurotic symptoms and the military experiences of the men studied, the data have been classified into two major groups.

Group I includes those men whose pre-military adjustment was good (or adequate) and whose psychosomatic symptoms appeared either during or since military service, or whose reaction to pre-existing symptoms became exaggerated.

Group II indicates those men whose pre-military adjustment was poor and whose psychosomatic symptoms, on the whole or in part, were present prior to military service. The following social-psychological criteria were used in establishing the bases for classification:

1) Employment or School Adjustment

The evaluation of the patient's employment adjustment was noted as "poor" when he had never worked or could not hold a job; "fair" when he

In some cases the patient was still attending high school or college and an employment history was absent or too short to evaluate.
CHAPTER III

PREPARATION AND ANALYSIS OF DATA

Criteria for Classification

This chapter is concerned with the presentation and analysis of the
relationship between the symptoms and the miliary carcinoma of the
lung.

As a result of this analysis that can be made to show the relation-
ship between these symptoms and the miliary carcinoma of the
lung, the facts have been classified into two major groups.

Group I includes those cases where the miliary carcinoma was
poorly or moderately advanced. In these cases, the relation-
ship between the symptoms and the miliary carcinoma was

Group II includes those cases where the miliary carcinoma was
poorly advanced. The following clinical-biopsiological criteria
were used in establishing the cases for analysis:

(Mention of the importance of various symptoms, etc.)

The treatment of the patients' symptoms is another aspect that
will be discussed. A few cases will be provided to give an idea of
how problems arise and how they can be managed.
changed jobs frequently due to his own inefficiency or instability; "average" when he gave evidence of having been employed steadily and was considered reliable by his employer; and "good" when he held a job which was suited to his abilities and from which he got satisfaction.

Criteria for school adjustment was based on the patient's academic achievement, the social aspects of his school experience and his attitude toward school. The patient's record was rated as "poor" when he was unable to get beyond the fifth grade and presented a personality problem; "fair" when he reached higher grades but did not graduate due to lack of ability or a slight personality problem; "average" when he graduated from grammar school or spent time in high school, or if he left school for economic reasons at an appropriate age; and "good" when he graduated from high school or trade school or had further educational achievement.

2) Social Adjustment

The social adjustment data were appraised in this manner: "poor" when the patient had few contacts outside the home or had difficulties with society; "fair" when he was excluded from outside groups, was not liked, had few friends, but had manifested no overt difficulties with the social milieu; "average" when he had contacts outside his home, an adequate number of friends, and was accepted by others; and "good" when he was able to establish and maintain healthy, mature relationships outside the home, and adjusted easily to various social groups.

3) Personality

The personality traits are presented in descriptive popular terms as they were given by lay informants, and technical terms have been
The concept of "book" development has been introduced in the document. It seems to be a new way to organize and present knowledge. The "book" is not only a collection of written words but also a tool for learning and understanding. This new approach might be more engaging and interactive compared to traditional "textbooks."
omitted. Those personality traits observed by the writer are also described in popular lay terms to avoid confusion.

The following summarized case histories will serve as examples of each of the classifications.

GROUP I

E.H., 21 year-old single white male, oldest of three male siblings. The cultural background of the closely knit family was Syrian-American. The father was naturalized and the mother was born in New York City. The family has always lived in urban areas and the father, who was a tailor, has always been able to maintain a comfortable standard. He is a somewhat strict person who is definitely the dominant figure in the home. The mother showed a considerable history of somatic complaints. The family, though living in a neighborhood of mixed cultures without friction, has remained quite isolated from other culture groups.

The patient started school at age six and maintained an excellent record until he entered the Navy. He was always an honor student and a very active leader in many school organizations and made an excellent adjustment. His pre-military social adjustment was an excellent one with many contacts and no conflicts with society. His pre-military personality was described as outgoing, warm, active, sensitive, though he overcompensated for his family's social isolation. He showed a strong dislike for authority and was inclined to be tense and emotionally dependent. He is not a religious person as such, but culturally he is highly intelligent and delves into the philosophical aspects of religion.

The patient's early health record indicated no unusual illnesses
or severe accidents, though he developed constipation at about age twelve which persisted for some years.

In 1942 he entered the Worcester Polytechnic Institute where he did excellent work, majoring in chemistry, until he went into the Navy in July 1944. He entered the Navy V-12 training program and here minor symptoms including excessive perspiration became exaggerated and new symptoms developed. While in the Navy he was admitted to a hospital where he developed a very severe mental disturbance which was diagnosed as a psychosis. Shortly after this he was discharged from the hospital and the service. He then returned to the Polytechnic Institute but soon found that his grades were unsatisfactory and so he was referred to the clinic after dropping out of school.

Presenting symptoms were: perspiration and swelling of the hands and feet, headaches, chest pains, depression, fatigue, withdrawal from society and a marked decline in scholastic ability. Since December, 1945 he has been attending the clinic regularly. He has now returned to Worcester Polytechnic Institute and is within a month of being graduated. His grades have improved considerably and all of his symptoms have disappeared except the perspiration, which is definitely less marked and which no longer bothers him.

The symptom of perspiration came to his attention at about the age of eleven or twelve and has since been aggravated or even started by emotional stress. His hands and feet would swell up so that he could not put his

\[2\] The patient has since been successfully graduated.
The exposure of benzene to the atmosphere is due to the leakage of some of the benzene from the storage tanks. Benzene is a highly flammable and toxic substance that can cause severe health problems if inhaled or absorbed through the skin. It is important to ensure proper safety measures are in place to prevent benzene exposure in industrial settings.

Benzene is a byproduct of the refining process of petroleum and is found in gasoline, which is used as a fuel in vehicles. The exposure of benzene to the atmosphere can occur through various means, such as spills, leaks, and emissions from industrial processes.

The table below summarizes the facts about benzene exposure.

<table>
<thead>
<tr>
<th>Source of Exposure</th>
<th>Type of Exposure</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Industrial Processes</td>
<td>Spills and Leaks</td>
<td>50%</td>
</tr>
<tr>
<td>Transportation</td>
<td>Emissions</td>
<td>25%</td>
</tr>
<tr>
<td>Residential Areas</td>
<td>Spills and Leaks</td>
<td>10%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>85%</td>
</tr>
</tbody>
</table>
shoes on. This was not related to outside temperature. There were definite indications of disturbances in adrenal functioning and carbohydrate metabolism.

Psychologically the attacks of perspiration are closely associated with the stress of having to submit to authority especially where the father image is involved. One incident seeming to be closely related to the development of his symptoms is an experience he had in the process of being baptized.

He is Greek-Orthodox and his parents are quite religious. The priests definitely play a paternal role in group activities. In the process of baptism, which is usually performed shortly after birth, the child is completely immersed by the priest three times. In the case of this patient some extraneous incidents had prevented baptism until this patient was four years old. He vividly remembers the great anxiety at being completely submerged and recounted as the outstanding picture in his mind his being held up by the priest with water dripping from five extremities; hands, feet and genitals. He said "I was urinating from all five extremities." Intense anxiety and a struggle against being submerged again accompanied this memory.

Until the age of sixteen he was afraid to go into water and the one experience which is at all similar to baptism took place at about age eleven when his father forcibly took him to the beach and dived into the water with him. Shortly after he began to notice the perspiration.
GROUP II

A.S., 27 year-old single white male, youngest of six siblings. Both parents were born and reared in Lithuania. Adherence to the old-country culture was always close on the part of the parents, although the children quickly and apparently with little difficulty followed the American patterns.

The patient's father was an unstable and abusive alcoholic who beat his wife and children frequently. The outstanding attitude of the family toward him was one of fear and intense hatred. He died of cancer of the stomach about eleven years ago when the patient was sixteen years old.

The mother is a nervous unstable woman about 60 years old, suffering from hypertension. Culturally she has never adopted American patterns, but remained isolated in the Lithuanian group. Relations with her children were not good because of her grasping, domineering attitude in the home. The attitude of the siblings was that the patient, because he was the youngest, was spoiled and babied by the mother and always permitted to have his own way.

Socially the family developed very poorly. Conflicts with the law, alcoholism and conflicts within the family group show a lack of healthy, positive growth and development within the community. All of the children went as far as junior high school, but then left in order to work in the factories. Economically the family was on a dependent or marginal level until the children matured and were able to contribute to the family income.
The patient's birth and early development were normal, though as a baby he was somewhat thin and underweight. When he was about six years old, he began to have trouble with his teeth, and throughout his school career he failed to receive adequate treatment. His childhood was marked by nervousness, headaches, sleep disturbances and occasional sore throats. He entered school at the age of six, and although his grades were average, he made a poor group adjustment, showed little interest in school and was always afraid of the teachers. He left school after finishing grade eight at the age of sixteen. He then held several jobs, driving trucks and working in machine shops, but unless he was working alone he did not adjust well. He had difficulty taking orders and was unable to get along with his fellow workers because he was so sensitive.

He enlisted into the Army in 1942 although he was afraid of Army service. He spent two years overseas. While in service he made a fair adjustment until shortly before being discharged when he became quite irritable and grouchy. In spite of these minor difficulties and the somatic complaints which led to his discharge, he states that he actually did not want to come home because he had more "fun" while in service, where no one bothered him. He felt that when he returned home his mother would want to "boss" him and manage his money. Overtly his attitude toward his mother has been one of extreme resentment.

Before and after his discharge from service he was hospitalized because of a "nervous stomach" and "burning pains" in the stomach. No organic basis could be established and so he was discharged from the hospitals. Here again he disliked returning home.
The patient's health may result from a variety of factors. When the patient's health is maintained, it is often the case that the patient feels better. The doctor's role is to help the patient improve their health. The doctor considers many factors when making a diagnosis. The doctor may talk to the patient about their diet, exercise, and other habits. The doctor may also order tests to help determine the best course of treatment. The doctor may recommend lifestyle changes or medications to help improve the patient's health.
Though the patient seldom drank before he entered the service, he began to drink heavily when he returned home, and "only felt normal after a few drinks of beer". Since his discharge in January 1946 he has been unable to hold a job because of his overwhelming fear of people, his somatic symptoms, and his drinking. The general attitude of the family now is that the patient is a lazy bum who ought to go back to work.

When he appeared at the clinic in October, 1946 his symptoms included: pains in the eyes, neck and stomach, perspiring hands, constriction in the chest and fear of people. At first he was afraid to come to the clinic unless accompanied by his sister, (who had also been receiving treatment at the Psychosomatic Clinic).

During therapeutic interviews the patient exhibited marked feelings of inferiority, ideas of reference, emotional dependence, anxiety, instability and neurotic preoccupation with his somatic complaints. At present he is continuing his visits to the clinic and is able to come without his sister although he is highly dependent on the doctor. He still functions on a severely neurotic level and is psychiatrically incapacitated for any kind of work because he continues to drink large quantities of beer to get courage to leave the house.
CHAPTER IV

DISCUSSION OF MATERIAL

A. Social Factors

Table 1 (p. 26) presents a numerical summary of social factors of the two groups and includes family background, school adjustment, pre-military social adjustment and pre-military employment adjustment.

As might be expected physical diseases appeared in the family background in all cases of both groups. Included are such diseases as cancer, diabetes, pneumonia, hernia, etc. This is not per se especially significant in that most families at one time or another are subject to incapacitating physical diseases. It is significant to note, however, that the emphasis or meaning which the different family groups place upon disease varies quantitatively and qualitatively and may influence the attitudes of other members of the family. In group I, for example:

L.M's mother, after nineteen years of suffering, died of asthma. She was a fat, good-natured woman despite her suffering and her constant need for care. The oldest daughter in this family left school when she was in the sixth grade in order to care for the mother and the home. Much money was spent by the father in seeking cures for his wife's condition but with little success. His frustrations found expression in a resentful, quarrelsome attitude toward his children. Our patient who has had numerous contacts with other outpatient clinics, has found in illness an escape into a protective, dependent state.

Whereas, in Group II:

When A.L. was seventeen years old his mother died, after a long illness of Bright's Disease. The patient had always been very closely attached to his mother, and after she died the family fell apart. The patient blames his father for her death, stating that the father did not believe in doctors and kept telling his wife there was nothing wrong with her. The patient remembered mornings when his mother would get breakfast though
she was hardly able to walk. The father's temper became more severe during the twelve years illness of his wife, and the patient's resentment of the father eventually became so great that he left home.

Nervous or mental illnesses appeared with greater frequency in Group II than in Group I. The number of cases studied, however, is too small to permit any valid generalizations in regard to this factor, although it does raise the question of the influence of the constitutional element in this kind of problem.

Alcoholism appeared twice in each group in male siblings and fathers. In both groups alcoholism in the father was characterized by the patient's inability to form healthy relationships with the father. In Group I:

L.S's father had been an alcoholic as long as the patient could remember. He was a kind, easy-going, passive, dependent personality who provided adequately for his family in a material way. There was marital conflict because of his drinking, but there was not complete family disintegration, for the mother was a dominant, outgoing, stable personality who held the family together emotionally.

In Group II, however:

A.S's father was strict, cruel and abusive to his wife and children. The entire family was terrified of the father, and when he died the patient showed very little grief reaction. Because of a large family of small children the mother was unable to work outside the home. The father's drinking and instability kept the family emotionally upset as well as economically dependent.

Economic stress, e.g., when the families were at a marginal level or below, was present in two cases of group I and in five cases of Group II. It is interesting to note that in all cases of economic stress contacts with other social agencies and other outpatient clinics were numerous. The "habit" of attending clinics was a well established pattern in these families.
### Table 1

**SOCIAL FACTORS OCCURRING IN FIFTEEN PATIENTS OF THE WORCESTER PSYCHOSOMATIC CLINIC**

<table>
<thead>
<tr>
<th>Factors</th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family background</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical disease</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Nervous or mental illness</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Alcoholism in family</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Economic stress</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Broken home</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Family conflict</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>School adjustment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Fair</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Average</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Good</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Employment adjustment (pre-military)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Fair</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Average</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Good</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>No history*</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Social adjustment (pre-military)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Fair</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Average</td>
<td>9</td>
<td>0</td>
</tr>
</tbody>
</table>

*In those cases where the patient was still attending school or college and the employment history was absent or too short to evaluate.*
<table>
<thead>
<tr>
<th>Family Income</th>
<th>Grade</th>
<th>School Performance</th>
<th>Employment (Parental)</th>
<th>Employment (Relative)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>Poor</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>0</td>
<td>Fair</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td>Average</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>Good</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*In those cases where the parents are/affiliated to the college.
Broken homes, implying the physical absence of one or both parents, occurred in three cases of each group. Although no significant differences are apparent between the two groups in regard to this factor, it is important in relation to the organization and stability of the family group in general.

Family conflict, e.g., friction in the home between the parents, parents and siblings, or among the siblings is closely related to the above factors in the family background situation. This factor appeared in both groups, though not in especially significant proportion. The nature of the conflict or friction is interesting, if not significant, in the development of satisfying family relationships.

A.L. . . the family relationship was not a smooth running one. The patient stated that he could only think of turmoil when he thought of his childhood. He did not get along at all with one of his sisters. Her promiscuity was a constant source of conflict in the family. He spoke with contempt of her and said she took after his aunt on his father's side.

The school adjustment of the two groups varied considerably. The educational history which includes adjustment to the school group as well as scholastic achievement, was higher in Group I than in Group II. Whereas the majority of men in Group I made good or average adjustments, the majority of the men in Group II made fair or poor adjustments. This may indicate that they had better opportunities because of better economic status and interest of the family.

The employment adjustment was also especially significant when contrasted in the two groups. Whereas seven of the nine cases in Group I made good adjustments, five of the six cases in Group II made poor
proper form, tabulating the physical space of one or both parents.

Affirming the importance of the family

encompasses between the two groups. It is important to refer to the organization and functions of the family

Groups in General

Health and conflict, in particular, are the same to the concept of the family. The health of the family is obviously related to the

benevolent and stabilizing factors in the stability of the family. The research indicates that the family's condition is important in the

development of the family's socialization.

The school's concern for the home as a socializing experience

causes many factors to influence the development of the family. As

well as education for knowledge, new parents to Group I are looking for more systematic education.

Upon the majority of men in Group II and Group III, there is little or lack of home training.

The home influence that plays an important part of parent

education stems its interest on the family

The employment patterns vary also economically significant with

comparisons in the two groups. Whereas seven of the nine cases in Group II were boys

I was long subsistence, live the six cases in Group II were boys.
adjustments. A typical case showing a good adjustment in Group I is that of N.A.:

He had been graduated from trade school as a well-trained auto mechanic. Because of the nature of his personality, (he was rigid, obsessive, exact), he was well suited for mechanical work. He was efficient, well paid, and liked his job very much.

Whereas in Group II:

A.M. had never made a satisfactory work adjustment. After quitting school to go to work he shifted from one job to another. His main objective he stated was always "more money" with which to buy the numerous things he had been deprived of because of his family's poverty. His erratic work history resulted in several altercations with company employers, and he felt that they gave him a poor recommendation as a worker.

The pre-military social adjustment of the two groups also showed significant differences in that all nine of the men in Group I were considered to have made average or adequate adjustments prior to service, while four of the men in Group II made poor adjustments, and the remaining two made only fair adjustments. This would indicate a better constituted personality which, when interacting with society, adjusted well, but when removed from the accustomed group into the military situation, broke down. For example:

Prior to entering the Army A.V. had many friends outside his family group. He was a member of the Boy's Club where he spent much of his spare time. He was active in group affairs and well-liked because of his warm friendliness and his ability to work well with groups.

Group II, however, presented quite a different picture. The pre-military social adjustment of this group was poor to begin with. The development of symptoms was partly expressive of this poor adjustment and became more severe when additional strain was placed on them.
The plan of Group II

The plan of Group II was based on the assumption that the members of this group would have a more varied and interesting background and therefore be able to contribute to the discussion with a wider range of knowledge and experience. The group was therefore designed to be more flexible and adaptable, with a focus on promoting open and constructive dialogue. The members of Group II were selected on the basis of their ability to engage in meaningful conversations and their willingness to participate actively in the group's discussions.

The plan of Group II was to meet once a week for a period of six months, with the aim of fostering a deeper understanding of each other's perspectives and experiences. Each meeting would be structured around a specific theme, which would be chosen in consultation with the members of the group. The themes would be selected to reflect the diverse interests and experiences of the group, and would be designed to encourage open and honest communication.

During each meeting, the group would begin with a brief introduction to the theme of the day, followed by an opportunity for members to share their thoughts and ideas. The group would then engage in a series of small group discussions, culminating in a whole group discussion. The facilitator would encourage everyone to participate, and would ensure that the discussion remained on topic and productive.

At the end of the six-month period, the group would reflect on its experiences and evaluate the effectiveness of the plan. The feedback would be used to inform any necessary adjustments to the plan for future meetings.
For example:

As a child A.R. did not make friends easily, but preferred to be alone and play by himself. In the family situation he was overprotected by his mother, who readily made excuses for his shortcomings. He had no responsibilities in the home and was seldom asked to do any of the housework despite the fact that both parents had cardiac conditions. When he grew up he had little interest in girls and he never took the initiative to ask for a date. If a date was prearranged he would accept in order not to seem "queer".¹

It is interesting to note that on the whole Group II has gone on to develop much more severe personality disturbances than Group I. This was to be expected since the psychosomatic manifestations were sufficient perhaps to serve as an outlet until additional strain was superimposed by service.

Investigation of the social factors in the fifteen cases, then, revealed several definitely negative factors in the family background and early home environment of both groups. In this respect, however, Group I showed more stability, healthier attitudes and relationships than did Group II. Nervous and mental illness was more prevalent in Group II. Although alcoholism, economic stress and conflict occurred in the family groups of all the men, the deleterious and disorganizing effect was greater in Group II. School and employment adjustment, in general, was much better in Group I. These men displayed more positive attitudes and more initiative in regard to personal progress. The pre-military social adjustment of Group I, as was indicated earlier, was

¹This patient has since been admitted to a mental hospital with a diagnosis of Dementia Praecox.
If it is necessary to note that on the whole Group II far some no to

even develop many more severe negative aftereffects than Group I.

The importance of the social factors in the illness case, I

reverse several negative aftereffects reported in the literature on

mental patients. In this respect, however, Group I showed more negative, critical attitudes and emotional

problems. In Group II, however, my personal illness was more prevalent in

those high Group II patients. At some point in Group I, I

became more critical, impatient, sensitive, and conflict ridden.

At the family groups at the end we took a definite decision and

affirmative attitude towards Group I as an initially conclusive

I think that I have been reading to a certain point with a

agreement to possible future
considerably more adequate than that of Group II. Contacts outside the home were stronger and more numerous in Group I and there were indications of better constituted personalities which facilitated healthy social interaction. When removed from the accustomed group, however, this group tended to break down.

B. General Pre-Military Personality Factors

Table 2 (p. 32) summarizes by groups the general pre-military personality factors of the men studied, including somatic factors in the patients (with and without strong emotional components), sexual adjustment and most frequently occurring personality traits.

"Somatic factors only" refers to usual childhood diseases without marked sequelae, minor accidents or organic disfunctions with normal emotional involvement. "Somatic factors with strong emotional component" indicates those cases mentioned above when they have become chronic, or where an unusual amount of attention has been paid physical disturbances by the patient or his family. Included under this heading also are those cases which have presented rather consistent histories of numerous physical ailments, however minor, necessitating numerous contacts with various outpatient clinics.

In this regard Group I showed much less of a positive history of referrals to clinics or references to previous illnesses of a psychosomatic nature than does Group II. There is always the question of whether this means that there were actually no occurrences of this type in the patients of Group I, or that the families paid less attention to them. Whichever the case may be, the point is significant because it indicates
either that in Group I the patients' personalities were better adjusted, or that the setting was less conducive to psychosomatic symptoms, or both.

Evaluation of the sexual adjustment of the men was interesting in that five men in Group I were married while only one in Group II was married. The term "average" sexual adjustment was used to describe those cases where the heterosexual interests of the men were appropriate to their ages; "attenuated" when they had lengthy engagements or friendships or when they were underactive for their age; and "none" when there was no interest in the opposite sex.

In Group I the sexual adjustment was "average" in seven cases, "attenuated" in two; whereas in Group II it was "average" in one case and "none" in the remaining five cases. In other words Group I on the whole showed a relatively normal sexual adjustment while Group II on the whole presented a poor, more retarded sexual adjustment.

In examining the personality traits two rather distinct types were observed. Group I seemed to be definitely more of an outgoing, friendly, hardworking, active, self-sufficient, sociable type, while Group II was made up almost entirely of inadequate, dependent and withdrawn, sensitive, passive personality types.
after that in Group I the patients’ personality were better established
so that the severity was less continuing to the progression syndrome at part.

Synthesis of the sexual schizophrenia of the new interview
in

that the new in Group I were matched with only one in Group II
were

mentioned. The case "vanity" sexless schizophrenia may need to recognize those

case above the features and differences of the new sex appropriate to

there seems "astonishment" which only that family experience to

no new care any more care even now those were

so interested in the situation ever.

In Group I the new sexless schizophrenia "vanity" ever case

"astonishment" to raise appears in Group II in the case II in the new

made among a relatively normal sexless schizophrenia with Group II in the

made decreased book, more interesting sexless schizophrenia

In examining the personalized tastes and other aspects those were

conscious. Group I seemed to be Griffith role as an ordinary

primarily scientific self-introspection, socialises those while Group II were

make no minor curiosity of the obstacles, questioning any interesting

because personality...
## TABLE 2

**GENERAL PRE-MILITARY PERSONALITY FACTORS OCCURRING MOST FREQUENTLY IN THE PATIENTS**

<table>
<thead>
<tr>
<th>Items</th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somatic factors only</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Somatic factors with strong emotional component</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Sexual adjustment (pre-military)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Attenuated</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>None</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Personality traits (pre-military)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friendly</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Hardworking</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Active</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Rigid</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Inadequate</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Sensitive</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Passive</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Dependent</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Fearful</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Suspicious</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

He was hospitalized there for over 12 months for combat wounds involving the back, arms and legs. This patient has been very tense, irritable and quick tempered ever since his legs were burned. He gets shaky after working, tired easily and "just wants to be left alone." He has also had severe temper outbursts with his family.

And in Group II:

A 26 year-old veteran of the U.S. Army, with 3 months service. He had shown a long history of somatic complaints prior to entering military service. After receiving his basic training at a camp near his home, he was then transferred to another section.
<table>
<thead>
<tr>
<th>Group II</th>
<th>Group I</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>Some features only</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td>Some features with strong emotional component</td>
</tr>
<tr>
<td>0</td>
<td>2</td>
<td>Secondary adjustment (e.g., anxiety)</td>
</tr>
<tr>
<td>0</td>
<td>3</td>
<td>Depression</td>
</tr>
<tr>
<td>0</td>
<td>4</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>0</td>
<td>5</td>
<td>Paranoia</td>
</tr>
<tr>
<td>0</td>
<td>6</td>
<td>Mania</td>
</tr>
<tr>
<td>0</td>
<td>7</td>
<td>Schizophrenia (latent)</td>
</tr>
<tr>
<td>0</td>
<td>8</td>
<td>Depressed</td>
</tr>
<tr>
<td>0</td>
<td>9</td>
<td>Suicidal</td>
</tr>
<tr>
<td>0</td>
<td>10</td>
<td>Paraphilia</td>
</tr>
<tr>
<td>0</td>
<td>11</td>
<td>Schizophrenia (active)</td>
</tr>
<tr>
<td>0</td>
<td>12</td>
<td>Mania</td>
</tr>
<tr>
<td>0</td>
<td>13</td>
<td>Paranoia</td>
</tr>
<tr>
<td>0</td>
<td>14</td>
<td>Depression</td>
</tr>
<tr>
<td>0</td>
<td>15</td>
<td>Suicidal</td>
</tr>
<tr>
<td>0</td>
<td>16</td>
<td>Paraphilia</td>
</tr>
</tbody>
</table>

**TABLE 2**

**GENERAL PSYCHOLOGICAL AND OCCUPATIONAL PROBLEMS**

**MORALITY IN THE AVIATION**
C. Military Factors

Table 3 (p. 35) presents the military factors in the cases of the men studied. It can be seen from this table that the length of service for the whole group presented a very wide range, from four to eighty-four months. Group I, however, spent a larger period in service (an average of 54 months) than did Group II (an average of 28 months).

Although all but four of the total cases studied spent some time overseas, only three men in Group I and one man in Group II were in combat.

Practically all of the fifteen patients studied were hospitalized during service. However, whereas most of the men in Group I were hospitalized for wounds or infections, all but one of Group II were hospitalized for nervous or psychosomatic disturbances. This suggests that for the men in Group II hospitalization was the result of their poor adjustment, while for the men in Group I the reverse is observed, e.g., their poor adjustment was due in part to organic breakdown and hospitalization. For example, a case from Group I shows:

N.A., age 25, is a veteran of U.S. Marines with 43 months service, 24 of which were spent overseas in the Pacific areas. He was hospitalized there for over 12 months for combat wounds involving the back, arms and legs. This patient has been very tense, irritable and quick tempered ever since his legs were burned. He gets shaky after working, tires easily and "just wants to be left alone". He has also had severe temper outbursts with his family.

And in Group II:

A.R., 23, veteran of the U.S. Army, with 4 months service. He had shown a long history of somatic complaints prior to entering military service. After receiving his basic training at a camp near his home he was then transferred to another section
of the country. There he made a very poor adjustment and soon began to complain of leg and back pains. He became tense, irritable and worried a great deal, ostensibly about his sick parents. He also became easily fatigued. No organic pathology could be found to account for the somatic complaints and he was hospitalized with a diagnosis of neurasthenia and lumbo-sacral strain. One month later he was medically discharged from the hospital and the service.

To speculate as to the psychological meaning of the military experience for the men it might be said that Group I was less adaptable to the rigidity and demands for flexibility inherent in the military situation. This would be explained in the light of the general resentment against authority which this group manifested as well as the rigidity in their own personalities.

In general the military factors operating in these cases are:

longer periods of time spent in service by Group I with a higher incidence of overseas combat experience and with less neurotic manifestations than appeared in Group II.

---

To determine the importance of the different experience for the men at night, that the group I was more sensitive to the light and similarly to the light of the enemy. The enemy's awareness of the group was more noticeable as well as the light from our personnel.

In general, the enemy's tactics seemed to be based on a sense of security and a display of caution. My experience was with a group of troops who were more comfortable with the enemy than was typical.
<table>
<thead>
<tr>
<th>Group I</th>
<th>Length of Oversea Service</th>
<th>Oversea Combat</th>
<th>Hospitalized Nervous-Mental</th>
<th>Organic or Combat Wounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A.M.</td>
<td>43*</td>
<td>Yes</td>
<td>hypertension</td>
<td>combat wounds</td>
</tr>
<tr>
<td>2. A.R.</td>
<td>45</td>
<td>No</td>
<td>psychoneurosis</td>
<td>thyroid</td>
</tr>
<tr>
<td>3. E.H.</td>
<td>12</td>
<td>No</td>
<td></td>
<td>combat wounds</td>
</tr>
<tr>
<td>4. J.D.</td>
<td>33</td>
<td>Yes</td>
<td>psychoorganic</td>
<td>neurocirculatory asthenia</td>
</tr>
<tr>
<td>5. A.H.</td>
<td>17</td>
<td>Yes</td>
<td>nerves</td>
<td>accidental explosion</td>
</tr>
<tr>
<td>6. L.S.</td>
<td>22</td>
<td>No</td>
<td></td>
<td>ear trouble, stomach trouble</td>
</tr>
<tr>
<td>7. L.L.</td>
<td>46</td>
<td>No</td>
<td></td>
<td>malaria, broken hand</td>
</tr>
<tr>
<td>8. A.L.</td>
<td>84</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. A.V.</td>
<td>20</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group II</th>
<th>Length of Oversea Service</th>
<th>Oversea Combat</th>
<th>Hospitalized Nervous-Mental</th>
<th>Organic or Combat Wounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A.M.</td>
<td>14</td>
<td>No</td>
<td>psychogenic skin disorder</td>
<td></td>
</tr>
<tr>
<td>2. A.R.</td>
<td>4</td>
<td>No</td>
<td>neurasthenia</td>
<td></td>
</tr>
<tr>
<td>3. L.M.</td>
<td>56</td>
<td>Yes</td>
<td>nerves and exhaustion</td>
<td></td>
</tr>
<tr>
<td>4. C.T.</td>
<td>54</td>
<td>No</td>
<td>nervous stomach</td>
<td></td>
</tr>
<tr>
<td>5. A.S.</td>
<td>37</td>
<td>No</td>
<td>nervousness, headaches, blackout</td>
<td></td>
</tr>
<tr>
<td>6. L.G.</td>
<td>4</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Length of time in service is figured in months.
<table>
<thead>
<tr>
<th>Military Service</th>
<th>Rank of Company</th>
<th>Company</th>
<th>Section of Company</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company Warrant</td>
<td>A</td>
<td>A.H.</td>
<td>I</td>
</tr>
<tr>
<td>Company Warrant</td>
<td>A</td>
<td>B.L.</td>
<td>S</td>
</tr>
<tr>
<td>Company Warrant</td>
<td>X</td>
<td>D.L.</td>
<td>E</td>
</tr>
<tr>
<td>Company Warrant</td>
<td>X</td>
<td>C.L.</td>
<td>A</td>
</tr>
<tr>
<td>Company Warrant</td>
<td>X</td>
<td>E.A.</td>
<td>F</td>
</tr>
<tr>
<td>Company Warrant</td>
<td>X</td>
<td>F.L.</td>
<td>G</td>
</tr>
<tr>
<td>Company Warrant</td>
<td>X</td>
<td>J.L.</td>
<td>T</td>
</tr>
<tr>
<td>Company Warrant</td>
<td>X</td>
<td>I.A.</td>
<td>S</td>
</tr>
<tr>
<td>Company Warrant</td>
<td>X</td>
<td>V.A.</td>
<td>T</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Officer</th>
<th>Rank of Company</th>
<th>Company</th>
<th>Section of Company</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>A</td>
<td>A.</td>
<td>I</td>
</tr>
<tr>
<td>No</td>
<td>A</td>
<td>B.A.</td>
<td>S</td>
</tr>
<tr>
<td>No</td>
<td>X</td>
<td>D.L.</td>
<td>E</td>
</tr>
<tr>
<td>No</td>
<td>X</td>
<td>C.L.</td>
<td>A</td>
</tr>
<tr>
<td>No</td>
<td>X</td>
<td>E.A.</td>
<td>F</td>
</tr>
<tr>
<td>No</td>
<td>X</td>
<td>F.L.</td>
<td>G</td>
</tr>
<tr>
<td>No</td>
<td>X</td>
<td>J.L.</td>
<td>T</td>
</tr>
<tr>
<td>No</td>
<td>X</td>
<td>I.A.</td>
<td>S</td>
</tr>
<tr>
<td>No</td>
<td>X</td>
<td>V.A.</td>
<td>T</td>
</tr>
</tbody>
</table>
D. Post-Military Factors

In order to achieve a comprehensive understanding of the problems presented by the fifteen cases in this study, it was important to consider the significant post-military factors in relation to the military and pre-military factors. These include the attitude of the patient toward his veteran's status, the attitude of the family toward the patient's illness and the results of treatment.

Table 4, (p. 39) presents a numerical summary of these factors as they were found in the two groups. In regard to the patient's attitude toward his veteran's status, Group I was composed entirely of men who were bitter, resentful or blamed the service experience for their problems. Two-thirds of them showed considerable preoccupation with receiving compensation for their service in the armed forces, and none of them held positive attitudes toward their service experience. Group II, on the other hand, showed a very sharp contrast, in that only one case presented an attitude of resentment to military service. One other showed preoccupation with receiving compensation, while five cases displayed positive attitudes toward their experience. Although between the two groups there seems to be little difference in the general attitude toward society, they both have tended to lose contact and are still somewhat resentful. This is borne out by the fact that both groups are sick and feel they are not getting what they want.

The attitude of the families toward the patients' illnesses also showed a sharp contrast. All of the families in Group I demonstrated sympathy toward the patient in this respect, and they all accepted the
In order to derive a comprehensive understanding of the problems
presented by the different cases in this analysis, it was important to consider
the following points:

- The importance of the background information in relation to the problem
- The influence of the current situation on the outcome

Table 1: (p. 20)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>15</td>
</tr>
<tr>
<td>Abnormal</td>
<td>5</td>
</tr>
</tbody>
</table>

From these results, it is clear that the current situation is more
complex than initially anticipated. Further research is needed to
fully understand the implications of these findings.

Two-phase analysis of the current conditions revealed the need for
additional consideration in the next phase, and it is hoped that
this process will lead to a more comprehensive understanding.

In the future, it is recommended that additional research be
conducted to explore the potential implications of these findings.

The implications of these findings are significant and warrant
further investigation.

For further reading, please consult:

  understanding complex systems. John Wiley & Sons.


symptoms as illness for which the patient needs help. There were no evidences of intolerance of the patient's somatic complaints on the part of the families. In Group II, however, only one family gave evidence of sympathy or understanding, while the remaining five showed intolerance of the patient's complaints and almost a complete lack of insight. Typical attitudes expressed were that the patient was "a bum", "lazy", "ought to go back to work".

Treatment in all cases was psychotherapy, while in some few cases medication was given. In addition many of these men received social therapy by the social worker. This included various services, such as contacting employers and personnel men for the purpose of adjusting work programs and helping to create better understanding among employers in industry in the problem of returning these men to industry. Close contact by the social worker with the patient and his family helped to alleviate many of the difficulties arising out of social problems. The results of treatment were evaluated in terms of the patient's present adjustment. Factors considered were the increase or decrease of the somatic symptoms which the patient presented on admission to the clinic, and the extent to which he was thereby hampered or aided in his readjustment to society.

As can be seen in Table 4 (p. 39) six men in Group I are better, two are the same and one in worse. In Group II, two men are better, one is the same and three are worse.

The post-military factors, then, as seen in the two groups show rather definite significant trends. Group I is made up of men who are generally bitter toward their military service. Because of real problems caused by
military service; e.g., wounds or illness, interruption of education, etc. they felt resentful and expressed this through prolonged and concerted efforts at filing for disability compensation. As might be expected, then, there is little or no expression of positive feeling for the military experience. The attitude of their families is largely one of sympathy and acceptance of the symptoms as an illness, though in some cases there is little real insight. In some cases of this group there has been definite improvement, while in others there has been no change.

Group II, on the other hand, is made up of men who show, in general, no overt resentment toward their veteran's status. While their adjustment, on the whole has always been poor and inadequate, their best adjustment, in most cases, was made while in the service. They presented, in general, positive attitudes toward the military situation. Attitudes of their families toward the symptoms showed a definite intolerance, irritation and impatience. Insight was definitely lacking among them, and to some extent this was an important factor in the patients' attitude toward the clinic and therapy. Results of treatment in this group showed a definite improvement in some cases and a definite increase in pathology in others.
### TABLE 4

**POST MILITARY FACTORS**

<table>
<thead>
<tr>
<th>Factors</th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attitude of Patient Toward His Veteran’s Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resentful - Bitter</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Preoccupation with Receiving Compensation</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Positive Attitude to Service</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td><strong>Attitude of Family Toward Patient’s Illness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sympathy</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Accepts Symptoms as Illness</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Intolerant of Patient’s Complaints</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td><strong>Results of Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Better</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Same</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Worse</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

As was stated in the beginning, the fifteen cases were divided into three groups based on the relative degree of adjustment in the psychological, social, and medical aspects of the veteran. The psychological group was composed of those cases in which the veteran was exposed to stressful situations which were not able to be resolved. The social group consisted of those cases in which the veteran was exposed to stressful situations which were not able to be resolved, and the medical group was composed of those cases in which the veteran was exposed to stressful situations which were able to be resolved. The military group was composed of those cases in which the veteran was exposed to stressful situations which were able to be resolved, and the post-military group was composed of those cases in which the veteran was exposed to stressful situations which were able to be resolved.

As can be seen from the table, the military group was composed of the veterans who were exposed to stressful situations which were able to be resolved. The post-military group was composed of the veterans who were exposed to stressful situations which were able to be resolved, and the social group was composed of the veterans who were exposed to stressful situations which were able to be resolved.
<table>
<thead>
<tr>
<th>Group II</th>
<th>Group I</th>
<th>Report</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Attitude of Patient Toward His Vetner's Station</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Recently Better</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Progression with Receiving Compensation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Positive Attitude to Service</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Attitude of Family Toward Patient's Illness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improved with Symptom or Illness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improvement of Patient's Complication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Results of Treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Better</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Same</td>
</tr>
<tr>
<td></td>
<td></td>
<td>None</td>
</tr>
</tbody>
</table>
CHAPTER V

SUMMARY AND CONCLUSIONS

The evidence presented in the fifteen cases was analyzed and discussed from the point of view of 1) Social Factors, 2) General Personality Factors, 3) Military Factors and 4) Post-Military Factors.

It was found that for all of the patients the military experience was a stressful situation to which they reacted with pathological symptoms. As was stated in the beginning, the fifteen cases, upon investigation, showed differing degrees of adjustment in the social-dynamic area and on this basis were classified in Group I and II.

Group I on the whole revealed more stable, positive and healthier family backgrounds. Although there was definite family conflict, alcoholism, physical and nervous disease in some of these cases, there was at the same time someone in the family group who provided considerable stability, which prevented complete family disorganization. In most cases a dominant mother figure filled this role. Economic stress and histories of nervous and mental illness in other family members were less prevalent in this group, which seemed to indicate stronger feelings of security and fewer incidents of basic feelings of inferiority and inadequacy. Concomitantly, the educational and employment adjustment was higher in this group, as regards both achievement and adjustment to the social group.

Family background and early home environment in Group II showed marked inadequacy and instability. Incidence of nervous or mental illness characterized all of these cases. Broken homes and economic
CHAPTER V
SUMMARY AND CONCLUSIONS

The evidence presented in the thirteen cases more thoroughly and also
say from the point of view of (1) Social Factors, (2) General Economic
Factors, (3) Military Factors, and (4) Post-Military Factors.

If we turn back to our little table of the percentage the military experience
was a dominant attention to whom their interest with participation
sympathetic, as we seek to identify the primary, the little case, now
involvement, more than a minor gesture of importation to the social

In sum, these are not in the sense were adequately pointing and possibly
Group I on the whole revealing more specific pointing and possibly
family background, although there was greater family cohesion, it is not the
psychological or relationship of some of these cases, there was no

were the cases these someone in the family group who playing combination
studies, which have revealed some family communities, in more
economic areas and cases a common motive behind the little idea. More
Economic Areas, it can create a combination motive behind the little idea. More
instances of nation and society, more in other family members were
likely, and it may be that this group, who seems to indicate a combination

consequences. Consequently, the situation and organization of the
was likely to this group, we appear to develop and sometimes to

the social change.

Family background may explain some commonalities in Group II

Factors that may have some commonalities in Group II.
stress with its accompanying aspects of insecurity and demoralization were strong negative influences in most of this group. School and work adjustments were consistently poor. Instead of encouragement toward independence and emotional growth by their families, there was a strong element of overprotection and dependence among the men of Group II. This was not only a source of conflict in the home, but seemed to prevent the establishment and maintenance of adequate contacts outside the home. The objective level of the homes of this group were, on the whole, much lower than in Group I. With a poor social adjustment to begin with, then, the development of symptoms in Group II was partly expressive of this poor adjustment and these became still more severe when the additional strain of the military situation was placed upon them.

When interacting with society Group I seemed to adjust rather well. A more stable family background and an environment which provided more satisfactions contributed to produce better integrated personalities. It was significant, however, that when these men were removed from their accustomed environments into the stressful military situation, they tended to break down and develop symptoms. It is reasonable, then, to expect that the course of development of the personality is largely dependent upon these constitutional and early environmental factors. The general personality factors found in Group I were rather consistent with this point of view.

Compared with Group II they seemed to be definitely more outgoing, friendly, hardworking, ambitious, active, sociable and somewhat self-sufficient. There was a tendency toward rigidity and resentment of
I am not only a member of a large group, but a general of the department and a leader in the business community. Over the years, I have been involved in a number of community service projects and have always been active in helping others.

The question level of the group is quite high, and members are expected to perform well. With a board of directors and a director to perform with, I have been able to demonstrate my leadership skills and my ability to manage a large group.

When interacting with society, I have always been the leader in various organizations and have brought about many positive changes. For instance, I started a community center for children, and it has been a great success. I have also been involved in many other community projects, and I believe that I can continue to contribute to the community in the future.

This is my point of view, and I hope to continue to be an active participant in community service.
authority among them, however. Sexually they seemed to have made a more adequate adjustment. Although there was a considerable background history of physical ailments, there was a conspicuous absence of the strong emotional component. This seems further to indicate that their personalities were better adjusted or that the pre-military setting for these men was less conducive to psychosomatic disturbances.

Group II was made up almost entirely of inadequate, dependent and withdrawn, sensitive personality types. They were a passive insecure group who were, on the whole, more retarded and immature in their sexual adjustment. They showed a rather consistent history of physical ailments, either frequent or chronic, accompanied by considerable emotional reaction. In this regard, the higher incidence of nervous or mental illness among relatives of these men may be significant socio-dynamically, if not as a direct constitutional factor.

As was mentioned previously the military situation was, in effect, traumatic for both groups, though in distinctly different ways and for different reasons. Both groups went into the service with certain life experiences and personalities which interacted with certain factors inherent in the military situation. It is these factors and the meaning of these factors which sheds some light on the nature of the relative adjustment of the two groups.

Military factors of special significance in Group I seemed to be more objective reality factors. On the whole they spent longer periods of time in the service (an average of fifty-four months) and had more actual combat experience. Hospitalization and development of symptoms
speech was a common practice among the military personnel. Unfortunately, there were a couple of minor errors in the protocol of communication that caused some confusion. The term 'protocol' means a set of rules or procedures that guide the behavior of participants in the military setting. In some cases, military personnel were better educated on such protocols, making them more responsible and professional.

Group II was also tasked with studying the impact of communication errors. They were a passive audience. At the meeting, the group of three members were seated in a private room of the building. The audience listened to the presentation of the case study.

Attention to the details is critical in the military situation. It is not as simple as you think it is. The case study demonstrated the importance of attention to detail in the military situation. It is not as simple as you think it is. The case study demonstrated the importance of attention to detail in the military situation.

Military personnel of special assignments in Group I seemed to be more objective in their perception of the situation at first glance. However, the more they dug deeper into the situation, the more they came to realize the significance of their role in the chain of command. The personnel in Group II, who were responsible for developing and implementing new strategies, also recognized the importance of their role in the chain of command.
was primarily and almost entirely due to their experiences in service, with major factors being combat wounds and organic disease. Symptoms in this group were more clear-cut, definite psychosomatic symptoms. It may be noted, however, that Group II spent a relatively much shorter period in service, (an average of twenty-eight months) and there was only one case of actual combat service. Symptoms on the whole were vague, not related to any particular organ system, and there were numerous personality deviations.

Under even the best of circumstances military service, with its regimentation and restrictions, is a stress situation. It demands of the individual adaptability and flexibility in order to meet inevitable changes. From what is known of their early environment and personalities the men in Group I managed to adjust fairly well in their restricted settings, prior to entering the service. However, when removed and placed in the military situation they were unable, because of their rigidity and resentment of authority, to make the necessary adjustment, and broke down.

For the men in Group II, however, who had few assets to begin with, there was a different reaction. Because of their general passivity, dependence and generally poorer backgrounds, they found in the military situation certain subjective satisfactions in the way of freedom from responsibility and initiative. At the same time the military situation was objectively stressful for these men as well.

It is interesting to note that on the whole Group II, since discharge from service, has gone on to develop more severe personality
disturbances than Group I. This was to be expected, since it appears that the psychosomatic manifestations were sufficient perhaps to serve as an outlet until additional strain was superimposed by the service experience. It may seem paradoxical to say that in most cases the men in Group II made their best adjustment while in service. However, this is understandable in view of the fact that their ability to adjust back into civilian life was made more precarious by the subjective factors in the military situation.

The present adjustment, or post-military factors, in the two groups present some significant trends. Group I is made up almost entirely of men who express bitterness and resentment toward their military experience. They are the men who spend a great deal of time and energy in trying to secure compensation. They have in general, shown a definite decrease in symptoms. The attitude of their families toward their illnesses shows considerably more sympathy and understanding which is obviously an asset in this kind of problem.

Group II, on the other hand, shows actual psychosis in one case and strong suggestions of psychosis in two other cases. In general, the family attitude toward their illnesses is definitely intolerant. In those cases of Group II which have shown a definite increase in pathology there has been an inability to establish rapport between the doctor and the patient because the patients failed to return to the clinic.

The purpose of this study was to try to determine some of the social-psychological factors contributing to psychosomatic disturbances in the cases of fifteen veterans of World War II who were seen at the Worcester
Psychosomatic Clinic. The attempt was also made to point out the differences between those men who made rather good adjustments prior to military service, and whose symptoms appeared (or became exaggerated) during and after military service, as contrasted with those men whose adjustments were already poor prior to military service.

It is extremely difficult, if not impossible in a study of this kind, to establish any very definite conclusions. As was mentioned previously, the sample of cases is too small to permit any statistically valid findings or correlations. Furthermore, more complete data and analysis of other factors, such as psychological, physiological and clinical and their relationship to the social factors, must be made in order to reach definite conclusions. Certain areas for further study are also indicated. A group of ex-servicemen with similar family backgrounds who did not develop psychosomatic symptoms might be used as a control group. This would offer a more valid means of checking the findings of this study. It is felt, however, that from the preceding evidence certain conclusions can be reached which are within the limits of the scope of this thesis.

The outstanding points are as follows:

1. Certain constitutional predispositions, when combined with early socio-psychological factors, produced personalities which had a tendency to utilize somatic ailments as a means of adjusting to certain emotional situations.

2. Some of these persons, when functioning in a restricted setting, were able to adjust adequately, e.g., somatic symptoms were absent or
The complex we also wish to point out the difficulty of assembling some of the fragments of the photograph, such as the one showing the model of the building. The model itself was taken with a high-speed camera, which allowed for a detailed examination of the structure. However, due to the nature of the material, it was not possible to capture all the details in a single shot. Consequently, we had to piece together various fragments to create a comprehensive picture of the model. The process was laborious and required a high level of technical expertise. Despite the challenges, we believe that the end result is a valuable contribution to our understanding of the building's design and function.
were mildly present, but not incapacitating. But when faced with stress situations, such as those encountered in military life, the personalities tended to retreat into somatic dysfunction.

3. Others of this type, with more negative constitutional and early socio-psychological factors, developed poorly to begin with. The normal stresses of military life followed by their return to an unsatisfying civilian status only served further to incapacitate them, even to the extent of precipitating a psychotic condition.

In the course of this study certain factors have emerged as important to successful organization and functioning of a psychosomatic clinic. To reemphasize a point made earlier, a clinic of this type would be most effective when affiliated with a general hospital, rather than a mental hospital or a regular psychiatric clinic. This would make available the much needed services of other outpatient clinics, such as medical, cardiac, dental, surgical, orthopedic, genito-urinary, etc., for referral and consultive purposes. In addition, much of the stigma, disgrace and failure associated with emotional disturbances would thereby be diminished, resulting perhaps, in healthier, more objective attitudes. The importance of increasing the services of such a clinic also become apparent. Ideally, it should be a daily clinic with a full time social casework staff and, if possible, a full time medical staff to meet the increasing community need. The importance of continued cooperation with other social agencies and industry is also indicated. These problems will be with us for many years. By increasing services for immediate problems and at the same time developing a preventive educational program in the community, it is hoped
In the course of this study certain factors have emerged as important

To emphasize the point made earlier, a table of data was used to illustrate the relationship between psychological factors and a number of variables involved in the psychological testing of a group of workers. The table included information on the extent of participation in recreational activities and the social life of the group, and on the amount of time spent in various activities. The importance of knowing the nature and extent of such activities is evident, and

It is believed that a study of similar nature should be conducted to determine the importance of sex in the development of personality. The importance of the nature of the tests used in the study is also evident. The study of personality is an important aspect of social and psychological research.

An additional factor that has been considered in the study is the influence of the community on the development of personality. The study has shown that the community has a significant influence on the development of personality. The findings of the study have been presented in the form of a report, and are available for further analysis.
that the principles of mental hygiene will penetrate and enrich lives of the future.

Approved,

[Signature]

Richard K. Conant, Dean
of the physical and mental anguish with which he is subjected. For each case of
BIBLIOGRAPHY


BIBLIOGRAPHY


In "System, Forms, and Society: Some Social-Psychological Studies of a Mental Health Clinic,"


APPENDIX A

APPENDIX

1. Sources of Information

A. Name, address, relationship, how interviewed (letter, questionnaire, personal interview).

B. Length and intimacy of acquaintance with patient

C. Evaluation of reliability and adequacy of information

II. Circumstances Leading to Referral

A. Course of present illness in detail

B. In what way has this caused patient to become a social problem

III. Family History

(Give in as complete detail as possible)

A. Names, addresses, if living, cause of death

B. Occurrence of cancer, tuberculosis, diabetes, of mental and neurological illness

APPENDIX

C. Details of social-economic background (get as much specific identifying data as possible re: age, marital position, education, occupation, etc.)

1. Paternal Relatives

   a. Parents
   b. Siblings

2. Maternal Relatives

   a. Parents
   b. Siblings

3. Parents

   a. Father: complete description of early life, occupation, marriages, and relations with patient and other members of family; health and personality
APPENDIX A

Social History

I. Sources of Information

A. Name; address; relationship, how interviewed (letter, questionnaire, personal interview).

B. Length and intimacy of acquaintance with patient

C. Evaluation of reliability and adequacy of information

II. Circumstances Leading to Referral

A. Onset of present illness in detail

B. In what way has this caused patient to become a social problem

III. Family History

(Give in as complete detail as possible:)

A. Names, addresses if living, causes of death

B. Occurrence of cancer, tuberculosis, diabetes; of mental and neurological illness

C. Details of social-economic background (get as much specific identifying data as possible re: age, ordinal position, education, occupation, etc.)

1. Paternal Relatives
   a. Parents
   b. Siblings

2. Maternal Relatives
   a. Parents
   b. Siblings

3. Parents
   a. Father: complete description of early life, occupation, marriage, and relations with patient and other members of family; health and personality
A.

B.

C.

D.

E.

F.

G.

H.

I.

J.

K.

L.

M.

N.

O.

P.

Q.

R.

S.

T.

U.

V.

W.

X.

Y.

Z.
b. **Mother:** same as above

**Siblings:** complete information, especially relations with patient; note also sibling deaths and their effect on patient

4. **Wife (Wives):** Complete and detailed information

5. General statement of family's cultural and social background and position in community

### IV. **Personal History**

#### A. Prenatal and birth: Mother's health, psychological status and family circumstances during her pregnancy; delivery

#### B. Infancy and Pre-School Period

1. **Developmental:** age of weaning, walking, talking, toilet training, etc. and reaction to these

2. **Medical history**

3. **Unusual or significant emotional experiences**

4. **Relationship with parents and siblings**

5. **Early personality**

#### C. Education

1. **Academic record:** school reports, etc.

2. **Special interests, abilities, weaknesses; how reacted to success and failure**

3. **Relationship with teachers, other pupils**

4. **Participation in school activities and extracurricular activities**

5. **Personality as evaluated by schoolmates and teachers**

#### D. Religion

1. **Church and denomination**

2. **Interested more in religious aspects or in social aspects**

3. **Relation to minister and his evaluation of patient**

#### E. Employment

1. **When first began to work (summer work)**

2. **Jobs specifically held (dates, wages, kind of work)**

3. **Relationship to employer, fellow-workers**

4. **Attitudes toward his work (specific and general)**

   a. How he reacts to success and failure

   b. **Interest**

   c. **Attitude of sex norms of group: prurish, promiscuous, abnormal**
F. Emigration and Settlement

1. Dates, place from which emigrated
2. Particular emphasis on ease of readjustment from old group to new one
   a. Old attitudes and customs retained
   b. Attitude toward new customs, mores, etc.
3. How related to concept of "marginality"; was this period prolonged?

G. Enlistment

1. Date of enlistment and discharge; company, position, reason for discharge, compensation
2. Attitude toward military situation; toward war
   a. consistent with previous attitudes or source of conflict

H. Delinquencies and Court Record

1. Record of offenses, penalties, etc.
2. Evaluation of apparent causes of these conflicts with the authorities
3. Relation of difficulties to home, school, community

I. Adjustment to Significant Individuals and Groups from Childhood to Onset of Present Illness

1. Childhood
   a. Playmates: kind, number, relation to them.
   b. Many friends, a few close friends, a "lone wolf"
   c. Preference for siblings or outside playmates

2. Relationship with family
   a. Protected, babied; encouraged to be independent; given responsibilities and duties from an early age
   b. How did he accept role as defined by family
   c. Specific relationship with father, mother, siblings, others in home.

3. Relationship to: (a descriptive analysis by social worker, not repetitive, factual information)
   a. School groups
   b. Employment groups
   c. Church groups
   d. Social groups
   e. Political, community groups

4. Relationship to opposite sex
   a. History of sexual development
   b. Attitude of sex mores of group—prudish, promiscuous, abnormal
An examination of the text on the page reveals a list of items, possibly related to a research or survey. The text is partially legible, with some words and phrases obscured. Here is a transcription of the visible text:

1. Date of employment and present employment position
2. Duration of present position
3. Relation of difficulties to present or school community

C. Other information
1. Difficulty of current job, family, or health
2. Previous work experience and difficulties in the workplace
3. Other factors affecting employment

D. Referral forms
1. Referral for medical attention
2. Referral for counseling
3. Referral for vocational guidance

**Note:** The text is fragmented and the full context is not clear. The content suggests a focus on employment and personal difficulties, possibly in the context of a larger study or report.
5. Marital adjustment
   a. Date of marriage (s); name of spouse; separated, divorced, deserted, dead
   b. Full description of patient's role in his marital family group
      1). Attitude toward children
      2). Attitude toward spouse
      3). Definition of their roles in family group
   c. Attitude toward parental family group as related to the marital one
   d. Sexual adjustment - general attitude toward sexual relationships

6. General description of personality
   a. As a child, adolescent, adult
   b. Note any changes in personality and discover any changes in social situation that might have influenced these

7. Recreation interests and activities
   a. Active: sports, clubs, etc.
   b. Literary, artistic, musical

V. Present Maladjustment
   A. Relationship between patient and his various groups now as contrasted with the time before present illness was developed
   B. Evaluation of patient in relation to these groups with an attempt to find leads of importance in readjusting him when he finishes treatment

VI. Future Plans for Patient
   A. Plan proposed by staff
   B. Resources of family and community to carry out this plan with assistance of social worker