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Understanding Madmen: A *DSM-IV* Assessment of Adolf Hitler

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ABSTRACT - Adolf Hitler's personality was investigated posthumously through the use of an informant version of the Coolidge Axis II Inventory (CATI), which is designed for the assessment of personality, clinical, and neuropsychological disorders. Five academic Hitler historians completed the CATI. The overall mean inter-rater correlation was moderately high for all 38 CATI scales' *T* scores (median $r = .72$). On Axis I, the highest mean *T* scores across raters were Posttraumatic Stress Disorder (76), Psychotic Thinking (73) and Schizophrenia (69). On Axis II, the highest mean *T* scores on the CATI scales were Paranoid Personality Disorder (78), Antisocial Personality Disorder (78), Narcissistic Personality Disorder (77), and Sadistic Personality Disorder (76). Results of the present study support the reliability and preliminary validity of informant reports for psychological investigations of historical or contemporary figures.

The name Adolf Hitler conjures-up images of a madman in power, Nazi concentration camps in Germany and Europe, and an evil of such magnitude that millions of Jewish people and others were subjected to unimaginable torture, terror and death. The present study attempts to evaluate posthumously Adolf Hitler's personality according to the current *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000). Tolerance and enlightened acceptance of various peoples has been heralded as one of the major accomplishments of modern societies in the last 50 years. With this advancement, it has often been taken for granted that a leader of Hitlerian proportion could never again attain such power and influence. However, we know now that there are many who threaten world peace and stability. It is hoped that this study of Adolf Hitler's personality (1) will be useful in understanding the role psychopathology might play in the execution of heinous acts, and (2) will establish the reliability of the informant method in the diagnosis of psychopathology. It is important to note at the outset that regardless of any inferred *DSM-IV* psychopathology, explanation does not equal exculpation: The present study is not intended to excuse Hitler's actions or make him any less morally culpable.

There have been many different and highly contentious theories attempting to understand Hitler and the Holocaust. The most common approach centers Hitler firmly as the cause of the

Holocaust. This approach is epitomized by Himmelfarb's (1984) famous essay, "No Hitler, no Holocaust." Himmelfarb viewed Hitler as an evil genius who started the Holocaust because of his personal will and desire to exterminate Jews. Yet within this approach, opinions run the gamut from attributing Hitler's behavior to his psychopathology to stating firmly that Hitler was inexplicably evil.

One of the first published reports of Hitler's personality was by Carl Jung in 1939 (McGuire & Hull, 1977). In the late 1930s, Jung met and observed Hitler and Italian dictator Mussolini interact in Berlin. Jung noted that Mussolini appeared to be an "original man" who had warmth and energy, where as Jung said Hitler inspired in him only fear. During their interaction, Jung said Hitler never laughed, and it appeared as if Hitler was "in a bad humor, sulking." Jung viewed him as sexless and inhuman, with a singleness of purpose: to establish the Third Reich, a mystical, all-powerful German nation, which would overcome all of Hitler's perceived threats and previous insults in Germany's history.

Langer (1943/1972) provided a psychoanalytic evaluation of Hitler during WWII for the Office of Strategic Services. Using sources only available up until 1943, Langer diagnosed Hitler as a neurotic bordering on psychotic with a messiah complex, masochistic tendencies, strong sexual perversions, and a high likelihood of homosexuality. He also stated that Hitler had many schizophrenic tendencies and that the most plausible outcome for Hitler would be that he would commit suicide. Langer's views heralded later ideas that Hitler's primary later adult motivations may have been formed when he was hospitalized (at the age of 29) in 1918 at Pasewalk hospital in Pomerania (Germany) while serving in WWI on the Russian front. Hitler, and the troops he served with, were attacked with mustard gas. For many theorists, Pasewalk is a seminal event in the development of Hitler's anti-Semitism and for the formation of his psychopathology. In *Mein Kampf* (which most scholars agree it cannot be taken as completely factual), Hitler (1925/1999) reports that on the evening of October 13, 1918, gas shells rained on them "all night more or less violently. As early as midnight, a number of us passed out, a few of our comrades forever. Toward morning I, too, was seized with pain which grew worse with every quarter hour, and at seven in the morning I stumbled and tottered back with burning eyes; taking with me my last report of the war. A few hours later, my eyes had turned into glowing coals; it had grown dark around me" (p. 202). During the next month, Hitler stated that the piercing pain in his eyes had diminished and that he could now perceive broad outlines of objects around him. He wrote that he began to believe that he would recover his eyesight well enough to work again but not well enough to be able to draw again.

On November 10, Hitler reported that a pastor came to the hospital to announce that Germany would capitulate and that the German fatherland would thus be exposed to "dire oppression." Hitler reported, "Again everything went black before my eyes; I tottered and groped my way back to the dormitory, threw myself on my bunk, and dug my burning head into my blanket and

pillow" (p. 204). He stated that he wept and came to the conviction that "all personal suffering vanishes in comparison with the misfortune of the fatherland" (p. 204). He wrote that he came to see that the ignominy of Germany's defeat must be blamed on "miserable and degenerate criminals" and in Hitler's view, it was the Jews. In the last two sentences of the chapter, he wrote: "There is no making pacts with Jews; there can only be the hard: either-or. I for my part, decided to go into politics" (p. 206).

Interestingly, Langer (1943/1972) reported that Hitler had been exposed to only a "slight case of mustard gas." Langer wrote: "It was definitely established that both the blindness and the mutism were of an hysterical nature." (p. 175). In other words, in Langer's view, Hitler was exaggerating or making up his symptoms. Apart from the issue of how Langer could 'definitely' know Hitler's symptoms were hysterical in nature, Langer reported that Hitler's resolutions at Pasewalk came to him in a divinely-inspired vision. Langer wrote that Hitler's vision had told him that he had been "chosen by Providence" to accomplish a great mission. Others have called it a nervous breakdown, hysterical neurosis, hallucinatory episode, or in Hitler's own view, a providential vision from on high (e.g., Rosenbaum, 1998). In terms of establishing Hitler's psychopathology, the incident is crucial because one of his chief suspected diagnoses is schizophrenia, which would require evidence of hallucinations or delusions.

Murray (1943/2005) also prepared a confidential psychological evaluation of Hitler for the Office of Strategic Services in October, 1943 using similar sources as Langer. Murray wrote that a thorough study of Hitler's personality was an important contribution to psychiatry and science, in part, because he viewed a carefully documented publication of Hitler's behavior would serve as a deterrent to other "would-be Hitlers". Murray saw Hitler's personality type as developing counteractively in response to overcoming early perceived disabilities and weaknesses, and to revenge his perceived humiliations, injuries, and insults to his own pride and his imagined pride of Germany. Murray thought Hitler's overall personality fell within the "normal range" although this determination was highly qualified, that is, Murray thought Hitler exhibited all the classic symptoms of schizophrenia including paranoia and hypersensitivity, panic attacks, irrational jealousy, and delusions of persecution, omnipotence, megalomania, and "messiahship." Murray also thought Hitler was extremely paranoid and suffered from hysterical dissociation (like Langer, Murray's chief evidence for the later came from Hitler's Pasewalk report in *Mein Kampf.*

Given this bleak and frightening psychological picture, how could Hitler have risen to power and how could he not go insane? According to Murray, Hitler by 1943, had not yet gone insane, although Murray noted that Hitler's "neurotic spells" were increasing in frequency, and he thought that Hitler's mental powers were deteriorating since November, 1942. Furthermore, Murray made the prophetic prediction Hitler would commit suicide when German forces were faced with certain defeat because Hitler's delusions of grandeur for Germany would be crushed. Murray also noted that Hitler managed to gain a large measure of control over his hysterical and

paranoid trends, using them consciously to inflame the nationalistic passions of the German people and fan hatred against its imagined persecutors. Also, by dedicating himself to a sociocentric purpose, Murray thought Hitler helped gain the support of the German people, and it allowed him to impose his will, visions, and delusions. Thus, Murray saw Hitler's personal insane world as "real" and "insanity is sanity."

In a strong psychoanalytic framework, Fromm (1973) labeled Hitler a nonsexual necrophilous character and malignant aggressor. He viewed Hitler as having a malignant form of the anal character determined by an increase in narcissism, unrelatedness to others, and destructiveness. Fromm argued that such a tendency was always present in Hitler, but exacerbated by life circumstances, such as an authoritarian father. Characteristic of narcissism, Fromm wrote that Hitler would have had little insight into his condition and that he often blamed teachers, his father, and society for causing his early failures. Fromm also proposed that Hitler suffered from an Oedipal conflict. He believed Hitler transferred these Oedipal feelings for his mother into undying allegiance to the German nation and corresponding conflict with "her" persecutors. Hitler's rejecting father figure, whom he "unconsciously" wished to kill, became Jewish Marxist intellectuals, and by association, all other Jews.

Taylor (1961/1982) saw Hitler as responsible for the Holocaust, but minimized his psychopathology. Taylor thought Hitler a fanatic, but essentially he saw him as a conventional and highly effective statesman. In Taylor's view, Hitler had 'traditional' goals, expansion of territory and political and financial influence, at least up until 1939. Numerous speeches and declarations at this time, however, revealed the depths of his German nationalism but more importantly, his revealed his blatant anti-Semitism, "We are going to destroy the Jews," "..the Jews ..received with laughter my prophecies that I would someday achieve the leadership of the state, then, among many other things, achieve a solution of the Jewish problem" (as cited by Rosenbaum, 1998, pp. 384-385). Dawidowicz (1998) also attributed Hitler's motivation to eliminate Jews to his hospitalization at Pasewalk. Yet, she disagreed with Taylor's statesman's goal for Hitler: She claims Hitler's main goal was always to wage war but against Jews. Heston and Heston (1980) attributed Hitler's characterological changes, particularly in the last few years of his rule, to the oral intake and injections of amphetamines.

There is also a group of Holocaust theorists who, for varying reasons, believe that Hitler, although culpable for the Holocaust and evil, cannot or should not be explained. Trevor-Roper (1998) found Hitler "a frightening mystery." Bullock (1962) wrote, "The more I learn about Hitler, the harder I find it to explain." Rosenfeld (1985) wrote, "No representation of Adolf Hitler has seemed able to present the man or satisfactorily explain him." Bauer stated that Hitler is not inexplicable but because something is explicable does not mean it has been explained. Fackenheim argued that Hitler is not explicable and that he stands beyond explanation. In his view, no amount of information would ever be enough. Lanzmann even goes beyond these views.

In his opinion, any explanation of Hitler is immoral and an obscenity (for a comprehensive review of Bauer, Fackenheim, and Lanzmann comments and others, see Rosenbaum, 1998).

Mayer (1993) noted that dangerous leaders typically have apologists who discount their destructive methods in favor of viewing their behavior as consonant with "laudable" goals. Mayer attempted to develop a psychologically-based dangerous leader profile, while noting that for scientists to create such a profile does not exonerate dangerous leaders' behavior but requires a willingness to take a stand against destructiveness and hatred. He also noted that objective psychological-behavioral criteria might promote an international consensus as to which leaders are dangerous. The latter action, Mayer argued, would be akin to identifying countries, as is done today by international consensus, which violate human rights. Mayer proposed that diagnosing mad or dangerous leaders would also offer a number of possibilities for intervention, including international containment and isolation.

Mayer's proposal for a dangerous leader disorder included three major categories of behavior: (1) indifference, manifested by murdering rivals, members of one's family, citizens, and genocide, (2) intolerance, manifested by censoring the press, secret police, and condoning torture, and (3) grandiosity, manifested by seeing oneself as a "uniter" of people, increases in military and overestimation of military power, identification with religion/nationalism, and promulgating a grand plan. Mayer further investigated these three categories by contrasting Hitler, Stalin, and Hussein with their opponent leaders Churchill, Eisenhower, and Bush (the 41st president). He found, of course, that Hitler, Stalin, and Hussein all met far more of the criteria than their counterparts, although a "promulgating plan" was characteristic of all six leaders.

A more recent and controversial approach to understanding Hitler is epitomized by Goldhagen's (1996) contention that it was not so much Hitler's psychopathology being responsible for the Holocaust as it was social conditions in Germany at the time of his rise to power. Goldhagen viewed Hitler as a facilitator of an irresistible force of anti-Semitism within Germany rather than a charismatic instigator. Goldhagen disagreed with Himmelfarb's basic thesis "No Hitler, no Holocaust", and he thought that any one like Hitler could have accomplished the same heinous acts because German society already contained the seeds of genocide from centuries of anti-Semitism. He called this particularly virulent form, eliminationist anti-Semitism.

Psychological studies of Nazis, using the Rorschach, have revealed no single pathological trait (Zillmer, Harrower, Ritzler, & Archer, 1995). In a study of 21 Nuremberg defendants after World War II, the only striking similarity detected was above average to very superior intelligence, with IQs of 17 of the 21 defendants in the 95th percentile and above. In addition, over 200 Rorschachs were reviewed that had been given to German rank and file military personnel and Nazi corroborators in Denmark. Again, more differences than similarities were detected. When compared to the elite Nazis, the main divergences were education, occupation, and social

class, but not psychopathology. These authors asserted that we cannot be soothed with a homogenous characteristic capable of explaining the widespread allegiance to Hitler or the hope to identify a single, deranged Nazi personality type.

Informant Ratings of Psychopathology

Historically, clinical interviews, face-to-face psychological testing, and self-report measures have been used in psychological assessment. Of course, in the present study, a clinical interview was obviously impossible. With the increased passage of time, there are also few informants alive who directly interacted with Hitler. Thus, the present study used informants who did not directly interact with Hitler but interviewed those who did. The present informants also read the first-hand stories and reports of those who knew Hitler. Klonsky, Oltmanns, and Turkheimer (2002), in a meta-analysis of 17 personality disorder studies that included self and informant report ratings, found agreement between these different sources to range from modest (.18) to moderately high (.80). Oltmanns, Turkheimer, and Strauss (1998), in a study of personality disorder traits, also found that self-report and peer correlations tended to be modest (ranging to .30), but inter-rater agreement tended to be much stronger ranging from .48 to .89. The authors noted that self-report measures are inherently limited by the perceptions of a single rater (the self-reporter) as well as the difficulty of a person with a personality disorder to assess their own psychopathology accurately. They concluded that multiple informant ratings of personality disorders might be of potential value in the assessment of this type of psychopathology.

In a study of married couples and their friends, Coolidge, Burns, and Mooney (1995) used self and informant forms of the Coolidge Axis II Inventory (CATI; Coolidge & Merwin, 1992; Coolidge, 1993; Coolidge, 1999), a measure of personality, clinical, and neuropsychological disorders and aligned with the criteria in the *DSM-IV* (American Psychiatric Association, 1994). Assessment targets and their spouses were found to be in greater agreement (.51) than targets and friends (.36), where as spouses and friends had moderate agreement at .41. Length of acquaintance was not significantly correlated with strength of agreement.

It appears that a posthumous *DSM* assessment by means of informant ratings has been attempted only once. Coolidge (1999) assessed his grandmother's personality traits 10 years after her death by using her three elder daughters (all in their 70's) as informants. He found moderately reliable agreement among the three daughters (r = .56).

In the present study, academicians who had published books or articles about Hitler were chosen to evaluate Hitler by completing the informant version of the CATI. On Axis I of the *DSM-IV*, it was hypothesized that Hitler would be diagnosed with schizophrenia, paranoid type. This hypothesis was based upon his frequent preoccupation with delusions of persecution (e.g., by his disapproving father, those unwilling to recognize his "talents," and Jewish protagonists), and grandiosity (e.g., fantasies of unlimited success and recognition, his "prophesies", etc.), his

early academic/interpersonal/occupational dysfunction, his extremely virulent and paranoiac delusions about Jews, and his debatable grandiose delusion at Pasewalk. Hitler's callous disregard for human life would make it highly likely that he would be diagnosed with antisocial and sadistic personality disorders. His persistent sense of self-importance and entitlement makes it likely that he would have had a narcissistic personality disorder. His preoccupation with Jews as Germany's antagonists and his irrational beliefs of Jewish disease contagion makes it likely he also had a paranoid personality disorder.

Method

Participants and Procedure

The participants initially chosen to be in this study were 19 academicians and/or historians. Criteria for selection were at least 10 years of Hitlerian studies, current or former university faculty appointment, and a published book or journal articles about Hitler and Nazi Germany. All 19 participants were contacted by letter. Those who did not respond in eight weeks were sent a follow-up letter four weeks later and four weeks after that. All participants were promised anonymity. Eight participants replied within the 16-week span of the study. Three participants declined; one questioned the value and validity of the study, one expressed waning interest in Hitler studies, and one felt he was guessing too much on the items for his results to be of value. All of the five participants who completed the CATI were white males.

Materials

The CATI is a 225-item self-report inventory with each item assessed on a 4-point true-false Likert scale ranging from (1) *strongly false,* (2) *more false than true,* (3) *more true than false,* to (4) *strongly true.* The CATI measures 12 personality disorders in *DSM-IV* and 2 personality disorders from *DSM-III-R* (self-defeating and sadistic). The CATI also measures selected Axis I disorders (e.g., Generalized Anxiety Disorder, Major Depressive Disorder, Posttraumatic Stress Disorder, Schizophrenia [with a Psychotic Thinking subscale] and Social Phobia [with a Withdrawal subscale]). The CATI also has a scale for the assessment of general neuropsychological dysfunction (with three subscales assessing Memory and Concentration Problems, Language Dysfunction, and Neurosomatic Complaints). The CATI also has an 18-item scale measuring executive function deficits of the frontal lobes (with three subscales assessing Decision-Making Difficulties, Planning Problems, and Task Completion Difficulties). There are five scales measuring personality change due to a general medical condition. They are Emotional Lability, Disinhibition, Aggression, Apathy, and Paranoia. There are three hostility scales measuring Anger, Dangerousness, and Impulsiveness. Finally, there is one non-clinical scale on the CATI measuring Introversion-Extroversion. In addition, critical items are included to assess drug and alcohol abuse, and sexual identity and orientation. The CATI also possesses a

bidimensional validity scale of 97-items measuring excessive denial or extreme maladjustment. The CATI possesses evidence of good reliability and validity (Coolidge, 1993, 1999).

The CATI instructions were modified to instruct participants to describe Hitler's adult behavior between age 18 (in 1907) and his appointment as German Chancellor at age 43 (in 1933). It was the intent of the study to assess his stable personality traits in adulthood before potential influences from his later possible drug use and the effects of becoming a dictator.

Results

Denial/Maladjustment

First, the 97-item validity scale was examined, and there was no evidence for denial. For the five raters, the mean validity sum was 240.4 (*SD* = 29.5) and the range was 191 to 265 (note: the normative sample [purportedly normal adults] mean on this scale is 175 (*SD* = 30). According to the CATI manual, scores in Hitler's range may indicate extreme maladjustment (Coolidge, 1999).

Inter-Rater Reliabilities

Inter-rater reliability was examined for the degree of agreement among the raters' *T* scores. Pearson Product-Moment correlation matrices were created for the Axis I scales, Axis II scales, Neuropsychological scales, Personality Change scales, Hostility and Introversion-Extraversion scales, and rater agreement across all 38 CATI scales, and these results appear in Table 1. Agreement across all 38 scales was good (median *r* = .72).

Table 1

Correlations Among Raters: 7 Axis I Scales and Subscales

Rater	1	2	3	4	5	Mean*
1	-	.87	.84	.65	.87	.81
2	-	-	.97	.21	.88	.73
3	-	-	-	.18	.87	.71
4	-	-	-	-	.44	.37
5	-	-	-	-	-	.76
					Overall Median	.73

*Mean correlation of each rater's correlation with the 4 other raters.

Correlations Among Raters: 14 Axis II Scales

Rater	1	2	3	4	5	Mean
1	-	.72	.15	.65	.76	.57
2	-	-	.11	.61	.76	.55
3	-	-	-	.18	.51	.24
4	-	-	-	-	.51	.49
5	-	-	-	-	-	.64
					Overall Median	.55

Table 1 cont…

Correlations Among Raters: 8 Neuropsychological Disorders Scales

Rater	1	2	3	4	5	Mean
1	-	.70	.34	.56	.70	.57
2	-	-	.90	.76	.95	.82
3	-	-	-	.67	.83	.68
4	-	-	-	-	.84	.71
5	-	-	-	-	-	.83
					Overall Median	.68

Correlations Among Raters: 5 Personality Change Due to a Medical Condition Scales

Rater	1	2	3	4	5	Mean
1	-	.93	.95	.08	.99	.74
2	-	-	.93	.35	.89	.77
3	-	-	-	.00	.95	.24
4	-	-	-	-	.00	.11
5	-	-	-	-	-	.71
					Overall Median	.71

Correlations Among Raters: 3 Hostility Scales and Introversion-Extroversion Scale

Rater	1	2	3	4	5	Mean
1	-	.97	.90	.80	.99	.91
2	-	-	.96	.92	.98	.96
3	-	-	-	.98	.95	.95
4	-	-	-	-	.87	.89
5	-	-	-	-	-	.95
					Overall Median	.94

Correlations Among Raters: All 38 CATI Scales

Rater	1	2	3	4	5	Mean
1	-	.83	.56	.60	.90	.72
2	-	-	.62	.63	.85	.73
3	-	-	-	.33	.70	.55
4	-	-	-	-	.55	.53
5	-	-	-	-	-	.75
					Overall Median	.72

Rater Consensus T Scores, Means (SDs)

A rater consensus for each scale was formed by obtaining the mean of the five raters' *T* scores. This single consensus profile was then used to evaluate the present hypotheses. According to the CATI manual (Coolidge, 1999), *T* scores of 70 (two standard deviations above the mean) or greater *may* indicate the presence of a psychological disorder. For the five groups of CATI scales, the rater's *T* scores, means (*SD*s) and consensus scores are presented in Table 2.

Axis I Scales

Examination of the table reveals that the raters' highest mean *T* score occurred for the Posttraumatic Stress Disorder scale (M = 76) and four of the five raters gave Hitler *T* scores at least two standard deviations above the normative mean. The second highest was the 45-item Schizophrenia scale, which was consistent with the first hypothesis. Three of the five raters gave

Hitler *T* scores in the clinical range (above 70). On the Psychotic Thinking subscale, which is an 11-item subset of the Schizophrenia scale and specifically assesses hallucinations, delusions, extreme paranoia, bizarre somatic complaints and ideas of reference, four of the five raters gave Hitler *T* scores in the clinical range. The evidence for Generalized Anxiety Disorder and Major Depressive Disorder was weaker, and there was minimal evidence for a social phobia or social withdrawal.

Table 2
Rater's Mean T Scores and Consensus Means (SDs)

	Informant						
Axis I Scales	**1**	**2**	**3**	**4**	**5**	**Mean**	***SD***
Posttraumatic Stress Disorder	82	77	77	60	82	76	9.1
Psychotic Thinking	80	76	80	53	74	73	11.3
Schizophrenia	77	75	67	54	74	69	9.4
Major Depressive Disorder	73	63	59	61	72	66	6.5
Generalized Anxiety Disorder	67	64	59	52	68	62	6.6
Withdrawal	68	56	45	62	65	59	9.1
Social Phobia	52	55	47	41	64	52	8.6

	Informant						
Personality Disorder	**1**	**2**	**3**	**4**	**5**	**Mean**	***SD***
Paranoid	90	75	75	68	85	78	8.8
Antisocial	81	75	77	67	89	78	8.1
Narcissistic	79	86	67	67	85	77	9.3
Sadistic	74	81	68	74	83	76	6.0
Schizoid	73	65	54	85	61	67	11.9
Schizotypal	78	61	66	62	68	67	6.8
Borderline	75	56	71	50	76	66	11.8
Passive-Aggressive	82	75	38	52	70	64	18.0
Depressive	72	69	56	50	61	62	9.1
Obsessive-Compulsive	66	59	51	59	63	60	5.6
Avoidant	63	62	55	48	65	59	7.0
Dependent	52	61	64	36	62	55	11.6
Histrionic	54	45	73	44	54	54	11.6
Self-Defeating	59	44	51	40	59	51	8.6

	Informant						
Neuropsychological Scales	**1**	**2**	**3**	**4**	**5**	**Mean**	***SD***
Neurosomatic Complaints	70	80	80	67	73	74	5.9
Overall Executive Functions	62	55	63	49	62	58	6.1
Decision-Making Difficulties	54	59	70	46	62	58	9.0
Planning Problems	57	50	57	61	57	57	4.0
Task Completion Difficulties	67	50	46	39	53	51	10.4
Language Dysfunction	52	49	63	39	49	50	8.6
Overall Neuropsy. Dysfunction	55	49	58	41	51	43	6.5
Memory & Concen. Problems	51	36	44	36	46	43	6.5

Table 2 cont…

	Informant						
Pers. Change - Medical Cond.	**1**	**2**	**3**	**4**	**5**	**Mean**	***SD***
Paranoia	80	74	76	61	78	74	7.5
Emotional Lability	80	60	75	44	83	68	16.3
Disinhibition	78	58	64	55	81	67	11.7
Aggression	80	62	62	58	75	67	9.5
Apathy	41	32	32	53	26	37	10.5

	Informant						
Hostility Scales and I-E Scale	**1**	**2**	**3**	**4**	**5**	**Mean**	***SD***
Dangerousness	84	79	76	74	91	81	6.8
Anger	83	69	61	56	80	70	11.7
Impulsiveness	76	57	62	54	79	66	11.3
Introversion-Extroversion	26	21	42	41	29	32	9.3

Axis II Scales

An examination of the consensus mean *T* scores for the 14 Personality Disorder scales reveals that there are four scales with *T* score consensus means above 70 (Paranoid, Antisocial, Narcissistic, and Sadistic Personality Disorders). Thus, all four scales were elevated as hypothesized.

Neuropsychological Scales

Examination of the Table 2 reveals that the raters' highest mean *T* score occurred for the Neurosomatic Complaint subscale. Though no specific hypotheses were made with regard to these scales, the elevated *T* score of the Neurosomatic Complaint subscale seems reasonable given Hitler's documented and pervasive somatic problems. There was no evidence for any overall neuropsychological dysfunction, particularly in regard to memory or language dysfunction. There was some minor elevation in the overall Execution Functions Deficits scale. The elevation appeared to be largely due to some deficits in decision-making.

Personality Change Due to a General Medical Condition Scales

Examination of the Table 2 reveals that the raters' highest mean *T* score occurred for the Paranoia scale (M = 74) and four of the five raters gave Hitler *T* scores at least two standard deviations above the normative mean. Again, these results generally support the hypothesis of a paranoid type of schizophrenia for Hitler. His general medical condition might have been the mustard gas to which he was exposed on the Russian front.

Hostility and Introversion-Extroversion Scales

The raters' highest consensus mean *T* scores occurred on the Dangerousness (M = 81) and Anger (M = 70) scales.

Critical items

Critical items were also examined pertaining to drug and alcohol abuse and homosexual tendencies. None of the five raters viewed Hitler as having a drug or alcohol problem. With regard to his sexual orientation, raters were split: Three out of five raters thought Hitler was not comfortable being a man. Interestingly, two out of five raters suspected that Hitler wanted to be a woman. None of the five raters thought Hitler dressed or presented himself as a woman. Two of the five raters suspected that Hitler was a homosexual (overt or repressed).

A Different Form of Consensus

An alternate consensus profile was formed by taking the mean of each individual item of the 225-item CATI for the five informants. A mean was calculated across the five raters' scores for each item. This, in effect, produced a hypothetical "sixth" rater. The resulting *T* score profile was correlated to the consensus mean *T* score profile across the five informants. The resulting correlation was $r\ (36) = .99$, $p < .0005$. These results indicate that the two different consensus methods yield nearly identical results.

Discussion

The main hypothesis was that Hitler would have been diagnosed with schizophrenia, paranoid type. Although it was not his highest Axis I elevation, the mean consensus *T* score for the Schizophrenia scale was nearly two standard deviations above the normative mean. Hitler's clinical elevations on the Psychotic Thinking and Paranoid scales also support this diagnosis. It could, of course, be questioned whether someone with a schizophrenic disorder could rise to such a high position of power and control of others, given that schizophrenia is generally such a debilitating disease, particularly socially and occupationally. However, there are other documented cases of murderous schizophrenic persons who have had extraordinary influence on groups of others (e.g., Charles Manson, James Jones, etc.)

Examination of the current *DSM-IV* criteria for schizophrenia, paranoid type, also support this diagnosis. It lists symptoms such as preoccupation with one or more persecutory or grandiose delusions usually organized around a coherent theme. Associated features include anxiety, anger, aloofness, and argumentativeness. The *DSM-IV* also states that persecutory themes may predispose schizophrenic individuals to suicidal behavior, while a combination of persecutory themes, grandiose delusions, and anger may predispose such an individual to violence. The *DSM* further indicates that such individuals may have a superior or patronizing manner and stilted or intense interpersonal interactions. Further, the *DSM* states such an individual may display little or no cognitive impairment and have a good prognosis in the areas of occupational functioning and independent living. One important detail in establishing a diagnosis of schizophrenia would be Hitler's reported divine vision at Pasewalk Hospital (e.g., Langer, 1943/1972). However, as noted

earlier, it is apparently debatable whether he did report his 'vision' as divinely inspired (C. Browning, personal communication, Oct. 22, 2003).

It was unexpected finding that the PTSD scale so highly elevated. The consensus mean *T* score (76) was the highest of all the Axis I scales, and two of the four raters saw Hitler three standard deviations above the normative mean while two others rated him above two standard deviations. Even the rater with the lowest *T* score was a full standard deviation above the normative mean. Although the CATI PTSD scale does not contain all of the current *DSM* criteria, it does have many of its critical elements, including instability of emotions, aloofness, troubled dreams, anger, anxiety, and irritation, and there are numerous examples of these behaviors consistently throughout Hitler's life. However, it may be argued that the CATI PTSD scale may be more a measure of general maladjustment than specifically PTSD. However, it is clear that Hitler's hospitalization at Pasewalk was important in Hitler's life. Whether it metamorphosed him or was absolutely pivotal to his later behavior is debatable. Also, although a diagnosis of PTSD in no way can account for Hitler's later atrocities, it may have exacerbated his early paranoid, antisocial, narcissistic, and sadistic temperaments. Undoubtedly, his trauma was also enhanced, even before the mustard gas episode, by his experience directly on the Russian front. There is also evidence from recent studies of the effects of mustard gas upon humans (Bullman & Kang, 1994; Pinkston et al., 2001) to establish that this incident would qualify as an extreme traumatic stressor involving death and serious injury, as is required by the *DSM* for a diagnosis of PTSD.

With regard to personality disorders, there were clinical elevations on the Antisocial, Narcissistic, Paranoid, and Sadistic scales. All of these personality disorder findings are well supported by numerous reports throughout his adult life. Although the Borderline scale did not reach clinical significance, three of five raters evaluated Hitler at least two standard deviations above the normative mean. Descriptions from Hitler's life appear to meet many of the borderline criteria including unstable and intense interpersonal relationships, identity and sexual identity issues, and anger. The borderline criteria also include suicidal gestures, and it is accepted as near fact that Hitler committed suicide in 1945.

There was little or no evidence for neuropsychological dysfunction except on the Neurosomatic Complaints subscale. This scale was designed to measure physical manifestations of underlying brain dysfunction (Coolidge, 1993, 1999), although the scale also appears to be sensitive to general somatic concerns. All five raters strongly endorsed the single critical item regarding Hitler having numerous physical complaints. It is possible that some of these complaints could possibly be post morbid repercussions of mustard gas exposure. With regard to executive function deficits, there was a minor elevation of the overall scale largely due to the Decision-Making Difficulties subscale. One of the raters gave Hitler a *T* score of 70, another gave him a 60, and a third gave him a 59. Interestingly, there is support from the literature of Hitler's indecisiveness. Rosenbaum (1998) characterizes Hitler as a nebbish or Hamlet (i.e., a

procrastinator) and presents evidence that supports the contention "Hitler could not make up his mind" (p. 369). Browning (as cited by Rosenbaum) also contended that Hitler had trouble making the decision for the Final Solution and that Hitler hesitated even after he took that horrific step. Murray (1943/2005) also noted that Hitler's later life was characterized by increasing periods of inertia and indecisiveness.

Probably least surprising was that Hitler was found to be elevated on the Anger and Dangerousness scales. His anger and hatred has been well documented and that he ended up being a dangerous person is without question. Finally, all five raters saw him as a strong introvert. This seems consistent with the fact that Hitler was socially awkward and often unable to converse with others, but rather preferred to talk at them.

Informant agreement was uniformly strong across most scales and raters. This finding is consistent with the conclusions of Oltmanns et al. (1998) who found that inter-rater agreement tends to be moderately strong. They noted that the relatively high uniformity among raters in personality disorder studies suggests the general validity of such evaluations. Certainly, the high reliabilities obtained in the present study do not guarantee the validity of these diagnoses. However, it is a necessary step. Because self-ratings are certainly impossible with deceased persons and often highly problematic with extremely pathological people, inter-rater reliability may be the only evidence of validity in these circumstances.

One limitation of the present study was the small sample size, although often in clinical interviews with families, five family informants might be considered an adequate sample size. One method of reliability that might have enhanced the present findings would have been to contact Nazi sympathizers and Holocaust deniers. Given that these raters probably would also be knowledgeable about Hitler, it would be potentially significant if they also endorsed psychopathology in the same direction as the historians.

Another potential difficulty encountered in the present study was the possibility of the raters focusing on Hitler's later life as opposed to his life before chancellorhood. However, it was most likely an impossible task to separate Hitler before age 33 or after. An alternate instruction to the raters might have been to consider Hitler's behavior, "as he was most of his life." It should also be noted two different consensus means were used to generate Hitler's profile, yet the results were virtually identical.

Psychohistorians have long desired some explanation for Hitler's behavior. Often it involves a search for some latent variable like repressed homosexuality (e.g., Machtan, 2001), sexual perversion, his brother's early death, the Pasewalk incident, etc. There has even been a shift from viewing Hitler as *a sine qua non* factor in the Holocaust (e.g., Himmelfarb, 1984) to a pawn of Germanic societal conditions and ills (e.g., Goldhagen, 1996). The disciplines of psychology and psychiatry fall far short in their current theories and methods of being able to determine with any degree of certainty *why* Hitler or *why* the Holocaust. Indeed, there is merit to the arguments that

explaining Hitler or gathering stories from his victims trivializes the horrendous suffering of so many people. However, it might be of value to use the present methods of informant ratings to determine whether common psychological traits are associated with murderous national leaders. The prediction, understanding, and control of such individuals' behaviors could benefit generations. As Mayer (1993) has noted, there are international citizens' groups that monitor human rights. Perhaps, an international group of mental health professionals could identify, assess, and monitor the activities of dangerous current world leaders, and the analysis of previous dangerous leaders, such as Hitler, might be a fruitful place to begin.

Author Note

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