THE COUNSELING OF OVERSEAS VETERANS AND THE IMPLICATIONS FOR EDUCATION

by

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CHAPTER I

INTRODUCTION

Torn from their homes and thrust into the maelstrom of a world conflict, men have been subjected to stresses as great if not greater than ever before in history. The youth of American have been prisoners of the Japanese in the Philippines and soldiers of the lost battalion in Burma. They are boys who made the landing on Pacific islands, at Casablanca, in Sicily and Italy; boys who sat on lonely islands in the Aleutians; boys who sweat and fought in the tropic murkiness of Guadalcanal and the Solomons; boys who held the beach-head at Anzio; boys who did the impossible at New Guinea; boys who were in Normandy on D-day; boys who have been in the Caribbean, Greenland, Iceland and South America. They are American youth to whom Biak, Hollandia and Guam were not just spots on a map. They are liberated prisoners of the nazis, showing the scars of their imprisonment. The boys of America have been scattered the world over; India, Iran, China, Japan and Java, Russian and Korea, and Tongatabu. Every continent has seen them as soldiers of America.

Not only have they traveled the earth in this war, but they have been paratroopers, infantry men, and artillery man They fought in tanks and hauled supplies under fire. They have shot mortars, rifles, bazookas, and anti-aircraft

guns. They have landed on hostile beaches and have been torpedoed in the oceans of the world. They have been wounded.

These American youth after months and years overseas, under living conditions differing from all their experience at home, are the men who returned to the United States. Their problems are varied and intense. The physical and mental reactions from their experiences are tremendous. The problem of the counselor who tries to help them is even more tremendous. The literature is limited. The demands on the counselor are unlimited. The subjects of this thesis are those boys. The problems tabulated are their problems.

Statement of the Problem

This thesis is based upon the counseling of these overseas enlisted veterans and the implications of such counseling for education. The following data are dealt with: military data about each individual, the personal data of each individual, the family background of each individual, and a history of his behavior and experiences.

The case histories used in this thesis raise many questions: (1) Is there a definite pattern of predisposing factors in so-called "war neurosis"? (2) At what age are men most susceptible to "war neurosis"? (3) Is intelligence a factor in "war neurosis"? (4) Are the pre-

disposing factors in pre-army life? (5) Are the predisposing factors experiences or learnings that could be corrected or prevented by proper education in the home and school? (6) From what types of homes and communities do these boys come ? (7) Are combat experiences or wounds necessary to develop "war neurosis"?

These and many other questions are raised by this study. The answers to all probably cannot be given, but the compilation of case history data certainly will show trends or lack of trends, in the various items compiled. The whole problem is: (1) What are the backgrounds of enlisted overseas veterans with neurotic tendencies? (2) Why do they have these tendencies? (3) What will be the course of those responsible for the preparation of Youth for life in the light of these data?

Purpose of the Study

The purposes of this study are to assemble the data of the case histories of a large sample of these men, and to share them with those who counsel veterans and those who educate our youth. Such a compilation of data should point the way to prevent a repetition of this influx of neurotic tendencies in our youth under stress. To see whether the predisposing factors of these neuroses are from the pre-army life or caused purely by stress of war.

Importance of the Study

The large number of case histories of one group of the population offers an unusual opportunity to gain information for future counseling and for education for the future. If the large number of neuropsychiatric casualties and neurotic reactions of our young men are traceable to childhood and youthful experiences, then it is of utmost importance for us to study these factors and see if we can improve our techniques and correct the conditions that have caused these tendencies in the youth of our nation.

These factors are important to the college and universities where a great number of these men are taking advantage of the educational provisions of Public Law 16, and Public Law 346, which is called the G.I.Bill of Rights.

Any study of a statistically significant number of veterans ought, also, to be important to the Veterans' Administration Counseling and Guidance Program, since to date, there have been no studies of large groups of returned overseas veterans.

The value to the psychiatrist and psychologist is self-evident. The use of the case history technique in collecting the data fits into the psychological and psychiatric approach. The accumulated data will give a picture of real significance to any one in the field, that can be used in future counseling and psychotherapy.

Location of the Study

This study was made at the Army Ground Force-Service Force Redistribution Station at Santa Barbara, California, in the Psychological Section. The Redistribution Station was a hotel-type installation, consisting of the Biltmore, Mar Monte, and Miramar Hotels.

The Psychological Section of the Redistribution Station was responsible for personnel consultant problems, administering and interpretation, personality, aptitude and clinical tests, assisting in the adjustment of the individual, personal problems of a psychological nature, and the administering of psychotherapy under the supervision of the Medical Processing Branch.

Number and Types of Cases

One thousand and sixteen case histories were complete enough to use in this study out of 13,648 enlisted men passing through the station at the time the study was made from October 1, 1944, to June 31, 1945.

The diagnoses of the cases as made by the station Psychiatrists were as follows:

313 Anxiety States

330 Reactive Tension States

40 Constitutional Psychopathic States

30 Hysterics

40 Adult Maladjustments

20 Neurasthenias

207 Mixed Neuroses

Total - 1,016

Sources of Data

The sources of the data are the case history work sheets* used in interviewing the men.

The returned overseas enlisted man upon completion of his furlough home was assigned to the Redistribution Station from seven to fourteen days, for reclassification and assignment. This process consisted of four parts: (1) a records and personnel interview (2) a complete physical examination (3) a classification and assignment interview (4) eight orientation lectures.

The subjects were 1,016 enlisted men returned from overseas, and some of them liberated prisoners of war, interviewed personally about psychological problems. These men came for interview from four sources: (1) Voluntary as a result of orientation lectures given by the psychologists (2) Recommendation of some other enlisted man who had been helped (3) Referral by psychiatrists in Medical Processing Branch (4) Referral by Personnel Technician Interviewers in Classification and Assignment Branch.

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* See Appendix A

Types of Data

A. Name

Army Serial Number

Race

Age

Civilian Occupation

Military Speciality

Appearance

Manner

Referral

Home Location

Months Overseas

Theater of Operation

Marital Status

B. Statement of Problems:

1. The Complaint Problem

2. Nature of Problem

3. History of Problem

C. Family and Social Environment:

1. Persons in the Home:

a. Father

b. Mother

c. Step-parents if any

d. Siblings, age and sex

e. Grandparents in home

f. Other relatives in home

g. Boarders or other unrelated persons in home.

2. Home Attitudes

3. Control and Discipline in home

4. Cultural Status of family

5. Economic Status of family

6. Language spoken in home

7. Neighborhood

D. Physical Conditions and conditions related to adjustment.

E. Developmental History

1. Intellectual Development

a. Test scores

2. Speech or reading defects

F. Educational History

1. School progress

2. Educational Status

3. School adjustment

4. Educational plans and ambitions

G. Economic History

1. Military

2. Occupational history

3. Vocational plans after demobilization

H. Legal History

1. Routine habits

a. Sleeping

b. eating

2. Recreation, hobbies and interests

3. Imaginative satisfactions

a. day dreams

b. nocturnal dreams

4. Sex Habits

a. autoerotic behavior

b. heterosexual behavior

c. homosexual behavior

5. Social Habits

J. Personality Adjustments

On many items insufficient data were obtained to be used in this study.

Procedures Used in the Study

The first contact with the men of the station was a lecture given to all men by the psychologists, called "Lets Be Normal". The purposes of the lecture were: (1) to give the men insight into their reaction after return from combat, (2) to establish rapport between the psychologist and the men, (3) to explain the work of the Psychological Section, advise the men of their freedom to come at any time for help, and assure them that their problems would not be included in their army records, but be kept in confidence by the Psychologist.

Each psychologist had an interviewing room which was furnished in complete contrast to any Army office. Army

office equipment was not used. The furnishings of the psychologist's office were an overstuffed chair, comfortable davenport, a Spanish credenza desk and chair to match, an oriental rug, and an attractive oil painting. The entire room was restful in appearance.

The man who wished to be helped reported to the Office Secretary, who took his name and showed him the waiting room, which had comfortable chairs and reading material. The Secretary then secured the military and physical records of the man and gave them to the psychologist before the interview. These records consisted of the Classification Card, the Personnel Interviewer's work sheet, the Service Record, and the Medical Profile.

As soon as the psychologist was free, the secretary called in the man. After greeting the man, the psychologist invited him into the interview room, and the following procedure was followed: Preliminary conversation was informal and often based on some observable point of contact. It is found advisable to use a case history work sheet. If the case objects to a written record it is explained away on the basis of the number of cases seen and the possibility of getting stories mixed unless notes are taken. The case is also reassured that anything the slightest bit confidential will be put down in a private system of abbreviation and will not be read-

able by others. The man is asked his name, age, and like data. He is then asked what he came to see the psychologist about. Regardless of whether his statements are concealing the real problem, the psychologist listens carefully and attentively making notes, interrupting rarely only to clarify some point.

After the case talks himself out, the psychologist informs him that some embarrassing questions may be asked, necessary to the whole picture, but reassures him that they will be kept confidential and asks him if he wishes to continue with the interview. He is then asked about his family, home life, physical history, educational history, work history, recreation, appetite, and sleeping habits. This leads to the dreams of the man which are generally significant. After listening to the recital of dreams, the psychologist asks if he had certain basic types of dreams and with what variations. This is followed by examination of his emotional, love, and fear behavior. Sex behavior is the next logical step. By this time the case seems to be convinced that the psychologist knows a great deal about him anyway and generally tells all. It has been observed that until the case tells of his sex experiences, fears, and guilts, the real story of his problem does not emerge. Many times after a recital of sexual behavior the case reveals unsuspected and, at times, serious problems. After the case history is completed the man is

encouraged to examine the things he has exposed and talk them out more fully with the psychologist. This talk continues until there is evidence of insight and relief. This is the first step of the psychotherapeutic procedure. The basic concept of psychotherapy as re-education is kept constantly in mind.

In tension states and anxiety states, and in some other neuroses, whether the trouble is manifested by tremors, sweaty palms, insomnia, battle dreams or nausea, the mere catharsis of a case history interview reveals the cause but does not stop the symptoms.

In order to stop the symptoms it has been found necessary to conform to the following procedure called relaxation therapy:

The patient is asked if he will take a few simple tests and is given one or two simple suggestion tests. Regardless of the reaction, the patient is told that the results show that something now will work in clearing up his trouble.

The patient is asked if he will sit in a comfortable arm chair and tighten up every muscle in his body as tightly as it is possible to do. After having muscles tensed for about thirty seconds, he is told to let go completely, lay back his head, and completely relax. He is then told to close his eyes, and the psychologist gently touches his

forehead asking him in a very quiet, monotonous voice to think of relaxing and that the tenseness is flowing from his forehead into the fingers of the psychologist. Without lifting his hands the psychologist moves them slowly to each side of the case's body, asking the patient to think of each section of the body releasing and relaxing under the fingers of the psychologist and finally flowing out of the toes and fingertips.

Then the psychologist places the patient's hands palms up and asks him to tense the hands so that they are really antenna letting all the tenseness flow out. Constantly talking in a very low voice, the psychologist reviews the problems and THE PATIENT'S NEW VIEWPOINT OF HIS PROBLEM, saying that no longer is there any necessity for the hands to shake or sweat or for the nausea or whatever symptoms he had to remain. Then the patient is told not to move under any circumstances, and is left in the room in that same position for three to five minutes, when he is told to waken and look at his hands. They are dry and not shaking, and the look of surprise and gratitude is heart rending.

The patient then is told to repeat the performance five times each day by himself and to come back to the psychologist for further treatment for three days. He is also told, that each night he should take a warm,

not hot, not cold, tub bath, and soak for about ten minutes with only head above the water, blot himself dry with a towel and go to bed directly. He is to tense his muscles when he gets in bed as he had at the office of the psychologist and then relax, to imagine the hands of the psychologist starting at the head and all tenseness flowing slowly out of the body. The patient will generally find that he has gone to sleep before completing the relaxation and that he will sleep soundly and not have any dreams.

This technique is varied with different types of symptoms, such as stuttering, tics, paralysis, etc., that are demonstrated to be of psychogenetic origin.

In deafness, it is necessary to use narcosynthesis since hypnosis is not easily obtained without the use of the voice.

The technique used is to have a doctor give approximately 10 cc. of sodium pentathol, and as soon as the case is asleep awaken him, and he will hear the voice of the psychologist. After his hearing is tested, the patient is made to re-live the incident that caused the deafness. His ears are sprayed with a cold-producing liquid and he is told that his deafness has disappeared and that he is cured and will not be sent into anymore combat situations. When the drug wears off, the psychologist continues talking

and the patient hears; when he is fully conscious, he is still hearing.

In enuresis, tics, and similar cases of psychosomatic origin the causative factors are back in infancy and the best procedure is hypnosis. The case generally cannot bring back to his conscious memory the actual causative incident. The patient is made to re-live his infancy and will assume an infantile sleeping position. Many times the patient will awaken when he comes to the year of the cause. This gives a clue which generally can be explained by the parents of the case. On the next hypnosis the psychologist guides the patient through the causative incident, and in the majority of cases the enuresis will be stopped at once.

All psychotherapy of the cases in this study given by the psychologist was under supervision of Army doctors.

Limitations of the Study

It was impossible to obtain from all veterans passing through the Redistribution Station data of such personal nature as used in this study. Such data are obtainable only through case history interviews; on most items included in the study, this makes comparisons with the entire group an impossibility.

Another limitation is that much of the data is the personal evaluation of the man involved, as to his likes

and dislikes, his home conditions, his family's economic status, etc.. The case history technique tends to emphasize the man's evaluation and insight into his own situation rather than a statistical comparison.

CHAPTER II

STUDIES IN WAR NEUROSES

This study of neurotic groups of enlisted men with overseas service is of great importance to our national life. Since World War I the recognition of the problem of neuropsychiatric casualties has been growing steadily. The cost of caring for World War I neuropsychiatric cases has averaged around $30,000 each. When the number of such patients is considered a realization of the importance to the nation from an economic point of view, as well as the loss to our national life of the potentials of these men if they had not been mental casualties, may be seen.

To quote Weider and associates:

> Each person with a neuropsychiatric disorder revealed subsequent to induction costs the government $30,000 to $35,000, that twenty-seven hospitals with a capacity for 33,000 patients are devoted to the care of veterans from the first world war with neuropsychiatric disorders, that approximately a billion dollars has been spent on the care of these patients and that 60 per cent of all ex-members of military services requiring hospitalization are admitted for neuropsychiatric disabilities are facts which have been repeatedly presented in the literature[1]

Similar figures are quoted by Knight:

> .....68,000 neuropsychiatric casualties---58 per cent of all living World War casualties of whatever kind---are still being cared for in Veterans' Hospitals in this country; and the average cost of

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1. Weider, A., Mittelmann, B., Wechsler, D., Wolff, H.G., "Cornell Selectee Index", Jrnl. A.M.A., vol. 124, p. 824, 1944.

treatment from onset of the neurosis until death is $30,000 per patient. 2

In World War I our mental casualties were less than those of our allies, by reason of rejection of many men by induction boards for neuropsychiatric reasons. Weider and associates make this very plain in the following quotation:

> As the result of the work of neuropsychiatric boards in the United States, the American Expeditionary Force of World War I had a far smaller percentage of nervous and mental casualties than did the armies of our allies. Even so, 110,137 neuropsychiatric casualties occurred in the Army from April 1, 1917 to December 31, 1919 at a rate of 26 per thousand. It has been estimated, furthermore, that had it not been for the psychiatric selection process 40,000 more casualties of this type would have occurred in our forces. No small wonder that the editors of the volume on neuropsychiatry of the History of the Medical Department of the United States Army would have been advisable to reject totally all mentally unfit individuals at the draft boards rather than to have selected some of them for full or even limited service. 3

Bowman in his study recommended much greater caution in the preliminary neuropsychiatric examination of inductees and the use of all possible previous records.

Bowman wrote:

> Many of these neuropsychiatric casualties could have been prevented, if a careful screening had been made at induction. Practically every

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2. Knight, R.P., "The Treatment of Psychoneuroses of War", Bulletin of the Menniger Clinic, pp. 148-155, vol. 7, No. 4, July 1943.
3. Weider, A., Mittelmann, B., Wechsler, D., Wolff, H.G., loc. cit..

study has found that the predisposing factors of the so-called "war neuroses" are in a majority of cases found in pre-army life. 4

Weider and associates write:

> The vast majority of persons who show evidence of difficulty in adjustment of "break down" under the circumstances of civil life can be expedted to "break" under the circumstances of military life. Hence a procedure which would "screen out" the borderline and proved inadequates before induction would lessen the incidence of illness in the armed forces. To detect such persons is desirable because neuropsychiatric and psychosomatic disorders have become important military problems. Furthermore, because of a paucity of neuropsychiatrists, devices that are time and energy saving are essential. 5

Rosenberg and Lambert[6] in a study of 200 consecutive case histories of soldiers discharged from Camp Lee Virginia on diagnosis of psychoneurosis found that 88 per cent had symptoms before induction.

Miller in his study of neuroses in war recognized the predisposition of neuroses in our army and says:

> Men who are liable to breakdown can frequently be detected during enlistment. Since the treatment of psychological disorders, as compared with others, tends to be disproportionately costly and difficult prophylaxis is correspondingly important. 7

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4. Bowman, K.M., "Psychiatric Examination of Applicants in Armed Forces", War Med., vol. I, p. 213, March 1941.
5. Weider, A., Mittelmann, B., Wechsler, D., Wolff, H.G., op. cit., p. 228.
6. Rosenberg, S.J., and Lambert, R.H., "Analysis of Certain Factors in Histories of 200 Soldiers Discharged from the Army for Neuropsychiatric Disabilities", Am. Jrnl. Psychiat. vol. 99, p. 164, 1942.
7. Miller, E., The Neuroses in War. 1940, p. 23.

The predisposition in pre-army life reoccurrs in study after study:

> The reaction to war is seen to be a repetition of old reactions to previous conflicts. There are no great resistances against the release of the old situation. Hence our therapeutic achievements are frequently more than a removal of recently developed anxiety but often include an unexpected beneficial reorientation of the total personality. 8

Wender says:

> The ground for neurotic behavior is laid early in life, commencing with the Oedipus situation, followed by sibling rivalry, then by maladjustment in school, etc. Thus we see that as the group becomes larger and the requirements of adjustment more complicated, the neurotic manifestations become more severe. 9

Sutherland arrives at a similar figure when he found out of one hundred men suffering from psychoneurosis following combat, that eighty of them had previous tendencies and traits of emotional instability. Thirty-six of his cases of the "war neuroses" were merely aggravation of previous psychoneurosis and thirty-three were associated with a definite predisposition to breakdown. Eleven others were emotionally and temperamentally unstable.

Schwab and associates in a study of enlisted navy

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8. Grinker, R., "Treatment of War Neuroses", Jrnl. A.M.A., vol. 126, No. 3, p. 145, September 16, 1944.
9. Wender, L., "Group Psychotherapy", The Psych. Quartr., vol. 14, p. 709, 1940.
10. Sutherland, J.D., "A Survey of One Hundred Cases of War Neuroses", Brit. Med. Jrnl., vol. 2, p. 365, 1941.

personnel have found that, in neuroses developing after exposure to combat, a history of previous psychoneurotic symptoms existing before combat situation existed in 80 per cent of the cases. To quote them:

> Characteristic Features of Psychopathic Personality. With the foregoing case history as a prototype, and taking into consideration others that are similar to it, a definition can be constructed for the purposes of delimitation as well as characterization of the concept of "psychopathic personality". The features that stand out as characteristic of this person are:
>
> 1. Psychopathic trends in the family history.
> 2. A history of instability running through the whole adjustment period of the patient himself and characterized primarily by emotional lability, a consistent lack of ability or desire to stick to an established adjustment setting for any length of time.
> 3. The episodic exaggerations of these difficulties, particularly in relation to stresses and strains.
> 4. Certain conditions that existed in the early social background of the patient which have tended to exaggerate or modify his particular weakness.
> 5. Certain assets such as good initial adjustment to new situations, and a number of positive personality characteristics which, if they had more stability, could have rendered him quite successful.
> 6. Finally, a normal intelligence level, which would eliminate the possibility of a lack of realization of the consequences as the main reason for the difficulty.
>
> The most common syndrome encountered is that of anxiety neurosis, with the absence of repetitive anxiety dreams, and the startle reaction. Depressive reactions, hysterical paralyses, and blindness, obsessive and compulsive symptoms, and neurasthenia are not seen infrequently. The patients usually have a past history of similar symptoms which appear more frequently or in an exaggerated form upon induction into the Armed Forces. It seems that conflict between desire and duty, the military discipline and routines, and the separation from family, with its stimuli of minimal intensity can precipitate symptoms. In the experimental situation these patients

show reactions of greater intensity and duration when records are made of ventilation, heart rate, and muscle tension. 11

The authorities are nearly unanimous on the predisposition of war neuroses in pre-army life. To quote a few more:

Sargant says:

> This is not to deny the importance of constitutional factors, even in this latter group of cases, compared to an average population, they would almost certainly show an excessive proportion of men who had suffered from nervous troubles in earlier life, and an excessive frequency of psychiatric disorder in the nearer blood relatives. 12

Zeligs, in his article, says:

> In young persons, usually unmarried, in whom the anxiety state derives from such things as the early separation from parental protection, emotional immaturity and dependency, the satisfaction of being returned home again experiencing the pleasures of parental love might easily produce regression and retention of symptoms. 13

From a War Dept. Technical Manual:

> Mental disorders, excluding those of organic origin, are thought of as failures to effect harmonious adjustment. The symptoms manifested, no matter how grotesque, fantastic, or seemingly inexplicable, are evolved from materials somewhere in the individual's mental past. Nothing is created. Every mental fact has its efficient cause in an antecedent mental state, and every bit of conduct is an end product conditioned by what has gone before and out of which it issues. This is the law

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11. Schwab, E.S., Finesinger, J.E., and Brazier, M.A.B., "A Study of Traumatic Neuroses in Enlisted Navy Personnel" Trans. Amer. Neurol. A., 1943.
12. Sargant, W., "Acute War Neuroses", The Lancet, p. 1, July, 6, 1940.
13. Zeligs, M., "War Neuroses", War Med., vol. 6, p. 172, September 1944.

of determinism.

> The basic factors involved are heredity and environment; by environment is meant the sum of the individual's conditionings and life experiences. How much either of these is a factor cannot be established at the present time. The increasing belief is that heredity has been overemphasized. The present-day opinion is that improper early mental hygiene or improper guidance is the cause of many of the psychologic problems that were generally held to be of hereditary origin. Thus the conclusion which may be drawn is that the symptoms of a psychosis depend upon the mental makeup of the individual, the character of his mental trends, and his developmental history. 14

The British have found in their studies during the war similar conclusions:

> Of 100 psychiatric casualties received from the Normandy beach-head during the first ten days of the campaign, 6 were severe chronic neurotics, 5 could be regarded as cases of pure physical exhaustion, 2 were schizophrenics, and the rest were men with history of childhood neurosis who had adjusted superficially in maturity but gave way under severe stress. 15

One of the predisposing factors which is outstanding in most studies is the home and mother. Americans are predisposed to psychoneurotic difficulties because of this factor more than any other one thing.

Henderson and Moore in their study describe this in detail, so vividly that the following excerpts from their paper are included:

> From the early history of these patients it was found that 65 per cent had bitten their fingernails

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14. War Dept. Tech. Manual, TM 8-325, "Outline of Neuropsychiatry in Aviation Medicine", p. 267, 1944.
15. Anderson, C., "Psychiatric Casualties from the Normandy Beach-Head", The Lancet, p. 220, Aug. 12, 1944.

when young and the majority of them had continued this habit up to the time of admission. Five per cent had begun biting their nails after entering the combat zone. This finding correlated over 95 per cent with anxiety symptoms. Enuresis in childhood had occurred in 15 per cent, but few had developed this symptom as the result of combat. There was no special relation of bedwetting to the particular psychoneurosis that the patient later developed. Walking and talking during sleep had occurred in 20 per cent of the cases and persisted in a few up to the time of admission. This was limited to those who developed hysteria.

. . . . . .

Nightmares occurred almost universally among these patients, even after they had been evacuated to a place of safety, and they were severe enough to wake them. The patients reported that in their dreams they were terrified and often felt paralyzed.

. . . . . .

Repetitive dreams of combat were absent only in the psychotic patients and in a few of the markedly hysterical patients who could not remember what they had dreamed.

. . . . . .

Previous mention has been made of the frequency with which these patients came from broken or distorted homes, and we re-emphasize the opinion that this is the most important of all the predisposing factors that have been analyzed.

In studying the home background of the patients a certain pattern became apparent. The mother was found to stand out. She was uaually a "nervous woman" and had often had a nervous breakdown but was rarely hospitalized for it. She was easily excitable and quickly "went to pieces" under stress.

She tended to worry, particularly about her children, and to be overly concerned about them. For example, most of the mothers had waited up for their boys to come in at night up to the time that they entered the service. The father seemed to be in the background. He was away at work much of the time, and when he was at home it appeared that he was not much interested in or affectionate toward the children. About half the fathers drank to excess. From these observations the following interpretation is made: The mother is an immature person who feels herself insecure and in her marriage tends to establish a childish dependent relation to her husband. This, somehow, is not successful;

the reason is not clear. It may be that the husband is also trying to establish a childish dependent relation to his wife, as indicated by the frequency of alcoholism. The mother accordingly makes many compromises but remains insecure and identifies herself strongly with her children. Along with her insecurity she also vaguely senses that the world is hostile. Her subconscious thinking may then run along these lines: "If the world is bigger than I am, it may overwhelm me; it is hostile. I shall therefore feel hostile toward it." or, "If the world is hostile, then I can make no attachment to it, therefore I shall make a doubly strong attachment to my children." So it may be that she and her children come to form a unit and feel together, relatively helpless in a hostile world. They are unable to do anything about this except to suffer and to repress their natural counter hostility. The chief result of this is that the mother and the child never learn to deal with hostility, particularly the child, who later becomes a patient.

As previously mentioned, the father was in the background most of the time. When he was drinking, however, there frequently occurred an explosion of verbal and often physical abuse, to which the mother usually reacted by an attitude of hopelessness and defeat, with fearfulness and anxiety in the intervals. In this way the acceptance of the overwhelming nature of hostility may have become established in the patient along with the necessity to avoid it.

In studying the relations between the patient and his mother, these points come out again and again, and are corroborated by the letters the mother sometimes writes to her son who is in combat. Often her letters are anxiety laden and disturb him accordingly. Without denying the possibility that this is a natural reaction on the part of any mother whose son has gone forth to battle and may be killed, it is a fact, vouchsafed by many, that when he went into combat he was more worried about the situation at home---as it had been relayed to him by his mother---than he was about himself.

This vicious emotional cycle in the family set-up was repeatedly described, and in nearly every case a mutually dependent neurotic relation existed between mother and child. The mother, in view of this emotional need, unconsciously tended to perpetuate this relation and thus attempted to

prevent the son's growing up, since in doing so he would outgrow his need for her. Such a loss seems to be as great as though she had lost a part of herself. It is this child-to-child relation that she understands best and that holds the least danger from her point of view. The child growing up and breaking away thus becomes a hostile act. But the mother cannot express her counter-hostility, for this would more surely lead to the loss of what she is trying to hold. This situation leaves little room for either hostility or love, the latter of which on the mother's part would move her in the direction of aiding the child to develop into an independent adult. This inhibited emotional energy seems to find a common outlet in worry and concern. In the light of this situation, the child remains immature, insecure and dependent and reflects the mother's shortcomings. He does not acquire security within himself. He can attain adulthood only by breaking his mother's hold (rebellion). Attempts in this direction produce such pain and suffering on the mother's part and lead to situations where he feels such insecurity and anxiety that he comes into the service with the fundamentals of this interdependent relation still essentially unchanged, not having dealt with his stronger forces---having lived a life chiefly receptive and more identified with his mother than with his father. Thus, it would appear that in the combat situation, being oriented toward life in a receptive way, he is more concerned with what is coming at him from the enemy than with what he is sending toward the enemy. The conscious complaints and the dreams of these patients were universally passive and receptive---"bombs falling on me"---"being chased by a shell" "shooting at me"---etc. 16

From the psychoanalytical point of view, Simmel explains these predisposing factors as follows:

We should bear in mind that the super-ego, although functioning as the intra-mental representative of society, has only become so through the mediation of our internalized parents. Therefore,

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16. Henderson, J. S., and Moore, M., "The Psychoneuroses of War", The New Eng. Jrnl. of Med., vol. 230, p.273, March 9, 1944.

if society, i.e. a nation, as an external representative of our super-ego, decides to go to war, this does not imply that, under normal conditions, our inner parental super-ego, allows such collective cannibalistic regression to be followed by a corresponding regression of our individual ego. On the contrary, it helps the ego to test the changed, external reality and become adapted to it, by strengthening its inner position and defences.

The way a soldier is indoctrinated into military life shows clearly this tendency to have the soldier regress to the relationship to his superior officers. As an example, I have to refer only as to how the new recruit is trained in making his bed correctly, as if final victory depends on whether it is smooth or wrinkled. Indeed, language, which preserved the latent meaning of forgotten concepts, proves the correctness of my assumption.

The term for fighting unit which, up to this war, was a basic force of every army is the infantry. Infantry designates a group of infants. I found out about this in the dreams of my patients, and a confirmation in an etymological dictionary.

The child-parent relationship gives the soldier in his relationship to his superiors all those advantages of the child, which we have observed in bombed areas. It makes him feel secure and even immune against the fear of death, as long as he feels secure in the love--that is--in the appreciation of his superior.

The soldier's lack of personal object love is compensated for by identification love, which blinds him libidinally to his leaders and his comrades. Wearing the "uniform" is the symbolic manifestation of a unity which represents him and which is represented by him. This narcissistic-libidinal entity is reflected in the group spirit.

It depends upon the degree of maturity of the soldier's super-ego, if and to what degree his ego can withstand narcissistic injuries without disintegration of its mental system.

Soldiers are mentally predisposed to narcissistic traumata if, before entering the military service, they still have been carrying in their unconscious the residues of an unsolved Oedipus conflict. Many of them did not show manifest neurotic symptoms in civilian life. These men had managed to save themselves from such symptoms by "acting out" their unconscious, infantile tendencies. An irrational trend in their lives had created for them and

> their environment an atmosphere of "neurotic misery". They suffered because they found themselves entangled in unhappy love relationships or in seemingly unsolvable conflicts with their parents or their co-workers. For this category of soldiers, going to war meant relief from civilian misery. It is understandable that they are inclined to volunteer for war services.
>
> To the predisposed, war represents the acutalization of the original Oedipus situation: Their country symbolized the mother, and the enemy the father. 17

There are many reasons why the war precipitates neuroses; the routine monotony and regimentation of army life aggravates what neurotic tendencies are present in the personality of the individual. Some of the reasons for the precipitation of neuroses of the Army are shown in a book used frequently in Army orientation courses and written by a committee of the National Research Council:

> In a Democratic, civilian army, millions of men are suddenly, abruptly thrown into a new way of life. It is in many ways a tough life.
>
> Men, used to going their own ways, choosing their own jobs, associates, neckties, times for going to bed, now have to follow military orders about all these things.
>
> Men accustomed to a comfortable litter of belongings around them, find the bare neatness of policed barracks hard to get used to. Those used to steam heat, warm shower baths, and breakfast eggs cooked just three and a half minutes at home, may be pretty uncomfortable when they have to put up with a bed on the ground and cold water for shaves.
>
> There is, moreover, no privacy in the Army. If a man oversleeps and his corporal dumps him out of his bunk, the whole company knows about it. If he looks at his girl's photograph a lot, they know that too. The business of living in a gold-fish

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17. Simmel, Ernst, "War Neuroses", pp. 227-234, Psychoanalysis Today, New York, International University Press, 1944.

> bowl and having to take razzing from his fellow soldiers is about the hardest thing for a sensitive recruit to get used to.
>
> Not every man, of course, meets hardships for the first time when he goes into the Army. Some have known hunger and cold and hard work. Some never saw a flush toilet or a shower bath before they got to camp; some never had a good square meal; well cooked. For them, the Army is providing luxuries.
>
> But farmer, lawyer, banker, section hand, college man or man of little schooling---they all must adjust themselves to an entirely new way of living. All must learn new habits. 18

The army life itself is the definite precipitating factor rather than combat. Civilians who are in their homes do not become as neurotic under combat conditions as the soldiers who are away from their homes.

Strecker notes this:

> It is important to note that there has been a definite difference in the Army and in civilian life. I think there will be no change in the number of neuropsychiatric casualties in the armed forces. As a result of bombing in England, in London, Liverpool, Coventry, Plymouth and other places, it appears that functional symptoms in civilians are quite rare and constitute less than 2 per cent of the hospital admissions. Here we have an important fact which needs thorough consideration by the students of psychosomatic medicine. Evidently, even though the stress and strain are great, if the human being is not away from his home and from those whom he loves and who love him, he does not succumb to "shell shock". This means that he retains a protective measure of security. 19

Morale of the unit in which the man is assigned is always one of the factors. Units with good morale have

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18. Committee of National Research Council, The Psychology of the Fighting Man, 1944, p. 283.
19. Strecker, E.A., "The Leaven of Psychosomatic Medicine" Annals of Internal Medicine., vol. 18, p. 736, 1943.

fewer neuropsychiatric casualties than units where the morale is poor.

At a meeting of the section of Psychiatry (Royal Society of Medicine) on May 9, with East in the chair as discussion on MORALE, Stokes suggested:

> The individual is governed from moment to moment by a balance between the herd or group instinct and the ego instincts---self preservation, nutrition, and sex. The balance may, at any given moment, be the result of antagonism, synergy or compromise between these instincts, and hence is variable; and the outcome therefore varies from time to time. Thus there is a rise in the incidence of neurosis in times of economic stress; and there are more cases of neurotic breakdown in units with bad morale than in those where morale is good. 20

There seems to be little difference between so-called "war neuroses" and the standard classifications of neuroses as used in civilian life.

However, the name war neuroses which is used more commonly in this war rather than "shell shock" which was the popular diagnosis in the World War I.

Knight believes:

> The psychoneuroses of war are identical with the traumatic neuroses of civil life except for the character of the trauma. They were called "shell shock" during most of World War I, a term coined by a British pathologi t, Col. Frederick Mott, who regarded them as organic conditions produced by minute petechial hemorrhages of the brain. It was finally realized that a very small percentage of cases had any such petechial hemorrhages, and indeed that many so-called "shell shock" cases had never been

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20. From report of meeting of the Royal Society of Medicine., The Lancet, p. 662, 1944.

near an exploding shell. So this term has been discarded and the designation "war neurosis" or "traumatic neurosis of war" is the approved term. 21

Murray says:

> There are also large numbers of men who have completed a prescribed tour of duty in the theaters of operation and who, pursuant to War Department policies, are rotated back to this country. A certain percentage of these men show evidences of persistent symptoms akin to those common in civilian psychoneurotic illness. It is clearly evident that the problem of the care of these men is a most important and pressing one and that our programs for this care will soon need to be fully developed.
>
> The term neurosis or psychoneurosis ordinarily denotes the presence of symptoms which are basically dependent on unconscious conflicts which arose early in childhood. 22

Dr. Slater and a group from an English Medical Service Neurological unit say:

> The psychopathology of war neuroses is more complex than has been described by some writers who gained their experience in the last war. Apart from the nature of the precipitating agent, the structure of the cases seen so far, especially late cases with much anxiety and depression, has resembled that of the occupation and post-traumatic neuroses of peace. 23

The occurrence of these classifications of neuropsychiatric symptoms are ample proof that "war neuroses" are merely commonly recognized neuroses precipitated by war situation, with definite result of predisposing

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21. Knight, R.P., op. cit., p. 148.
22. Murray, J.M., "Psychiatric Evaluation of Those Returning from Combat", Jrnl., A.M.A., vol. 126, No. 3, p. 148, September 1944.
23. Slater, E., Sargant,W.,Hill,D.,Debenham,G., "Treatment of War Neuroses", The Lancet, p. 197, 1941.

tendencies in the life history of the case. The war seems to bring these predisposing tendencies to the surface with the result of our present neuropsychiatric problem.

Strecker says:

> I think I may predict with safety that the neuropsychiatric problem eventuating from this war will be much greater than from the previous one.
>
> As you know, these casualties will be largely psychoneurotic. They will consist of "shell shock" (conversion hysteria), neurasthenia, anxiety neuroses, and a relatively smaller number of psychoses. In other words, a very large majority of the casualties will consist of functional symptoms, that is, there will be demonstrated again on a massive scale the close entwining of body and mind and there will be clinical examples that properly fall within the domain of psychosomatic medicine.
>
> Reports would already indicate that a very large numbe of functional symptoms are within the gastrointestinal field. Furthermore, there have been definite indications that sometimes anxiety is productive of structural pathology, perhaps chiefly peptic ulcer. 24

The types of cases found in other studies reflect this prevalence of civilian type neuroses.

In the study of Henderson and Moore we find:

> The importance of the problem of psychoneurosis in war is reflected in the fact that the number of neuropsychiatric cases rose from 12 to 17 per cent of total admissions during the first four months the hospital was in operation. Furthermore, an additional 6 per cent of cases were transferred to the Neuropsychiatric Service within the hospital as the result of consultations that revealed concurrent neuropsychiatric disorders. Thus, the neuropsychiatric cases among the total admissions amounted to 23 per cent, or approximately 1 case out of 5.

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24. Strecker, E., op. cit., p. 740.

> The term "war neurosis" is not used here since we have come to believe that a clearer picture of the neurotic reaction is obtained from the standard classification. In most of these cases it appeared that the hysterical mechanism was essentially a means of immobilizing anxiety by converting it into a symptom that resulted in relative freedom from anxiety at the expense of loss of physical or mental function. This process was seldom complete, so that an admixture of anxiety and hysteria was often found in the same patient. In arriving at a diagnosis hysterical reactions were emphasized because they appeared to be of more serious import than others and affected the prognosis accordingly. It is interesting to note that the percentage of cases with anxiety neurosis was originally higher and continued so until recently, when a group of 70 patients arrived. Half of these were Army patients and over half of them were found to have hysteria, many of them giving a history of severe amnesia, which in some cases persisted on admission. 25

Knight finds similar evidence, but his predictions did not consider the vast number to whom army life alone, not combat, was the precipitating factor:

> A wide range of psychiatric conditions fall under this category---in fact, practically every functional psychiatric condition seen in peace time. It is expected that the neuroses of the war will be similar to those of 1914-18 except that, because of the more terrifying combat conditions of this war due to aerial bombing and mechanized warfare, more anxiety states were anticipated; and, along with the peace-time trends, fewer hysterias and more psychosomatic conditions such as peptic ulcer, hypertension, effort syndrome and gastro-intestinal organ neuroses might be expected. 26

The psychoanalyst describes symptomatology similarly:

> I saw about two thousand war neurotics--half

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25. Henderson, J.S., and Moore, M., op. cit., p. 273.
26. Knight, R.P., op. cit., p. 149.

> of them I treated myself with a combination of psychoanalysis and hypnosis. Their symptomatology might be described summarily as ego impairments which made it impossible for the soldier to continue attending to his military duties. Spastic or paretic conditions of the entire muscular system, or parts of it (legs or arms), impaired to lesser or greater degree the soldier's ability to move. This impairment of the muscular system very often represented itself, also, in the form of compulsive, involuntary body movements or body postures. The functioning of organs became disturbed, the use of which enable the individual to sustain his contact with the environmental world, for example; speech disturbances, ranging from spastic stammering to complete mutism;---and disturbance of vision and hearing, from over-sensitiveness to light and sound to complete blindness and deafness. Many soldiers were stricken by epileptiform attacks which precipitated seizure of unconsciousness associated with cramplike, more or less uncoordinated movements of the arms and legs. Disturbances in the intellectual sphere manifested themselves in the loss of selected faculties, such as reading, reckoning, and particularly in the disturbance of the memory functions, frequently resulting in total amnesia.
>
> The essential symptoms common to all cases deserving the name of war neuroses, was a general emotional instability and irritability, a tendency to emotional outbursts, particularly of rage---and a characteristic sleep disturbance due to tormenting dreams repeating the terrifying war experiences, often associated with a tendency to act vehemently while still sleeping, (somnambulism). 27

The treatment of the neuroses precipitated by war is one of the problems of all those interested in mental illness.

The war has also brought forth a new understanding between the psychiatrist and the psychologist. This study in itself is a result of such understanding and cooperation:

> We may say that intimate cooperation between

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27. Simmel, Ernst, op. cit., p. 228.

> psychiatrists and psychologists is essential. They must work together as a team. When they do this, the objective techniques of the psychologist are invaluable complement to the clinical approach of the psychiatrist. Clinical judgment, however, at the present stage of test development, must remain the final court of appeal. While psychology has developed many tests to assist the psychiatrist in his work, it has yet to develop one that can supplant him. 28

In the first part of the war case work was principally done by Red Cross Workers but later the Army recognized the need of trained psychologists and assigned one or more to each Redistribution Station and one to each thousand-bed hospital.

Of case work done in the Army by Red Cross workers, Maxine Slingsby says:

> In considering what is intrinsic to the patient's situation, the case worker, to be effective in her approach, must have an appreciation of the difference in the point of view and adjustment of the patient himself because he is a soldier as well as a patient. He is no longer a private citizen, but rather a member of a vast group working and living together. His success is dependent not only upon his own individual initiative and enterprise, but also upon team work and a cooperative spirit so essential in group life. This principle, perhaps already introduced through his membership in his school football or basketball team, plays an even more important part in the Army where team work is essential in every phase of his existence. In other words, individualization, the basic factor in case work, must in the best interest of the patient, consider the patient's needs always in terms of his relation to his group and particularly to his commanding officer.

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28. Hunt, W. A., Wittson, C. L., Harris, H. I., Solomon, P., and Jackson, M. M., "Psychometric Procedures in the Detection of the Neuropsychiatrically Unfit", United States Naval Medical Bulletin, vol. XLI, p. 479, 1943.

> The soldier develops loyalties and responsibilities in the Army and yet attempts to continue his loyalties and responsibilities to home and family. This two-fold responsibility is something to which the majority, fortunately, are able to adjust. Others, however, develop problems of varying degrees because of this dual position and these problems become acute in the mind of the soldier when he is hospitalized and has more time to think about his difficulties. Thus the patient must adjust to being a soldier, to being ill, and to being separated from his family. We all know that illness itself makes even simple adjustments more difficult.
>
> The strains and demands imposed upon a soldier serve as a challenge to some. They see in this new life an opportunity for recognition and advancement. To others, the responsibilities and pressures are too great and the outlet is physical or mental illness. Many are granted medical discharges from the Army for "psychoneurosis" and others for more serious mental conditions. 29

Case histories were taken by psychologists, psychiatrists, psychoanalysts, and we find the importance of the past history of the case is recognized throughout the literature:

> As the person becomes able to recognize and accept his real self, then, he finds his past and present experiences falling into a new pattern; he finds himself approaching his life situation with a new perspective.
>
> . . . . . .
>
> Some of the elements of insight, then, are (1) recognition and emotional acceptance of the real attitudes and desires of the self, (2) a clearer understanding of the causes behind one's behavior, (3) a fresh perception of the life situation--old facts are interpreted in a new frame of reference--and (4) clarification of the decisions that must be made and the possible courses of action. 30

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29. Slingsby, M., "Case Work in a Military Setting", Bulletin Amer. A. Med. Soc. Workers, pp. 88-89, Sept. 1943.
30. Rogers, C., and Wallen, J. L., Counseling with Returned Servicemen, p. 54, 1946.

The English use the same method:

> Once the patient realizes that the symptoms need not cause anxiety, and that the origination cause is in the past, the way is prepared for re-education; this is directed towards correcting wrong habits of thinking which have become a part of the patient's life, and which may have persisted for many years. In this re-education the patient takes an active part, using the knowledge which the explanation has given him to help his own reasoning.
>
> The method is simple. The first interview with the patient is diagnostic, and must achieve objects, namely:
>
> 1. To decide whether the patient is suited for this method of treatment. (Elderly or deaf people cannot be expected to benefit, and many cases of psychosis are unsuitable, although one case of suicidal depression has been cured.)
> 2. To discover the cause of the illness, and at what period of the patient's life it originated.
> 3. To explain to the patient the purpose of the new method of treatment.
>
> By arranging a special case form for this history the work is much simplified and anyone accustomed to interviewing can soon learn how to use the form. It is devised to explore the five successive phases of the patient's life; childhood, school life, adolescence, working life, and married life or its equivalent. 31

Every symptom from the dreams was utilized in trying to give these men insight and relief from their difficulties.

Simmel who has had wide experience says:

> From the very beginning my attention was captured by the characteristic dream life of my patients. I recognized that tendency to repeat the traumatic experience and conceived that this must indicate a latent tendency at a self-cure. I also found out that soldiers with epileptiform seizures sometimes, during their states of unconsciousness, hallucinated

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31. Snowden, E. N., "Mass Psychotherapy", Lancet, Dec. 21, 1940.

> conflict situations, characterized by the emotion of anxiety or rage. I learned to understand that their tonic-clonic muscle spasms signified a discharge of their rage in the form of uncoordinated movements. I became aware of this by being able, under hypnosis, to lift the amnesia for these fits, or by getting contact with the individual even during his original state of unconsciousness. I concluded that I must make use of this self-curing tendency, manifesting itself during sleep and in epileptiform seizures and must give the patient the opportunity to repeat this trauma under hypnotic condition of unconsciousness.
>
> I consider my patients as practically cured when their dream-life appeared to change definitely by losing its tormenting character, so that sleep could fulfill its psycho-biological task of restoration and recreation. 32

But as in this study the most important factor in most of the cases was disturbances in the family background.

Henderson and Moore found:

> In attempting to analyze predisposing conditions, the most important factor was found to be a disturbance in the family background. This was strikingly constant in almost every case. Those patients who came from homes that were broken by separation, divorce, or death, or distorted by neurotic parents, were found to have personalities insufficiently developed to deal rapidly or adequately with the problems of life, particularly with the problems of war. On the basis of the histories given by the patients--which in most cases have been accepted as reasonably reliable--we have attempted roughly to estimate this disturbance in the home environment as follows: normal, 4 per cent; slightly disturbed, 25 per cent; moderately disturbed, 42 per cent; and severely disturbed, 29 per cent.
>
> These patients were all young men; 70 per cent were between the ages of seventeen and twenty-five. Six per cent had entered college. One third of the entire group had completed the eighth grade only,

32. Simmel, Ernest, loc. cit.

> whereas 8 per cent had not gone that far. Their educational accomplishments were not considered remarkable or directly related to the type of psychoneurotic reactions that later developed. 33

If these factors appear throughout the study of neuroses in the armed forces, it is time that society does something about it. However, Bion and Rickman say:

> Society has not yet been driven to seek treatment of its psychological disorders by psychological means because it has not achieved sufficient insight to appreciate the nature of its distress. 34

However, society must gain sufficient insight. Educators, psychologists must re-examine the environmental influences of our youth. Parents must be made aware of the disastrous results of their behavior upon their offspring. We must prevent our youth from being predisposed to neuroses in times of stress, by giving them a pattern of adjustment to their environment for as it has been aptly said:

> It seems that the man who has developed a so-called "war neurosis" was predetermined before he entered the Service. It might even be said that war neuroses are "made in America" and only come to light or are labled in combat. 35

That is the challenge of this thesis and certainly the challenge of all future work in the field.

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33. Henderson, J. S., and Moore, M., op. cit., pp. 276-277.
34. Bion, W. R., & Rickman, J., "Intra-Group Tensions in Therapy", The Lancet, p. 678.
35. Moore, M., and Henderson, J. S., op. cit., p. 277.

CHAPTER III

PRESENTATION OF DATA

In this chapter assembled data of the study are presented. The data are presented in four major groups: (1) military data, (overseas service, rank, etc.), (2) personal differences, (age, aptitude, education), (3) home and family differences, and (4) behavior differences, (sex, love, fear, emotional). On all items where data were obtainable from the station statistical section, comparisons are made of the station population with the various diagnostic groupings. Other comparisons are made on the basis of known psychological and psychiatric experiences.

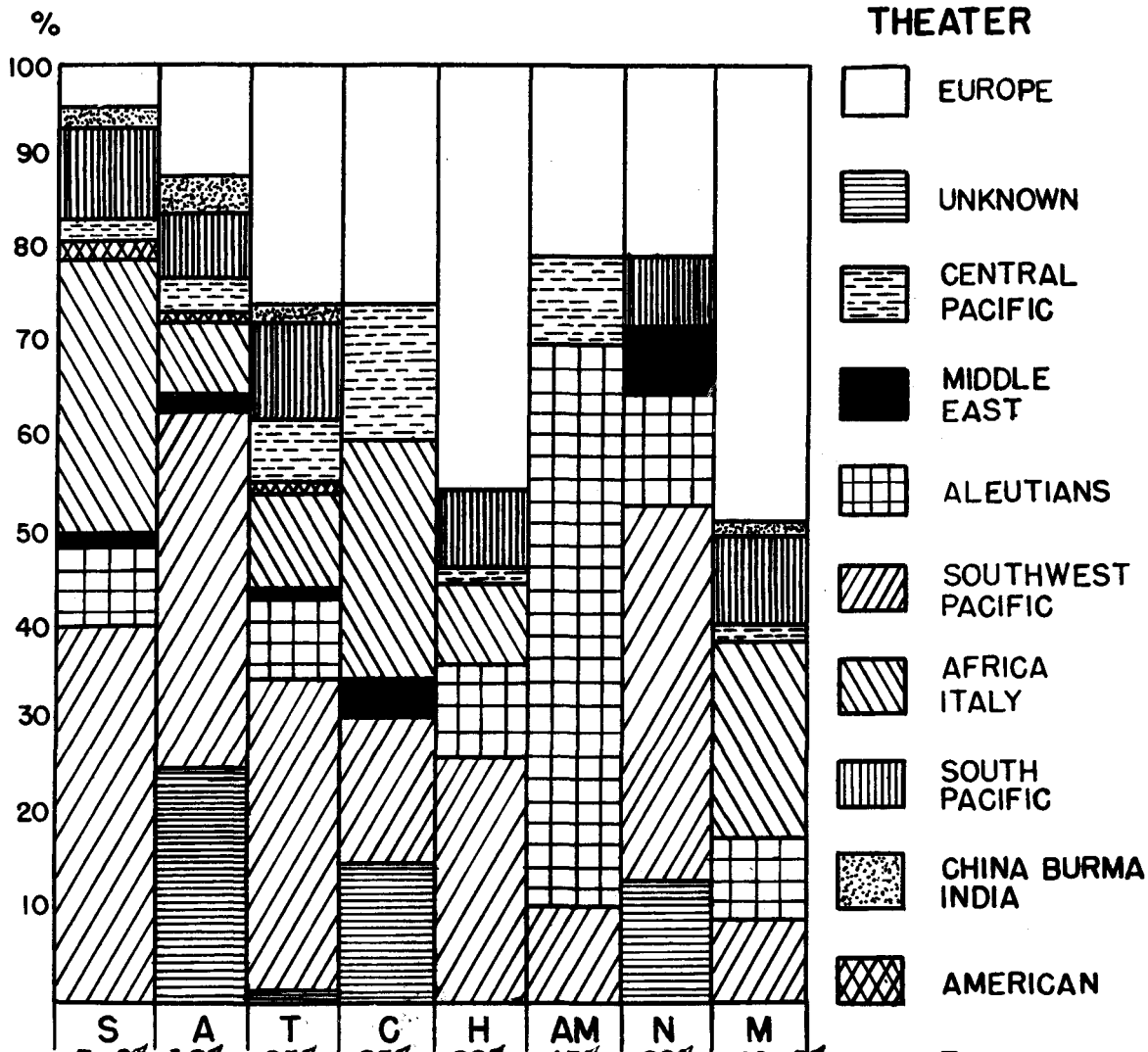
It is hoped that this study will (1) bring about a better understanding of the overseas veteran and his problems (2) challenge educators to examine their techniques, curricula and philosophies, so that the future generations will not be predisposed to neurosis under the precipitating factors of stress or change in living.

In tables and graphs throughout, the following abbreviations are used:

S ---- Station Population
A ---- Anxiety States
T ---- Reactive Tension States
C ---- Constitutional Psychopathic States
H ---- Hysterics
AM --- Adult Maladjustment States
N ---- Neurasthenics
M ---- Mixed Neuroses

GRAPH I

PERCENTAGES SERVING IN VARIOUS THEATERS OF WAR



S	A	T	C	H	AM	N	M	
3.6%	12%	25%	25%	20%	45%	20%	48.2%	Europe
- -	23.4%	2%	15%	13.6%	- -	- -	- -	Unknown
2.2%	4%	7%	15%	- -	7.5%	10%	- -	Cent. Pac.
.8%	1%	.5%	5%	6.6%	- -	- -	- -	Mid. East
19%	- -	7%	- -	13.2%	10%	60%	6.8%	Aleutians
40%	40%	33%	15%	40%	27.5%	10%	9%	S.W. Pac.
20%	9%	11%	25%	- -	7.5%	- -	22%	Afr-Italy
9.8%	7%	12%	- -	6.6%	7.5%	- -	9%	S. Pac.
2.1%	3%	2%	- -	- -	- -	- -	1%	C.B.I.
2.3%	.6%	.5%	- -	- -	- -	- -	3%	American

Military Data

The time spent overseas by the enlisted men in this study ranged from one to sixty-seven months. The data on overseas service of the veterans interviewed are shown in Table I.

Table I

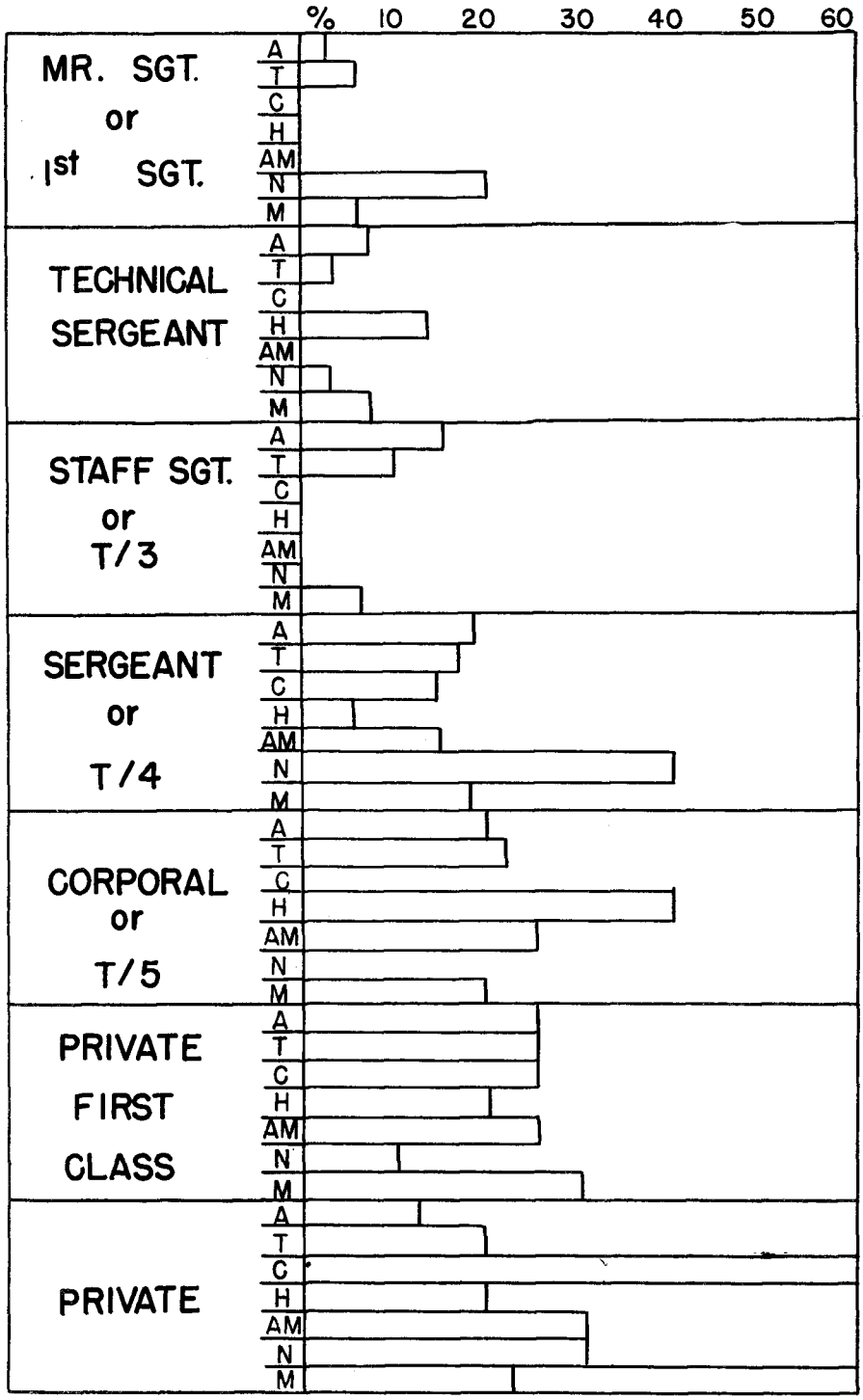
Comparison of Overseas Service of Various Neurotic Groups with the Station Population

	S	A	T	C	H	AM	N	M
M	26.28	22.71	25.60	19.45	29.30	25.20	15.50	26.16
S.D.	9.06	10.20	11.80	11.00	10.00	12.40	7.30	11.80

The mean months of overseas service is less in anxiety states, constitutional psychopathic states and neurasthenics than the station population. The neurasthenics spent less time overseas than any other type. The hysterics had a higher mean than any other group. This may have been caused by hospitalization overseas for the various conversion symptoms which are typical of this neurosis. The differences between the standard deviations of the station population and that of the neuroses are due to the distribution of the groups. The station population being a more nearly normal distribution than any of the neurotic groups which tend to group at either end of the range. This is true of all groups with the exception of the neurasthenics who spent much less time overseas than any other group.

GRAPH 2

ARMY RATINGS IN NEUROTIC GROUPS



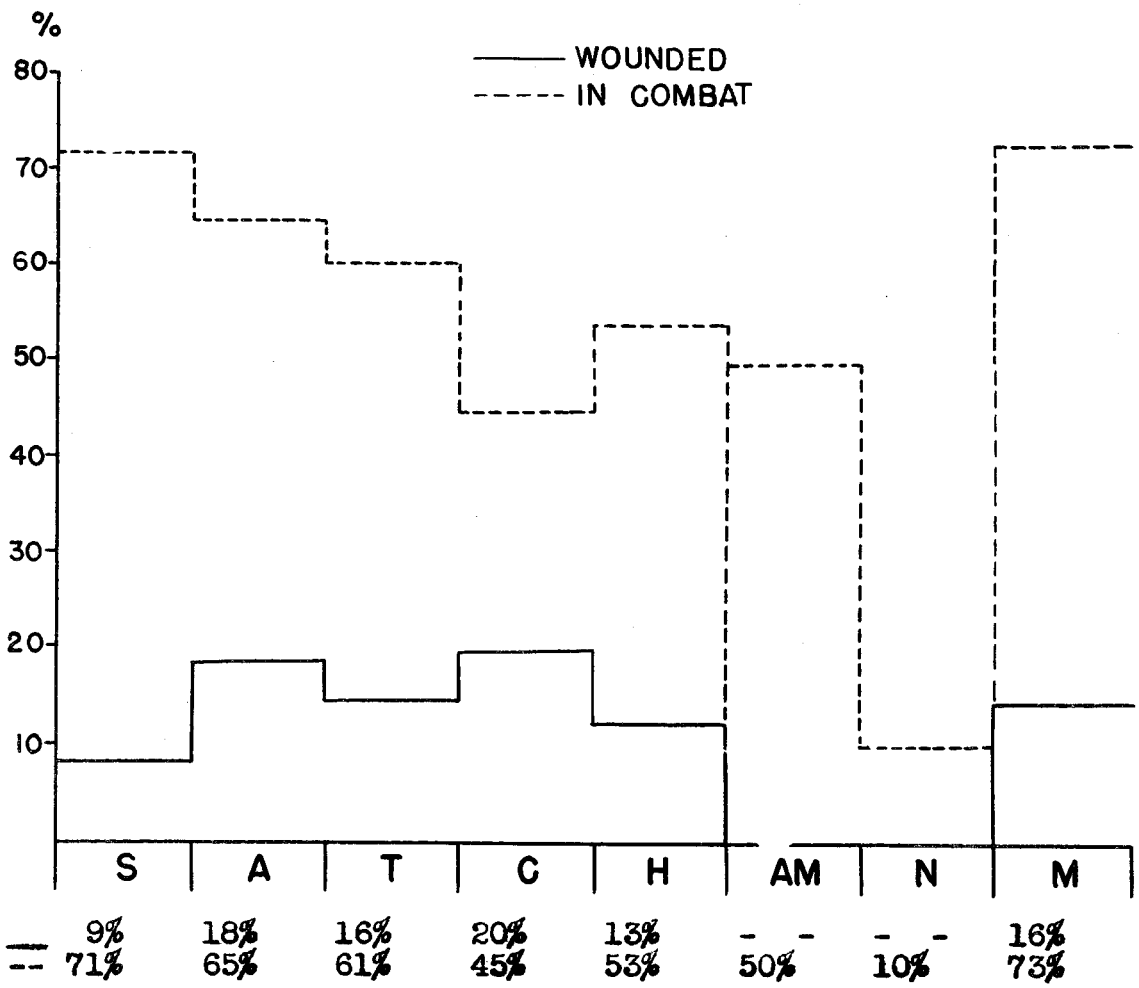
Graph 1 on page 41 shows the distribution according to the various combat theaters of the war. The high percentage of neuroses in the European theater in comparison with the percentage of the station population from the European theater is evident. This may be caused or weighted by the preponderance of liberated prisoners of war, most of whom were from the European theater. The Aleutians and Central Pacific, both of which saw little combat, seem to produce more than their proportionate number of neurasthenic cases.

On page 43 the comparison of military rank and the neurotic group is shown by Graph 2. Neurasthenia seems to be the neurosis of sergeants and first or master sergeants, all of whom have a responsibility with men. This is interesting in comparison with Table I as we find they get out of their responsibility with very short overseas service and as shown in Graph 1, they seem to prevail in non-combat areas. Constitutional psychopathics do not advance in rank. Eighty-five per cent of the adult maladjustment cases are in the first three grades (Private, Private first class, and Corporal), although, they are the most intelligent group in this study as shown in Graph 5.

Graph 3 on the next page shows that the neurotics seem to have less combat experience than the station

GRAPH 3

COMBAT SERVICE AND WOUNDS OF STATION POPULATION AND NEUROTIC GROUPS



population. This is due to many breaking down overseas while awaiting combat. The neurasthenics have been successful in avoiding battle experiences as only ten per cent were subjected to actual combat and none were wounded.

Table II shows the types of fire to which the entire neurotic group has been subjected. The figures in this table differ from Graph 3 since bombing was not included in the combat figures. This was omitted in the combat figures as much of the bombing was a single occurrence in some area quite remote from actual combat.

Table II

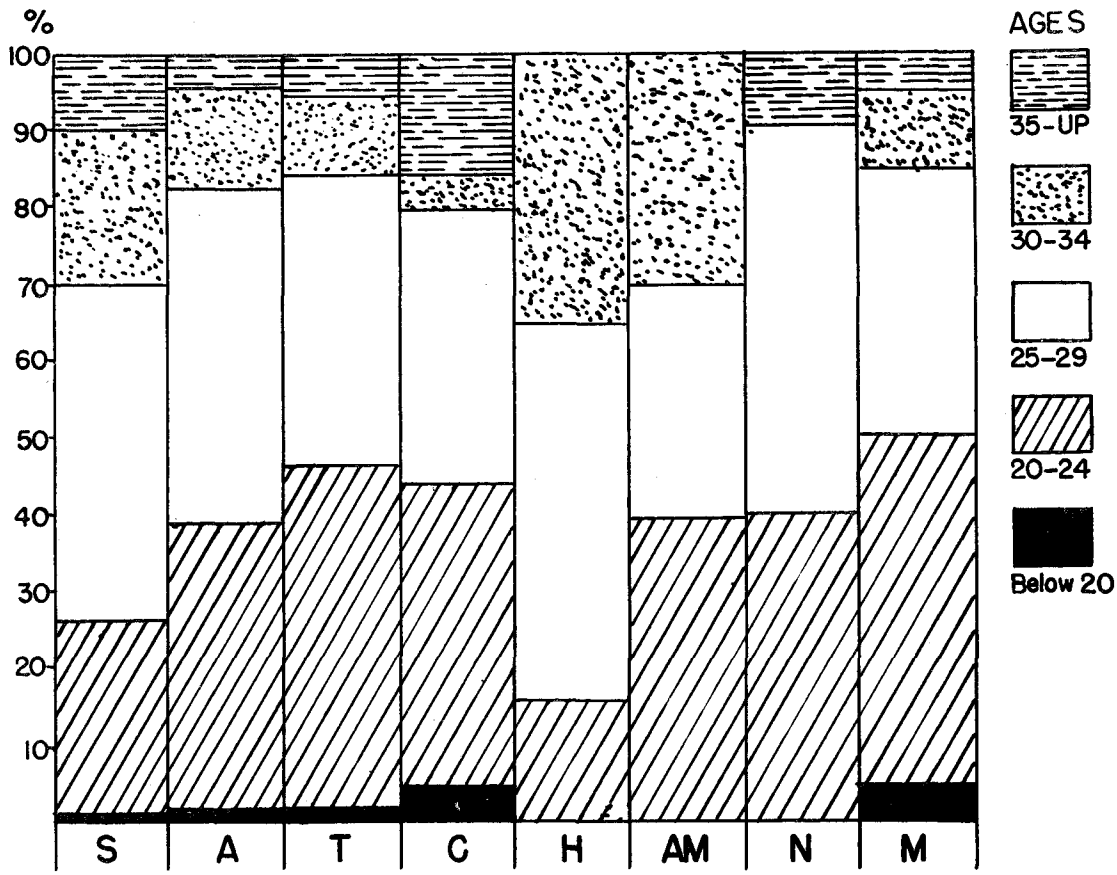
Percentage of Neurotics Subjected to Each Type of Fire

Bomb Only	Artil Only	Rifle Only	Bomb Artil	Bomb Rifle	Artil Rifle	Bomb Artil Rifle	None
13%	.1%	.5%	.4%	3%	2%	60%	17.4%

This table shows, of those neurotics subjected to combat, the greatest percentage were subjected to all types of fire. It also shows that bombing alone is a considerable factor in the neuroses. Graph 3 also shows that 50 per cent of the adult maladjustment cases were in combat and none were wounded. This is to be expected from the very nature of their neurosis, however, all other types of cases except the neurasthenics and the adult maladjustments showed a higher percentage wounded than the station population.

GRAPH 4

AGE GROUPS OF NEUROTICS AND STATION POPULATION



AGE GROUPS	S	A	T	C	H	AM	N	M
Below 20	.3%	.1%	.2%	.5%	--	--	--	.5%
20 - 24	27%	38%	45%	40%	14%	40%	40%	45%
25 - 29	42.6%	44%	39%	35%	51%	30%	50%	34%
30 - 34	17.6%	13%	9%	5%	35%	30%	--	11%
35 - up	12.5%	4%	5%	15%	--	--	10%	5%

Personal Data

Graph 4 on page 47 shows the age distribution of the neurotic group. In this study, like many reviewed in chapter two, the younger men are more subject to neuroses than are the older men. The larger proportion of men between 20 and 24 is noticeable at a glance when compared with the ages of the station population. To clarify this and to show the definite age groups within the various neurotic groups, Table III is introduced. This table shows more clearly the differences in the percentages in age group of neurotics and the percentages in age groups of station population.

Table III

Comparison of Age Groups of Neurotics with Same Age Groups of Station Population

Neuroses	Percentage in Age Group of Neurotics	Percentage in Age Group of Stat. Pop.	Difference
A	83% below 29	69.9% below 29	13.1%
T	86% below 29	69.9% below 29	16.1%
C	80% below 29	69.9% below 29	10.1%
M	84% below 29	69.9% below 29	14.1%
N	90% 20 to 29	69.6% 20 to 29	20.1%
AM	100% 20 to 34	87.2% 20 to 34	12.8%
H	86% 25 to 34	60.2% 25 to 34	25.8%

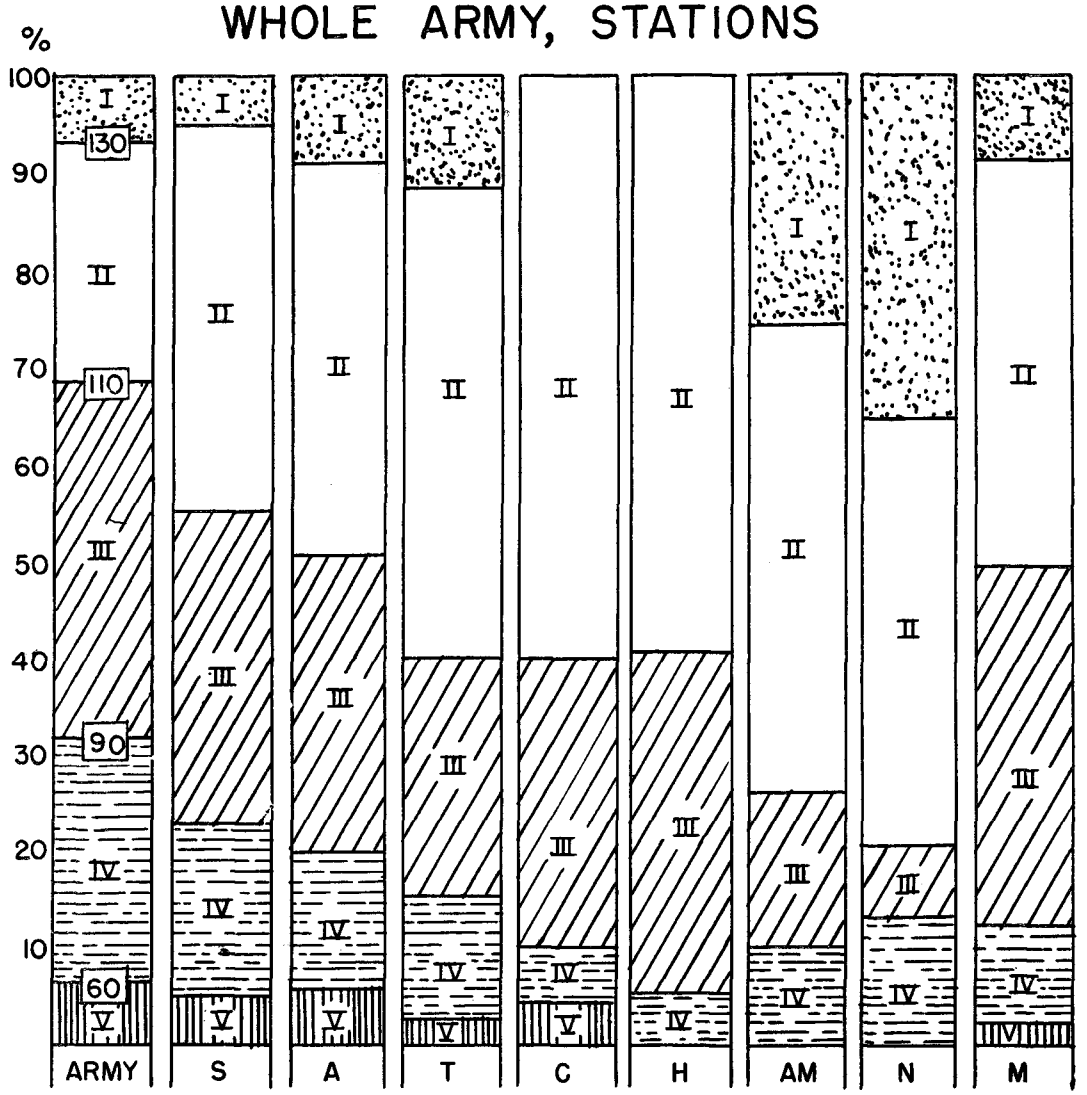
This table shows that the majority of neurotics are below 29 years of age with the exception of the hysterics which diagnosis seems more apt to occurr between the ages of 25 and 34. It appears that the

GRAPH 5

COMPARISONS

AGCT. SCORES

WHOLE ARMY, STATIONS



AGCT SCORES ☐

AGCT GROUPS	Army	S	A	T	C	H	Am	N	M
I	7%	5%	8%	11%	--	--	35%	25%	9%
II	24%	37%	41%	49%	60%	59%	45%	50%	42%
III	38%	33%	31%	24%	30%	34%	5%	15%	33%
IV	24%	19%	14%	12%	5%	7%	15%	10%	11%
V	7%	5%	6%	2%	5%	--	--	--	4%

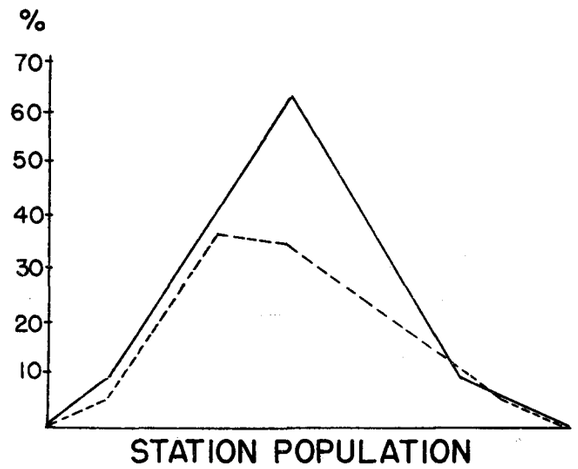
nearer the home situation the more apt the soldier is to be neurotic since the younger men seem to be more subject to neurosis than the older men who have been away from home longer before their army experience.

Another phase of the data which appears as significant is shown on Graph 5 on page 49. This is the comparison of the scores made by the neurotic groups in the Army General Classification Test (aptitude test) with the scores made by the station population and the army as a whole. The station population had a higher aptitude than the army as a whole. During overseas service many of the brighter and the duller seem to have been elimnated by retention, dropping out, and casualties. It is common practice in the army overseas to retain especially brilliant and efficient men as long as possible, also to transfer out, or return to the states men who are trouble because of low mentality. This would perhaps give a partial explanation of the smaller number of Group I and Group V in the station population. The neurotics, however, have much higher aptitude tests scores than the average station population. The more intelligent the enlisted man is, the more apt to have neurotic tendencies.

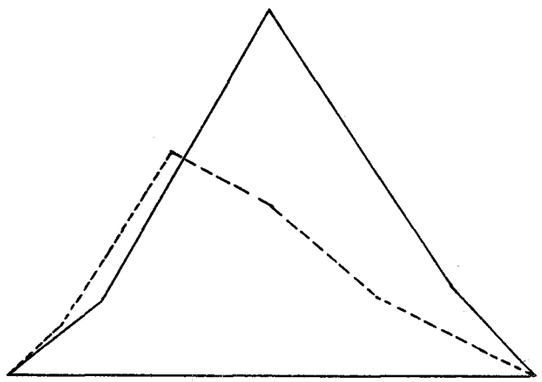
Another difference which is very evident is shown

GRAPH 6

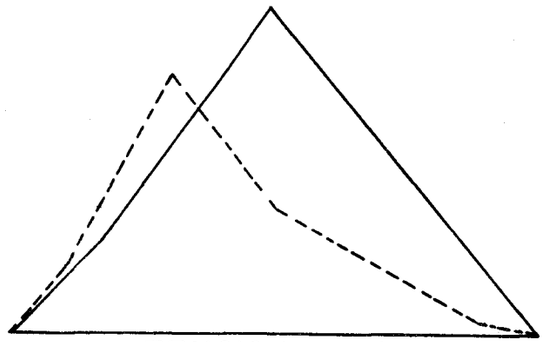
COMPARISON OF APTITUDE SCORES AND EDUCATIONAL ACHIEVEMENT



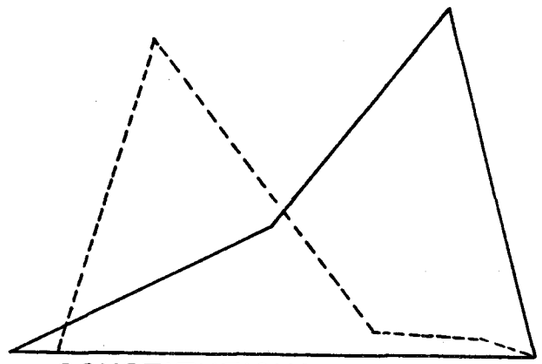
STATION POPULATION



ANXIETY STATES



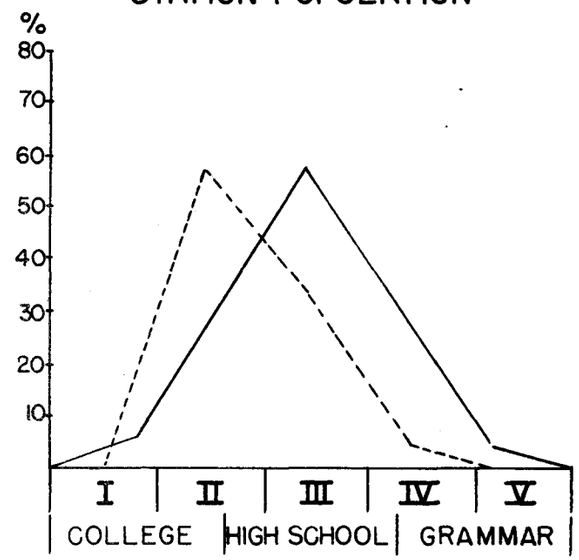
TENSION STATES



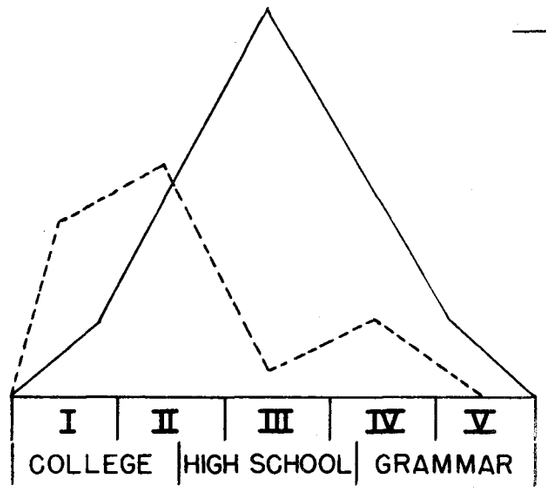
CONSTITUTIONAL PSYCHOPATHICS

---- APTITUDE SCORES

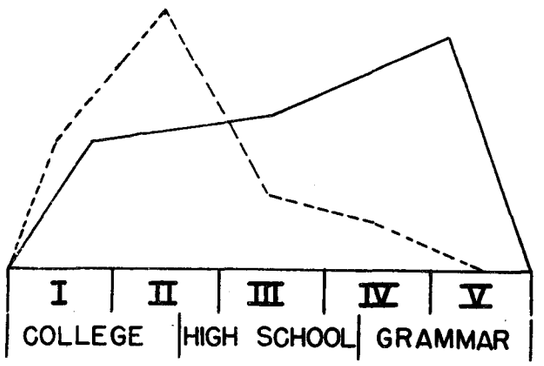
—— EDUCATIONAL ACHIEVEMENT



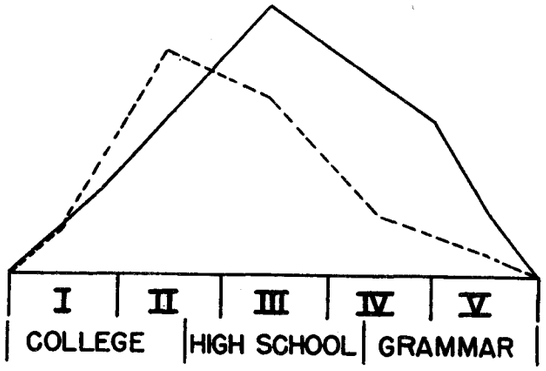
HYSTERICS



ADULT MALADJUSTMENTS



NEURASTHENICS



MIXED NEUROSES

graphically in Graph 6 on page 51. This graph compares the aptitude and the educational achievement of both the station population and the neurotic groups. In the graph labeled Station Population the educational achievement is higher than the aptitude. Without exception, in all the neurotic groups the aptitude is higher than the educational achievement. This reversal certainly appears to be indicative of a real difference. It may be an indication that the neurotics through pre-army maladjustment were not able to adjust to the school situation as well as the average, as shown by the station population. It also can be interpreted that the frustration of not being able to develop to the fullest extent of their ability is a factor in the neurotic tendencies of the group studied. Proof of either of these hypotheses cannot be given since the full circumstances could not be obtained except through the man's own evaluation for not having more education. However, the observable difference shown in Graph 6 is provocative and certainly indicative of some definite coincidence or a real differential between the entire station group and the neurotic groups.

Table IV shows the prevalence of enuresis, stuttering and stammering in the case history of the individuals of the neurotic groups. The enuresis figures in this

table are based upon present enuretics having a pre-war history of enuresis or neurotics, not now enuretics, but having a pre-war history of enuresis. Two cases of enuresis, appearing for the first time during army experience are not included, since both men admitted they had used this as a possible way for discharge from the army. Hence they were not true enuretics and after talking with the psychologists had no recurrence of symptoms. Stuttering and stammering data used in the table are based upon those cases now stuttering or stammering whether or not they had a pre-war history of speech difficulties.

Table IV

Occurrence of Enuresis, Stammering and Stuttering in the Case Histories

	A	T	C	H	AM	N	M
Enuresis	8%	11%	10%		15%		1.6%
Stuttering & Stammering	9%	11%	25%		10%		8%

This table shows that enuresis, stuttering and stammering were more prevalent in tensions states, constitutional psychopathic states, and adult maladjustment cases. There was complete absence of these syndromes in either the hysterics or neurasthenics. It appeared that enuresis and speech difficulties found in these veterans were generally of psychic origin. The presence of either, in

childhood or in adulthood, certainly raises the question as to whether they are neurotic indicators. Most of the enuresis cases could be traced through case history techniques, to excessive attachment and over-dependence to the mother. Many of the speech difficulties are directly traceable to repressions in childhood. In the psychotherapy used with the cases in this study, ninety per cent of the stammering and stuttering (without physical causation) and a hundred per cent of the enuretics were cured by the discovery of the predisposing factor and the case gaining insight into such factors.

The most frequent complaints of men coming for help were sweaty palms, tremors, and extreme tension. The percentage of these three complaints in the various neurotic groups is shown in Table V. One of these three complaints is nearly always the reason given by the case for coming to the psychologist for help.

Table V

Primary Complaints of Cases Coming To the Psychologists for Aid

	A	T	C	H	AM	N	M
Sweaty Palms	69%	38%	60%		10%		30.4%
Tension	68%	61%	62.5%	59.4%	65%	70%	80%
Tremors	24%	34%	62.5%	20%	30%		57.6%

Extreme tension is the most prevalent of these three complaints. Ninety per cent of the above complaints

can be stopped in the limited time the case was at the redistribution station. When (1) a complete case history was taken (2) relaxation therapy was given. It was observed that unless the complete case history was taken, very few cases improved under the relaxation therapy alone. This indicates the catharsis of the case history and the insight given into its factors during the relaxation therapy was the major therapeutic instrument. The causative factors in the three above complaints were in nearly every case based in pre-army life.

Table VI shows other complaints which were given infrequently as primary but frequently as secondary. These complaints were chronic alcoholism, excessive emotionalism, and tics.

Table VI

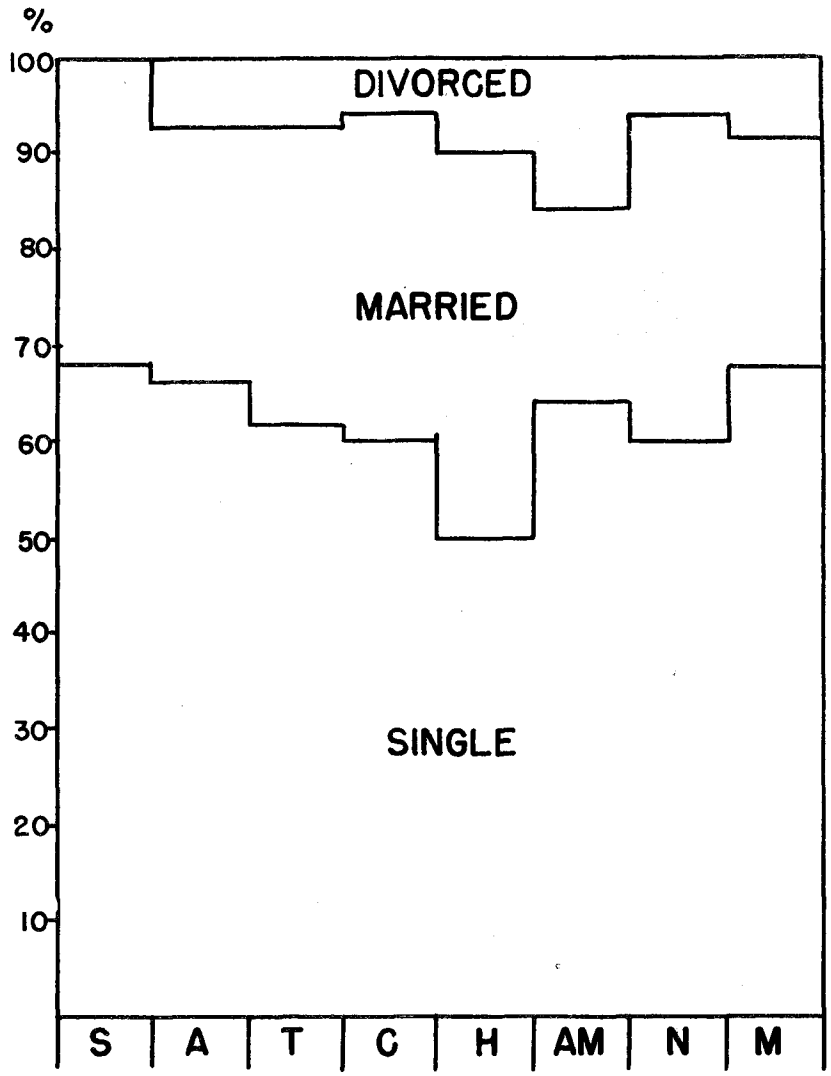
Secondary Complaints of Cases Coming To the Psychologist for Aid

	A	T	C	H	AM	N	M
Emotionalism				33.3%	47.5%		11.2%
Alcoholism	5%	8%	35%	13.2%	35%	30%	14.4%
Tics		5%		5%		10%	1.6%

This table shows the constitutional psychopathics, the adult maladjustments and the neurasthenics were very prone to attempt escape with alcohol. The case histories show that this has been true, not only while they were in the army but before. The hysterics and adult malad-

GRAPH 7

MARITAL STATUS OF STATION POPULATION AND NEUROTIC GROUPS



STATUS	S	A	T	C	H	AM	N	M
Married	30.6%	26%	30%	35%	40%	20%	35%	33%
Single	69.4%	68%	64%	60%	50%	65%	60%	67%
Divorced	*	6%	6%	5%	10%	15%	5%	8%

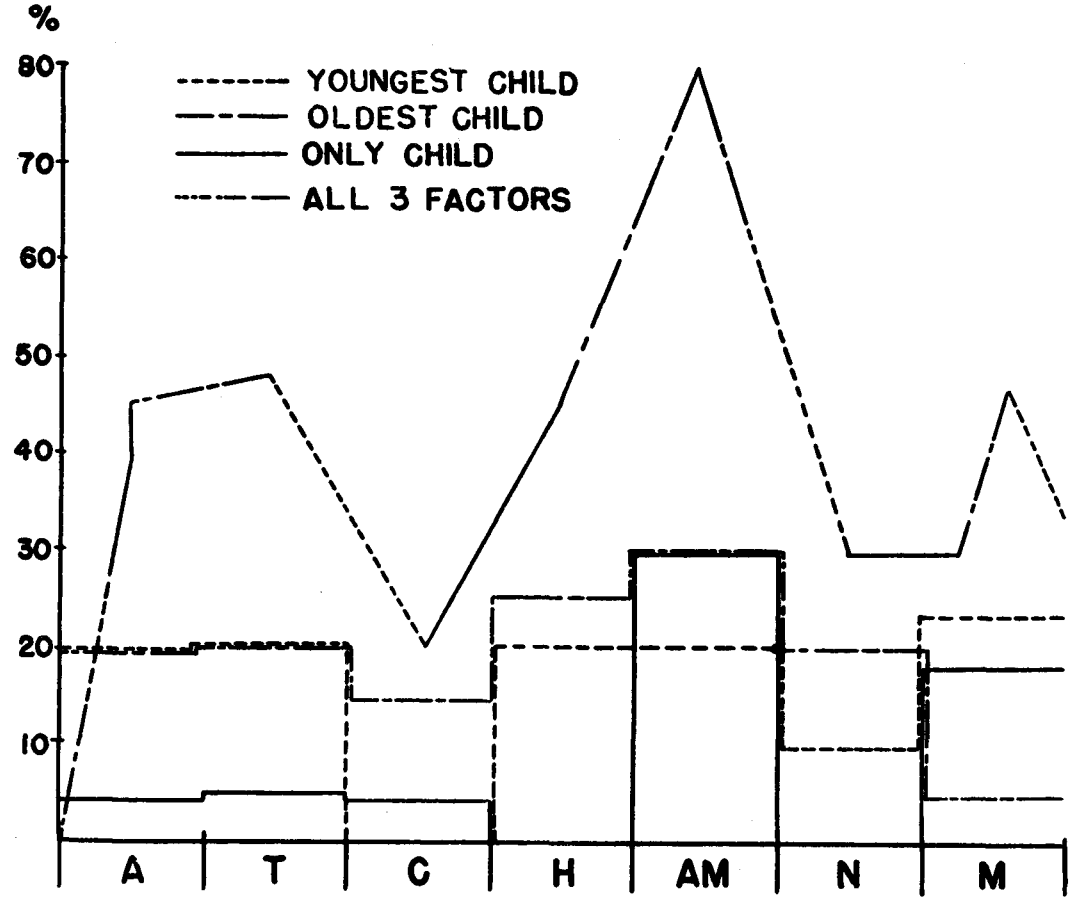
* Divorced men counted as single men.

justment cases were extremely emotional, many times demonstrating their emotional instability during the case history interview. Tics were more prevalent in cases classified by the psychiatrist as tension states, hysterics, and neurasthenics. This would probably be true since the tic is included in the symptoms used in making the diagnosis. The limited time that these men were available for psychotherapeutic procedures made it impossible to do more than give them insight into the reasons for their alcoholism and suggestions for them to recondition themselves against the excessive drinking of alcohol. Tics responded to the case history catharsis and relaxation therapy and disappeared in all but one case during their stay at the station. Extremely emotional cases appeared to calm down after the case history and relaxation therapy and in many cases distinct improvement was seen, however, some seemed to enjoy their emotional "spells" so much that they seemed to have no desire to correct it.

Graph 7 on page 56 gives a picture of the marital status of the station population and the neurotic groups. The marital status of the groups interviewed does not seem to differ from the marital status of the station population with the exception of the adult maladjustment cases. The adult maladjustment cases seem less apt to

GRAPH 8

PLACE IN FAMILY OF NEUROTIC GROUPS



	A	T	C	H	AM	N	M
Yng.	20%	21%	- -	20%	20%	10%	22.4%
Old.	20%	21%	15%	26.4%	30%	20%	4.8%
One	5%	6%	5%	- -	30%	- -	19.2%
All	45%	48%	20%	46.4%	80%	30%	46.4%

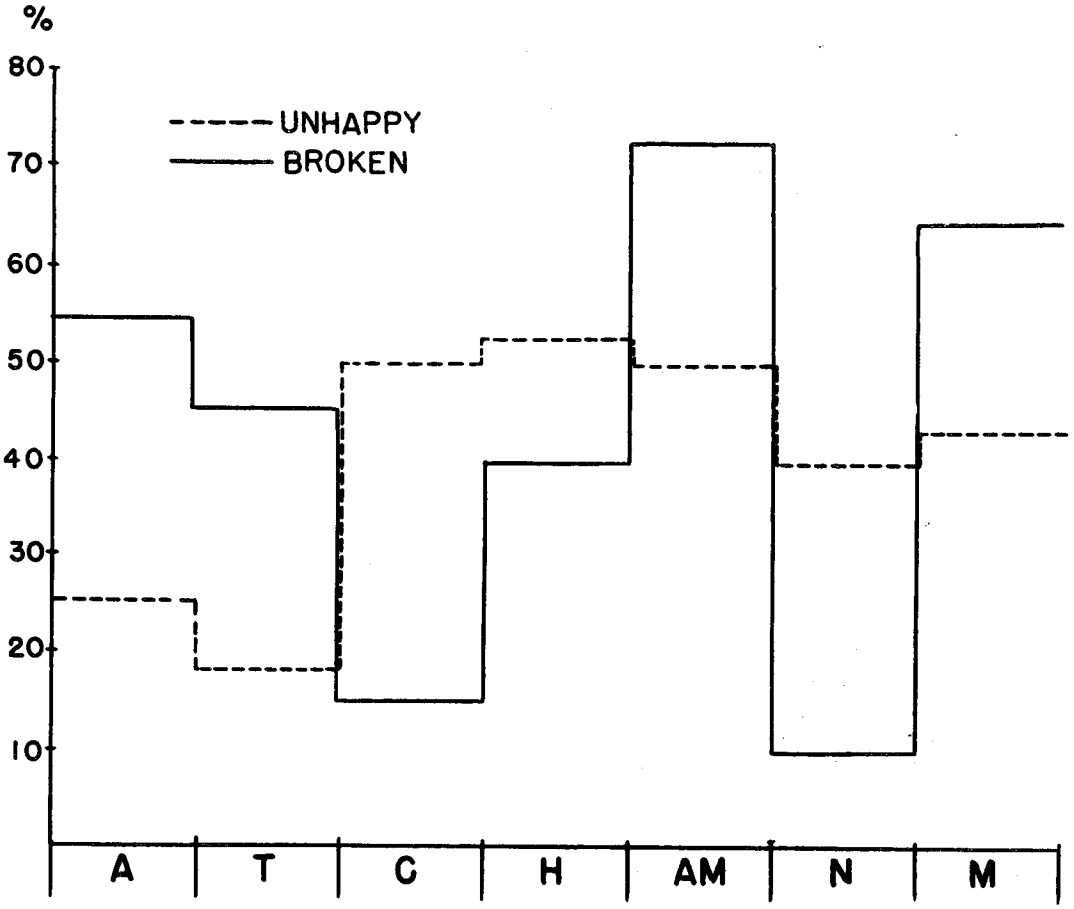
marry and also show a higher divorce rate than any other type of neurosis. Marriage does not seem to be a factor in the other types of cases.

Home and Family Differences

Most of the studies reviewed in Chapter II have found a high percentage of war neurosis cases have a poor home and family background. A number of factors have appeared in the tabulation of the data of this study which confirm and re-enforce the above view. Graph 8 shows that the place in the family may be a definite factor in predisposition to neurosis. Most of the cases came from rather large families. Only children, contrary to previous views, seem much less apt to be neurotic than the children of larger families. In 1940, 19,469,710 families had children under 21 while 7,625,843 families had only one child. In other words, 39 per cent of the families having children had only one child. This compared with the eight per cent of the neurotic only children interviewed in this study is significant. Graph 8 also shows that the youngest child and the oldest child have a greater chance of becoming neurotic than others in the family. The average family in this study, excluding families with only one child, has five and nine tenths children. This gives sixteen per cent who are youngest or oldest children. With the exception of the

GRAPH 9

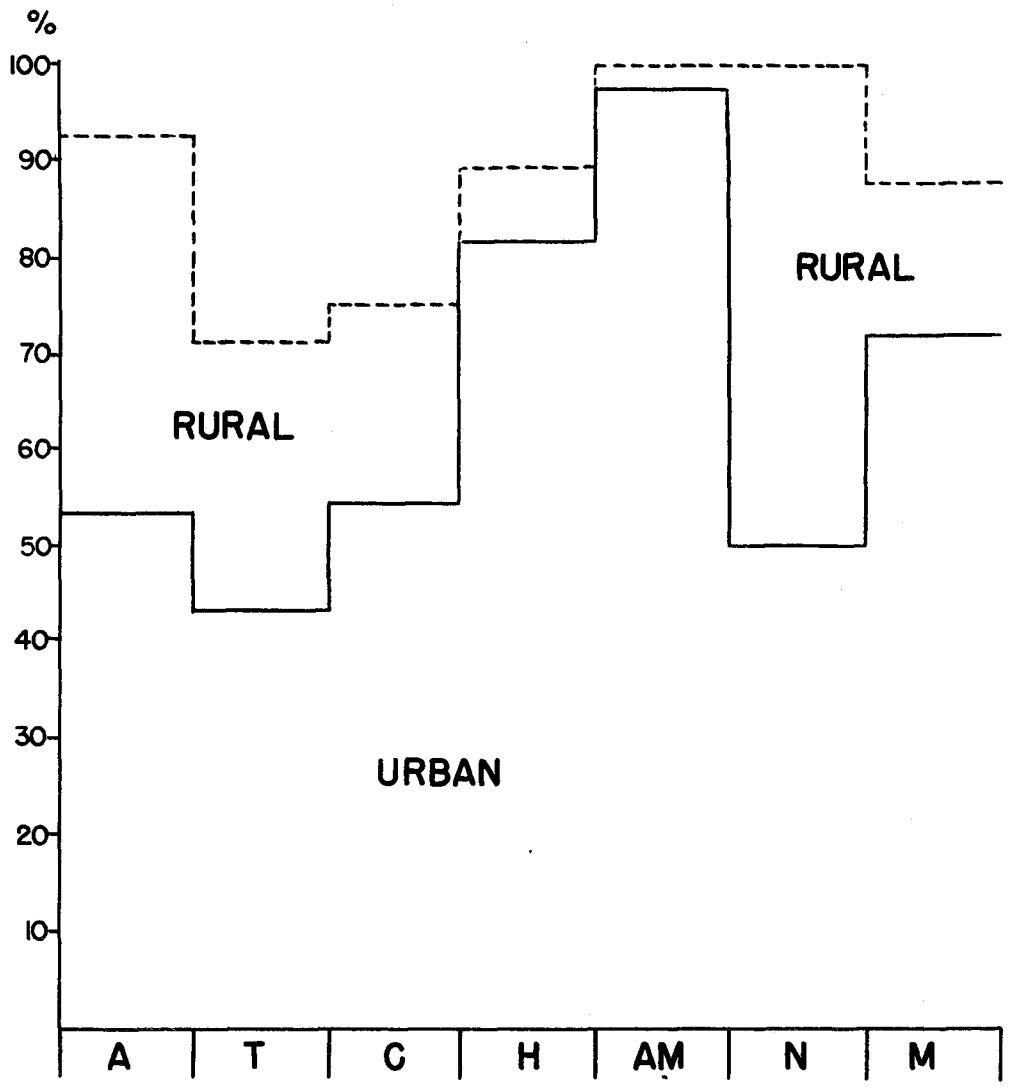
INDIVIDUAL EVALUATION OF HOME LIFE



HOME	A	T	C	H	AM	N	M
Broken	54%	46%	25%	40%	72.5%	10%	64%
Happy strict	40%	40%	15%	33%	40%	40%	37%
Happy lax	21%	13%	5%	--	10%	20%	12.8%
Unhappy strict	23%	15%	15%	13.2%	10%	40%	25.6%
Unhappy lax	12%	13%	35%	40%	40%	--	16%

GRAPH 10

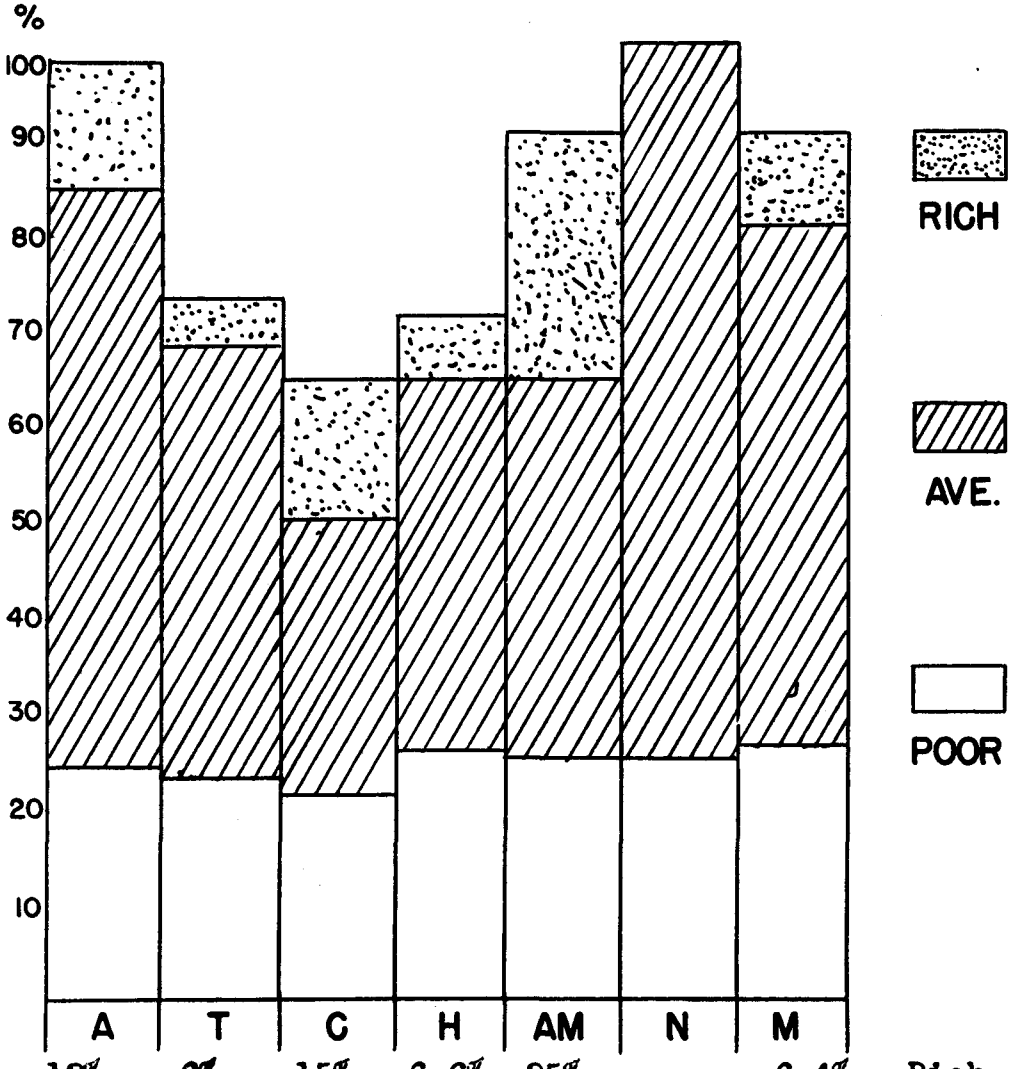
RESIDENCE OF NEUROTICS
URBAN OR RURAL



LOCATION	A	T	C	H	AM	N	M
Rural	38%	28%	20%	6.6%	2.5%	50%	16%
Urban	54%	44%	55%	82.5%	97.5%	50%	72%
No record	8%	28%	25%	10.9%	--	--	12%

GRAPH II

HOME ECONOMIC STATUS OF NEUROTIC GROUPS (INDIVIDUALS EVALUATION)



	A	T	C	H	AM	N	M	
	12%	6%	15%	6.6%	25%	--	6.4%	Rich
	59%	45%	30%	40%	40%	75%	56%	Ave.
	26%	24%	20%	26.4%	25%	25%	25.6%	Poor
	3%	25%	35%	27%	10%	--	12%	No record

constitutional psychopathic states the place in the family in the case of either being the oldest or youngest child seems to be a causative factor. In every group, with the exception of the neurasthenics and mixed neurosis, being the oldest or youngest child is evident.

The men's evaluation of their home is shown in Graph 9 on page 60. From 28 per cent to 50 per cent consider their childhood homelife unhappy. From 10 per cent to 72.5 per cent of their homes were broken by the death of one or both of the parents or by divorce.

In 1940, 43 per cent of the population of the United States lived in communities of 2500 and under and 57 per cent in communities of 2500 or over. Graph 10 on page 61 shows there is a definite trend for hysterics and adult maladjustment cases to come from urban areas. The very nature of these neuroses would be encouraged by the type of living, the close quarters, and forced intimacy of the urban communities.

The economic status from the men's own evaluation of their homes, as shown in Graph 11 on the preceding page, does not show any unusual difference. The neurasthenics did not evaluate their family's financial status as wealthy. It is necessary in studying the family background to show the incidence of one parent being dead or the parents divorced. Table VII shows the percentages of the data only when it occurred in the childhood of

the case.

Table VII

Data Concerning Parents During Childhood of Cases

		A	T	C	H	AM	N	M
Father:	alive	80%	76%	95%	53.4%	60%	100%	62.8%
	dead	19%	23%	5%	40%	40%		34%
	unknown	1%	1%		6.6%			3.2%
Mother:	alive	90%	81%	90%	66.9%	67.5%	90%	73.4%
	dead	10%	18%	5%	23.2%	32.5%	10%	25%
	unknown		1%					1.6%
Parents:	divorced	1%	20%	25%	6.6%	15%	10%	24%

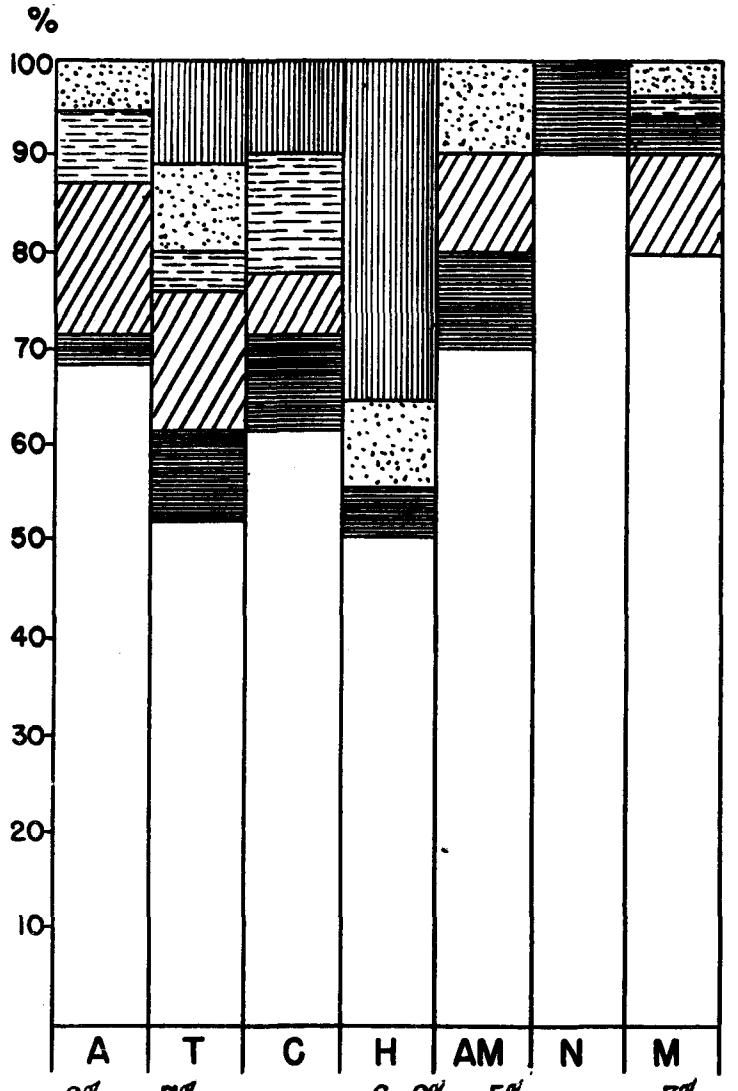
This table shows that from 29 to 73.2 per cent of the cases lost a parent during childhood. The percentage is especially high in the hysterics and adult maladjustment cases. The tension states, constitutional psychopathic states and mixed neurosis cases come from homes where divorces were more prevalent. A high prevalence of homes broken by either death or divorce indicate a definite pre-army predisposing factor.

Behavior Data

In this section the data concerning various types of behavior, as exposed through the case histories is grouped. Two of the most common reactions of all the neurotic groups, except neurasthenics, are insomnia and poor appetite. The sleeplessness runs the gamut from being unable to go to sleep for hours, restless and

GRAPH 12

LOVE BEHAVIOR IN HOME OF NEUROTIC GROUPS



OUTSIDERS
FATHER
BOTH PARENTS
NO INFORMATION
NOBODY
MOTHER

A	T	C	H	AM	N	M	
6%	7%	--	6.6%	5%	--	3%	Outsiders
15%	15%	5%	--	10%	--	10%	Father
7%	5%	12.5%	--	--	--	2%	Both
--	11%	10%	36.8%	--	--	--	No information
3%	9%	10%	6.6%	10%	10%	5%	Nobody
69%	53%	62.5%	50%	70%	90%	80%	Mother

troubled sleep, awakening several times during the night, sometimes with extreme startle reactions, and nightmares with extreme fear reactions upon awakening. The poor appetites may consist of merely picking at food, nausea after eating, to the regurgitation of whatever they eat, whenever they eat. Table XIII shows the incidence of these symptoms as found in the case histories.

Table VIII

Occurrence of Insomnia and Poor Appetite in Various Neuroses

	A	T	C	H	AM	N	M
Insomnia	66%	65%	50%	67%	60%	30%	84.8%
Poor Appetite	44%	34%	35%	59.4%	55%		32%

Insomnia runs high for the men of the ages of these cases with the exception of the neurasthenics. This is true also in the cases of poor appetites. Psychotherapeutic techniques were successful in every case where physical causation was not demonstrated. The disappearance of these symptoms was immediate, when corrected by insight, into the pre-army causes that are brought out in the case history technique.

Graph 12 on the preceding page tabulates the love behavior of the various neurotic groups. It shows a definite trend that is mentioned by several authors as one of the primary causations of the neurotic tendencies in our youth; mother fixation. In the group interviewed a

very small percentage have normal love behavior toward both parents and a surprisingly large group say that they love no one. The preponderance of cases were quite definite in their preference for their mother and in the follow-up questioning, in every case, the preference was definitely an excessive, and therefore mentally unhealthy, attachment. It is also interesting that not a single hysteric or neurasthenic case loved either both parents or their father best. The hysterics were particularly unresponsive when questioned in this area.

The major behavior pattern found in this study, under the classification of emotional behavior are indicated in Table IX.

Table IX

Emotional Behavior of Neurosis Cases

	A	T	C	H	AM	N	M
Moodiness	58%	55%	50%	33.3%	80%	50%	56%
Supersensitive	82%	55%	55%	33.3%	80%	50%	38%
Flash Temper	52%	55%	50%	40%	80%	60%	61%
Slow Temper	8%	4%	2.5%	6.6%			1.6%
Depressed	26%	17%	2.5%		40%	10%	25.6%

The three outstanding emotional behavior patterns are: moodiness, supersensitiveness, and flash temper. These are pre-army behavior patterns and are indicative of neurotic maladjustment.

The fear behavior of the neurotics is shown in Table X. Any fear or phobia which was mentioned in a case history interview was noted. However, the table includes

GRAPH 13

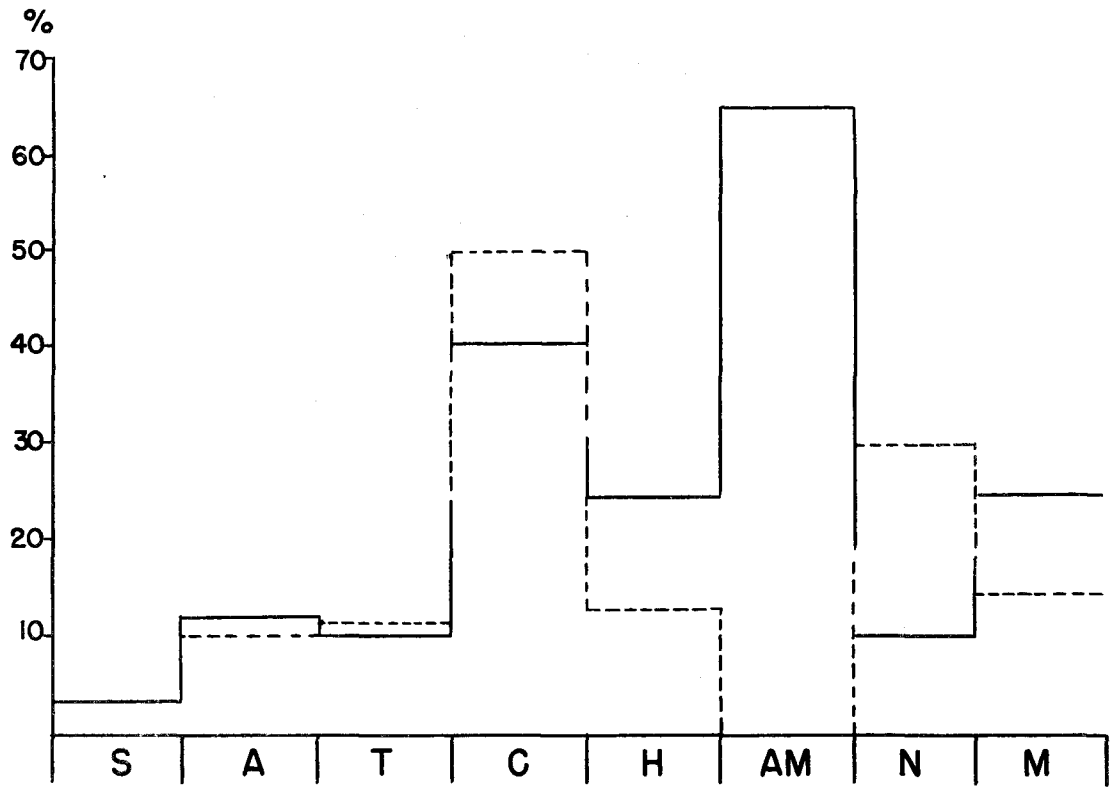
DELINQUENCY OF

CIVILIAN AND MILITARY

OF STATION AND NEUROTIC GROUPS

——— ARMY

----- CIVILIAN



Delinquency	S	A	T	C	H	AM	N	M
Military	1.2%	12%	10%	40%	26.4%	65%	10%	24%
Civilian		10%	11%	50%	13.2%	--	30%	15%

only those which appeared in a number of cases.

Table X

Fear Behavior of Neurotic Groups

	A	T	C	H	AM	N	M
Nyctophobia	76%	67%	50%	33.3%	70%	10%	56%
Acrophobia	64%	49%	40%	52.8%	80%		34%
Hydrophobia	34%	32%		33.3%	50%		13%
Zoophobia	1%	2%			10%	10%	3.1%
Necrophobia	2%	1%					1.6%
Taphophobia	1%	.6%					1.6%
Claustrophobia	30%	40%	30%	13.2%	50%		21%
Xenophobia		2%				10%	8%

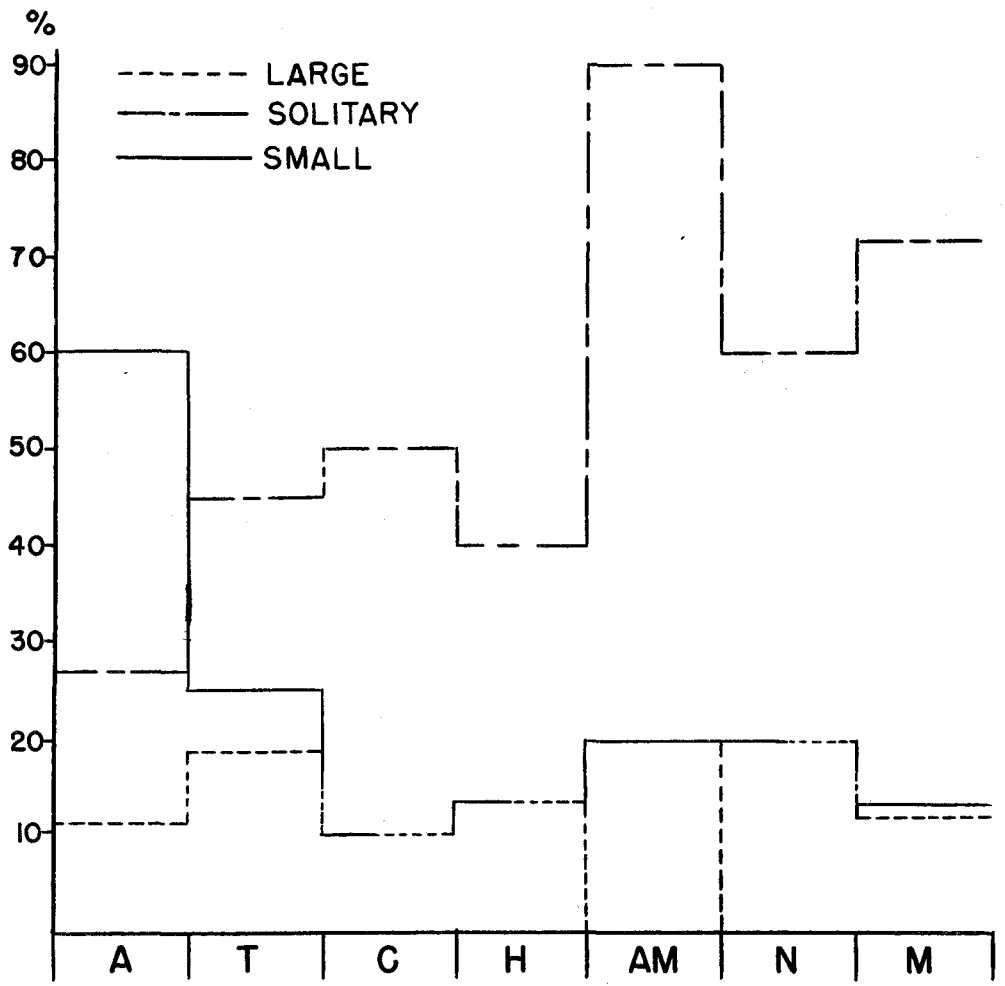
The above table shows the phobias of the neurotic seem to be principally nyctophobia, acrophobia, hydrophobia, and claustrophobia. One or more of these appears in each case history except those of the neurasthenics. All have their cause in childhood experience without exception.

Graph 13 on the preceding page illustrates the military and civilian delinquency rate of the neurotic groups and the military delinquency rate for the station population. The rate of courts martial for station population was 1.2 per cent while in the neurotic group, the rate runs from 10 per cent to 65 per cent. This is certainly evidence of maladjustment to military life. The pre-army delinquency rate, which includes juvenile as well as adult delinquency, runs from none to 50 per cent. The entire lack of civilian delinquency records in the adult maladjustment cases shows that when they are in a home situation they keep out of trouble with society, but in

GRAPH 14

RECREATION HABITS

SIZE OF GROUP OF FAVORITE RECREATION OF NEUROTICS



GROUP SIZE	A	T	C	H	AM	N	M
Large	12%	19%	10%	13.2%	--	20%	12%
Small	60%	25%	10%	13.2%	20%	20%	16%
Solitary	27%	46%	50%	40%	90%	60%	72%
Mixed	31%	3%	--	6.6%	5%	10%	3%

the army they have the highest rate of any of the neurotic groups. The constitutional psychopathics have a high occurrence of delinquency in both civilian and military life. However, the entire civilian record of all the neurotic groups, except the adult maladjustments, indicates a predisposition and a definite anti-social tendency.

The recreational habits of the neurotics were found by asking the case to state his favorite pre-war recreation or hobby and his second-favorite recreation. To facilitate the examination of these data the various recreations were arbitrarily classified by the size of the group. For example: reading, making models, movies, hunting or fishing alone, etc., were classified as solitary. Ping pong, tennis, dancing, etc., were classified as small groups. Baseball, football, parties, etc., were classified as large groups. Dancing parties, etc., were also classified as mixed groups. Graph 14 on the preceding page illustrates this distribution. The large percentage of solitary and small group recreational preferences are certainly evident in all types of cases. The tendency to withdraw and to prefer solitary recreation is a definite anti-social and neurotic tendency.

Only such personality traits that appear in ten per cent or more of any one group are shown in Table XI. All of these are taken from the case histories upon the man's own admission. All were prevelent in the pre-army life of

the cases. The traits listed in this table are all definite predisposing factors of the present neurosis.

Table XI

Major Personality Traits Shown in Neurotic Groups

	A	T	C	H	AM	N	M
Inferiority	22%	28%	15%	20%	30%	65%	9.6%
Unloved	4%	12%		6.6%	20%		4.8%
"Lone Wolf"	19%	8%	35%		35%		6.4%
Shy & Bashful	9%	17%	5%		7.5%		9.6%
Under Observation.	4%	2%	5%		20%	20%	1.6%

The unusually high percentage of inferiority feelings in the neurasthenic stands out from all other figures in this table. This follows the pattern shown in their feeling of inadequacy in positions of leadership and their avoidance of combat. The adult maladjustment cases show a fairly high percentage in all the factors. These personality maladjustments are very much interrelated, and although any one of them may be the one mentioned or brought out in a case history some degree of each is generally present.

Table XII gives a tabulation of the principal dreams that are remembered by the various neurotics. The dream life is asked principally to check other factors in case histories, and is included here merely as a matter of interest. The following table shows the percentage of cases of the principal types of dreams remembered.

Table XII

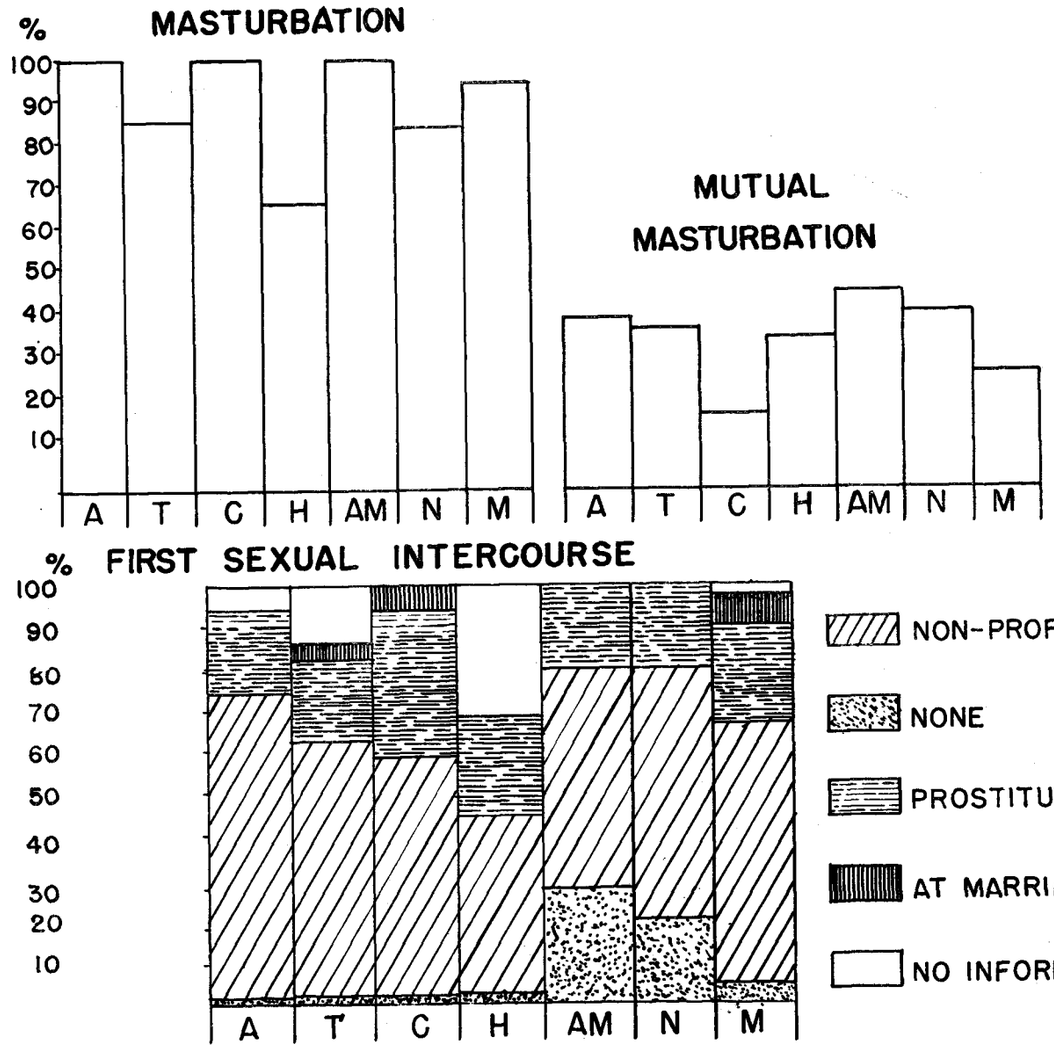
Principal Dreams Remembered by the Neurotic Groups

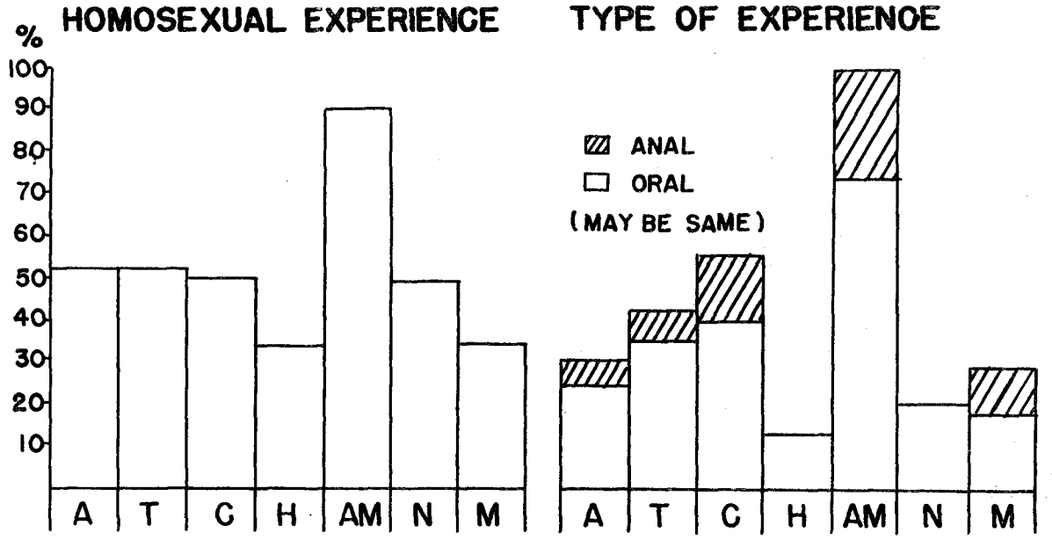
	A	T	C	H	AM	N	M
Falling	49%	43%	30%	33%	65%	50%	34%
Being Chased	50%	50%	30%	26.4%	55%	40%	34%
Combat	47%	42%	30%	20%	40%	30%	50%
Home	12%	16%	25%	20%	2.5%	30%	11.2%
Water	9%	18%	15%	6.6%	30%	10%	9.6%
Floating	3%	3%	5%		2.5%		1.6%
Sex	11%	28%	20%	6.6%	30%	10%	19.2%
Flying	4%	3%	10%	6.6%		10%	4.8%
Being Crushed	12%	17%	30%	6.6%	30%	10%	4.8%
Whirling	2%	6%	5%		10%		
Death	2%	19%	35%		12.5%		14.4%
Wrecks	3%	8%	5%		7.5%	20%	6.4%
Killing	3%	6%	20%	6.6%	5%		8%
Religion	1%	1%					
Fantastic	32%	15%	20%		35%		3.2%

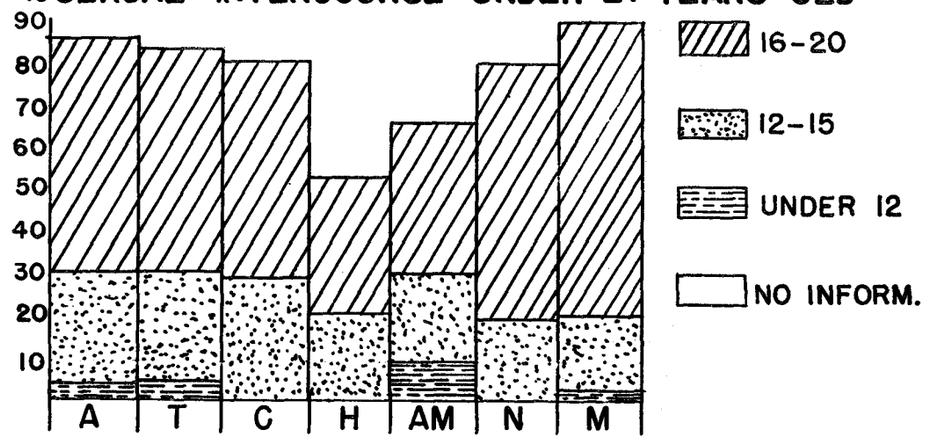
This table shows the dreams remembered by the cases follow a rather definite pattern. It was found if one of the dreams with common psychological interpretation appeared in the case history, without the accompanying behavior history, questioning always revealed that such behavior history had been held back by the case. Interviewees will talk about their dreams much more easily than they will the behavior that is so often indicated by the dreams.

The sexual behavior of the neurotic groups is varied as well as startling. The assurance that no military record would be kept of this history made it possible to get the complete data that are shown in Table XIII. The one exception to this is the hysteric group, one third of which refused to talk about its sexual history.

GRAPH 15
SEX BEHAVIOR
OF NEUROTIC GROUPS







The cases all seem anxious and relieved to talk about their sexual experiences. All had more or less guilt feeling about their sex experiences and many mentioned that it was the first time they had felt free to talk with anyone about them. A great many of the predisposing factors of neurosis were found in the sexual behavior or experiences. Psychotherapy was much more effective in every case where complete sexual history was obtained than in any case where it was not obtained.

The figures in certain sexual behavior as shown in Table XIII are much higher than those in any previous studies or literature. None of the cases interviewed had had any formal sexual education previous to their army experience except sporadic moralistic sex lectures.

Table XIII on the next page, in line with other studies on sexual behavior, shows that masturbation is present in most of the case histories where information was given. The only deviation is that 15 per cent of the neurasthenics claim no masturbation. The most prevalent source of original masturbation information was being shown how to masturbate by an older boy. The graphic presentation is shown in Graph 15 on the preceding page. Mutual masturbation appears first in pre-army experience in every case but is continued in army experience.

Table XIII

Sexual Behavior of Neurotic Groups as Revealed in Case Histories

	A	T	C	H *	AM	N	M
M	95%	86%	100%	67%	100%	85%	92%
MM	39%	38%	15%	33.3%	45%	40%	25.6%
OBS	51%	41%	50%	13.2%	55%	60%	36.8%
No M	5%	5%				15%	4.8%
H Exp.	53%	52%	50%	33.3%	90%	50%	35%
HO	26%	34%	40%	13.2%	75%	20%	17.6%
HA	4%	9%	15%		25%		11.2%
Beast.	1%	5.5%			10%		1.6%
Exhibit.		.3%	5%		2.5%		
Frict.		.6%	5%				
Cunni.	1%	1%	10%		15%		
Ling.		4%			7.5%		
Fell W.	16%	18%	30%		45%		9.6%
Group	2%	4%	20%	6.6%	10%	10%	
1st SI:NP	71%	58%	27.5%	39.6%	50%	60%	60.8%
" HP	22%	19%	20%	13.2%	20%	20%	24%
M	4%	3%	5%				1.6%
OW	54%	56%	32.5%	46.2%	50%	60%	68.8%
SA	11%	9%	10%	6.6%	15%	5%	12.8%
YW	7%	6%		6.6%	5%	15%	1.6%
No SI	3%	5%	5%	6.6%	30%	20%	4.8%
HP once	15%	6%			2.5%		3.2%
HP	59%	42%	35%	13.2%	60%	80%	51.2%
Pre. Adol.	2%	11%	5%		30%	20%	9.6%

* 33.3% refused information

Other forms of homosexual experience follow nearly in the same pattern. In practically every case some pre-army experience is shown. Also, all cases with homosexual experience had a definite mother fixation. In Table XIII and Graph 15, mutual masturbation, anal and oral homosexual experience are all grouped under the item Homosexual Experience. The figures under this item do not correspond with the totals of the various types of homosexual experience since this item is the percent of individuals who had experienced one or more types of homosexual behavior.

The other types of chaotic sexuality such as exhibitionism, beastiality, cunnilingualism, and other forms of lingual sexuality, group sex, both homosexual and heterosexual, fellation by a woman, and anal sex with a woman appears with much greater frequency than is generally expected. Comment is unnecessary.

Heterosexual activity of the neurotic groups is surprising in two factors: (1) The few who have not had sexual intercourse, (2) Extremely small number who remain continent until marriage. Among those who could give definite data on the age of their first sexual partner it was observed that every case who had had his first sexual intercourse with an older woman had previously reported a mother fixation. The large percentage of non-professional partners in first sexual intercourse certainly places

a doubt on the myth of the continence of the American people. To quote Wylie: "So many boys fornicate that the girls must".[1] The number of cases who had sexual intercourse before they were 21 is shown in Graph 15. Certainly, it shows the idea of sexual innocence is not as prevalent as we like to think and that sexual education is definitely needed. The figures on pre-adolescent sexual experience (an arbitrary age of 12 was set) with other people certainly gives rise to the question of where sex instruction should begin. This study indicates that it is time we become realistic about sex education instead of as Wylie[2] says, "Presenting ourselves to each other as the inhabitants of a highly continent society, monogamous, virginal to the altar, each bride and groom sworn to forsake all others, and one and all so delicately sensitive to the manifestations of sex that we arrest persons for going nude and teach our children about storks or flowers rather than people..... .....innocence, which on examination, appears to be neither more or less than ignorance, is everlastingly lauded by the populace."

This whole set of sexual behavior data indicates that educators should re-examine our pre-set ideas and do something to correct the lack of sexual knowledge and the

1. Wylie, P., Generation of Vipers. New York, Farrar & Rinehart, 1942, p. 55.
2. Wylie, P., Ibid., p. 54.

resultant experimentation in our youth. Psychotherapeutic success shows that sex guilt is the greatest of all predisposing factors in the neurotic group study. The guilt present because of sexual ignorance and the American unrealistic idealism regarding sexual behavior is definitely one of the greatest perils to the mental health and adjustment of our youth.

CHAPTER IV

SUMMARY AND RECOMMENDATIONS

The entire nation has a counseling problem with veterans who have neurotic tendencies. It is a fair assumption that many veterans returned to civilian life are in the same category as the veterans in this study. All men in this study were men who had been overseas and who were sent to the redistribution station for reclassification and assignment. None of the neuroses or neurotic tendencies were thought to be great enough for hospitalization or discharge when sent to the redistribution station. Most of the men were utilized somewhere in the continental United States after leaving this station. Approximately 1 per cent were hospitalized and 6 per cent discharged. These men and thousands like them will now return to civilian life. Many will need further counseling and therapy. This dissertation gives a picture of a cross-section of these men and the data concerning them.

The data in this study are based on the analysis of 1016 case histories of enlisted veterans with overseas service. Statistical comparisons could not be made in this study, since a control group could not be found. A majority of the same age group were in the armed services and subjected to much the same stress. The higher prevalence of war neuroses among army personnel than the

incidents among civilian populations subject to the bombing is indicative that a man secure among his loved ones and in familiar environment is less apt to become neurotic than the man separated from home, family, and familiar environment.

From the counseling of these overseas veterans a number of implications for education come and pose many questions for which an answer is sought, not conclusively established, but so far as indicated by the evidence.

A review of the literature has shown that the so-called "war neuroses" do not differ appreciably from neuroses, that the army is the precipitating factor and that the predisposing factors are in pre-army life. With these facts in mind, this study of the data of a larger number of neurotics than previous studies was made. The following questions are answered by the assembled data of this study.

The first question: "Is there a definite pattern of predisposing factors in the so-called "war neuroses"?" In this study as well as other studies made in this war and reviewed in Chapter II there seems to be very definite pattern of predisposing factors. Predisposing factors in ordinary maladjustments lie far back in personal history. In the cases studied in this study psycho-

therapy was effective only in the cases where insight was given into the predisposing factors shown in case histories. The catharsis of the case history technique was ineffective when the army and war history alone was taken, and remained ineffective until the entire case history was taken. This in itself is very convincing evidence that the major causes of "war neuroses" of these cases were the predisposing factors in the early history of the men affected.

The proof of this pattern is in the success of psychotherapy after the catharsis of the case history. The first pattern in predisposing factors appears to be the home and the family. The data of this study show from 29 to 73 per cent of the cases lost a parent during childhood. The high prevalence of homes broken either by death or divorce is a preponderant factor. Not only was the home broken, but 28 to 50 per cent of the men in evaluation of their home life considered their childhood home life unhappy.

The second question: "At what age are men most susceptible to "war neuroses"?" This is shown clearly in the grouping of the neurotics as to age in comparison with the station population. Most neurotics are below 29 years of age and in a much larger proportion than the group which passed through the station. It appears that the nearer

the home situation the soldier is the more subject he is to neuroses.

The third question: "Is intelligence a factor in war neuroses?" The answer to this question as far as this study is concerned is very clearly shown in the much higher aptitude of the neurotic groups than of the station population or the army as a whole. However, a strange paradox is seen in that the neurotic group had higher aptitude than educational achievement while the station population had higher educational achievement than was to be expected for its aptitude.

The fourth question: "Are these predisposing factors in pre-army life?" This question may be answered in the affirmative as far as this study is concerned, since the majority of the cases show neurotic symptoms previous to their army training in their sex, their fear, their love, and their emotional behavior. Their education has promoted guilt feelings. The high percentage of mother fixations (from 50 per cent to 90 per cent) as contrasting with the attitude of the so-called normal child in liking both parents is startling. The varied and unusual sex behavior, the prevalence of phobias, these fears and guilts based on childhood experience, the insecurity of broken homes, the civilian delinquency records all point to predisposing factors in pre-army

life. The trend of the times in education appears to have been to inculcate into the personalities of our youth a semantic unreality as to their basic drives and social relationships. The guilt feelings which are common to the neurotic are indigent to accumulated camouflage taught in our schools, homes and churches in the matter of human relationships, pretence and "finding it pays to appear to be other than you are". These guilt feelings are primary causes of the maladjustment of our youth, and the basis of their conflicts. They are all pre-army predisposing factors. It is also interesting to note that most of the symptoms of tensions, sweaty palms, conversions, etc., could not be relieved until insight was given to these predisposing factors.

The fifth question: "Are the predisposing factors, experiences and learnings such that could be corrected by proper education in the home and the school?" The fact that not a single man had had any formal sex education and their sex behavior clearly shows it, in itself points to one necessity or recommendation for the future. The prevalence of broken homes indicates classes in marital relations or family relations would be of value to the average student.

The matter of fears and the various emotional behavior indicates a need for a practical course in per-

sonal mental hygiene. These are but a few of the factors which could be corrected by proper education and care to prevent such neurotic tendencies in the future.

The sixth: "From what type of homes and communities do the people come?" The city seems to contribute far more than its share of neurotics. This may be based on the living conditions in the crowded urban areas. The family life of the boys in this study was considered unhappy by far too many of them. The broken home is a known factor in both neuroticism and delinquency. The preponderance of mother fixation makes it certainly appear that the fathers of America are not doing their part in living and raising their children.

The seventh question asked in this thesis: "Are combat experiences or wounds necessary to develop war neuroses?" Far less of the neurotic group show combat experiences than of the group which passed through the station, but the percentage of wounded among the neurotic was higher than the percentage of wounded in the station population. Whether their being wounded is the precipitating factor of the neuroses or whether the neuroses are the precipitating factors of wounds is merely a matter of conjecture. However, from all other evidence in this study, it appears that army life in itself is the real precipitating factor, and the neuroses was present

in most of the cases before they were wounded.

To summarize this dissertation, the following items are evident: First, war neuroses are made in America. The predisposing factors were present in pre-army life.

Second, the army life itself rather than combat precipitated the so-called "war neurosis."

Third, war neuroses are no different than civilian neuroses and have the same basic causes and symptoms.

Fourth, many of the neurotic tendencies in these boys could have been prevented or at least lessened by proper sex instruction and a secure and happy home life.

The recommendations for education in the future, are clearly indicated: (1) A counseling and guidance program based upon reality and under adequately and professionally trained personnel, starting at adolescence; (2) Classes in personal mental hygiene under well-oriented and professionally trained experts; (3) Classes in marital and family relationships in high school; (4) Formal sex education starting at adolescence based on human beings, taught not from a moralistic viewpoint, developing guilts, but from the viewpoint of knowledge and the control that comes from self-knowledge; (5) Education through articles and other means in the

"Importance of Being a Father", (6) A definite effort to obtain more male teachers especially for elementary schools to counteract, somewhat, the preponderant female domination of our youth; (7) A definite program of Adult Education giving courses on fatherhood, motherhood and Family Relations; (8) Education in the home, school and church should be critically re-examined on the basis of reality and semantic values.

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APPENDIX

PERSONNEL CONSULTANT WORK SHEET

CASE HISTORY (A) Name: XX Roster: 7-23
Grade: Pvt. CasCo: XX ASN XX Race: W Age: 21
Civil Occupation: Truck Driver MOS XX Appearance: Untidy
Manner: harassed Referred by: Interviewer
Home: City Mos Overseas: 10 Theater:
Philippines Marital: M. 1 child. 14 mos. old.

B. Statement of Problem:

1. The Complaint Problem:
   Sweaty palms, shakes.

2. Nature of Complaint:
   Restless, extreme sweaty palms, tremors, nightmares, "cant consentrate".

3. History of Problem:
   Left home at 16; married at 19. Always restless, disliked Army greatly. Worries over wife and child. Financial trouble. Combat made him afraid they would be left alone.

C. Family and Social Environment:

1. Persons in the Home:
   a. Father X
   b. Mother X
   c. Step-parents, if any
   d. Siblings - ages 3 F. 1 M.
   e. Grandparents
   f. Other relatives
   g. Boarders, or other unrelated persons
   h. Parents' associates
2. Home attitudes Happy "OK until grown"
3. Control and discipline strict
4. Economic status of the family Moderate
5. Cultural status of the family
6. Language spoken in the home
7. Neighborhood City

D. Physical Conditions and History:

1. Physical development and conditions related to adjustment:
   C 321114 XR WOUNDED
   ANXIETY STATE, Chronic Mod.

E. Developmental History:

1. Intellectual development: AGCT IV - 80 MA III 95

2. Speech or reading defects:
   None

3. Emotional development:

a. Fear behavior
Afraid of dark, doesn't like heights, strong CLAUSTROPHOBIA.

b. Love Behavior
Mother

c. Emotional balance.
Moody, depressed, sensitive flash temper but holds grudges.

F. Education History: Quit because he was left handed;
1. School progress (8). teachers wanted him right".
2. Educational status
3. School adjustment poor
4. Educational plans and ambitions

G. Economic History:
1. Military
2. Occupational history
3. Vocational plans, after demobilization

H. Legal History:
1. Delinquencies, Court Records Jv. Ct., 17, molesting girl and vagrancy. 12 days in jail, $100 fine and 1 yr. probation.

I. Habits, Adjustments and Satisfactions:
1. Routine habits:
Trouble sleeping and has a good appetite.

2. Recreation, hobbies and interests:
"hop up", cars & motorcycles, likes "western" music

3. Imaginative satisfactions:
Always dreams he is in tight place, surrounded. Something happening to family, falling, always getting caught by monsters (like huge octopus), people trying to kill him, in airplane and it crashes, racing car rolling off track, walking in mud and sinking deeper and deeper.

4. Sex Habits:
M 12, OBS, HO 18, 1st SI 14, OW NP, No HP.

5. Social Habits:
Doesn't dance, doesn't like people to look at him (feels under observation)

J. Personality Adjustments:
"Happy-go-lucky", lacks self-confidence, bothered with lack of education, Rec. release from Infantry into QM-C., Seemed to be relieved some of anxiety, relaxation therapy releived some sweatiness and tension, man seemed to feel if he got allright he would be put back in infantry.

PERSONNEL CONSULTANT WORK SHEET

CASE HISTORY (A) Name: XX Roster: 8-23
Grade: T/4 Cas Co: XX ASN XX Race: W Age: 27
Civil Occupation: MOS Appearance: Excel.
Manner: Refined Referred by: Psychiatrist
Home: City Mos Overseas: 21 Theater: Italy
Marital: S

POW, 12 mos., 16 days in Germany.

B. Statement of Problem:

1. The Complaint Problem:
   Tremors, Sweaty Palms, some Stuttering.

2. Nature of Complaint:
   Ext. Tension, Tremors, Irritable, Battle dreams, Loss of Appetite, Insomnia.

3. History of Problem:
   History of nightmares before overseas. Claims symptoms started in combat and became worse while in prison camp and on German work patrols. Worried about Father considerably.

C. Family and Social Environment:

1. Persons in the Home:
   a. Father x sick
   b. Mother x
   c. Step-parents, if any
   d. Siblings-ages x M
   e. Grandparents
   f. Other relatives
   g. Boarders, or other unrelated persons
   h. Parents' associates
2. Home attitudes happy
3. Control and discipline strict
4. Economic status of the Family moderate
5. Cultural status of the Family middle class
6. Language spoken in the home English
7. Neighborhood City

D. Physical Conditions and History:

1. Physical development and conditions related to adjustment:
   Rare enuresis until 19, WOUNDED,
   Profile: 211113 XTC, CHRONIC TENSION STATE.

E. Developmental History:

1. Intellectual development, AGCT I (140) MA 1 135
   CA 1 1 151

2. Speech or reading defects:
   Sometimes stutters and stammers since the war.

3. Emotional development:

a. Fear behavior:	b. Love behavior:	c. Emotional
Apprehension of dark NOW. Real fear of heights; was paratrooper because he was afraid to do it. Claustrophobia and childhood fear of water.	Both	balance; Moody, depressed, very sensitive, flash temper.

F. Educational History:
1. School progress 12
2. Educational Status 1 year night school
3. School adjustment
4. Educatinal plans and ambitions

G. Economic History:
1. Military T/4
2. Occupational history Playgrnd.work.WPA.2½Yr.Chauffer.
3. Vocational plans, after demobilization College?

H. Legal History:
1. Delinquencies, Court Records None

I. Habits, Adjustments and Satisfactions:
1. Routine habits:
Has trouble sleeping and terrific nightmares, appetite spotty, could not think of anything but food as a POW, now can't eat at times.
2. Recreation, hobbies and interests:
Nightball, baseball, dancing. Likes music a lot.
3. Imaginative satisfactions:
Dream of his capture, combat dreams, S.S. Troopers surrounding him, sex (women), falling, chased by German soldiers and frightening them off with jackknife. Flying through air like Superman. Crossing bridge and falling into deep canyon, lands in soft mass and yet could feel shock through body.
4. Sex habits:
M 14 ST
PED 10 15
Exhib. 16
SI 19 SA
HP Fell W
5. Social habits:
Dances; afraid and nervous of crowds.

J. Personality Adjustments:
Inferiority feelings both physical and mental. Tension relieved and appetite improved while in Station. Battle dreams and nightmares stopped.

CASE HISTORY (A) Name: XX Roster: 5-22
Grade: Pvt. Cas. Co: XX ASN XX Race: W Age: 23
Civil Occupation: Laborer, Farm MOS Appearance: Good
Manner: Extreme restless Referred by:
Psychiatrist Home: Country Mos Overseas: 12 Theater:
France Martial: M. 3½ yrs., wife pregnant.

B. Statement of Problem:
1. The Complaint Problem:
Slapped wife and is always quarreling with her, tension.

2. Nature of Complaint:
Tension, Emotional.

3. History of Problem:
Has been tense and emotionally upset since his outfit (paratroops) was surrounded in Holland. WOUNDED, 2nd day.

C. Family and Social Environment:
1. Persons in the Home:
a. Father "Quarrelsome when drunk", gone for mos.
b. Mother neurotic
c. Step-parents, if any none
d. Siblings 2F, 1 M
e. Grandparents
f. Other relatives
g. Boarders, or other unrelated persons
h. Parents' associates
2. Home attitudes Unhappy
3. Control and discipline "Not strict enough"
4. Economic status of family poor
5. Cultural status of family Farm laborers
6. Language spoken in home English
7. Neighborhood Rural

D. Physical Conditions and History:
1. Physical development and conditions related to adjustment:
Enuresis until 14. Profile: 111-114 XDC.
CONSTITUTIONAL PSYCHOPATHIC STATE.

E. Developmental History:
1. Intellectual development: AGCT 1 * 130 Other XX
2. Speech or reading defects: none.
3. Emotional development:
a. Fear behavior: Afraid of dark, NOW, Claustrophobia
b. Love behavior: Mother
c. Emotional balance: impatient supersensitive.

afraid of heights,"scared" of water.	moody, flash temper.

F. Educational History:
1. School progress 12
2. Educational status CCC,6 mos., did not get along.
3. School adjustment
4. Educational plans and ambitions

G. Economic History:
1. Military Staff Sgt.; reduced to Pvt.
2. Occupational history farm labor, changed jobs often.
3. Vocational plans, after demobilization none

H. Legal History:
1. Delinquencies, Court Records Reform Sch. 13 mos.(stole car), SpCM, (Drunk, Disorderly, Stole sleeping bag.)3mos. SpCM, tried claim against govt.

I. Habits, Adjustments and Satisfactions:
1. Routine habits:
Sleeps well, good appetite.

2. Recreation, hobbies and interests:
boxing, (likes to see blood), music.

3. Imaginative satisfactions:
Planes strafing, Dreams of german boy he killed with trench knife, falling, rooms without openings, suffocating.

4. Sex habits:

M 12 OBS	Fell W
MM 14 on	Beast.15
HO 17 on	Cunni. (was disgusted, onlyonce)
SI 15 OW NP	HP lived with nurse overseas.

5. Social habits:
Dances, drinks to excess(in civilian life too)

J. Personality Adjustments:
Likes to try everything once. On defensive. All changing crowds (that had more money). Can't stand to hurt anything. Relaxation helped tension. Prognosis for future not good.

PERSONNEL CONSULTANT WORK SHEET

CASE HISTORY (A) Name: XX Roster: 12-15
Grade: XX Case Co: XX ASN XX Race: W Age: 25
Civil Occupation: Magazine Salesman MOS Appearance: Neat Manner: Erotic Referred by: Psychiatrist
Home: City Mos Overseas: 35 Theater: S.W. Pacific Marital: M., overseas, wife in Australia

B. Statement of Problem:

1. The Complaint Problem:

Can't write anymore. Tremors so great in right arm (only).

2. Nature of Complaint:

Claims total deafness one ear (NO ORGANIC BASIS) Tremors in right arm, couldn't even write name. Tremors appeared in left when suggested he learn to write with left.

3. History of Problem:

Ship was bombed and he was knocked into water. Buddy next to him was killed. Had promised each other to write folks if anything happened. He has never been able to keep promise because of right arm. Has been bombed 19 times (NO COMBAT). Sweaty palms, tension, headaches, partial paralysis of right leg, confused thinking and poor pronunciation.

C. Family and Social Environment:

1. Persons in the Home:
   a. Father X
   b. Mother Extremely fanatical about religion
   c. Step-parents, if any
   d. Siblings, ages 3 M. 2 F.
   e. Grandparents
   f. Other relatives
   g. Boarders, or other unrelated persons
   h. Parents' associates
2. Home attitudes happy
3. Control and discipline moderately strict
4. Economic status of family moderate
5. Cultural status of family moderate
6. Language spoken in the home English
7. Neighborhood City

D. Physical Conditions and History:

1. Physical development and conditions related to adjustment:

B 112213 X, HYSTERIA WITH CONVERSION SYMPTOMS. Flat feet. Psychosomatic complaints. Accident when child -- hit by car.

E. Developmental History:

1. Intellectual development: AGCT III 109 MA II 119

2. Speech or reading defects:
Some speech defect now.

3. Emotional development:

a. Fear behavior	b. Love behavior	c. Emotional balance.
Dark, NOW, Heights, Water.	Mother	Moody, depressed, flash temper, extremely emotional.

F. Educational History:

1. School progress 11
2. Educational status
3. School adjustment "quit because young and foolish"
4. Ecucational plans and ambitions ?

G. Economic History:

1. Military Cpl.
2. Occupational history Mag. Salesman, odd jobs.
3. Vocational plans, after demobilization ?/

H. Legal History:

1. Delinquencies, Court Records None

I. Habits, Adjustments and Satisfactions:

1. Routine habits:
Trouble going to sleep. Called "pregnant kid" overseas because he used to vomit so much.

2. Recreation, hobbies, and interests:
Swim

3. Imaginative satisfactions:
Somebody after him, falling, being bombed (awakens screaming), running away from air raids.

4. Sex Habits:
M 14, OBS, MM 15, HO, 1st SI 18, NP, OW.

5. Social Habits:
Dances

J. Personality Adjustments:

"Worries a lot about things that don't concern him". After five sessions, Deafness disappeared, Tremors disappeared after insisting he dictate story of buddy to secretary and send as a letter to boy's parents. Sweaty

palms disappeared first relaxation treatment, after case history had been taken.

PERSONNEL CONSULTANT WORK SHEET

CASE HISTORY (A) Name: XX Roster: 5-5
Grade: T/3 Cas Co: XX ASN XX Race: W Age: 35
Civil Occupation: XX MOS XX Appearance: above average Manner: effeminate Referred by: self
Home: small city Mos Overseas: 35 Theater: S.W. Pacific Marital: S.

B. Statement of Problem:
1. The Complaint Problem:
Sweaty palms, tension.

2. Nature of Complaint:
Sweaty palms, feeling of inferiority, tension state, feels he is a misfit.

3. History of Problem:
Mother's favorite, still lives at home. Intelligent, but seems unable to fit in with other men.

C. Family and Social Environment:
1. Persons in the Home:
a. Father x
b. Mother x
c. Step-parents, if any
d. Siblings, ages x M
e. Grandparents
f. Other relatives
g. Boarders, or other unrelated persons
h. Parents' associates
2. Home attitudes happy
3. Control and discipline lax
4. Economic status of family moderate
5. Cultural status of family moderate
6. Language spoken in home English
7. Neighborhood 10,000

D. Physical Conditions and History:
1. Physical development and conditions related to adjustment: C 111114XD ADULT MALADJUSTMENT
Enuresis until 12.

E. Developmental History:
1. Intellectual development: AGCT I 130 Other XX
2. Speech or reading defects: none.
3. Emotional Development:
a. Fear behavior Dark, NOW. Fire, as child was afraid of
b. Love behavior mother fixation
c. Emotional balance moody, depressed, flash

being trapped in garret room. Engine of car caught fire, felt paralyzed.

temper

F. Educational History:
1. School progress College grad.
2. Educational status
3. School adjustment Good in studies.
4. Educational plans and ambitions None

G. Economic History:
1. Military T/3
2. Occupational history Bank Teller
3. Vocational plans, after demobilization Return home to mother and bank.

H. Legal History:
1. Delinquencies, Court Records None

I. Habits, Adjustments and Satisfactions:
1. Routine habits:
Doesn't sleep well, fair appetite here but not for reg. army food.

2. Recreation, hobbies and interests:
Gardening(flowers), photography, violin, swimming, and boating.

3. Imaginative satisfactions:
(repeater) Plate on plate-rail with dutch boy and he dreams whirl of sand and dust was chasing him and enveloping him (he was dutch boy).

4. Sex habits:
M 12 ST M-OS
14 MM Ped.
MM as adult
No SI

When 9 or 10 parents caught him and two other little boys examining each others genitals. Very embarrassed about it.

5. Social habits:
dances, shy as child, brother very aggressive, slightly effeminate.

J. Personality Adjustments:
Relaxation therapy stopped sweaty palms and tension. Good insight into his problem. Returned 4 times. No recurrence of symptoms.

CASE HISTORY (A) Name: XX Roster: 10-14
Grade: S/Sgt. Cas Co: XX ASN XX Race: W Age: 28
Civil Occupation: Tractor Driver MOS XX Appearance: Good
Manner: hesitant Referred by: inter-
viewer Home: rural Mos Overseas: 16 Theater: Africa
Italy Marital: Div., after 6 yrs., marriage, wife
frigid, in-law trouble. Didn't get
to see two sons on furlough.

B. Statement of Problem:

1. The Complaint Problem:
"nervousness"

2. Nature of Complaint:
Inadequacy, not able to keep up. Tension, vague heart complaints.

3. History of Problem:
Fear of leaving fox hole. Difficulty in leading squad. Many of friends killed and wounded causing fear and nervousness. Hesitated to carry out advances, not able to create spirit and enthusiasm for job. Heart began to bother him.

C. Family and Social Environment:

1. Persons in the Home:
   a. Father x
   b. Mother dead
   c. Step-parents, if any
   d. Siblings, ages x ffmffm
   e. Grandparents
   f. Other relatives
   g. Boarders or other unrelated persons
2. Home Attitudes unhappy
3. Control and discipline lax
4. Economic Status of family moderate
5. Cultural Status of family farmers
6. Language spoken in the home English
7. Neighborhood farm

D. Physical Conditions and History:

1. Physical development and conditions related to adjustment: C111114XD, NEURASTHENIA (CIRCULATORY) ASTHENIA PALPITATION and tachycardia.

E. Developmental History:

1. Intellectual development: AGCT III 105 MA IV 89
2. Speech or reading defects: none
3. Emotional development:
   a. Fear behavior Dark as child.
   b. Love behavior mother
   c. Emotional balance: flash temper, depressed.

F. Educational History:
1. School progress 8
2. Educational status Quit; didn't like school.
3. School adjustment Didn't get along.
4. Educational plans and ambitions none

G. Economic History:
1. Military S/Sgt.
2. Occupational history Truck & tractor driver.
3. Vocational plans, after demobilization none

H. Legal History:
1. Delinquencies, Court Records none

I. Habits, Adjustments and Satisfactions:
1. Routine habits:
Sleeps OK, appetite fair.

2. Recreation, hobbies and interests:
Drink, doesn't like sports, no hobbies.

3. Imaginative satisfactions:
Combat dreams, dreams of home, and people he hasn't seen for years.

4. Sex habits:
M 14 OBS MM 18
1st SI 15 OW -- OW took active part, seduced him
HP Gon. 1 and her son(16 or 17) walked in on them. Prefers to go with older women.

5. Social habits:
Dances.

J. Personality Adjustments:
Upon being told not eligible for further Overseas service, seemed less tense. Not particularly good insight first visit. Second visit seemed to realize factors in trouble. Heart pains disappeared by third visit. No work after he left station.

CASE HISTORY (A) Name: XX Roster: 11-6
Grade: PFC Case Co: XX ASN XX Race: W Age: 28
Civil Occupation: Cable splicer MOS Appearance: Good
Manner: Tense Referred by: Psychiatrist
Home: City Mos Overseas: 23 Theater: Africa, Italy, France Marital: M.

B. Statement of Problem:

1. The Complaint Problem:
Tremors

2. Nature of Complaint:
Extreme tremors, tension, noise sensitivity, sweaty palms, insomnia.

3. History of Problem:
All combat service. Knocked unconscious by shell nearby(Italy), use of flame throwers, phosphorous bothered him. Planes strafed, bombed, artillery fire, and wounded in combat.

C. Family and Social Environment:

1. Persons in the Home:
a. Father died 4
b. Mother alive
c. Step-parents, if any father at 12 OK
d. Siblings, ages 0 29 x
e. Grandparents
f. Other relatives
g. Boarders, or other unrelated persons
h. Parents' associates
2. Home attitudes happy
3. Control and discipline strict
4. Economic status of family poor
5. Cultural status of family moderate
6. Language spoken in home English
7. Neighborhood Large city.

D. Physical Conditions and History:

1. Physical development and conditions related to adjustment: 111 - 114 XD - C, NEUROSIS, MIXED TYPE, MOD.

E. Developmental History:

1. Intellectual development: AGCT III 107 MA III 99
2. Speech or reading defects: none.
3. Emotional development:
a. Fear behavior Dark, NOW, imagines mother things in the dark.
b. Love behavior
c. Emotional balance. moody, depressed, flash temper.

F. Educational History:
1. School progress 12
2. Educational status High School Grad.
3. School adjustment
4. Educational plans and ambitions

G. Economic History:
1. Military Was Cpl., now Pfc.
2. Occupational history cable splicer & electrician
3. Vocational plans, after demobilization ?

H. Legal History:
1. Delinquencies, Court Records None

I. Habits, Adjustments and Satisfactions:
1. Routine habits:
Trouble going to sleep, walks until worn out sometimes to 2:00 a. m.

2. Recreation, hobbies and interests:
Skate---roller and ice.

3. Imaginative satisfactions:
Dreams, somone turning flame thrower in face. Man sitting on a rock who, everytime he kills a man, carves a notch in his leg which has turned green.

4. Sex habits:
M 15 OW did it to him (25)
1st SI 16 NP
HP once, France (bothers him)

5. Social habits:
Dances.

J. Personality Adjustments:
Extreme tense. People now bother him.

Nervous symptoms all disappeared after four visits. Letter 3/5 says still OK.