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An analysis of the pre-war, military and post-war adjustment of fifty World War II veterans with a diagnosis of service connected psychosis

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AN ANALYSIS OF THE PRE-WAR, MILITARY AND POST-WAR
ADJUSTMENT OF FIFTY WORLD WAR II VETERANS
WITH A DIAGNOSIS OF SERVICE CONNECTED PSYCHOSIS

A Thesis

Submitted by

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Chapter I
INTRODUCTION

PURPOSE

The purpose of this study is to evaluate the pre-war, service, and post-war adjustments of fifty World War II veterans who were diagnosed as psychotic, either in the service or shortly thereafter. Through such a study certain findings may evolve such as: 1) Were there factors in the early adjustment of all these men which would indicate that a serious breakdown would result by placing these men under the severe strain of being war-time soldiers? 2) Were severe combat conditions the proximate cause of all or most of these men becoming psychotic? 3) Does a return to the pre-war environment after discharge from service and the return of the nation to peace, result in a marked improvement in these veterans?

The Social Service Case Folders, the Medical Records, and the Claim Folders of the Boston Regional Office of the Veterans Administration were available to the author for this study. The author gratefully acknowledges the cooperation of Theodore H. Karam, Chief Social Worker of the Boston Regional Office, Veterans Administration, for his assistance in making available the records mentioned above.

METHOD

The following method of procedure was established by the author:

1. He reviewed the Social Service Master cards for the years 1948 and 1949 of World War II veterans and selected the cards on which was noted a service connected psychosis. Social Service records were used rather than some other Veterans Administration Unit records such as Contact to insure that there would be complete and up-to-date adjustment histories. It might be noted here that the Social Service Master card is a five by eight inch card made out on each veteran at the time of referral to Social Service. On the card is noted identifying data such as name, address, claim number, diagnosis, percentage of disability, and the reason for the referral. Of the three hundred veterans with a diagnosis of a psychosis, all were excluded who were given this diagnosis shortly after entering the service. Only veterans with overseas service were selected. No effort was made to exclude officers, but by chance none were finally included in this study.

2. After the fifty cases were selected, the author then set up a schedule designed to gather data concerning the pre-war, service, and post-war adjustment of these men. This schedule was patterned after the anamnesis outline as used in many psychiatric clinics.

3. The chapters of this thesis are set up so that Chapter II is devoted to a review of present-day thinking in

psychiatry as related to this study. Chapter III demonstrates in chart form the pre-war, service, and post-war adjustment of the veterans under study. Chapter IV includes case histories which demonstrate the three points raised as questions in the "Purpose." Chapter V is a summary.

SCOPE

This study includes all veterans known to Social Service of the Boston Regional Office of the Veterans Administration who were in the armed forces during World War II and who were diagnosed as psychotic, either in the service or shortly thereafter. While the study is intended to include both officers and enlisted men, the final selection of fifty cases found only enlisted men in the group. This may be due to the fact that there were far less officers in the service than enlisted men.

Chapter II

REVIEW OF THE GENERIC ASPECTS OF SCHIZOPHRENIA AND MANIC DEPRESSIVE PSYCHOSIS

In this chapter the author will present first the viewpoints of authorities on Schizophrenia and Manic Depressive Psychosis in their broader aspects and then as these disorders pertain to the soldier.

While there are many types of psychoses, the author will restrict himself to a consideration of the two mentioned above because only these appeared as diagnoses in the cases selected for study.

If, as is increasingly believed by psychiatrists, schizophrenia represents a special type of personality disorganization, a maladapted way of life manifested by one grappling unsuccessfully with environmental stresses and internal difficulties, its causes are to be found in the basic personality of the individual and the limits of his adaptive power, in the experiences which life has brought him and in the mental mechanisms and patterns of reaction by which he has attempted to deal with his special problems - faulty methods which constitute the symptoms of the disorder... One will therefore seek to formulate the clinical picture of schizophrenia in terms of the familiar problems and forces of human life rather than those of an impersonal disease entity.¹

We find that the majority of people who become ill with schizophrenia have been unable to meet the ordinary challenges of life. This indicates a failure to mature. This lack of

1 Arthur P. Noyes, M.D. - Modern Clinical Psychiatry - p.434

maturity becomes obvious during adolescence and continuing through the period when men are expected to adapt themselves to gainful pursuits.

Malzberg finds that the maximum among males is between the ages of 20 to 24.¹

The following gives a picture of the importance of this disease in the United States:

Schizophrenia is one of the most frequent forms of the major psychosis, constituting from 15 to 20 per cent of the first admissions to public hospitals for mental diseases.²

The New York Annual Report for 1941 states that 40.1 per cent of all readmissions for that year were dementia praecox.³

Psychiatry today states that there are four different types of schizophrenia. The psychiatrists feel that these types are but different steps of one illness. These types are:

1. Simple Type.
2. Hebephrenic Type.
3. Catatonic Type.
4. Paranoid Type.

The Simple Type is usually slow in manifesting itself and the main symptoms are a personality change, a change in emotional demonstrations which are childlike and inappropriate.

1 Leopold Bellak, M.D. - Dementia Praecox, p. 68.

2 Arthur P. Noyes, M.D. - Modern Clinical Psychiatry, p. 435

3 Leopold Bellak, M.D. - Dementia Praecox, p. 10.

There is a lack of appreciation of the niceties of life, and no sense of responsibility. The patient frequently is silly and inane and is unable to direct his attention toward the completion of even a slight complex task. While there are usually no delusions or hallucinations, the patient may be observed talking and laughing to himself.

The Hebephrenic Type is the least well defined of these groups and is frequently used as a diagnosis when the patient's symptoms are not sufficiently clear cut to place him in one of the other groups. Hallucinations are common, phantasy and fragmentary delusions as opposed to systematized delusions are present. The patient may be incoherent and silly, regressive features are prominent. He is introverted and hard to reach. Depression is the first noticeable symptom.

The Catatonic Type frequently is acute in onset and strikes the 15 to 25 age group most severely. There are phases of stupor or elation which alternate. Sometimes one phase may remain throughout a catatonic episode. In the catatonic stupor there is first a depression and then the patient becomes increasingly less talkative and is inattentive, pre-occupied and lacks emotional content. His gaze may be fixed and staring. He is extremely negativistic and may on the one hand attempt to retain his urine and bowel movements and on the other hand soil himself and be very unclean in his ways of excretion.

Meger considers that catatonia is a psychological reaction. Hohman quotes him as describing it as closely related to what is seen in hypnotic states and in mystical fancies... When the problems of life are too great we naturally seek death but are deterred from suicide by the instinct of self-preservation. Many psychiatrists, therefore, look upon catatonic stupor as a profound regression, a dramatization of death. Kirby suggests that it represents an attitude of defense. Others look upon it as a self-exclusion from the world.¹

The Paranoid Type is marked by delusions with complete disregard for reality. There may be hallucinations and the typical schizophrenic pattern of lack of affect, negativism, and unreal conduct.

Paranoid reaction characterizes the greater proportion of situational psychotic breakdowns occurring on the field of battle. The soldier begins to view his comrades with suspicion. Perhaps they are spies. Then he becomes convinced that certain of the officers or men are in league with the enemy. As the process accelerates, the paranoid ideas become more personal. His food, never too good in the front lines, is poisoned. He is being sent on especially dangerous missions by an officer who is anxious to get rid of him. One sees all degrees of this type of reaction, from the mildly suspicious to the actively combative individual who views everyone without distinction as an enemy and has therefore to be kept under continual restraint. Although in such cases there may appear some fear of the individuals involved in the supposed persecution, the principal reaction is one of hostility or rage.²

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- 1 Arthur P. Noyes, M.D. - Modern Clinical Psychiatry, p. 459.
 - 2 Roy R. Grinker, M.C. and John R. Spiegel, M.D., WAR Neuroses, p. 44.

The Manic Depressive Psychoses has two clear-cut phases, the excited phase and the depressive phase. There is no constant sequence or alternation in these reactions. In the manic state the patient is gay, extravagant and boastful. He is self-assured and talks freely. He hates routine. He does not concentrate well. If his wishes are not granted he becomes angry and abusive. The mood changes quickly. Pressure does not produce fatigue and rest is not sought.

While most people stricken with this disorder have both manic and depressed phases, many have only the depressive type. There are varying degrees of depression ranging from feeling blue to complete morose dejection. The patient is downhearted and lacks confidence. No undertaking is assumed lightly but rather is looked upon as a heavy burden. He avoids people and is sad. His conversation is spotty and he speaks low and frequently does not complete a sentence. He is usually suspicious and has strong guilt feelings.

Heredity seems to have a strong predisposing influence in the manic-depressive psychoses yet we know very little as to the processes through which it acts. Rudin has stated that the incidence of manic-depressive psychoses is twenty-five times as high among the siblings of manic-depressive patients as in the average population. Luxemburger alleges that there is a probability for the development of the disorder in 32 per cent of the children of manic-depressive patients.¹

¹ Arthur P. Noyes, M.D. - Modern Clinical Psychiatry, p. 396.

Far less people suffer from Manic Depressive psychosis than from schizophrenia. Leading groups of first admissions to New York Civil State hospitals per 100,000 general population, 1943, shows 22.3 for schizophrenia and 4.4 for Manic Depressive.¹ Out of the fifty veterans studied in this thesis, only three had a diagnosis of Manic Depressive.

If the veterans had not been placed in the position of being soldiers serving overseas in war-time would they have escaped from reality and developed a psychosis? A definite yes or no answer could not be given with certitude in each particular case. However, these men developed these disorders at a particular time in their lives and they did have imprinted in their makeups the stamp of their heredity and environment. The authorities have very definite statements regarding these factors.

The etiology of schizophrenia is unsettled, its pathology unknown, and its clinical limits in dispute; and yet it is a more serious problem than either tuberculosis or carcinoma. There are twice as many hospital cases of schizophrenia as of tuberculosis. Each year not less than thirty thousand individuals, soon after adolescence or in the first flush of manhood or womanhood, fall victims of this condition. Annually seventy-five thousand new patients are admitted to state hospitals and at least one fourth are schizophrenics.²

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- 1 State of New York Fifty-fifth Annual Report of the Department of Mental Hygiene, Albany, N.Y., 1944, p. 164.
 - 2 Edward Strecher, M.D. and Franklin Erbaugh, M.D., Practical Clinical Psychiatry, p. 379.

The age group of our veterans falls in the category of "the first flush of manhood" as stated above.

Malzberg after studying the influence of economic factors on mental health comes to the following conclusions. There is a marked difference in rates of mental diseases between groups in the very low rates of mental diseases between groups in the very low occupational brackets and those in the higher groups. Unskilled workers, one of the lowest economic groups, have the highest rate of mental disease. Social and physical selection have some influence on this rate, as do age, nativity, race, etc. The only general conclusion to which one can come is that socio-economic factors have some positive relationship to the incidence of mental disease.¹

We shall see in Chapter III how the findings in this thesis coincide with the above.

The authorities have formed some definite opinions on the relationship of war and all that it implies to the development of mental conditions among veterans.

As far as the authors have been able to ascertain, there are few studies concerned with the family background of schizophrenia as such. Malamud and Malamud studied the background of 33 patients who had schizophrenic episodes while serving in the armed forces. Their study was focused mainly around screening potential schizophrenics from the services. The material was obtained from many sources; social agencies, army and hospital records, communication and contact with relatives, and the patients themselves. Malamud and Malamud concluded, conservatively, that "certain types of conditioning factors seem to render adjustment to military life particularly precarious...thus we frequently

1 Leopold Bellak, M.D. - Dementia Praecox, p. 12

find represented such factors as disorganized or broken homes, suppression or overprotection, strong emotional attitudes to parents either of extreme affection and dependence or of hostility and high standards of achievement forced upon the patient by his family.¹

Craigie reports on his two years' experience in the Middle East. A strikingly large percentage of the total number of psychiatric cases arising in the Middle East Forces during this period showed evidence of severe psychopathic traits in the previous history. These psychopathic traits were not of an abstruse character, nor based upon any controversial psychopathological theory, but were of a fairly obvious and easily recognizable type, which would have been evident in the careful taking of any case history. In many cases (over 20 per cent) there was a history of serious nervous breakdowns in civil life, some patients had previously been patients in mental defective colonies, or in mental hospitals; and in many more there was evidence of a bad previous record dating from childhood and adolescence. This group of patients reacts badly to overseas service or to the prospects of service in a forward area. Many develop a psychiatric breakdown on the voyage, having to be admitted to the hospital on disembarkation and may often have to be returned home without seeing any service at all (thirty-six cases of this type were admitted direct from convoys to one psychiatric center alone in the second quarter of 1943.) A very much larger percentage break within a few weeks or months of arrival at an overseas station. It is perhaps important to remember that these cases are obvious, not only to the psychiatrist, but to the officers - they are often of the last resort type, sent to him when all the efforts of the company commanders as unit medical officers have proved unsuccessful. It is clear that the efficiency of any

1 Donald L. Gerard, M.D. and Joseph Seigel, M.D., The Family Background of Schizophrenia, the Psychiatric Quarterly, vol. 24, 1950, No. 1, p. 47.

expeditionary force must suffer if it includes large numbers of officers and men who, by virtue of their previous histories are likely to develop a psychiatric breakdown. -- Finally, Craigie states that perhaps half of the work of psychiatrists in the Middle East Force would have been eliminated if a better selection procedure had been established earlier.¹

To date the authorities have not published any material on the post-war adjustment of veterans who became psychotic in the service. Only five years have elapsed since the end of World War II and it is too early to draw definite conclusions as to the manner in which these veterans will adapt to society and overcome their illness. The findings of the author relative to the post-war adjustment of the fifty veterans under study must be evaluated in the light of this time interval. It may be that the next five years will result in adjustments quite dissimilar to those put forth in this study.

1 Harry C. Solomon and Paul J. Yahovler, Manual of Military Neuropsychiatry, p. 659 - 660.

Chapter III

PRE-WAR, SERVICE, AND POST-WAR ADJUSTMENT OF
 FIFTY VETERANS WITH A DIAGNOSIS OF
 SCHIZOPHRENIA AND MANIC DEPRESSIVE PSYCHOSIS

A. Pre-War Adjustment

The pre-war adjustment of the veterans under study is considered from these various aspects: heredity, infancy, early development, school record, legal record, sex record, and work record.

TABLE I

HEREDITY

Psychotic	Neurotic	Alcoholic	Psychotic and Alcoholic	Neurotic & Alcoholic
4	17	9	1	7

The above table pertains to the parents of the veterans under study. Thirty-eight of the veterans had parents who fell into the above categories. Twelve had parents who were free of these illnesses.

TABLE II

INFANCY

Training Difficulties	Temper Tantrums	Thumb Sucking
10	3	5

In addition to training difficulties, temper tantrums, and thumb sucking, traumatic injuries at birth were also considered. There were no cases in this category. Of the 18 veterans noted in Table II, all but one had parents who were included in Table I. It is doubtful if the figures in Table I show a true picture. It is difficult to obtain the truth surrounding this part of a person's life. Siblings are frequently unable to give accurate information and parents have difficulty remembering such things about a particular child. Parents also tend to shield any deviation from the normal. It is quite possible that more intensive study would reveal weakness in these categories in a larger number of these veterans.

TABLE III
DEVELOPMENT

<u>Section 1</u>						<u>Section 2</u>
Poor Eco- nomic Condi- tions	Over Indul- gence	Quar- reling	Soli- tary	Broken Home	Nomad- ian	Neurotic Traits
8	5	6	20	7	2	44

In Section 1 of Table III we find that forty-six of the fifty veterans studied are included in the categories listed.

In Section 2, we find that forty-four of the veterans studied suffered from neurotic traits other than those listed in Section 1. These traits include such disorders as enuresis, nail biting, phobias (dark, storms, etc.), stuttering, exces-

sive blinking, irritability, etc.

Only one of the fifty veterans studied is not included in either of the above two sections of Table III.

TABLE IV
SCHOOL RECORD

	Grades 1-4	5-6	7-8	Years 1-3	4	1-3	4
Grammar	1	2	13				
High				17	12		
College						4	1

All the veterans studied are literate. None was classified in the Army Classification Test below the grade of dull normal.

For the grammar school years these veterans have approximately the same record as set forth in the Sixteenth Census of the United States; 1940, Population, VII Part III, Table 13, Massachusetts for males in Massachusetts. The veterans in this study made a slightly poorer showing in their High School attainments and a far poorer showing in their college attainments than did males in Massachusetts as set forth in the above mentioned document.

The Legal Record of our veterans shows that eight had histories of arrests. None was arrested for crimes such as armed robbery, rape, etc. The arrests were for misdemeanors such as petty larceny, and minor incidents of property destruction.

Of these eight men, two were nomads, two came from broken homes, three were solitary and one was over-indulged in his childhood. All showed evidence of neurotic traits in the pre-school period.

TABLE V
SEX RECORD

Negative	Promiscuous	Retardation	Homosexuality	Single	Married	Divorced
28	6	15	1	44	5	1

The term negative in Table V means that the veteran did not manifest symptoms or express fears, doubts, or feelings of inadequacy concerning sexual problems. The men in this category enjoyed both the company of men and women, they had several dates, and in general made what might be called a normal adjustment in their sex life.

Six of these men were promiscuous, having had numerous sexual experiences with many different partners. All of them indulged in some homosexuality, but these practices were infrequent and not actively sought after.

Fifteen preferred to remain by themselves during their adolescence and early manhood. They manifested no desire to court young ladies and seldom if ever went to a dance.

One veteran was a homosexual.

The marital status of these fifty men is more or less what one would expect for this period in their lives. Prior to

World War II, the vast majority of these men were too young to marry according to American standards. Thus we find that forty-four were single, five were married, and one was divorced.

TABLE VI
WORK RECORD

Steady Employment	Irregular Work	School
13	33	4

As Table VI indicates, the vast majority of the veterans under study had irregular work histories. By irregular work we mean that there were long periods of unemployment followed by brief periods of employment. Of the men in this group, none worked longer than five and one half months at a particular job. Ninety per cent of these thirty-three men held more than three jobs. The reason which most frequently occurred for a man leaving a job was that he had difficulty in getting along with his employer. It is interesting to note that every veteran that had a legal record fell into the classification of irregular employment.

The author considered a man to be steadily employed if he held a job for six months or if he left one job and went directly to another. Men who had only been out of school for a few months prior to entering the service and were gainfully

employed during this interval were considered as steadily employed.

The most significant findings of the pre-war adjustment of these fifty veterans are: 1) Seventy-six per cent of the veterans under study had parents who were mentally ill; 2) Ninety-eight per cent of these veterans suffered neurotic traits or were underprivileged or were the products of broken homes; 3) Sixty-six per cent had poor work records prior to service.

These statistics indicate that these veterans were poorly equipped to face the ordinary problems of everyday life much less the burdens placed upon a soldier in war time.

They did not know love and security in their childhood and early manhood. Since lack of security is the forerunner of fear and since fear is the basic element in any escape from reality, it is readily seen that these men were disposed to mental illness prior to the war. They have the backgrounds which the authorities state are commonly found in the schizophrenic patient.

B. Service Adjustment

The tables in this part of Chapter III will show when these men entered the service, i.e., the date in relation to the progress of the war; the length of time each spent in uniform; the rank attained; the number who were subjected to military punishment; the number that suffered physical injury in combat; the number who developed a psychosis in combat as

opposed to non-combat; their acceptance of military discipline; and the manner in which they were discharged from the service.

TABLE VII
INDUCTION DATE

Year	1940	1941	1942	1943	1944	1945
Number	1	6	25	14	3	1

The vast majority, seventy-eight per cent, entered the service during 1942 and 1943. During these years the outlook regarding the war was at its bleakest point. Many thought that England and Africa would fall. The Japanese were surging ahead and they were well established in the Aleutian Islands. Authorities were predicting a ten-year war. The news during these two years gave every indication that a long bloody battle had to be fought in which the number of soldiers killed would be exceedingly high. One did not have to be in the service at all to be fearful for his safety. Many fully expected the United States to be bombed. The veterans under study, insecure as they already were in their own personal adjustment, were confronted with the newspaper reports and with the added anxieties of being uprooted from their home settings and the adjustments they had made. Each step of the way from Pearl Harbor to the arrival in the combat zone was filled with ever-mounting fear. Only four of our veterans entered the service

after a certain amount of stability in the war situation had been realized. None of these veterans was "an old army man."

TABLE VIII
ACTIVE DUTY YEARS

Years	$1\frac{1}{2}$	2	$2\frac{1}{2}$	3	4
Number	2	26	6	9	7

It has previously been stated that all veterans who were diagnosed as psychotic and who had been in the service only a short period of time were excluded from this study because it is evident that such veterans slipped by the draft boards even though they were psychotic. After such a screening process, it is to be expected that one and a half years is the minimum time that any of our veterans under study spent in the service. Twenty-eight were able to stand the rigors of service life for two years or less. Thirty-four out of fifty reached the breaking point by the end of two and one half years. Sixteen had sufficient reserves to endure three or more years of war service.

Six out of the seven men who served for four years entered the service prior to the declaration of war. All of these men entered the service because they could not find suitable employment and it appears that they found some element of security in the service. They had voluntarily entered the service and were not drafted. As a result they had a healthier

attitude toward a military life than did those forced into it.

Of the nine who served three years, all entered prior to the declaration of war or very shortly thereafter.

Although all fifty of the veterans under study had overseas service, the total number that were in actual combat amounted to eleven. The remainder were in the combat zone or the Communication Zone. While those in actual combat underwent the greatest strain, those subjected to airplane bombings and buzz bombings knew what close proximity to death meant. This factor, fear of death, undoubtedly contributed toward the actual breakdown in the mental health of these men.

TABLE IX
HIGHEST RANK ATTAINED

Pvt.	Seaman P.F.C.	S/2 CL Corporal	Sergeant	Staff Sergeant
27	9	6	5	3

Fifty-four per cent of the veterans under study did not advance beyond the lowest rank.

Twenty-eight per cent were non-commissioned officers. The highest rank attained was Staff Sergeant and while this is a relatively high enlisted grade, there are two higher ranks.

Prior to service, relatively few of these veterans had court records. This pattern of behavior did not change in the service. None of these fifty men was court martialed.

Only four received Company Punishment under Article of War 107. One went AWOL for which he was not punished. From the case histories, we find that several performed acts or neglected to perform acts which under ordinary circumstances would have resulted in severe punishment. Due to their mental condition at the time these soldiers were not punished.

TABLE X
PHYSICAL INJURY - MENTAL BREAKDOWN

	Physical Injury	Mental Breakdown
Combat	1	11
Non-Combat	3	36
Post-War		3

It is believed by many that the mentally ill veteran became sick as the result of long and arduous combat or because of a head injury. None of the veterans under study received any head injuries. Only eleven were in combat and all these men broke down while in combat. Thirty-six veterans, while never in combat, became psychotic while in the combat zone or the Communication Zone. Three men did not break down until after they were discharged. None of the physical injuries noted above contributed greatly to the mental breakdown of the individual concerned.

TABLE XI
ATTITUDE TOWARD MILITARY LIFE

Acceptance of Military Discipline	20
Resentment Toward Military Discipline	30

Table XI seems to indicate that twenty veterans liked the service while thirty hated it. Actually, none of these men liked military life. Twenty accepted it as something to be endured and did not continually complain about conditions and against their superiors. In the histories it is difficult to find evidence of enjoyment of any aspect of the service by any of these men.

The thirty who resented the discipline of the service were chronic complainers and when performing their duties, did so in a manner that would demonstrate in no uncertain way their dislike for things military.

It is interesting to compare the figures of this table with those in Table IX. In Table IX we find that a total of twenty-three men received a promotion while twenty-seven were never promoted. In Table XI we find that twenty accepted the discipline of the service while thirty resented it.

TABLE XII
TYPE OF DISCHARGE

Certified Disability Discharge	47
Convenience of the Government	3

There are many different ways of being discharged from military service, such as Termination of Enlistment, Bad Conduct, Dishonorable Discharge, Section VIII, etc.

The majority of veterans of World War II received the type of discharge known as "Convenience of the Government." This means that the war was over and the government had no further use for their services. Three of the fifty veterans fell into this category. The remaining forty-seven men were given "Certified Disability Discharges" because of their psychotic conditions at the time of discharge.

The tables in part B of this chapter clearly indicate that these veterans made a relatively poor adjustment in the service.

C. Post-War Adjustment

Over five years have elapsed since these men were diagnosed as psychotics. They have been discharged from the service and practically all have been discharged from hospitals. While five years may not be sufficient time to tell whether or not these men have made their best adjustments, a review of these years will show the trends.

We shall first study their social adjustments, the manner in which they mingled with their neighbors and participated in the social activities of their communities. Then we will examine their relationships with their parents, siblings and wives. Following this, we shall review their employment records and then chart their specific diagnoses, and the improvement which has been made in relation to the purely mental

aspects.

TABLE XIII
SOCIAL ADJUSTMENTS

Enjoys social contacts and activities	6
Shuns social contacts and activities	44

In the pre-war adjustment we found that twenty men manifested solitary symptoms. We now find that there are forty-four of these veterans who shun social contacts and activities. This is retrogression. The fact that forty-four out of fifty are solitary is extremely important for it is quite difficult to imagine anyone who is withdrawn making an adequate adjustment. Being solitary and lonely has a depressing effect on the total personality, and unless this condition improves, it appears that the other symptoms will become worse. Five years of peace and the return to pre-war environment has not brought solace.

TABLE XIV
FAMILY ADJUSTMENT

	Good	Fair	Poor
<u>Single = 37</u>			
Adjustment with parents and siblings	0	13	24
<u>Married = 9</u>			
Adjustment with wives	3	0	3
Separated	3		
<u>Divorced = 4</u>			

Prior to service five men were married and one was divorced. Five years after service we find that nine are married and four are divorced. Of the married men, three are separated from their wives.

Of the thirteen men who married, three are separated, four divorced, and of the six who are living with their wives three have a poor marital adjustment. Of the three who have good relationships with their wives, we find that one was recently married, the second is extremely passive and dependent and the wife enjoys this type of husband, and the third gets along well with his wife because she is extremely sympathetic and understanding.

Thirty-seven out of fifty have remained single. None of this group has good relationships with his parents or siblings. Thirteen have made fair adjustments with members of the family constellation. Twenty-four find it extremely difficult, and in some cases impossible, to get along with their parents or siblings.

TABLE XV
EMPLOYMENT RECORD

Steady Employment	2
Irregular Employment	24
Unemployed	22
School	2

The term steady employment means that the veteran had remained on a job for at least six months and upon leaving one job started another relatively soon.

Irregular employment means that up to the time of this study the veteran held more than two jobs for brief periods and between jobs there have been long periods of unemployment. Unemployed means that the veteran has not worked at all since discharge or if he did work, it was for a period of less than three months.

Two men are steadily employed. Two are in school and we cannot predict their work adjustments. The remaining forty-six men have not been able to assume the responsibilities of gainful work.

Prior to service thirteen were steadily employed, thirty-three had irregular work histories and four were in school. None was classified as unemployed.

It is quite evident that a marked personality change has occurred in these veterans since they entered service.

We find from the individual histories that the reasons for unemployment or irregular employment vary from case to case. There are certain overall patterns. The entire group might be divided into three categories. First, those who are hospitalized and cannot work. Second, those who are in the community but are not well enough to perform tasks more complicated than feeding themselves, clothing themselves, and taking walks. These men are out of touch with reality. Third,

those whose symptoms are in remission. This group is in the majority at the time of this study. These men have little confidence in their own abilities and subconsciously they seem to think that honest effort will meet with no success. They live in the shadow of the acute phase of their illness. They are convinced that the entire community knows of their hospitalization and regards them as insane men. If they try to work and experience a setback, they are prone to look upon this one effort as all that is required and any further attempt would be a waste. They look upon a job as a test and while on it they keep testing themselves in various ways until they find a failing point. When this is found they quit.

Some attempt self employment in order to avoid coping with the community. The ventures they undertake soon become boring when they lose the first appeal of an adventure.

The two veterans who are steadily employed are working for members of their families. Their families report that they put up with a great deal in order to help these veterans develop a sense of responsibility.

TABLE XVI
DIAGNOSIS

Manic Depressive	3
<hr/>	
Dementia Praecox	
Simple Schizophrenia	5
Schizophrenia Unclassified	7
Catatonic	14
Hebephrenic	5
Paranoid	16
<hr/>	
<u>Improvement</u>	
<hr/>	
Limited Improvement	16
<hr/>	
No Improvement	29
<hr/>	
Retrogression	5
<hr/>	

Forty-seven out of the fifty veterans studied were diagnosed as schizophrenics. Three were diagnosed as manic depressives. This is about the proportion as set forth by the authorities in Chapter II.

The term "limited improvement" means that the veteran is not subjected to unreal experiences and he is oriented in all spheres.

The term "no improvement" means that the veteran has not become symptom free and while he is able to get along to some degree in the community, very little can be expected of him.

The term "retrogression" means that the patient's symptoms have become progressively worse.

Chapter IV
CASE ILLUSTRATIONS

In the case studies it will be the purpose to evaluate (1) the family, school, and work adjustment of the pre-war history as possible contributory determinants to the psychosis; (2) the impact of combat or overseas duty as a proximate cause or an aggravation of pre-existing conditions to the psychosis; (3) the overall adjustment at home during the post-war period.

CASE NO. 1

Anthony R.

Twenty-eight year old, white, American born, Roman Catholic, who is separated from his wife. His parents were born in Poland. He was a Private in the Army for two and a half years with overseas and brief combat experience.

The past history reveals that he always has been nervous, emotionally unstable, and easily upset. In childhood he was abused by the father who was a chronic alcoholic and extremely neurotic. His mother was seclusive and suspicious. There is one older sibling, a brother of thirty-four who is neurotic but he has made a better adjustment than the veteran.

In school Veteran had difficulty learning. At age sixteen he left the sixth grade. Subsequently he worked as a laborer for various small companies. He couldn't get along with people, would get tense after a time and leave. He worked in a factory for eight months before he was inducted into the Army. Shortly after induction he married an employee of the factory where he had worked.

In the Army he made a marginal adjustment because of his seclusive tendencies and his slowness in learning. However, he had no major difficulties until he went into combat. Then he developed sensitivity to noise, became horrified of killing, and finally, following an explosion of gasoline in which he received burns on the left leg, had to be hospitalized in a state of excitement and confusion.

He was returned to this country with a diagnosis of schizophrenia, catatonic. After a few months in a Veterans Administration Hospital in 1945, he returned home because his psychotic symptoms had subsided.

His marriage has been in a turmoil. There is one two-year old child. There have been cultural and religious conflicts. While he had been going through various psychotic phases his wife became more exasperated and generally frustrated. Whenever the wife suggested that he obtain psychiatric treatment, he accused her of trying to rehospitalize him. He smashed doors and yelled and screamed at various times. Often he sat for several hours with his arms under his limbs. He sometimes repeats the same silly statements over and over again to his wife.

The mother, who also has exhibited occasional psychotic behavior, has fostered and aroused the Veteran's suspicions of his wife. In the presence of his mother he is very suggestible. The mother persuaded the Veteran to sleep downstairs in her apartment. Finally he moved into the mother's apartment. Until the wife's lawyer intervened, the Veteran had refused to pay the wife's grocery bills.

His employer, a relative, has been very helpful and extremely liberal with the Veteran. Undoubtedly the Veteran now would be unemployed and probably committed to a hospital had the company been less understanding. A few months after he returned to work in the factory, he threatened to kill the company official and several fellow employees. After the Veteran was given several months sick leave he was rehired as an assistant groundskeeper. He works by himself taking care of the grounds. Whenever he does not feel well or is upset he can leave work. Moreover he has taken several extensive periods of sick leave in the last few years. He still is unable to associate with the employees or do factory work.

Several times rehospitalization has been recommended. When the Veteran called into the Veterans Administration for compensation he was told this. However, the Veteran is terrified that he will have to return to a closed ward in a hospital. He steadfastly has turned down these hospitalization recommendations. When the Veteran was referred to the Social Service Section he finally accepted a plan to obtain treatment with a psychiatrist located in his home city.

The significant points in the family background were an abusive, alcoholic, neurotic father and a mother with pre-psychotic symptoms.

Responding to rejection and instability of the parents, the Veteran was emotionally unstable, easily upset, asocial, and unable to adjust well in school and work.

Although the Veteran manifested asocial behavior from the time of induction into the Army, he managed to function at a satisfactory level in training. However, the Veteran broke down shortly after he was subject to the stress of combat.

His psychotic symptoms abated during hospitalization after combat, but he again developed hallucinations and delusions after he returned home to his wife and family.

He was unable to accept his role as husband and father. In less than a year he went back to live with his severely disturbed mother.

CASE NO. 2

Thomas L.

Twenty-eight year old, white, American born, single male who was two and a half years in the Army with the rank of Private.

His father was a quiet, moody individual who drank rather heavily at times. When the Veteran was ten years old, the father was drowned at sea while pursuing his trade as fisherman.

His mother was a friendly, easily excitable, talkative, quick-moving little woman. Although he was the fifth oldest of ten children, he was "a mother's boy who was more or less tied to his mother's apron strings." The mother died due to heart trouble two years ago and shortly after this the Veteran was rehospitalized.

Veteran always was rather quiet, sociable, and well liked. He was conscientious and thoughtful, particularly of his mother. She felt that he never was cross or irritable.

He went to the seventh grade in school. He never cared

for school. As soon as he went to work he helped support the family. For three years he was a lumper on the fish wharves. He adjusted rather well within the family, especially with the mother, but he had few outside friends or interests.

During his first two years as a military policeman, he seemed to enjoy Army life. Six months after he was sent to the Southwest Pacific area, he began to cry and wanted to return home. During hospitalization he became periodically restless, withdrawn, and preoccupied. Following his return to an Army hospital in the United States, he later was transferred to a Veterans Administration Hospital. After several months hospitalization, there was a general improvement and he returned to his mother's home.

For a short time he was interested in going back to work. Although he was interviewed for several jobs he was not able to respond logically to the prospective employers.

He began staying in the house spending much of his time staring into space. No interest was shown in the opposite sex. During the day he drank beer quite frequently. He would stare at people and start laughing suddenly as if he heard voices. One day at home he pricked himself several times with a knife in the region of the heart. Subsequently he was re-hospitalized.

Important familial factors in this case included the inadequacy and loss of the father coupled with an overprotective, neurotic mother.

Early developmental years were marked by reserveness and a satisfactory social adjustment only within the family group.

Although able to adapt to state-side service the schizoid personality became apparent a relatively short time after service overseas.

Anticipated return to the home environment was a factor in the diminution of the mental illness. An unsuccessful, superficial effort to attain vocational rehabilitation subsequently stimulated an exacerbation of the mental symptoms. The death

of the mother, the only person with whom the Veteran had a close relationship, makes the prognosis guarded.

CASE NO. 3

Earl S.

Twenty-five year old, white, American born, Unitarian, single, male, was two years in the Navy attaining the rank of seaman second-class.

Veteran was the second youngest of four children. After the death of his mother in a mental hospital, the stepmother tried hard to reach the Veteran but she was rather oversolicitous. His father, who owns a contracting business, was not very interested in the family. As the father had very little understanding for the children, he generally disregarded them. The oldest sibling, a sister, had a tendency to dominate and be critical of the younger children, especially the Veteran.

Veteran enjoyed group activities but he was reticent and submissive to the wishes of the other members of the family. His lack of security increased when the father was impatient and irritable during Veteran's adolescence. After graduation from High School, he was an elevator operator and later a gasoline station attendant. Although he occasionally dated girls, he generally was reserved and somewhat indifferent to them.

During the first year in the Navy he accepted his superiors and fellow shipmates in a generally submissive manner in keeping with his personality. After a few months in a combat zone he showed definite paranoid symptoms. He became hostile and aggressive. He developed persecutory and sexual delusions.

When hospitalized his diagnosis was schizophrenia, paranoid. There was marked suspicion, withdrawal, and retardation. Insight and judgement were limited. During a good part of his hospitalization he was indolent and asocial.

After nine months hospitalization he went on trial visit to a married brother's home rather than return to the family home. He has had a limited recovery. As his suspicions, resentment, and aggression diminished, he again became withdrawn and easily dominated by his brother and sister-in-law. He works in the brother's electrical supply store but he has dizzy spells and occasionally stays home "to help out around the house."

There were several important factors in the family background. The mother's death was a traumatic experience for the Veteran. He was fearful of the oversolicitous step-mother. The other members of the family, especially the oldest sibling, were very aggressive towards the Veteran. The father was first indifferent and later completely rejected the Veteran.

Consequently the Veteran developed a reticent, submissive personality. The personality inadequacy gave way to paranoid, aggressive trends after two years service and slight stress in a combat zone.

Following hospitalization and partial remission of psychotic symptoms, the Veteran has made a limited adjustment. However, he is markedly retiring and subject to somatic complaints.

CASE NO. 4

Charles L.

Thirty-three year old, white, American born, Methodist, single, male was a Private First Class in the Army with two and a half years of service.

He was the youngest in a family of five girls and three boys. The father was a quiet, hard-working carpenter. During the Veteran's childhood the father was afflicted with cancer. Although the father continued to work, his health gradually deteriorated. The family income was low but the older siblings went to work in their teens to help out. The mother was a rather high strung, very active, dominating woman. The sister and oldest brother have made fairly good adjustments. The second brother, a few years older than the Veteran, is single and neurotic. The mother, and especially the sister, who were much older than the Veteran, overindulged the Veteran. He was especially dependent upon the mother.

The father became irritable and indifferent to his children as a result of his chronic illness. During the Veteran's

adolescence, the father died.

During early childhood Veteran was quick tempered and eneuretic until the age of six. He often had fights with his brother who was four years older than the Veteran.

He graduated from high school where he played several sports. Although he was active in several social organizations, he had no close friends. He was inclined to be hasty in his judgment. He enthusiastically pursued an activity for a time, but he would soon loose interest and quickly find some other undertaking. When he was rebuffed in some activity he easily became discouraged and hostile. At this time he was admitted to a State Hospital for a ten-day period of observation.

After he left school he worked as a carpenter with his oldest brother but he stayed only a few months. For a while he was an electrician's helper. At the time he went into the Army he was a machine operator in a cotton mill. He never developed a real interest in any type of work.

In the Army he adapted to routine and training fairly well. However he went on sick call several times because he felt "all in" and subject to pains in his arms and legs. When he felt ill he had "blue," moody periods. At Guadalcanal he did quite well in combat. When the unit moved to the Fiji Islands he first became overactive and foolish. Later he blocked completely and had to be prodded for information. After he was hospitalized, he thought he had a tumor on the brain. Finally he stated that he lost all hopes of returning home when his unit was transferred to the Fiji Islands. During hospitalization he spoke of taking poison. At times he was very depressed, apathetic and retarded. The diagnosis was manic depressive, depressed. Following eleven months' hospitalization in a Veterans Administration Hospital, he was placed on trial visit with him family. He still becomes very depressed and apathetic. Occasionally he has become very restless and assaultive. The mother and the sisters give the Veteran love and affection, but there is a tendency on the part of the family to cater to the Veteran. He sometimes gets very angry when his supper is not immediately served at the time he wants it. When he becomes depressed he sometimes will not eat for two days. Although he has expressed a desire to work, he has been restless or unable to concentrate each time he attempted to work around the house. Much of the time he spends walking great distances or watching the children play sports.

Again it is noted that the childhood period was extremely insecure due to home conditions. As the authorities point out,

this type of background provides fertile ground for mental breakdowns. Veteran had sufficient reserves to carry him through his initial combat campaign, but when this trying experience terminated his reserves were not sufficient to sustain him further and he broke. Previous pre-war hospitalization in a mental institution indicated, as the authorities point out, that he was a poor risk for service in the armed forces.

Chapter V

CONCLUSION

In the opening chapter, the author stated that the purpose of this study was to evaluate the pre-war, service, and post-war adjustment of fifty World War II veterans who were diagnosed as psychotic (schizophrenia manic-depressive) in the service or shortly thereafter. Through this study it was hoped that findings might result concerning: 1) the possibility of factors being present in the early adjustment of these men which would indicate that they might break down if placed in a wartime army; 2) the relationship between the actual breakdown and combat condition; 3) the improvement of these veterans after the stress of war had ended and they had been returned to the security of their homes.

Concerning the first point we have found that there were factors in the pre-war adjustment of these veterans which would indicate that they were emotionally unstable and possessed those negative factors set forth by the authorities as predisposing elements of psychosis in general. The statistics set forth in the tables pertaining to this period in their lives shows overwhelming evidence that these men did not have the advantages of what we consider as the normal home. Table No. 1 showed that the majority of the parents were mentally sick. Each succeeding table in this section clearly indicates

the inability of these men to cope with the ordinary problems of life. The neurotic traits they possessed indicated a flight from reality. The case histories set forth in Chapter IV vividly portray the weakness in the family structure. These are the weaknesses that Pollock, Malzburg, Fuller, Lidy, Noyes and numerous other psychiatrists write about more or less as *conditio sine qua non* of schizophrenia and manic-depressive psychoses. These men were not prepared for the burdens that are placed on soldiers. These are the men that Dr. Solomon and Yokovkv refer to when they say, "Experience in the last war (World War II) demonstrated that neuropsychiatric casualties were an important problem, especially in the expeditionary forces. It was found also that in a large percentage of these casualties, neuro-psychiatric symptoms had been present for many years before these men had been inducted into the service."¹

The statistics set forth in Section B of Chapter III demonstrate that the service adjustment of these fifty veterans was a continuation of the same inadequate pre-war adjustment. It was in the service and after they had experienced overseas life that all but three of these men became mentally ill. The well known insecurities and strains of army life in an overseas

¹ Harry C. Solomon, M.D. and Paul I. Yokovkv, M.D., Manual of Military Neuropsychiatry, W. B. Saunders Company, Philadelphia, 1944, p. 19.

station burdened these poorly equipped men beyond their limits of endurance and they fled the world of reality. As shown in Table X, it was the day by day worries and anxieties as experienced in the service that caused the majority of these men to become mentally ill. Combat per se was not the proximate cause for the breakdowns since most of the men were never in combat.

Concerning the post-war adjustment of these veterans, we find that once the illness has developed, a removal of the immediate causes does not produce a marked improvement either in the number or severity of the symptoms. While these veterans made a minimal adjustment prior to service, we find that following service their ability to perform has markedly deteriorated as the case histories typifying the average of these men indicates and as the statistics for all point out, they are unable to get along with their families and their friends. They cannot assume the responsibilities of a job. The major undertakings which they have attempted, such as marriage, have met with failure. They are withdrawn and in general manifest the schizoid traits of being shy, retiring, easily embarrassed, prone to fantasies, lacking aggressive qualities and emotional maturity.

That these men have not been able to adjust well up to this time does not mean that the future is without hope. Only five years have passed since these men became ill and when we consider that the seeds of the illness were planted many, many

years prior to their service in the armed forces and that these seeds took such a long time to reach their full growth it is only reasonable to assume that the process of getting well cannot be accomplished in a brief time.

We must further limit the findings of this study by pointing out again that the authorities have not published material on the post-war adjustment of psychotic veterans.

We know that these veterans are eligible for excellent care and treatment in Veterans Administration Hospitals and Out-Patient Clinics. They are served by well trained Psychiatric Social Workers who strive to aid them and their families with the numerous problems confronting a person who returns to his home after a period of hospitalization in a mental hospital. The professional staff of the Veterans Administration Hospitals and Clinics are following their progress with keen interest and they will continue to make available to these veterans the resources of their institutions and the results of their research so that they might overcome their mental disabilities and live useful, satisfying lives.

Approved



Richard K. Conant
Dean

SCHEDULE

See the three charts following this page.

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