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An Analysis of the Histories of Sixty-Three Patients Diagnosed as Psychoneurotic and Admitted to Chicago State Hospital During the Calender Year 1948

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AN ANALYSIS OF THE HISTORIES OF SIXTY-THREE PATIENTS DIAGNOSED AS PSYCHONEUROTIC AND ADMITTED TO CHICAGO STATE HOSPITAL DURING THE CALENDAR YEAR 1948

by

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TABLE OF CONTENTS

Chapter	Page
INTRODUCTION	iv
I. THE PSYCHONEUROTIC IN THE MENTAL HOSPITAL	1
II. THE STUDY GROUP	15
III. CIRCUMSTANCES SURROUNDING HOSPITALIZATION	28
IV. THE ADOLESCENT GROUP	46
SUMMARY	55
BIBLIOGRAPHY	59

LIST OF TABLES

Table — Page

I. DISTRIBUTION ACCORDING TO AGE AND SEX OF SIXTY-THREE PERSONS DIAGNOSED AS PSYCHONEUROTIC AT STATE HOSPITAL, 1948 16

II. DISTRIBUTION OF THE SIXTY-THREE PSYCHONEUROTIC PERSONS ACCORDING TO MARITAL STATUS. 18

III. ORIGINAL COMMITMENT DIAGNOSES OF SIXTEEN PERSONS DIAGNOSED BY STATE HOSPITAL AS PSYCHONEUROTIC IN 1948. 20

IV. CLASSIFICATION OF THE PSYCHONEUROTICS ACCORDING TO TYPE 22

V. THE LENGTH OF TIME IN MONTHS THE FORTY-SEVEN VOLUNTARY AND SIXTEEN COMMITTED PSYCHONEUROTICS SPENT IN STATE HOSPITAL IN CONNECTION WITH 1948 ADMISSION 23

VI. TREATMENT RECOMMENDED FOR THE SIXTY-THREE PERSONS DIAGNOSED AS PSYCHONEUROTIC AT STATE HOSPITAL, 1948 26

INTRODUCTION

This study was made at Chicago State Hospital, one of the nine state hospitals for the mentally ill, operated under the direction of the Illinois Department of Public Welfare. Like the other hospitals, Chicago State Hospital, in order to offer its patients a comprehensive plan of care and treatment, includes a medical and psychiatric department, a psychology department, a nursing department, a social service department and a department of non-medical therapy. The latter provides facilities for group recreation, occupational therapy and industrial therapy. The range and quality of the hospital's services have made it acceptable to the American Medical Association for residencies in psychiatry, general medicine and surgery.

The study was based on the analysis of the case histories of the sixty-three patients who were admitted to the hospital during 1948 and diagnosed as being psychoneurotic. The purpose of the study was to ascertain the reasons for the commitment or voluntary admittance of these patients to an institution whose major function was the care and treatment of psychotics. Interest was centered about such questions as: Who were these people in terms of age, sex, marital status, etc.? What were the immediate and remote circumstances which surrounded the admissions? What treatment was recommended for these people and how long did they remain in the hospital? No attempt was made to evaluate the treatment of these patients as the average period of hospitalization was, on the whole, too short to permit such consideration.

To obtain the list of the sixty-three persons in the study group it was necessary to review the diagnoses of approximately twenty-five hundred persons who were admitted to the hospital in 1948. Both the medical and social service records of these patients were then located and used to provide the information for the study. The pertinent statistical data were recorded on a schedule and, in addition, each case was summarized for its personal, psychiatric and social data. Particular attention was paid to those summaries which were to be included in the completed study as illustrative of the study group as a whole.

The material is presented in tabular and discussion form. Possible interpretations of the data, as related to the particular setting of the study, are explained. In addition, certain findings are examined and related to current psychiatric literature.

For the purposes of presentation, the material has been divided into sections, beginning with a description of the hospital's treatment program. This is followed by the presentation of the over-all statistical data, which is, in turn, followed by a section devoted to the personal, psychiatric and social information pertaining to the adult patients. This is followed by a special chapter devoted to the consideration of similar data pertaining to the adolescent group. The findings of the study are then summarized and the study is concluded with the presentation of the bibliography.

CHAPTER I

THE PSYCHONEUROTIC IN THE MENTAL HOSPITAL

The problem of mental illness has in recent years received a great deal of attention from both the medical profession and from laymen. It is a question whether the strain of modern life has produced a steadily increasing number of sufferers from nervous disorders, or whether an increasing number of people are beginning to avail themselves of the present opportunities for treatment. The Group for the Advancement of Psychiatry, an organization of approximately 150 members of the American Psychiatric Association, pointed out the seriousness of the problem with the following statistical estimates. Using figures compiled from the best available sources, the group concluded that in 1948 there were approximately 8,500,000 cases of mental illness in the United States.[1] This meant that about one in every eighteen Americans was suffering from some form of mental disorder. It was also estimated that approximately one out of every ten persons would need psychiatric treatment at some time during his life and that one out of eighteen persons would spend some part of his life in a mental hospital.

Concerned with the rising tide of mental illness the Congress of the United States passed, in July 1946, the National Mental Health Act. The

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1 Group for the Advancement of Psychiatry, Statistics Pertinent to Psychiatry in the United States, Report No. 8, March, 1949.

purpose of this act is to provide means whereby the development of mental illness may be curtailed through research, education, and community services. The activities for research and education provided for by the act are administered by the United States Public Health Service, which makes direct grants to agencies and institutions qualified to further these purposes of the act. The portion of the act relating to the development of community services provides for grants by the United States Health Service to the administrative authority of the mental health departments of the separate states.

The National Mental Health Act is of special interest to the estimated 5,000,000 psychoneurotic persons who comprise the largest diagnostic group among the 8,500,000 who are classified as mentally ill.[2] While psychoneurotics account for only 6.3 per cent of all new admissions to mental hospitals, they nevertheless, in the mistaken belief that they are suffering from a physical disorder, account for about one-half of all persons applying to the general medical practitioner.[3] To what extent the emotional instability associated with a psychoneurosis plays a part in the prevalence of divorce, juvenile delinquency, and adult crime is unknown. Many authorities, however, are convinced that this instability does play an important part in these recognised symptoms of social disorganization.[4] Though the psychoneuroses represent the most prevalent form of mental illness, they are nevertheless, generally speak-

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2 Ibid.

3 Ibid., 2

4 Ibid.

ing, more easily prevented and treated than are the other forms of functional mental disorder.[5] It is hoped that the early detection and treatment of this disorder, made increasingly possible by the passage of the National Mental Health Act, will serve to effect a significant over-all reduction of the frequency of mental illness.

Hinsie and Shatsky[6] define psychoneurosis as follows:

> A psychoneurosis is a pathological syndrome characterized in the main by special combinations of anxiety, phobias, compulsions, obsessions and conversion phenomena. These are but a few of the possible symptoms. Ordinarily a psychoneurotic individual possesses insight, that is, he is aware that his symptoms are manifestations of morbidity. Generally speaking, a psychoneurosis results only in a partial disorganization of the psyche, in contradistinction to a psychosis which usually disrupts all the functions of the psyche.

The psychoneuroses, as well as other forms of mental illness, such as schizophrenia and manic depressive psychoses, can be explained by the current dynamic theories of personality development and maladjustment. Brown and Menninger[7] have outlined the points upon which the theories agree. According to them, authorities are convinced that personality traits, both normal and abnormal, develop out of the inherited biological constitution through interaction with the environment. Some authorities attribute greater importance to the effect of heredity upon personality development; others consider the environment to be of greater importance. All agree, however, that both heredity and

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5 John J. B. Morgan, The Psychology of Abnormal People, New York, 1936, 456.

6 L. E. Hinsie and J. Shatsky, Psychiatric Dictionary, New York, 1940, 431.

7 J. F. Brown and Karl A. Menninger, The Psychodynamics of Abnormal Behavior, New York, 1940, 145-150.

environment play their parts and that the problem of personality and adjustment is basically a socio-psycho-biological one.

On the whole, in regard to the cases dealt with in this study, the interpretation of the patient's mental illness, as shown by the notes of the psychiatric staff, was usually psychoanalytic in nature or derivation. These interpretations, however, were of a practical, clinical nature and as such were of the kind that any dynamically oriented psychiatrist might make, regardless of whether or not he subscribed to the complete Freudian theory. These interpretations, whenever available, were used to explain the dynamics of mental illness in the cases summarized and presented as typical of the study group as a whole. Whenever possible, references in support of these interpretations were secured by a perusal of current psychiatric literature.

For a description of the treatment program which the hospital offered the patients of the study group, the Manual for State Hospital Social Workers was consulted.[8] It disclosed that there were no special provisions in the program for the psychoneurotic patients considered as a group. The needs of all patients, irrespective of their classification, were considered individually and their treatment planned accordingly. A description of the treatment program centers about the receiving ward, the diagnostic staff, the medical and nonmedical therapies, the improvement staff, the out-patient clinic, and the Social Service Department.

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8 Illinois Department of Public Welfare, Social Service in Institutions, Manual for State Hospital Social Workers, Springfield, 1945.

The Illinois Mental Health Act[9] provides for admission to the hospital upon voluntary application, court commitment, and emergency procedure. Voluntary admission involves application made by the patient, or by a relative or attorney who has the patient's consent to act upon his behalf. All persons who enter the hospital voluntarily have the right to leave the hospital fifteen days after giving the superintendent written notice of their desire to do so. Court commitment involves legal procedure within the County Court. An admission within forty-eight hours after examination and certification by a qualified physician constitutes an emergency admission. The patient thus admitted is not to be held more than fifteen days, pending judicial inquiry as to his mental condition. The persons of the study group entered the hospital either voluntarily or as a result of commitment.

Upon admission the patient was taken to the receiving ward of the diagnostic building. Arrangements were then made by the ward supervisor for control of the patient's personal property and money by the hospital business office. The patient's personal belongings were placed in the hospital vault and his money in a trust fund. The patient was then given a thorough physical examination by the ward physician, who also arranged for various laboratory tests, vaccination and inoculation against contagious diseases. While the patient remained in bed for a few days his clothing was checked, fumigated, and returned to the ward. The patient was then permitted as much freedom on the ward as his behavior indicated.

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9 Revised Mental Health Act of Illinois, October 1, 1945, Articles 4-6.

During a period of observation of about two weeks' duration the patient was observed and examined by the ward psychiatrist, who arrived at a tentative diagnosis. As an aid toward making the diagnosis the psychiatrist availed himself of the patient's social history taken by a social worker from the patient's relatives or friends either at the psychopathic or state hospital. The psychiatrist also considered the findings of the hospital psychologist, who tested the patient's intelligence and personality.

All patients, except those whose illness was due to senility or general paresis, were presented to the diagnostic staff. The senile patients and "G.P.'s" were not presented, for their mental and physical condition could be easily diagnosed by the ward physician and did not require the attention of the clinical director and the several psychiatrists who composed the diagnostic staff. The information contained in the social history, the findings of the physical, psychological, and mental examinations, and the patient's responses to questions were considered by the staff in classifying the patient and deciding upon the physical and mental treatment he should receive. Arrangements were then made to transfer the patient to the ward indicated by his classification, and the recommended treatment was initiated.

While the main function of the state hospital was the care and treatment of mental illness, all types of medical and surgical care were given. Many chronic conditions, such as malnutrition, tuberculosis, epilepsy, syphilis, anemia, and diabetes were treated. Close attention was always paid to the patient's physical illness, as it was often found that improvement of the mental condition could not be facilitated without an improvement in his phy-

sical health.

The treatment program for mental illness provided two main forms of therapy, medical and nonmedical. Medical therapy included shock therapy, lobotomy, fever treatment, hydrotherapy, and psychotherapy; nonmedical therapy included recreational therapy, occupational therapy, and industrial therapy. Plans for treatment of the patient frequently provided for the use of more than one form of therapy.

The different forms of medical therapy were usually applied as follows. Insulin and electric shock treatments were given to patients suffering from acute forms of manic depressive psychosis, involutional psychosis, and schizophrenia. Electric shock treatments were also given to psychoneurotic patients who were unusually agitated or depressed. In certain selected cases of chronic schizophrenia, arrangements could be made, upon permission of the relatives, for lobotomy. For paretics there were fever treatments and chemotherapy. For disturbed and unmanageable patients of all classifications, hydrotherapy and sedation were always available. Due to the limited number of psychiatrists, psychotherapy was precluded for general use. It was given, however, to certain selected patients who showed good insight.

Because the nonmedical therapies played such a large part in the daily life of all the patients, it is of interest to describe them in detail. The purpose of these therapies was to provide activities which would stimulate the patient to a higher level of integration in making social adjustments, so that he might return to the community as a useful member of society, or at least become capable of a happier and more useful institutional life. The direction of these therapies was in the care of a medical advisor who was assisted

by a supervising therapist. These persons conferred regularly with the therapists in charge of the recreational, occupational, and industrial divisions, and acted to coordinate the entire program. Because of their familiarity with the program as a whole, the medical advisor and the supervising therapist were responsible for assigning the patient to the activity most suited to his needs.

Recreational therapy, in one form or another, played a large role in the daily life of almost all the patients. Movies, concerts, plays, musicals, and baseball and basketball games furnished relaxation and entertainment to those patients who were able to obtain recreation only as spectators. For those who were able to participate somewhat more directly in recreational activity there were, in addition, community dances, community singfests, and roller skating. Small, intensive social therapy groups were specially organized for the more alert and socially conscious patients. These groups formed hobby clubs, orchestras, choruses, dramatic clubs, and sport clubs.

While recreational therapy in one degree or another was applied to all patients, occupational therapy was largely confined to the patients who were acutely ill, regressed, or organically handicapped. Training in such crafts as sewing, needlework, weaving, basketry, leather work, metal work, plastics, and gardening provided beneficial outlets for the energies of the acutely ill and the organically handicapped patients. Such training also served to stimulate the regressed and withdrawn patients. Though the main goal of this therapy was to develop good habits of behavior and increased social awareness, the development of specific manual skills was considered to be important, as it was often found that when patients became proud of their ability in some craft their mental condition improved.

The industrial therapy program played an important role in the institutional life of the more alert patients. These patients were assigned to such hospital industries as the tailor shop, barber shop, dietary service, laundry, commissary, and farm. They often worked side by side with the paid employees of the hospital. Because the main function of the hospital industries was not therapeutic in nature, great care was taken to see that they did serve as therapeutic facilities for the patients who were assigned to them. The assignment and promotion of the patients in these industries was largely the responsibility of the Nonmedical Therapy Department.

The ward physician was responsible for evaluating the progress a patient made under the medical and nonmedical treatment programs. When, in his opinion, the patient was well enough to be considered for release, he arranged to present the patient before the improvement staff, which was composed of the clinical director and several psychiatrists. If the staff concurred with the ward physician's opinion, the patient was given either an absolute discharge or a conditional discharge, or was released under the hospital's family care program.

Voluntary patients and some committed patients who were greatly improved or had recovered were given an absolute discharge. As a general rule, the committed patient was conditionally discharged for a period of one year to a relative who agreed to undertake his care and supervision. If the patient had no relatives, or if his relatives were considered to be incapable of giving him good care, he was recommended for release on the family care program. Under this program the State of Illinois paid up to sixty dollars a month for the supervision of the patient in a carefully selected boarding home. The

patient who was released on conditional discharge or on family care was ordinarily required to visit the out-patient psychiatric clinic at the hospital every Saturday. The clinic psychiatrist noted the patient's progress, made recommendations which would facilitate the patient's adjustment and finally, if the patient showed sufficient improvement, recommended him for an absolute discharge.

An outline of the activities of the Social Service Department completes the description of the services offered to the patient by the hospital. The social services were classified as intramural and extramural. Intramural services were services on behalf of the patient within the institution; extramural services were services on behalf of the patient who was released on conditional discharge or family care.

The intramural responsibilities of the social worker centered about five major activities; namely, (1) the securing of adequate social histories, (2) the interpretation of hospital services and the patient's mental condition to relatives and social agencies, (3) assisting the relatives with problems created by the patient's hospitalization, (4) the protection of the patient's interests outside of the hospital, and (5) the making of plans for the care and supervision of patients recommended for conditional discharge and family care.

A social service worker secured social histories for all of the patients who entered the hospital voluntarily. The relative who was most intimately associated with the patient was contacted for this information. Pertinent facts relating to the patient's family background, immediate family situation, personal life history, and onset of the mental illness were secured.

This information was an aid to the psychiatrist in making his diagnosis and in arriving at an understanding of the circumstances surrounding the mental illness. As a rule, the social worker obtained social histories only for the voluntary patient. She frequently acted, however, to supplement the social histories that accompanied the committed patient from the psychopathic hospital.

It was also a responsibility of the social worker to interpret to the relatives and interested social agencies the hospital routine and services. In addition, the social worker was frequently called upon by relatives and social agencies for interpretation of the patient's mental condition. Since the evaluation of the patient's mental condition was the responsibility of the psychiatrist, the social worker consulted him before responding to the relatives and social agencies. Another important responsibility of the social worker was to assist the relatives with problems created by the patient's hospitalisation. Relatives were often confronted with problems centering about financial support and care and custody of children. The social worker acted to refer these and other family problems to appropriate social agencies.

The protection of the patient's interests outside of the hospital was another responsibility of the social worker. Where the patient had no relatives to act on his behalf, the social worker arranged for control and custody of the patient's money, clothes, valuables, and property by the hospital. Where the patient's estate was large or when it was inconvenient for the hospital to accept the responsibility, as in the case of furniture, the social worker referred the problem to an appropriate social agency, which then arranged for the appointment of a conservator.

The final intramural responsibility of the social worker was to plan for the care and supervision of patients who were recommended for conditional discharge and family care. A social worker was always present to participate with the improvement staff in the discussions concerning the patient's release. In the cases of patients who were recommended for conditional discharge, it was the responsibility of the social worker to furnish information concerning the environment to which the patient was to return. If there was any question concerning the suitability of this environment, the decision to release the patient was withheld until a preparole study was made by the Social Service Department. In making the study, the following points were considered to be important: (1) The physical condition of the home offered to the patient. (2) The neighborhood influences to which the patient would return. (3) The character of the relatives, the nature of their relationships with each other and with the patient, and their ability to give the patient whatever special care and supervision he might need. The results of the preparole study were submitted to the psychiatrists of the improvement staff, who then made the decision in regard to the patient's release.

If the patient was recommended for family care, it was the responsibility of the social worker to place him in a home which was suitable for his needs. To this end the Social Service Department was constantly active in locating and evaluating possible family care homes in the community. The Social Service Department was also active in locating places of employment for the family care patient who was considered able to work.

The extramural responsibility of the social worker was to furnish casework services to the patients who were released on conditional discharge

and family care." In furnishing these services the social worker acted under the direction of the psychiatrist in charge of the out-patient clinic and carried out his recommendations. In the cases of the patients who were unable to attend the clinic, or who refused to do so, the social worker had the prime responsibility for making treatment plans and for evaluating the patient's adjustment. The social worker was also responsible, in these cases, for recommending and arranging for rehospitalization when the patient was unable to adjust in the community.

The foregoing description of the treatment program gives some indication of the care the patients received both inside and outside of the institution. It has also served to show the procedure which followed his admission and led to his release and after care. In regard to this latter, it must be mentioned that in only a few cases were plans made for the after care of the patients in the study group. This was mainly due to the fact that most of these patients entered the hospital voluntarily. The Social Service Manual makes the following statement: "Voluntary patients are given a complete discharge and no social service work is done unless it is requested."[10] An examination of the records showed that the psychiatric staff did not request social service planning in connection with the release and after care of any of the voluntary patients of the study group. Furthermore, for about half of the committed patients they did not request such planning; these patients were considered to be greatly improved and, like the voluntary patients, received

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10 Department of Public Welfare, Manual, 21.

absolute discharges. After care plans were made for only six of the sixty-three patients who comprised the study group. These patients had all been committed and they came to the attention of the Social Service Department through the procedure providing for planning and supervision in the cases of patients recommended for conditional discharge and family care.

CHAPTER II

THE STUDY GROUP

During the calendar year of 1948 a total of 2,463 persons were admitted to Chicago State Hospital. Of these, sixty-three persons were diagnosed as suffering from a psychoneurosis, and these psychoneurotic persons comprised the study group. This chapter deals with the statistical data pertinent to the group. Wherever necessary, for the sake of clarity and emphasis, the data are presented in both tabular and descriptive form. Where the data can be easily grasped the descriptive form alone is used. Significant findings are followed by interpretation.

The data relate to two major types of information, namely: (1) identifying social information, such as age, sex, nativity, race, religion, education, marital status and parental status, (2) information relative to illness and hospitalisation, such as number of previous admissions, form of admission, diagnosis, length of hospitalisation, treatment recommended and final disposition. The data are presented in this order. Table I shows the distribution of the study group according to age and sex.

There were no patients below the age of sixteen and none over the age of seventy-five. The admissions according to age group rose from eleven, in the sixteen to twenty-six group, to a peak of twenty-one in the thirty-six to forty-six group. From this peak there was an increasing drop, according to

age group, to a final single admission in the sixty-six to seventy-six group. While the peak of twenty-one admissions occurred in the thirty-six to forty-six year group, there were only four more cases in this group than in the twenty-six to thirty-six year group. Due to the small scope of the study, this difference did not appear to be significant.

TABLE I

DISTRIBUTION ACCORDING TO AGE AND SEX OF 63 PERSONS DIAGNOSED AS PSYCHONEUROTIC AT STATE HOSPITAL, 1948

Age	Total	Male	Female
Total	63	30	33
16 to 26	11	4	7
26 to 36	17	7	10
36 to 46	21	8	13
46 to 56	8	7	1
56 to 66	5	3	2
66 to 76	1	1	0
76 and over	0	0	0

The marked decrease of admissions after the age of forty-six could perhaps be explained by the increasing presence of bodily changes which provided the basis for diagnoses other than psychoneurosis. Where these bodily changes existed, the psychiatric staff undoubtedly found such diagnoses as involutional psychosis, senility and arteriosclerosis to be more fundamental and

appropriate.

There were thirty-three women and thirty men, an almost equal division as to sex. Up to the age of forty-six there seemed to be no significant differences in admissions as far as sex was concerned. The admissions of both sexes increased, according to age group, to a peak in the thirty-six to forty-six year group. The drop for females was then quite striking. Out of thirty-three females there were only three who fell into a forty-six or over group. Out of thirty males, eleven were forty-six or over. The female diagnostic picture was probably complicated by the climacteric, which, when it existed, may have led to a diagnosis of involutional melancholia.

In addition to the data on age and sex the records contained a limited amount of information concerning nativity, race and religion. The information indicated that approximately ninety per cent of the patients were both white and native born, and that the three major religions, Catholicism, Protestantism and Judaism, were represented in varying, though not significant, proportions. As far as it could be ascertained there seemed to be no particular relationship between these categories and admissions to the state hospital of those persons suffering from a psychoneurosis.

Nor did there seem to be any particular relationship between educational status and admissions. The amount of education received by the members of the study group ranged from three to sixteen years. Out of fifty-eight cases, where the educational status was known, the records showed that forty-eight completed eight grades or more. Thirty-one patients had attended high school, and, of these, twenty-three had received high school diplomas. Nine of the high school graduates entered college and, of these, five were graduated.

In contrast to the data pertaining to nativity, race, religion and education, the data pertaining to marital status disclosed certain significant findings. These data, obtained from the medical records, were confirmed by comparison with the information secured in the course of examinations made by the psychiatric staff. These examinations also brought out information other than statistical regarding marital status and frequently showed the person's attitude toward his marriage. Table II shows the distribution of the sixty-three psychoneurotic persons according to marital status.

TABLE II

DISTRIBUTION OF THE 63 PSYCHONEUROTIC PERSONS ACCORDING TO MARITAL STATUS

Status	Number of Persons
Total	63
Single	18
Married	21
Separated	11
Divorced	11
Widowed	2

Forty-five of the sixty-three patients were married or had been married at one time. Of these, twenty-two persons, or approximately half, were either separated or divorced. An analysis of the reports on the psychiatric examinations showed that these figures were inadequate to measure the marital unhappiness which the patients experienced. The psychiatric examinations showed that thirty-eight persons, or approximately eight-five per cent of the forty-five married patients, were unhappy in their marriages.

Of the forty-five patients who were married, nineteen were parents. While the records did not always show the relationship of these parents to their children, they showed that at least thirteen, or approximately two-thirds of these persons, were unable to function as adequate parents. One father was described as being unreasonably strict with his children and irresponsible in regard to their financial support. Another father was regarded as being an actual physical danger to his boy. A third father was described as alternating between affection and unreasonable irritation toward his sixteen month old son. The histories of eight mothers showed their resentment at having to cope with the problems connected with the care and training of their children. There were also two divorced mothers whose children were in custody of their fathers because these mothers were considered to be incapable of caring for the children.

The data on marital and parental status completes the presentation of the identifying social information. Subsequent data pertain to the illness and the hospitalisation. While the emphasis in the collection of these data was on the circumstances which surrounded the patient's hospitalisation in 1948, it was, nevertheless, noted that twenty-three of the sixty-three persons had been previously admitted to a state hospital. Of these, thirteen had had one previous admission; seven had two previous admissions; two had four previous admissions and one had been hospitalised seven times prior to the present admission. Approximately three-fourths of these admissions were voluntary in nature.

This could also be said of the admissions in 1948. Forty-seven per-

sons, or approximately three-fourths of those in the study group, entered the hospital upon their own initiative. The preponderance of voluntary admissions was probably due to the fact that the psychoneurotic person is often quite capable of recognizing the fact that he is mentally ill and in need of treatment. In addition, the symptoms of the psychoneurotic, being usually expressed symbolically and subjectively, are not such as to arouse his relatives to force hospitalization upon him. The patients who were committed were so disturbed, at the time, that they appeared to be psychotic and were committed as such. Table III shows the original commitment diagnosis of the sixteen patients who were not voluntary commitments.

TABLE III

ORIGINAL COMMITMENT DIAGNOSES OF 16 PERSONS DIAGNOSED BY STATE HOSPITAL AS PSYCHONEUROTIC IN 1948

Original Diagnosis	Number of Persons	MI *	NMT **
Total	16	10	6
Psychosis, Reactive Depression	5	2	3
Schizophrenia	5	3	2
Alcoholic Psychosis	3	3	0
Involutional Psychosis	2	2	0
Hysterical Reaction with Psychosis	1	0	1

* Mentally Ill Person

** Person in Need of Mental Treatment

Illinois law[1] provided for two possible types of commitment, namely: (1) as Mentally Ill and (2) as in Need of Mental Treatment. The law defined a "Mentally Ill Person" as being any person who, by reason of unsoundness of mind, was incapable of managing and caring for his own estate and was dangerous to himself or others if permitted to go at large. A "Person in Need of Mental Treatment" was defined in a negative manner. He was considered to be a person, who, though not "Mentally Ill", was, nevertheless, in such mental condition as to be a fit subject for care or treatment in a hospital duly licensed for the treatment of mental disorders. The persons who were committed as "Mentally Ill" lost their civil rights; those committed as "In Need of Mental Treatment" were considered to be legally responsible and they retained their civil rights. The two forms of commitment were entirely legal in nature and they bore no relationship to diagnostic classifications.

The differences in the diagnoses made at the psychopathic hospital and the state hospital were due to a number of circumstances. At the time of their admission to the psychopathic hospital the patients were acutely disturbed. By the time, however, that they were transferred to the state hospital, they presented milder forms of mental illness. For example, a nineteen year old boy was completely disoriented as to person, place and time while at the psychopathic hospital and he was diagnosed as being schisophrenic. At the state hospital, however, he suddenly became completely oriented and his condition was considered to be due to a hysterical state of amnesia. Table IV shows the diagnoses made at the state hospital according to type of psycho-

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1 Article 1, Revised Mental Health Act of Illinois, 10-1-45.

neurosis.

TABLE IV

CLASSIFICATION OF THE PSYCHONEUROTICS ACCORDING TO TYPE

Classification	Number of Persons
Total	63
Mixed	24
Chronic Alcoholism	18
Reactive Depression	4
Anxiety	3
Drug Addiction	3
Agitated Depressive Features	2
Hypochondriases	2
Hysteria	2
Psychasthenia	2
Character Neuroses	1
Depressive Trends	1
Neurasthenia	1

Twenty-four cases were classified as "Mixed". These cases showed a mixture of the symptoms associated with the classical categories of psychasthenia, neurasthenia, hysteria and anxiety neurosis. Next in order, eighteen cases were classified as "with chronic alcoholism." This diagnosis was based on the fact that the use of alcohol, as a factor in the patient's illness, was marked and unmistakable. There were not more than four cases in any of the other subdivisions. The classical categories of psychasthenia, neurasthenia,

hysteria, and anxiety neurosis showed only eight cases among them.

Table V shows the length of time, in months, that the patients spent in the State Hospital. The table does not show the length of the hospitalisation period according to type of psychoneurosis, as there was no correlation between the two.

TABLE V

THE LENGTH OF TIME IN MONTHS THE 47 VOLUNTARY AND 16 COMMITTED PSYCHONEUROTICS SPENT IN STATE HOSPITAL IN CONNECTION WITH 1948 ADMISSION

Time	Number of Persons	Voluntary	Committed
Total	63	47	16
Less than 1 month	30	25	5
1 to 2 months	13	10	3
2 to 3 months	6	6	0
3 to 4 months	1	0	1
4 to 5 months	1	0	1
5 to 6 months	3	0	3
6 to 7 months	4	3	1
7 to 8 months	1	1	0
Still in Hospital	4	2	2

At the time the data were collected, there were four patients who were still in the hospital. One was a fifty-six year old committed male who

was blind and diabetic. As the result of diabetic gangrene, he had had to have both legs amputated. This man was originally in an institution for the indigent ill, but his behavior was so combative that he was committed to the State Hospital. At the time of the study his behavior had improved but no other institution was willing to receive him and it seemed likely that he would end his days in the State Hospital. This was one of those patients for whom, for one reason or another, the State Hospital seemed to represent the only shelter.

Another case illustrated the same point, although it was that of a sixteen year old committed girl. Her release was recommended but there seemed to be no place in the community for her. She had been in innumerable foster homes and children's institutions but her promiscuity and combativeness had resulted in her being expelled from each of these. Several hospital psychiatrists had characterized her as a "psychopathic personality." Her official diagnosis, however, remained that of psychoneurosis, mixed type.

The other two cases were those of middle aged women who presented many involutional features and whose mental conditions were such that their release would have been unwise. In addition, the patients themselves, both voluntary, had indicated that they preferred to remain in the hospital.

Table V shows that thirty patients, or almost half of the total number, spent less than a month in the hospital. Forty-three patients, or approximately two-thirds of the total number, spent less than two months in the hospital. There were sixteen patients who were hospitalized from two to eight months. Discounting the four patients who were still in the hospital, the average stay for the total group was approximately one month and twenty-six days.

The average hospitalization period of the committed group exceeded that of the voluntary group by one month and six days. This was probably due to the fact that the committed group included a large percentage of the more disturbed persons. In addition, the committed group did not, like the voluntary group, have the option of "signing out." Discounting two cases "still here," the average stay for the remaining fourteen committed persons was two months and twenty-three days. Discounting two cases classified as "still here," the average stay for the remaining forty-five voluntary patients was one month and seventeen days.

A significant difference, in terms of the hospitalization period, also existed between those committed as "MI" and those committed as "NMT." Those committed as "MI" were hospitalized, on the average, one month and six days longer than those committed as "NMT." This was undoubtedly due to the fact that those committed "MI" were more seriously disturbed than those committed "NMT." Discounting one case classified as "still here," the average length of stay for those committed "MI" was three months and two days. Also discounting one case classified as "still here" the average length of stay for those committed "NMT" was one month and twenty-six days.

Table VI, on page twenty-six, shows the treatment recommendations for the persons of the study group.

Psychotherapy was indicated for forty-eight patients, in conjunction with industrial therapy, which was indicated for eighteen patients. The case records did not indicate why industrial therapy was recommended for some patients and not for others, nor did they indicate why recreational therapy was approved for three patients and not for others. Physical rehabilitation was

recommended in those cases in which there was a physical illness, and in the cases of those alcoholics who were physically depleted due to their constant drinking and accompanying neglect of food. Electric shock therapy was approved seven times. Examination of the records suggested that these patients were particularly agitated or depressed. "No Special Treatment" was listed for two persons who were to be discharged after a short stay in the hospital.

TABLE VI

TREATMENT RECOMMENDED FOR THE 63 PERSONS DIAGNOSED AS PSYCHONEUROTIC AT STATE HOSPITAL, 1948

Treatment	Times Recommended
Total	86
Psychotherapy	48
Industrial Therapy	18
Physical Rehabilitation	8
Electric Shock Therapy	7
Recreational Therapy	3
No Special Treatment	2

Of the fifty-nine persons released from the hospital, fifty-three were given an absolute discharge. One person was released on the hospital's family care program, and five persons were released on a year's conditional discharge. The patients released on conditional discharge and family care were commitment cases. The voluntary patients were always discharged absolutely.

This chapter dealt with the statistical data pertinent to the study group. It gave an overall picture of the group in relation to the identifying social information and to the information pertaining to illness and hospitali-

zation. About three fourths of the patients were married, or had been at one time, and of these, most were unhappy with their mates and children. Also, about three fourths of the patients had entered the hospital voluntarily and these remained in the institution for a considerably shorter time than those who were committed. More detailed and subjective information concerning the patients in the study group was uncovered in the study of the current and remote circumstances which surrounded, and led to, their hospitalization.

CHAPTER III

CIRCUMSTANCES SURROUNDING HOSPITALIZATION

This chapter deals with the circumstances surrounding the hospitalization of the fifty-seven patients who were over twenty-one years of age. The six adolescents are of special interest and will be considered separately in Chapter IV. For the purposes of analysis, the circumstances surrounding the admission of the adults are grouped about four topics, namely; (1) form of hospitalization, whether voluntary or legal commitment, (2) the incidents which precipitated the hospitalization, (3) the early environmental factors which seemed to lay the basis for the mental illness, and (4) the personal problems which were currently associated with the mental illness.

The fifty-seven adults entered the hospital either voluntarily or as a result of commitment action taken by various interested persons or agencies. The forty-four persons who entered voluntarily invariably arranged their own admissions. None was so confused as to require the help of another person. Why they volunteered at the particular time that they did was not always clear, outside of the fact that, in the words of some of them, they could no longer bear their "nervousness and unhappiness." In the cases of fifteen of these patients an immediate or fairly immediate precipitating incident could be assumed from the stories that they told. These fifteen patients were all unhappily married and applied for admission after a marital quarrel, a separation, or a divorce. An obvious desire for help was typical of the voluntary group

as a whole and statements such as the following are typical of their situations.

> A forty-five-year-old separated man said: "My wife is going through the change of life and is very irritable. She's always picking on me. I wanted her to go to a specialist, but she would not go. I left her because I could not stand it. I grieved over it. I couldn't work. I quit my job. Since I came here I have begun to forget and things don't play on your mind so much."
>
> One twenty-seven-year-old woman is quoted as saying: "I am very anxious to find out about myself. I have been quite nervous. I have a lot of worry about my husband. He drank when he came home from the Army. My husband was always jealous of me. He is fifteen years older than I. He is always telling me I'm crazy and is accusing me of wanting another man."
>
> A thirty-eight-year-old divorced man, a veteran, made the following statement: "My wife wrote for a divorce while I was overseas. So I came back to nothing. I seemed bored with everything. I started to drink. I need help for my drinking."

As can be seen from these statements, the voluntary patients actively sought treatment. The committed persons were, on the other hand, forcibly hospitalized. In general these persons never admitted that they were in need of care, and they constantly pressed the medical staff for release. Nevertheless, they all accepted, at least to some extent, the fact that they were mentally ill. They thought, however, that the seriousness of their illness was not such as to warrant commitment to a state institution. Even the persons who attempted suicide minimized the necessity of their forced hospitalization. On the whole, the committed group showed considerably less insight into their own conditions than did the voluntary group. The fact, however, that the committed persons all admitted to mental difficulties was undoubtedly one of the reasons why they were diagnosed as psychoneurotic rather than as psychotic. In addition, these patients did not manifest such gross psychotic symptoms as delusions and hallucinations.

The incidents which precipitated the admission of these committed persons were, on the whole, more striking and identifiable than were those associated with the admissions of the voluntary patients. This was not surprising, since the events leading to the commitment were necessarily of a sort that could attract the attention and concern of others. In the cases of the voluntary patients, the circumstances surrounding admission were, on the whole, more subjective. In many instances, the relatives of the voluntary patients failed to understand the seriousness of the patient's difficulties and the patient was hospitalized only when he, himself, sought treatment. On the other hand, the picture of illness manifested by the committed patients was definitely objective and striking. Six attempted suicide, four were combative, and three were unusually anxious and confused. These reactions are shown in statements contained in the histories relative to the precipitating incidents which led to commitment.

> Mrs. Harris, a twenty-four-year-old married colored woman, slashed her wrists after her husband beat her and tried to force her into prostitution. Her mother committed her to the institution.
>
> Mr. Smith, a thirty-six-year-old single man, took an overdose of sleeping tablets after quarreling with his father, whom he hated. His father made the commitment.
>
> Mr. Gold, a thirty-seven-year-old man, grew depressed and irritable when he developed cancer of the tongue. He was being successfully treated for this when he suffered a severe hand injury and was no longer able to pursue his trade as a carpenter. He began to drink and to intensify an already unhappy marital situation by cruelly beating his wife. She committed him to the institution.
>
> Mr. Carter, a fifty-six-year-old married man, was committed from an institution for the indigent ill. He had grown increasingly irritable and uncooperative when, because of a diabetic condition, he became blind and suffered the loss of both legs.

Miss Pool, a thirty-nine-year-old single woman, was committed from a general hospital where she had been under treatment for heart disease. She had attempted suicide through the use of sleeping pills.

Mrs. Jones, a twenty-four-year-old married woman, was sent to the Psychopathic Hospital by the police. After taking an overdose of sedatives she became confused on the street. She had recently separated from her husband, who was described as sadistic and homosexual.

These accounts show that the incidents which precipitated hospitalisation sprang from the current personal problems of the patients. Since these problems were the same for both the committed and the voluntary groups, it will no longer be necessary to consider the two groups separately. It is of interest, however, to discuss separately the problems of the forty-five married and the twelve single adults. The problems of the married patients centered about their relationships with their spouses and children. About 85 per cent of these persons experienced marked marital unhappiness. Out of the twenty-nine who were parents, about two-thirds were unable to love and care for their children properly. As for the single patients, their problems centered mainly about their inability to hold employment and to establish satisfactory social relationships and interests. In addition, in the cases of both the married and the single persons there were a few instances where physical illness or difficulty was of significance.

It would be superficial to discuss the current problems of these patients without considering the emotional adequacy or inadequacy of their childhood environment. The importance of proper parental care and love in the development of mature and mentally healthy adults is generally recognized. Saul, in his book Emotional Maturity, makes the following statement in this connec-

tion:

> What the child gets comes from his parents; when it matures it can be a parent and enjoy giving, whether to its mate, to its own children, or to society in the production of what is useful. If the child is emotionally deprived it tends to cling strongly to the getting and does not develop sufficient capacity for, or enjoyment of, giving. It is doomed to frustration and hence to anger; emotional frustration spells unhappiness, leads to anger, repressed or overt, and can become the basis for depressions and other neurotic reactions—for alcoholism, for unrest, and for anti-social behavior.[1]

An analysis of the early histories of the patients in the adult group generally bears out what Dr. Saul has to say. Whenever the histories contained data on relationships they showed those relationships to be depriving. About four-fifths of the patients did not receive proper parental care and love. The homes of about half of these persons were broken by death, divorce, or separation before the individual reached the age of sixteen. The remaining homes were intact but were otherwise inadequate. This inadequacy was manifested by marked parental cruelty and neglect.

Appreciation of the patient's current personal problems, therefore, inevitably involved consideration of the early parental relationship. Marital unhappiness and the inability to love and properly care for children could not be fully understood without this consideration. This was clearly brought out in the case of Mrs. Smith, who wanted to divorce her husband, although she admitted that she had no good reason to do so. The opinion of the hospital psychiatric staff was that, as a result of a disturbing parental relationship, Mrs. Smith did not develop the maturity that would have enabled her to meet the responsibilities of marriage and parenthood. Her husband was good to her

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1 Leon J. Saul, Emotional Maturity, Philadelphia, 1947, 8-9.

and her children were healthy and normal. Her impatience with both husband and children had no objective basis and derived from her own deeply disturbed personality. Typical of the voluntary patients, Mrs. Smith understood that she was ill.

> Mrs. Smith, thirty-one years old, was an only child and born of American parentage. Her mother drank to excess and her father engaged in extramarital affairs. The parents quarrelled constantly. Mrs. Smith stated that she never had much confidence in her mother. Her father alternated between cruelty and affection. He spanked her upon the slightest pretext and he seemed to derive sexual satisfaction from this. When Mrs. Smith was fourteen years old her father attempted to seduce her. She screamed and he left. Thereafter he made numerous sexual advances which she managed with great difficulty to repulse. He forbade her to go out with boys. She was in the second year of college when she met her future husband. The husband described her as being seclusive and antagonistic toward men. In a spirit of rebellion against her father, she threw herself into a love affair and demanded sexual relations. She left college, in her third year, to marry.
>
> At the time of her hospitalisation Mrs. Smith had three children, four years, twenty months, and seven months old. She had grown increasingly irritable and restless after the births of her second and third children and stated that she felt incompetent to care for them. A few months before her hospitalisation, when one of her children was slow in doing what she asked, she struck him and knocked him down. About this time she also began to ask her husband for a divorce. She admitted, however, that she had no good reason to divorce him. Frightened by her own behavior she carried out a voluntary commitment to the hospital.

The case of Mr. Burns also shows disturbing early environment and later ineffectual adjustment to marriage and parenthood.

> Mr. Burns, a forty-four-year-old white man, entered the hospital with the following statement: "I went to a psychiatrist because I felt I was acting funny in regard to my wife and child. Every little thing the child would do would make me nervous. I would start cursing. I knew I was blowing up but I couldn't help myself. The psychiatrist suggested that I come here for treatments. I came here to be treated for a bad disposition!"
>
> Mr. Burns' father, an alcoholic, died when Mr. Burns was five. His

mother drank, and neglected him. As she had to work, Mr. Burns was left to the care of an aunt who regarded him as a burden.

Mr. Burns had always been a nonconformist, undoubtedly because of his resentment against his family. Against his mother's and aunt's wishes he gave up the Catholic Church in his early teens and joined the Methodist Church. Later on he became a Communist. He broke completely with his mother and aunt when, at the age of thirty-four, he married a Jewish girl.

Mr. Burns' marriage was unhappy from the first, though his wife did her best to hold the marriage together. Mr. Burns was unable to participate in normal sexual relations and could obtain pleasure only through perverse acts. He soon took to a feminine form of homosexuality. He felt keenly his lack of masculinity and consequent inadequacy with his wife. He was jealous of his five-year-old daughter and his wife feared for the child's safety.

The lack of a proper father image, the inadequacy of his mother, and the absence of proper parental substitutes resulted, according to the hospital psychiatric staff, in this man's development into a homosexual. Related to the homosexuality was the fact that, when Mr. Burns married, he was unable to play the normal and natural role of husband and father.

Both Mrs. Smith and Mr. Burns were married to persons who were well intentioned and who did their best to hold the marriages together. This, however, was not true of all the marriages. About thirty of the forty-five marital partners were characterised as cruel, alcoholic, or otherwise inadequate. Nevertheless, it could not be said that the cruelty or irresponsibility was a prime factor either in the neurosis or in the marital unhappiness. It was always necessary to refer to the early environment for a proper understanding of the difficulties. The hospital psychiatric staff frequently pointed out that the very choice of an unsatisfactory mate was often intimately associated with a masochistic neurotic pattern that had been established in childhood. In his

book The Writer and Psychoanalysis, Dr. Edmund Bergler presents this point of view as follows: "A neurotic unconsciously becomes attached (in childhood) to the rejection level, and later repeats, unknowingly, the consciously disappointing situation. One may say that the victims of neurotically unhappy marriages have got just what they unconsciously asked for. There are no innocent victims in the marital graveyard."[2] The "attachment to the rejection level" was strikingly illustrated in the cases of Mrs. Harris and Mrs. Jones.

> Mrs. Harris, a twenty-three-year-old married Negro girl, was committed after she slashed her wrists in the presence of her mother. Her husband, who frequently beat her, had insisted that she "go out and hustle a man for money." Being extremely masochistic, Mrs. Harris prostituted herself for two nights. Finally reacting with revulsion she fought with her husband, broke off with him, and made her attempt at suicide.
>
> During her adolescence Mrs. Harris had frequent fantasies concerning cold, sneering men who made her grovel at their feet and who forced her into shameful behavior. She admitted that she had been attracted to her husband because he was "that kind of a man." In her premarital promiscuity she had always sought out the man who would mistreat her. She even went out of her way to provoke mistreatment. She said, "I'm real sweet to my men when I'm sober, but when I get drunk I'm mean and hateful to them and do things to make them beat me. I think I want them to mistreat me."
>
> The significant facts in her parental background are as follows: Her father drank to excess and beat both her and her mother. He deserted the family when Mrs. Harris was eight years old. When Mrs. Harris was thirteen years old her mother became involved sexually with another man. This man asked the mother to press the girl into having sexual relations with him. Fearful of losing her lover the mother agreed, but afterwards she became upset and snatched the girl away. The following summer all three spent a week end together, and this time the mother "gave" the patient to the man.

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2 Edmund Bergler, The Writer and Psychoanalysis, New York, 1950, 27.

> When Mrs. Harris told this story to the examining psychiatrist, she wept and wrung her hands. Nevertheless she denied vehemently that she felt any resentment against her mother. When the psychiatrist asked, "What did you have against your mother that you tried to commit suicide before her?", Mrs. Harris became furious and completely denied any hostility.

The examining psychiatrist summed up the dynamics in the case as follows: Because of her masochism, in which suffering became a pleasurable end in itself, Mrs. Harris chose a man who would beat her as did her father and exploit her as did her mother, (attachment to the rejection level). Despite his sex, the husband was masochistically identified in the patient's mind with her mother as well as her father. When her husband forced her to prostitute herself Mrs. Harris experienced the repetition of the earlier situation in which her mother forced her to submit to the lover. Thus the original rage toward the mother, which must have been extremely violent, was stirred up again. The patient could not externalize this rage and therefore masochistically directed it against herself in her suicide attempt. That the exploitation of the husband represented, in the patient's mind, a recapitulation of the earlier parental exploitation, is shown by the fact that she attempted to commit suicide in the presence of her mother. The case of Mrs. Harris shows how the current circumstances were often inextricably associated with events that took place in the patient's childhood.

The case of Mrs. Jones also illustrated masochistic attachment to the rejection level. The examining psychiatrist pointed out that Mrs. Jones was drawn to men who would most likely make her suffer. Because of her immaturity Mrs. Jones was unable to love and care for her children properly, and they had to be placed in foster homes.

Mrs. Jones; twenty-four years old, married and the mother of two children, was committed by the police after they found her wandering about in extreme confusion. She had attempted suicide through the use of nembutal.

Her early history disclosed an adverse parental influence. Throughout her childhood her father was intermittently hospitalised on account of mental illness. Though he frequently punished her severely for slight misdemeanors, she was quite attached to him and she suffered a period of depression at the age of thirteen when he died. Because her mother was obliged to work, Mrs. Jones and her two older siblings were left to shift for themselves during the day. Though the mother was well meaning she was not able to give Mrs. Jones the normal amount of attention. There is no information pertaining to Mrs. Jones' relationships with her siblings.

Mrs. Jones finished high school at the age of seventeen. She then did secretarial work until, at twenty, she married a man who was twenty-one years older than herself. The examining psychiatrist speculated that she identified this man with her father; for not only was her husband considerably older than herself, but he was in addition, like her father, mentally ill. He was both sadistic and overtly homosexual. He was incapable of performing normal sexual relations and he forced Mrs. Jones to submit to perverse acts. Nevertheless, despite her unhappiness she remained with him four years and bore two children.

Since Mrs. Jones was too disturbed to care for the children they were placed in foster homes soon after birth. Had she been capable of mature love for them she might have found purpose in living, despite her marital unhappiness. As it was, she attempted suicide shortly after her husband left her to indulge in a homosexual affair.

The fact that Mrs. Jones masochistically sought her own unhappiness was confirmed while she was still in the State Hospital. She fell in love with a fifty-year-old patient who had mistreated his wife and who had, in a temper tantrum, killed his father. Again she was attracted to a man who was mentally ill and considerably older than she. Since Mrs. Jones actually did not know this man's past history, the psychiatrist speculated that she sensed unconsciously that he was the sort of man who was likely to mistreat her.

This man with whom Mrs. Jones had fallen in love had spent ten years in a security hospital for the murder of his father. Since his presence in the State Hospital was voluntary, and since he was at the time without psychosis, he was released upon his own request. After her own discharge Mrs. Jones appeared at the out-patient clinic to admit that she was carrying on an affair with this man and intended to marry him as soon as she could arrange to divorce her husband. Be-

cause of the confidential nature of the records, the clinic psychiatrist could not inform her of her friend's past history.

The four preceding case summaries were illustrative of the inability of the married patients to find happiness, either with their marital partners or with their children. Analysis of their histories showed that the same basic immaturity lay behind both circumstances. It must be mentioned, however, that there were five cases where the patient was happily married but was, nevertheless, an inadequate, unhappy parent. In these cases the histories showed that the patient had chosen a mate who catered to his or her immaturity. The patient was happily married, but being fundamentally childish, was unable to cope with the responsibility of children. The case of Mrs. MacDougal was typical for this group of patients. As usual, her history showed a depriving early environment.

> Mrs. MacDougal's father died when she was five years old. Her mother was obliged to work and was therefore unable to give her the normal amount of attention. In addition the mother was a rather cold and aloof person. As a child Mrs. MacDougal was moved from relative to relative, to whichever one was able to look after her at the time. As a result Mrs. MacDougal never received the consistent and constructive love experience that would have enabled her to become a mature, independent adult.
>
> Mrs. MacDougal finished high school at the age of seventeen. She then supported herself for ten years as a stenographer, never, however, keeping the same job very long. Always insecure in her sense of her own personal value, she inevitably felt that she was disliked by her current employers and fellow employees.
>
> At the age of twenty-seven she married a capable man who was thirteen years older than herself. He played the role of father as well as husband to her. She leaned upon him and depended upon him to direct her life. Since he was kind to her, she was quite happy with him. She began, however, to suffer serious anxiety when, after a year of marriage, she became pregnant. After the birth of the child she broke down completely. The problem of caring for the child was too much for her. She could not bear the demands that it made on her and she was afraid that she might harm the child. In a panic of anxiety and guilt

she arranged to commit herself voluntarily.

Mrs. MacDougal appeared to understand that she was immature and dependent. While in the hospital she said, "I feel so much younger than my years, but I realize that I have to carry on as an adult. Some day something will happen to my husband and then I'll have to look out for myself. I just know I couldn't take care of myself." When asked what she would like most, she replied, "I would like to be home in bed and have my husband take care of me. He is a wonderful man." Because of Mrs. MacDougal's great immaturity the examining psychiatrist recommended that she have no more children.

As the case summaries of the married patients showed, a full understanding of the patient's current unhappiness required an examination of his or her parental relationship. This requirement held true for the single as well as the married patients. The current problems of the twelve single patients, their inability to keep employment and to establish satisfactory interests and social relationships, could not be properly understood without an examination of their past histories. The case history of Mr. Childs illustrates this point.

Mr. Childs, a thirty-six-year-old white man, was committed after he had taken an overdose of nembutal in the presence of his father, with whom he had been quarrelling.

Mr. Childs, the second oldest of three male siblings, grew up in a disturbing family atmosphere. The parents quarrelled constantly and the siblings fought the parents and each other. As will be seen, the father, who was an alcoholic, played the most important role in Mr. Childs' life. Of all the children, he appeared to dislike Mr. Childs the most. He punished the patient with savage cruelty, frequently knocking him unconscious.

When Mr. Childs was thirteen, his father forced him to leave school so that he might work and bring home his pay. Mr. Childs worked as a messenger until he reached maturity. He then learned bookkeeping and was able to earn a good living. Though Mr. Childs hated his father, he did not, like his brothers, leave home. The examining psychiatrist stated that Mr. Childs' father had simply "beaten all the independence out of him."

At the age of thirty years Mr. Childs was rejected from the Army

as psychoneurotic. His father found out about this and taunted the patient, saying that he was "a goof and a nut." After the humiliation of his rejection Mr. Childs became chronically anxious and could not hold steady employment. He gave up his bookkeeping and fell to the level of odd jobs. He became an alcoholic and remained drunk for days at a time. For long periods he was entirely dependent upon his father's support. He blamed his father for having made him "the weakling that he was," and admitted that he derived satisfaction from making his father support him. The psychiatrist commented on the fact that Mr. Childs seemed to have no interests at all, that the only stimulation he got out of life was through the "revenge" he took on his father. It was during a quarrel with his father over his idleness that Mr. Childs attempted to commit suicide.

The case history of Miss Wines also illustrates the poor parental background and the consequent inability of the single patient to establish genuine interests and relationships.

Miss Wines, a twenty-five-year-old unmarried white woman, voluntarily entered the hospital soon after she had completed a thirty-day sentence for disorderly conduct. She had been jailed following a wild, two-day spree in a hotel, where she had sexual relations, not only with the soldier she had picked up but also with the hotel bell boy. She attracted the attention of the hotel authorities after she had, with drunken exuberance, set fire to a bed spread. Frightened by her own reckless and irresponsible behavior, she actively sought treatment.

Miss Wines was an only child. Her parents drank, physically assaulted each other, and repeatedly separated. They were incapable of giving Miss Wines proper parental care and affection. Once when she was ten years old she was obliged to purchase the food for her parents who were too drunk to leave the house.

Miss Wines reacted to the insecurity at home by making a poor social and academic adjustment at school. She was so ashamed of her quarrelling and alcoholic parents that she felt she "was not as good as the other children," and she avoided her classes for days at a time.

Without any protest on the part of her parents she left school at the age of fifteen to work as a nursemaid. She thereafter went from job to job, never holding the same one for longer than three months. Not only could she not find interest in her work but she could not establish any meaningful social relationships with her own or the opposite sex.

Bored and restless, she threw herself at the age of nineteen into

alcoholism and the pursuit of pleasure through casual sexual contacts. When she was twenty-two she gave birth to an illegitimate child, whose care she forced upon her parents, while she herself continued to dissipate. The examining psychiatrist stated that behind her irresponsible pursuit of pleasure lay a desire to revenge herself upon her inadequate, unaffectionate parents.

The histories of the ten other single adults showed the same inability to develop mature interests. These persons were invariably unable to find healthy objectives and activities about which to center their energies. As a result they took to alcohol, dope, and promiscuity. Since they were unable to support themselves, they lived parasitically on their families. Their lives were characterized by lack of confidence in their ability to face the requirements of mature existence. This lack of confidence could invariably, whenever the histories were adequate, be traced to a childhood lacking in parental protection and love.

In all the cases offered thus far the patients were in reasonably good physical health. If they suffered from any physical difficulties, these were of such minor nature that the psychiatric staff did not attempt to relate them to the mental illness. There were, however, three cases in which physical illness and difficulty appeared to play a significant part in the development of the patient's neurosis. Following is a summary of one of these cases. It shows the usual inadequacy of parental background plus, however, the additional circumstances of severe physical illness and handicap.

Miss Browning, a thirty-nine-year-old single white woman, was committed from a general hospital where she had been under treatment for heart disease. She had attempted suicide through the means of sleeping pills.

Miss Browning's father died when she was fourteen, during the same year that she developed rheumatic heart disease. Her mother was characterized as always having been "peculiar" and incapable of

"loving anybody." Though Miss Browning was only fourteen and physically handicapped, the burden of the family support fell on her. She quit the ninth grade to work in a factory.

When she was twenty-one years old she was hospitalized for her heart condition and was given only a few days to live. Though she recovered from this particular heart attack her condition remained serious. Nevertheless, Miss Browning continued to look after her mother and to support her by doing light factory work. At times she broke down physically and had to be hospitalized.

It was the opinion of the hospital staff that her ill health and premature financial responsibilities had left her with no energy to develop social interests. She became shy and isolated and there were few satisfactions in her life. When in 1948 she was again hospitalized for her heart condition she decided that "life wasn't worth living" and she attempted suicide.

In the case of Miss Browning, physical illness and handicap were not the only adverse circumstances in her life. The early death of her father and the inadequacy of her mother resulted in an insecure childhood environment; had this environment been more adequate it is possible that her physical handicap would not have proved to be the burden that it was. Certainly, had her background been normal she would not have had to quit school and take a job at the age of fourteen. The following case also shows the effect of physical difficulty as an associative, rather than as a prime, cause of the mental illness and consequent commitment.

Mr. Press, a thirty-seven-year-old white man, was committed by his wife. While under the influence of liquor he beat her and threatened her with a shotgun.

His case history was extremely sparse and no conclusion could be drawn as to the adequacy or inadequacy of his early environment. The psychiatric staff, however, considered him to be suffering from a neurosis of long standing, as shown by the fact that he had been drinking to excess since the age of eighteen. The staff was of the opinion that his current physical difficulties served to precipitate an acute manifestation of his chronic neurosis. The patient's own words sum up quite effectively the circumstances sur-

rounding his hospitalization. "My wife and I haven't been getting along well. It's mostly due to the fact that I've been incapacitated through a series of accidents in 1947. I took out a journeyman's card in the carpenter's union. I was putting in a glass panel in a door; the door fell on me and I got a cut on my left wrist. They took about seventeen stitches. I have no use of my fingers now. That meant I had to give up carpentry. Then I took odd jobs and I got sunstroke while doing roofing. After I got over that I got cancer of the tongue. I battled the "Mrs." That made her upset and nervous. There was no harmony. I had a few drinks and she said I threatened to kill her. She called the police and I ended up here."

The psychiatric staff considered Mr. Press to be a chronic alcoholic. The opinion of the staff was that, due to the severity of the physical handicaps, the appropriate diagnosis was "Psychoneurosis, Reactive Depression." He left the hospital to continue treatment for cancer.

The remaining case in this group was that of a fifty-six-year-old man who was committed from an institution for the indigent ill. He had grown increasingly irritable and uncooperative when, because of a diabetic condition, he became blind and, in addition, suffered the loss of both legs. There was little in the patient's record other than the description of these circumstances. Since the staff psychiatrists considered the patient's physical misfortunes to be sufficient in themselves to explain his mental illness, they did not request a social history. The patient was diagnosed as "Psychoneurosis, Reactive Depression." The case of this man represented the only case in the study group where the psychiatric staff clearly indicated that an examination of the patient's childhood was irrelevant to an understanding of the mental illness.

Summary

What was most striking about the circumstances which surrounded the hospitalization of the adult group was the fact that whenever the histories

described the early home environment they invariably showed it to be inadequate. This was not entirely surprising, as current psychiatry has placed great emphasis on the role of the parents in preparing the child for consequent mental health or illness. It was, however, surprising not to find, even in this small group, at least one instance of an adequate parental relationship. As Dr. Bergler points out in his book The Battle of the Conscience, it is quite possible for the child to develop a neurosis even though he was raised by normal and loving parents. Dr. Bergler makes the following statement: "The child often projects his own aggression onto his educator and later introjects this 'severe' educator in identification; reality and environment can hardly be blamed for the distorted image of them petrified in identification."[3] Thus the child may be burdened with a harsh and punishing super-ego even when raised by affectionate parents. It was also surprising to find that the inadequate parental relationship inevitably represented a situation of crude and unmistakeable rejection for the patient. Not one of the case histories in the entire group revealed that more subtle form of rejection, parental overprotection.

It is possible that, in some of the cases at least, an adequate or an overprotective early environment would have been shown had the information concerning the patient been more objective. In many instances the patient's relatives or friends failed to come to the hospital to give the information. As a result the patient's record showed parental relationship as it was seen

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3 Edmund Bergler, The Battle of the Conscience, Washington, D.C. 1948, 191.

by the patient himself. It is possible that these patients had pictured as grossly rejecting a background that actually was adequate or even overprotective. Nevertheless, allowing for this possibility, examination of the circumstances surrounding the admission of the adult group supported, as a whole, the current psychiatric belief that an inadequate parental relationship plays an important role in the development of mental illness.

CHAPTER IV

THE ADOLESCENT GROUP

Six of the sixty-three patients in the study group ranged in age from sixteen to twenty years. Because of their youth they were still under the care of parents or social agencies. In the case of each of these patients, therefore, there was some informant who was available to offer a social history. As a result the case records were, generally speaking, more complete than were the records of the adults, a number of whom lived alone and had broken contact with their friends and families. In contrast to the records of the older group, the records of the adolescent group showed clearly in every case the circumstances which surrounded the hospitalisation. Furnishing the subject of this chapter, these circumstances are grouped, for the purposes of examination, about three topics; namely, (1) the factors which contributed to the patient's emotional insecurity, (2) the behavior problems manifested by the patient, and (3) the incidents which precipitated hospitalisation.

The factors which contributed to the emotional insecurity of the patients were primarily associated with the adverse character of their parental backgrounds. These factors were parental quarreling, rejection, physical abuse, death, and divorce. The records showed that the patients were born into homes where the parents quarrelled violently, and thus from their earliest years were

subjected to an atmosphere charged with hostility between father and mother. In addition, the patients were subjected to emotional rejection and even physical abuse by one or both of the parents. Finally, the home itself was broken either by death or divorce.

The adverse influence of parental quarreling on the development of the child's emotional growth is generally recognized. Dr. Samuel Kraines in his book, Therapy of the Neuroses and Psychoses makes the following statement in this connection:

> So much of emotional stability in adult life is determined by the kind and firmness of the early reaction patterns, that it is clear that the family situation in which they are established is of primary significance. Long before a child develops conflicts of his own he is sensitive to those of his environment. If friction exists between his parents, whether it be of the knock-down and drag-out type or of the grim suffering-in-silence variety, the child feels the tension and develops a sense of insecurity.[1]

The case of Jack, a nineteen-year-old voluntary patient, strikingly illustrated the atmosphere of friction to which all of the patients were subjected. Jack's earliest memory was that of his drunken father trying to choke his drunken mother.

According to the psychiatric staff, the insecurity of the patients was also furthered by the fact that they all experienced unmistakable rejection at the hands of at least one of the parents. Either the mother or father, or both, showed their disinterest by lack of love, attention, or economic support. For example, the father of Morris, a nineteen-year-old committed patient, was characterized as being "a stranger to his own child." Not only did

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1 Samuel Kraines, Therapy of the Neuroses and Psychoses, Philadelphia, 1941, 46.

this father fail to give Morris attention and affection but he further showed his lack of interest by spending his earnings on liquor and failing to contribute adequately to Morris's support.

Three of the six patients experienced physical abuse as well as rejection. The adverse effect of this abuse upon the patient's emotional stability was strikingly illustrated in the case of Sylvia, a seventeen-year-old committed girl. Sylvia suffered from hysterical states during which she imagined that she was fourteen years old and was being beaten by her mother. The psychiatric staff found that these states could be attributed to the traumatic effect of an actual beating which the patient received from her mother at the age of fourteen.

Also contributing to the insecurity of the six adolescent patients was the fact that their homes were broken by death or divorce. In five cases the homes were broken by death; in one case the home was broken by divorce. Ruth, whose father died when she was eight years old, and whose mother died when she was twelve, was raised in orphanages and foster homes. The home of Rose was broken by the death of her father when she was six years old. Because her mother was emotionally unstable and unable to care for her, Rose was placed, by court order, under the care of a children's agency, which placed her in a series of orphanages and foster homes. Jack, whose mother died when he was nine years old, was placed by his father in boarding school. Morris, whose father died when he was thirteen years old, and Frank, whose father died when he was eleven, were raised by their surviving mothers. Sylvia, whose parents were divorced when she was four years old, was raised alternately by her father and mother. Neither of her parents wanted to keep her permanently and

she was sent back and forth between them.

The emotional insecurity which these patients experienced in their childhood was responsible, in the opinion of the psychiatric staff, for the marked behavior problems manifested by five of the six patients. Ruth and Rose, who were raised in orphanages and foster homes, had constantly to be transferred to new placements because of temper tantrums and sexual promiscuity. Jack, who was placed in boarding school, ran away repeatedly to engage in petty thievery and, in one instance, in burglary. Furthermore, he had had early sexual experiences. Sylvia, who was sent back and forth between her divorced, rejecting parents, manifested both temper tantrums and homicidal tendencies, and her history also showed instances of early sexual experience. Morris and Frank, who were raised by their surviving mothers, were the best-behaved of any of the six. They were the only children who received affection from even one of the parents. Unfortunately, this affection was overprotective in its nature and consequently played its part in the development of the subsequent neurosis. Morris eventually rebelled against the over-attachment that existed between his mother and himself and, just prior to his hospitalization, he engaged in a drinking "spree" and in premature sexual experience. The other boy, Frank, always remained shy and timid and never manifested overt aggressive behavior.

The emotional insecurity of these children led to unmistakable manifestations of mental illness. These signs were recognized by the parents or by social agencies and led to the hospitalization of the patients. Sylvia was committed by her father after she slashed her wrists in an attempt at suicide. Taking an overdose of sleeping pills, Ruth also attempted suicide, and was

committed by the social agency responsible for her. The agency which bore the responsibility for Rose committed her after she developed hysterical paralysis of the legs. Morris was committed by his mother when he developed amnesia. Jack entered the hospital voluntarily, with the encouragement of his father, after he had run away from boarding school to engage in an alcoholic "spree." Frank was persuaded by his mother to enter the hospital as a voluntary patient when he became exceedingly anxious and fearful of venturing into the street.

The histories of three of these adolescents are presented in summary form and show quite clearly the interrelationship that existed between adverse parental relationship and the consequent neurosis. The original records gave very little information relative to the progress which the patients made in school. The records did show, however, that all of these patients made average intelligence scores when tested by the hospital psychologist.

The first summary pertains to Morris, one of the two boys raised by surviving, overprotective mothers.

> Morris, a nineteen-year-old Jewish boy, was committed by his mother after it became clear that he was suffering from amnesia. He returned from an all-night New Year's Eve party unable to remember who he was.
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> Morris, an only child, grew up in an unstable home atmosphere. The father drank to excess and beat both Morris and his mother. Because the father worked only irregularly as an unskilled laborer, the mother was obliged to support the family by operating a rooming house. When Morris was thirteen years old his father voluntarily entered a state hospital where he was diagnosed as "Psychoneurosis, Chronic Alcoholism." Shortly after leaving the hospital he committed suicide. Upon learning of the death, Morris said that he had always hated his father and that he was pleased that his father would no longer be able to mistreat him and his mother.
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> The examining psychiatrist pointed out that Morris's unhappy home life led to early manifestations of emotional instability. Morris sucked two fingers until he was nine years old. His school adjustment, both

socially and academically, was poor from the very beginning. He appeared to be afraid of the other children and he had to repeat the first grade. His grammar-school teachers complained that he had the habit of gazing abstractedly out of the window. He did no better in high school. He frequently played truant and, as a result, failed several more grades. He still was unable to form friendships and was, as his mother described him, a "lone wolf."

Throughout these years Morris lived alone with his mother. There were no other relatives to take an interest in him. His only uncle, his father's brother, was mentally ill and in a state hospital. As a result of conversations with Morris and his mother, the examining psychiatrist concluded that the mother, disillusioned soon after her marriage with Morris's father, had centered all of her affection on Morris. This affection was extreme and unhealthy and served to delay Morris's emotional maturity.

When he was nineteen, Morris left the fourth year of high school to take employment as a file clerk. He now, for the first time in his life, manifested strong social interests. Though he disliked his job, he worked steadily so that he might have money for flashy clothes and for dates. He now made many friends of both sexes and participated with them in a rather "wild" pursuit of good times. It was at a "wild" all-night New Year's Eve party, where the liquor flowed freely, that he lost his memory. Though he regained this while in the hospital, he could not remember what happened at the party except that he had "yelled so much that he had gotten laryngitis."

The examining psychiatrist concluded that Morris had broken down during an attempt to compensate for his shyness and over-attachment to his mother. The psychiatrist considered that Morris felt generally guilty over the "wickedness" of this attempt and that his breakdown had been precipitated when he had gone too far in some sexual episode at the party.

Ruth was one of the two girls raised in orphanages and foster homes. Neither of these girls could adjust to that plan of living and were frequently moved from one home to another. Finally they were committed to the hospital by the social agencies responsible for their care.

Ruth, a sixteen-year-old, was committed by a children's agency after she tried to commit suicide by drinking rubbing alcohol.

Her parents, who were both alcoholics, quarrelled bitterly and separated frequently. When she was three years old her father enlisted in

the Merchant Marine and was thereafter absent for long intervals. During these periods her mother, who found Ruth a handicap to her promiscuity, placed her in various orphanages. When Ruth's father returned he would remove her from the orphanage and, in anger, force the mother to care for her. As soon, however, as he went back to his ship the mother would again rid herself of Ruth. There was little information about Ruth's brother, other than that he was fourteen years older than she was and had been placed permanently in an orphanage.

After her father's death, which occurred when Ruth was eight years old, Ruth was given by her mother into the charge of a children's agency and consequently saw little of her mother, who died four years later. The agency placed Ruth in an orphanage, where she immediately proved herself to be a behavior problem. She flew into temper tantrums during which she would attack the adult in charge of her. The agency then placed her in a foster home, but she had to be returned to the orphanage after she kicked and struck her foster mother. She became so intractable that eventually the orphanage would no longer keep her.

When Ruth was thirteen she was placed in a boarding school, but soon after the placement she disappeared for several weeks. When she returned she was found to be suffering from gonorrhea. She was then placed in another foster home, where she got along well for about six months. She "worshipped" her foster parents, who had a reputation for skill in dealing with problem children. Her stay at this home was terminated when she grew jealous of a nine-year-old foster sister and brutally attacked her. Thereafter, until the age of sixteen, when she was committed to the state hospital, she was moved from one foster home to another.

Just prior to her committment she developed a tremor of the leg and was sent to the County Hospital. The tremor proved to be hysterical in nature. While in the hospital, Ruth grieved over her mistreatment of her latest foster mother. She expressed fear that she would not be permitted to return to her and she made her attempt at suicide.

The examining psychiatrist stated that the emotional insecurity that Ruth had experienced with her parents had rendered her incapable of believing that a parental substitute might be good to her. This evaluation was confirmed by Ruth's responses to the "Thematic Apperception Test" administered by the hospital psychologist. The psychologist summed up the dynamics which lay behind Ruth's behavior as follows: "The patient has ambivalent feelings toward parental figures. Although she wants to love them she cannot really believe her love will be reciprocated. Subject, therefore, to a great sense of frustration she strikes back with rage and misbehavior."

The story of Jack concludes the summaries. Jack was the only adolescent who was admitted twice in 1948. He was "tricked" into his first admission by his father, who told him that he was going to remain in the hospital for only one day, for the purpose of a psychiatric examination. Because Jack was a minor the papers for his voluntary admission were signed by his father. Since the boy, at the time of admission, was as cooperative as the voluntary patient usually is, the hospital did not suspect the father's "trickery." When Jack discovered that he was going to remain in the hospital for more than a day, he decided that this was for his benefit and he cooperated throughout the entire period of his hospitalization. Three months after his discharge he himself initiated the action which led to his readmission.

> Jack, nineteen years old, was brought to the hospital by his father after he had run away from boarding school to spend a month in alcoholic carousing in another state. During this period of dissipation he forged his father's name to checks and engaged in burglary.
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> Jack's first memory, as elicited by the psychiatrist, was that of his drunken father attempting to choke his drunken mother. This bitter quarreling between the parents persisted until the mother died when Jack was nine years old. For two years thereafter Jack was left to the haphazard care of a series of housekeepers while his father travelled about the country in connection with his prosperous manufacturing business.
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> When Jack was eleven years old his father enrolled him in a boarding school. Jack resented this keenly for he wanted to live with his parent. Despite his father's neglect and alcoholism Jack looked up to him and wanted his friendship. As a result of petty thievery and his inability to get along with his schoolmates, Jack was expelled from this boarding school, and afterwards from a series of others. The psychiatrist stated that Jack's trouble at school grew out of his desire to be sent back to his father. He wanted his father's pity and attention. The fact that his father reacted by always enrolling Jack in another school enhanced Jack's feeling of insecurity.
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> When Jack was seventeen years old he joined the Navy. While in the service he took to drinking and carousing with prostitutes. He was

reckless and irresponsible, and he was frequently censured for infractions of Navy discipline. After a year he was given a medical discharge for "nervousness and insomnia." Soon after he left the Navy, Jack's father again enrolled him in a boarding school. It was after he had run away from this school that his father brought him to the state hospital.

Jack was discharged after sixteen days. Three months later he again applied for admission, with the following statement: "I was feeling run down and in the dumps. I had a job but I didn't feel like going to work. I wasn't in any trouble at this time. I just never got to talk to my dad and that made me feel bad. He was drinking a lot. So one night I went out and got drunk too. I was sick the next day, so I called Dr._____ (the staff psychiatrist) and he suggested that I come here for a while.

The staff psychiatrist summed up the dynamics in Jack's case as follows: "The patient's life history is a striking example of the direct relationship between behavior disorders and a poor upbringing. Since childhood this boy has suffered from a lack of parental love and protection and from a continuous sense of insecurity. His anti-social tendencies are a direct response to his basic feeling of insecurity."

In each case the adverse parental background of the adolescent patient was marked and unmistakable. Such factors as parental quarrelling, rejection, physical cruelty, death, and divorce clearly contributed to the patient's emotional insecurity and consequent mental illness. It can be said without qualification that the histories of these patients confirmed the current psychiatric belief that an inadequate parental background plays an important role in the development of mental illness.

SUMMARY

The identifying social information showed that the sixty-three persons in the study group were almost equally divided as to sex and were dominantly white and native born. Four out of five of these persons had at least a grammar school education and one out of seven had been to college. Forty-five persons were married, or had been at one time, and, of these, thirty-eight suffered marked marital unhappiness. As far as age was concerned, there were patients as young as sixteen and as old as seventy-five. The admissions, according to age group, rose from eleven in the sixteen to twenty-six year group to a peak of twenty-one in the thirty-six to forty-six year group. There was a marked decrease in admissions after the age of forty-six, which was probably due to the fact that presence of bodily changes, in older patients, provided the basis for other diagnoses, such as involutional melancholia, senility and cerebral arteriosclerosis.

The information pertaining to illness and hospitalization showed that forty-seven persons entered the hospital voluntarily and that sixteen were committed. The preponderance of voluntary patients was not surprising as it was in keeping with the fact that the psychoneurotic person is usually quite capable of recognizing that he is mentally ill and in need of treatment. In addition, the behavior of the psychoneurotic is not usually such as to arouse his

family to take steps to hospitalize him by force. Analysis of the case records showed that those patients who were committed were so disturbed at the time as to appear to be psychotic. Since a differential diagnosis between a severe psychoneurosis and a psychosis is often difficult to make, it was not surprising that these psychoneurotic persons were considered to be psychotic.

The average length of hospitalization for the total group was approximately one month and twenty-six days. It was significant that the committed group remained in the hospital considerably longer than the voluntary group. This was probably due to the fact that the committed group was, on the whole, more seriously disturbed than the voluntary group. In addition, the persons of the committed group did not have the legal right to arrange personally for their release, as did the persons of the voluntary group. It was also interesting to note that the persons who were committed as "Mentally Ill" were hospitalized, on the average, significantly longer than those persons who were committed as "In Need of Mental Treatment." Undoubtedly, this was due to the fact that the persons who lost their civil rights were more seriously disturbed than were those who were permitted to retain them.

Analysis of the circumstances surrounding the admissions of the adult group showed that the incidents which precipitated the admissions of the committed patients were, generally speaking, more striking and identifiable than those which precipitated the admissions of the voluntary patients. This was not surprising, since the events leading to committment were necessarily of a sort that could attract the attention and concern of others. There was also another difference between the two groups. While the voluntary patients sought and accepted hospitalization, the committed persons never admitted that their

hospitalization was justified. On the whole, the committed patients showed considerably less insight than did the voluntary patients.

There was no difference between the voluntary and committed adults in regard to their current personal problems. A differentiation as to these, however, could be made between the married and the single persons. The problems of the married persons centered mainly about their inability to maintain satisfactory relationships with their spouses and children. On the other hand, the problems of the single persons centered about their inability to hold employment and to establish satisfactory social relationships and interests. Analysis of the current problems of both the single and the married patients showed that these could not be fully understood without consideration of the patient's childhood environment.

The analysis of social environments supported the current psychiatric belief that the inability of the adult to meet the responsibilities of life is often due to the fact that in his childhood he failed to receive satisfactory parental care and love. Whenever the histories contained data on the parental relationships they invariably showed these relationships to be depriving. They showed that about four-fifths of the patients did not receive proper parental care and love. The homes of about half of these patients were broken by death, separation or divorce before the individual reached the age of sixteen. The remaining homes remained intact, but they were characterized by marked cruelty and neglect of the patients.

The case records of the six adolescent patients showed, in an even more striking manner, the part which unsatisfactory parental relationships play

in the development of mental illness. All of the adolescent patients experienced crude and unmistakable rejection at the hands of at least one of the parents; in half of the cases the patient was subject to gross physical cruelty. Furthermore, it was found that death, in five cases, and divorce, in one case, served to effect the dissolution of the patient's home by the time the patient reached the age of thirteen. As a result, two of the adolescents were raised in orphanages and foster homes, one was raised in a boarding school, one was constantly shuttled between the divorced parents and two were raised by surviving overprotecting mothers. In every case the lives of these patients were marked by considerable emotional insecurity.

In five cases this insecurity expressed itself in the form of such behavior problems as combativeness, running away from home, alcoholism, thievery or premature sexual experience. In addition to manifesting behavior problems three of these patients were subject to various hysterical episodes. The one patient who did not misbehave was unusually shy and withdrawn.

In conclusion it must be mentioned that there were three cases in the study group in which physical illness or difficulty contributed to the mental illness. In two of these cases the physical handicap was considered by the psychiatric staff to have served as a causal factor, along with adverse social and psychological determinants. In the remaining case, however, the physical factor was of such a traumatic and handicapping nature that the psychiatric staff considered this factor to be, for all practical purposes, sufficient in itself to explain the mental illness.

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