The Persistence of the Individual Life Pattern in War Psychoses

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Our mental hospitals are rapidly filling with military casualties, many of them diagnosed as psychotic. If effective case work or psychotherapy can be of real value to these patients, what are some of the techniques available which make it possible for the psychiatric worker to help the patient toward at least a partial solution of his problem? Before presenting cases and undertaking to meet this question, certain background facts of a more general nature must be taken into consideration.

The exact nature of psychosis as distinguished from psychoneurosis has never been understood. That there is a distinction other than that of degree is an opinion now rather generally accepted in psychiatry. There would seem to be some predisposing factor, some constitutional inferiority, possibly of biochemical origin, which causes an individual to express his maladjustment in psychotic rather than neurotic form.[1]

But even if one accepts this view of the etiology of psychosis, we have said little in terms of the reality of therapy. We are seeing in our military and government hospitals today any number of cases in which the psychotic episode has been precipitated by the patient's experience of a new environment. In a few of these cases there is a history of previous similar attacks. In some cases the organic basis of the disease is comparatively easily established, as, for example, in paresis, epilepsy, Little's disease and postencephalitic conditions. But even in the case of such obviously physiologically conditioned cases of mental illness the fact remains that serious symptoms suddenly appear or, at least, assume larger proportions at that moment when the patient is confronted with a new and apparently overwhelming problem. This, of course, is true not only when the organic basis of the psychosis is clear but also in other psychoses, and in psychoneuroses as well. In a war situation the precipitating factors may stand out with a somewhat more apparent clarity, the more so when a patient has seen actual combat duty. As a matter of fact, however, the perils of, say, a boot training camp are almost equally obvious. Here we find cases of first separation from a mother or wife, acting as maternal surrogate; of new contacts with impersonal discipline; of first experiences growing out of newly found freedom. Here an individual has perhaps for the first time become conscious of wishes and desires hitherto suppressed because of a personal code or a cultural taboo.

We could take the next step back, as it were, and point out that it is a self-evident fact that mental symptoms may be precipitated without benefit of military service. Each individual seems to have a threshold of

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endurance in terms of what he himself experiences. But a man experiences his present in terms of his past and, in order even to approach an understanding of his present problem, his past must be understood in terms of what it has meant to him. Again we stress the experiencial factor, that factor which is purely subjective and quite individual. In the last analysis, there is no such thing as group experience.

In *The Science of Living*[2], as in many other writings, Alfred Adler has stressed the fact that, during the first years of life, when the personality which embodies the fictive goal of an individual is established, the individual becomes definitely oriented. From then on he perceives situations according to a personal scheme of apperception, known as the "style of life." Various stimuli induce only such specific behavior as is consistent with this dynamic pattern. "Whatever stimulates, stimulates only to save and fix a style of life."

Each case then must be studied in the light of its own psychogenesis. This is not to lose sight of the physiological factors which may or may not have been established as either etiological or contributing. This is simply to focus the spotlight of our attention upon one aspect of a case and in so doing to clarify the existing interrelationships which make up the whole individual.

The term *psychogenesis* is convenient but possibly misleading in that it is subject to misunderstanding. It is used here to cover such factors as are not of a somatic, morphological or biochemical nature, but are loosely covered by the term "psychological." Nevertheless, even academically and surely therapeutically speaking, there can be no sharp line of demarcation since we are studying experience and an individual can experience only with, through and in his body. In this connection it may be said that, while specialization is necessarily a limitation of function, it need not and should not connote a limitation of viewpoint.

In presenting these cases we may be indicating that actually there is no such thing as a war psychosis as such, although our two young men, in active service, saw no actual combat duty. The war situation, however, constituted a precipitating factor, and certain symptoms, interfering with the daily routine, necessitated hospitalization.

The psychiatric literature which followed World War I includes Dr. McCurdy's *War Neuroses*[3] in which this author attempts to distinguish between those neuroses "immediately determined by the conditions of modern warfare and (having) a symptomatology whose content is directly related to war" from those which "are determined by factors which are essentially those of civilian life." The first case cited had "never shown any neurotic tendencies . . . The only abnormality . . . . was a certain shyness with the other sex." Another was described as "more virtuous than his companions," shy with girls and seclusive, a third as of "high strung, nervous disposition" previous to enlistment, and so on throughout the cases mentioned. Whether such individuals

were "normal" prior to their military service is, at least, open to question.

Hoffman and Duval, in their interesting article on dementia praecox in military and civil life,* have also implied that there is such a thing as war psychosis which differs from psychosis observed in other situations. This, however, is perhaps only to say that, in time of war, young people come into certain more or less rigid dangerous situations, with which they ordinarily would not have to contend.

Our first illustrative case is that of a twenty-one year old sailor. Henry Dope was the only son of his parents, who were divorced when he was seven years old. His alcoholic father left the home when he was under three, and Henry said that he scarcely remembered him. Some two years after the divorce, the father was killed in an automobile accident, and a year later his mother remarried. At this time the patient was ten years old. He thought his mother and stepfather lived together as man and wife before they married. His stepfather, a "gangster-like man" of southern European origin, wounded in World War I, had a chronic illness and needed much nursing. He was an irritable person and boxed Henry's ears often. Henry was afraid of his stepfather but he says that he admired him because he went ahead and did things such as building a home and auto cabins that could be rented. Though only a little boy, Henry remembers that he helped him build. "He did things and I was only a tramp. I was no good." His stepfather died when Henry was sixteen years old.

He started school at the age of six and moved several times until his mother and stepfather finally arrived in a city where the climate was considered good for Mr. Tonelli's health. Henry says that he never liked school, that he was afraid when he first went, that the big buildings scared him. When he was in the third grade, he "got bad", chewed gum in school, talked when he was not supposed to, and did various things to annoy the teacher. Finally the teacher beat him with a ruler. The other kids, he said, tried not to cry, but he screamed just as loudly as he could, hoping that the people outside would hear him. Questioned, he said that his idea was not to call for help, but simply to let people know that he was being mistreated.

From that time on he grew progressively more seclusive and withdrawn, hating the teachers and failing frequently. Despite this fact, he went on to high school, entering at the age of fifteen, and made a fair adjustment. It was stated by one of his teachers that during his senior year in high school he seemed to have a marked personality change, becoming "cantankerous, argumentative, and antagonistic." She stated that she was amazed at the change in the boy. Formerly well mannered, he now showed no respect for her and, on occasion, would defy her in front of the class. At first, she said, she undertook to "straighten him out" but after two attempts to talk with him she let the matter go because, as she put it, she was actually "in awe of him." She feared that if she made

any further effort to change him, he would become violent. While formerly he had been a "respectful and refined boy," he suddenly seemed to become "wrathful and irritable."

This senior year in school was marked by frequent absences, during which the boy stayed in the woods or drove around by himself. He had a car, and he informed the worker that in it he would drive to the top of a lonely hill, turn on the radio, and just think. On certain occasions he studied geometry, in which he was much interested for a short time. Then he would sleep in the car all night, returning to his mother early in the morning. In his interview with the physician, he often referred to his love of peace, quiet, and solitude. Concerning his activities prior to entering the Navy he once said, "I would drive out in the country, always by myself, and find a little brook. Then I would lie on the ground and enjoy the quiet. Pretty soon I'd go to sleep and not get home until late. Oh, it was wonderful!"

His mother seemed to have little knowledge and less understanding of his problems. She knew only that he enlisted in the Navy the month following graduation. She claims he read avidly, books that were far too advanced for his age. She noticed that he had few friends, so she bought him a car, a telescope, a saxaphone and books to keep him occupied. She said that he had always been "highly nervous" and that he had frequently complained of stomach pains after eating fried or acid foods. For many years she had not been able to give him the various kinds of food which she felt were necessary for his health, and he was always undernourished and thin for his height. The patient had measles, mumps, whooping cough and pneumonia. He had night terrors and walked in his sleep until he was twelve years old, had always bitten his nails and had "feelings of weakness." He had scarlet fever while in high school, but Mrs. Tonelli could not remember any particular after effects.

He took his stepfather's name in high school, although sometimes it is said he went under the name of Greene, his mother's maiden name. Apparently, only in the Navy, having had to present a birth certificate, did he go under his legal name of Dope. In this connection, it is interesting to note that, when the Red Cross case worker first met this patient, she understood that a family name such as his would be likely to lay him open to ridicule, not knowing that he had taken his stepfather's name for most of the school period. To her question as to whether his schoolmates had ever called him a nickname which he did not like, he answered, "Nobody ever knew me well enough to call me a nickname."

He had his boot training in California and described it to one doctor as "horrible. I slept every spare minute." After about eight weeks he was sent to a college for four months of electrical training. He said he was more friendly with his colleagues at that time than at any other time in his life, but he did not like the work. He felt awkward with his hands, and that made it difficult. Nevertheless, he studied only about two days

a week and got through his examinations. Once on board ship, he says he became extremely fearful. "The other boys would talk together about how we might be hit or what could happen. I couldn't talk about it. Maybe it would have been better if I had. He described the unpleasantness of the ship's vibration, of the ring of metal, of the noise of the guns. He claimed he was too weak to work, and while on board, seemed to wander about in a fog. He could not sleep, lost his appetite, began to think water was pouring in the hatch and port holes. His loss of strength was finally so marked that he could hardly walk and was admitted to sick bay.

There, at first, he was vague, indifferent, and admitted hearing voices. On admission to St. Elizabeth's Hospital, he was detached, indefinite, smiled and laughed inappropriately, and showed defective judgment and insight. Physical and neurological examinations were essentially negative. He was seen to be a medium-sized, slim, fairly well-developed, young man, with wavy brown hair, and numerous small partially healed acneform lesions on his face. His appearance of delicacy and manner of moving inclined one to describe him as feminine in appearance. At an early examination, there was a fine adolescent stubble on his face which he claimed represented about three months' growth. His eyes were close-set under a high brow, his upper lip long, the lower short and full. His appearance was always clean, but rather careless and untidy. The diagnosis was schizophrenia—type undetermined.

This young man was seen by the Red Cross case worker several times during his four months' hospitalization. At the first interview, he showed a marked lack of ambition. The usual desire to get in a better ward and eventually to have ground parole seemed to be almost entirely lacking. He constantly referred to his "weakness." At one of the later interviews, when he mentioned the fact that the hospital had helped him to recover, he said, "They let me sleep for two months." As a matter of fact, this was not quite true, in that he was asked to do many little jobs on the ward and did them willingly, showed good cooperation, but never attempted anything of his own initiative. He took no interest in ward activities and, as a matter of fact, spent the greater part of the day in sleeping.

During one interview, it was suggested to the patient that he had always been an ambitious boy. He seemed a little surprised at this, but agreed that he had always wanted "to be tops" and was never satisfied with anything less than absolute perfection. He seemed to accept the worker's evaluation of him as an intelligent person. It was pointed out that the Navy had selected him for special training, despite the fact that he did not always get the best marks in his class. It was at this point that the patient happily told of his short-lived interest in geometry. The worker suggested that perhaps he escaped his problems by needing sleep, or "feeling weak," that perhaps he feared that, even if he remained alert and worked very hard, he might not be perfect. The necessity for work in our

culture was discussed, even if such work did not lead to the finest accomplishment or the highest salary.

As the discussion progressed, the worker asked the patient what he thought was the basis of our culture, and he said that he thought it was the home. She agreed that it was the home and the family. The patient then added that his father had been an alcoholic. The worker's suggestion that probably his father had been a very unhappy man and her explanation of how she reached this conclusion seemed to interest the patient greatly, and he said, "I never thought of it that way before." It was then suggested that probably the patient had felt rejected as a little child. In agreeing, he did not mention his father, but said that he never felt his mother cared for him very much. When it was suggested that the mother, although not rich, had seen him through high school and given him many expensive gifts, he agreed, but minimized her efforts by stating that she rented out the cabins his stepfather had left her and this brought an income. At a later interview, the question of the boy's attitude toward his mother again came up when plans for future work were being made. There was a possibility that he might get a job and contribute to the home. His reply to this was that his mother's needs had never been great; she had no interest in clothes nor did she eat much, and he did not believe she would have much use for additional income. He expressed himself as willing, however, to pay her enough, if he were earning, to reimburse her for his food and any expenses she might incur for him.

To a question put to him, "What would you do if you were not so weak?" he paused for a long time and then said, "I would not like to be a laborer." It was agreed that probably common labor was not for him. He paused again and then said, "I might want to go to college." The subject was not pursued at this time, but some three months later it came up in the discussion again. The patient asked questions about working one's way through college, wanted to know how many hours a day students studied and seemed appalled by the amount of work which would probably be required of him. At this point he was able to grasp the idea that perhaps college for him meant a negation of work, just as sleeping and "weakness" had, and was able to face reality to some extent in that he thought he might be interested in going to a vocational guidance bureau in order that his abilities might be tested and he be placed in a position where his capabilities could be used to best advantage.

In addition to the recollection, cited above, of helping his stepfather to build cabins, the patient remembered pushing a little iron cart about when he was two or three years old. We recall here his dislike of manual training, and this early recollection again points to a certain difficulty in motor coordination. We also begin to realize that probably the electrical training in the Navy constituted a greater strain on him than he knew. He also recalled that once he had a very long string which he wanted to unravel and that he spread it on the floor from chair to chair

until he came to the end of it. Again we have the impression of motor difficulty, of groping physically. May there not also be here some hint of the confusion which probably exists in a truly schizoid personality? On several occasions when the patient folded his hands, the left thumb was on top, a manifestation which Adler has cited as an indication of sinistrality. He said that he had never eaten with his left hand but did remember mending a bicycle and doing a great part of the work with his left hand with some ease. In answer to his question at this point, he was told that he was probably ambidexterous, and the meaning of the term was explained to him. He thought that this might be possible and said that he had had great difficulty in learning to type in high school. He also saw the need for keeping neat columns in bookkeeping as a great obstacle. At this point he was told that, although it might take him some time to accomplish these things, he could learn to use his hands and perhaps be above average, if he could only stick to the training period long enough. Doubtless in addition to other problems, we are here dealing with a partially reeducated sinistral.

Of the first day of school, he said, "I can always remember that it seemed very far away from home. It was twelve blocks away." Then he interpreted, saying, "I had not wanted to go, of course." At this point the difficulty that most children have in making a school adjustment was discussed; it was pointed out that it was particularly hard for an only child and that the emotion felt at the beginning of school often remained with a child until the end of his school career. He then repeated the recollection of yelling out loud in the third grade and when the worker recalled it, seemed pleased, saying, "You remember that much about me?" When the worker assured him that she did and that she was most interested in his problems, he proceeded to produce some dream material. He had had falling dreams all his life and, as he grew older, he dreamed that he fell out of airplanes. He also had read many fairy tales, and gold had always seemed better to him than money. He used to dream that he was in a room with piles of gold and, after waking from this dream, had a great feeling of loss and disappointment.

More material is available, but there is doubtless sufficient indication here that the actual trauma experienced on shipboard was merely a last and possibly the least factor in this case. This boy was a product of a broken home. In a recent study, 47% of a group of naval cases in St. Elizabeth's Hospital were found to be children of broken homes.[5] The father in this case was alcoholic and mistreated the mother. One can only surmise with what mixed feelings of affection and rejection the mother regarded the child of this union. Certainly the boy felt himself unloved and inferior at the time of her remarriage. There is nothing in our rather meagre history which accounts for the personality change which became apparent when he was eighteen. As far as we know this patient had had neither hetero- nor homosexual experiences. What he felt about the teach-

er toward whom his actions changed is not, unfortunately, a part of the record. But that this only child had always had difficulty in making social contacts, is not to be doubted. It affected his occupational as well as his social life; it interfered with his solution of his sexual problem. The conditions brought about by his military service simply enhanced his difficulties. Now he was forced into close contact with his fellow human beings. He no longer had the time or the opportunity to flee into the mountains in his car and he was forced to escape in the only way left to him—forgetfulness, a haze of thought and sleep.

The actual prognosis in this case is, of course, not known, since the events here described are of recent occurrence, but certainly the patient seemed to benefit from his hospital experience. Almost immediately on his return home he wrote to his Red Cross case worker. The letter was slightly humorous and gay in tone. It is interesting to note that, stepping out of the train at a wayside station, he almost missed it. Quite evidently he returned to his mother with mixed feelings. If adequate vocational guidance were given and he could at least have the satisfaction of being self-supporting and possibly of even helping his mother a little in a financial way, it might be that another psychotic episode could be avoided or at least delayed. Certainly, for anything like complete rehabilitation, further psychiatric guidance would be indicated here.

Our second case, Harry Fass, aged twenty-three, was the youngest boy and the seventh of nine children. His father was dead and his two oldest sisters married and out of the home before he joined the Navy. The parents had been emigrants from a middle European country and his mother spoke very little English. It was reported that during the menopause, about nine years ago, the mother suffered from a "nervous breakdown." From a medical standpoint his birth and early development were essentially negative. Never very interested in school, he left after completing the eighth grade. He himself stated that he began to masturbate at age fourteen and had his first heterosexual experience at twenty. He made a shifting occupational adjustment, sometimes as a clerk and sometimes as a factory worker, and enlisted in the Navy only because he feared he was about to be drafted into the Army.

Financially the family conditions had always been something less than marginal. The father, dying when the patient was seven years old, left them in dire straits. Inadequately fed, his older sister reported that he was always sensitive about his poor clothing and feared that people were commenting on it. When the boys made remarks, he fought them. According to this same older sister, he, being the youngest son, was his mother's favorite child; but apparently the boy never realized this fact as she was rather undemonstrative. He disliked his jobs and, on coming home, had attacks of nervous indigestion. Always afraid of the dark, he was teased by his older brothers who would tell him stories to increase his

fears, until the small boy was quite beside himself. All the children in the family were terrified by the violent quarrels between the parents.

He drank only in moderation. He was always quiet and retiring and made friends with difficulty. The sister said, "He thinks people don't like him. He has an inferiority complex." He had his first and later heterosexual experiences with an older brother's "girl friend" at the brother's suggestion. He felt guilty about this, although he always told his brother about it. After joining the Navy he had no relations with women.

During his year and a half of active duty, he seemed to do rather well and received a rating. Presently, however, he began to act in a dazed and peculiar manner and once almost walked into a moving propeller. It was not known whether or not this was a suicidal attempt, but at the time he was hospitalized he admitted hallucinations and said that he felt that people were against him. Neurological and physical examinations were essentially negative, but he took little interest in the usual ward activities and sat for long periods with his head in his hands, communicating with no one and appearing confused and depressed. He stated that he had thought of suicide many times, but had never actually made any attempts. He thought that his depression was due to the fact that he knew something was the matter with him, but that he could not figure it out. He had "visions and revelations and they must have come from God, as God is the only one who can give one visions.' He heard bells and ringings in his head and both men's and women's voices. He spoke slowly and, at times, seemed to block.

Upon admission to St. Elizabeth's Hospital he was still perplexed and confused. He admitted having always been shy, moody and seclusive, adding information that within the last year he had lost interest in his work and had had severe headaches. He had had neither auditory nor visual hallucinations for some time. In this connection it is interesting to note that this patient has a history of eidetic imagery, and one physician questioned whether the experiences reported were truly pathological hallucinations. The question is doubtless an interesting one, but the facts revealed would not account for the auditory hallucinations which were reported.

Seen on a rather quiet ward for the first time by his Red Cross case worker, he was revealed as a tall, slim, brown-eyed boy with a shock of curly blond hair. He seemed serious, even sad at times, smiling only two or three times during the interview. He described his position in the family as being "the third from the end of nine children." As the reason for his hospitalization he gave, "I got kind of homesick and did not like the work I was doing." This was mechanical work, for which he had asked when he first entered the Navy. Later he found he did not care for it. His hands were "not so good." He said he had never done any work like this before. He mentioned that he had done some farming and

helped a man fix lawns and do some landscape gardening. He did not mention the fact that he had been a moulder's helper for some time in a factory, reportedly distasteful to him.

The patient's first recollection is of his mother washing and of his sister playing close by. This was his sister Jane, just two years younger than he, and the one with whom he always had "a lot of arguments." On his first day in school he got mixed up about the room. After recess he came back into the school and got lost. An older sister was in the fifth grade and he came and sat down in back of her, and the teacher let him stay. When the worker asked him if this sister was Erika, who was corresponding with the hospital, he smiled and said it was. At this point the worker said, "The Navy must have been something like school on that first day." For the first time during the interview the boy's eyes really focussed on her and he grinned. Then she added, "But no sister to sit behind!" At this he chuckled out loud and said, "You're right there."

Since he was a small boy the patient had dreamed of a big man chasing him. Just before he was caught he fell down and woke up. Since he had been in the hospital he no longer had that dream, but he had what he considered a similar one which had to do with an airplane crash. Just before he hit the ground he woke up.

There were only a few interviews subsequent to this. The obvious leads in the first interview were followed and the patient was helped to solve his immediate problem of concentrating on ward work. This he was able to do with such success that he was soon transferred to a better ward. Shortly afterward, the case worker, realizing that even promotion, if it involved change, would present its problems to this patient, called on him. At this time he was able to speak freely of his difficulties, admitting, somewhat sheepishly, that meeting new people on a new ward had frightened him, even though the patients here were in better health and potentially better companions. He showed considerable insight into his "first day at school pattern" at this point, and, apparently, was able to understand the regressive nature of his emotional reaction which was quite inconsistent with the intellectual grasp of a situation. His condition improved with unusual rapidity and at a diagnostic conference, less than a month after the first interview, he was almost ready for ground parole. At that time he showed some insight, knew that he had been ill, and described the voices he had heard as imaginary. The diagnosis was of psychosis—type undetermined—mild paranoid features.

The patient was given work in the cafeteria and was allowed to attend psycho-drama and Red Cross dances. He told his worker that he was finding little difficulty in meeting new people and seemed very pleased with such social success as he was having. It was suggested that through his stay at the hospital he might learn something about himself which would help him to get on better after his discharge. He smiled very brightly at this point and said, "I've learned a lot already." He had

ground parole for over a month before his hospital discharge and became assistant manager of the baseball team, a position which he filled with great success. He was still quiet in manner and slow of speech; his expression was serious, but he smiled more frequently. He returned to his home and civil life and we have, to date, no post-discharge report.

Once more we are dealing with the case of a young man who had, apparently, inadequately solved his social, occupational, and sexual problems. He had no close friends outside his family. Even the women with whom he had sexual relations were chosen by his older brother, and, away from home, he found no other women. There was little satisfaction for him in school or the subsequent work which he undertook. A number of factors may have contributed to his exaggerated feeling of inferiority. The undoubted early pampering which he experienced at the hands of his mother was evidently continued by Erika, older sister and mother surrogate. The assumption that the younger sister Jane threatened his feeling of adequacy is corroborated in his early recollection of her and their continued "arguments." We know also that he was teased by his older brothers, that his parents quarrelled violently, and that he lost his father at an early age. Malnutrition doubtless also contributed to his physical inadequacy. In the light of all this we can appreciate the fact that the poor clothing, while doubtless an aggravating factor, may have been scarcely more than a rationalization for his inferiority feelings.

Again the military situation constitutes only one in a long chain of factors. The procedures of therapy, re-education, or case work need hardly differ from those utilized with patients who are suffering from other than war psychoses. We may go a step farther and suggest that, unless we can take into account the serviceman as a total individual, unless his life pattern of attitudes, his "style of life," established in early childhood, is understood, there can be no real basis for therapy and little hope for the patient's future adjustment.

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[2]Alfred Adler, **The Science of Living,** Greenberg, N. Y., 1929 P. 35 and Chapter IV.

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[4]Duval and Hoffman: "Dementia Praecox in Military Life and Dementia Praecox in Civil Life," **War Medicine,** Vol. I, Nov. 1941.

[5]A. Simon and M. Hagan: "Social Data in Psychiatric Casualties in the Armed Services, "**Amer. Jour. of Psychiatry,** Vol. 99 No. 3, Nov. 1942.

(*Editorial Note*: *names and places used in this article are of course not the real ones*)