HOME-SICKNESS AND IMMIGRANT PSYCHOSES.

AUSTRIAN AND GERMAN DOMESTIC SERVANTS THE BASIS OF STUDY.

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HOME-SICKNESS springs from the conflict between family ties and herd or group feelings, and among immigrants, such as those Austrian and German domestic servants working in London, the nostalgic reaction may lead to certifiable mental disorder. The present study concerns forty cases of this kind who, between 1931 and 1937, came under my care at Friern Hospital.

DEFINITION.

Immigrant psychoses arise among foreign domestic servants usually within eighteen months of their arrival in Britain. The onset may, however, follow immediately on debarkation or be delayed for two or three years, or even longer in a few instances. Acute confusional and schizophrenic disturbances associated with bodily signs of toxæmia commonly occur, but more conventional paraphrenic and involutional depressive patterns are seen in the older women. About 60% of the cases recover within about a year, or improve sufficiently within that time to justify repatriation. Only one case in my series was a political refugee in the strict sense; all, however, were victims of economic circumstances and came to England to work.

NEED FOR COMPANIONSHIP.

Views of Suttie, Freud and Trotter.

Emigration and home-sickness raise problems that centre round the human need for company. Suttie (1) believes that there is "an innate need for companionship", derived from the biological need of the infant for nurtural contact with the mother. This gives pleasure in *responsive* companionship, and is a correlative discomfort in loneliness and isolation. The need for company, moral encouragement, attention, protectiveness, leadership, etc., becomes a substitute for the mutually caressing relationship of child and mother, and puts the whole social environment in the place occupied by the mother. A joint interest in *things* has replaced the reciprocal interest in

persons; friendship has developed out of love. There is no need to postulate a special social instinct.

Freud (2) believes that the group feeling is not inborn, but arises "as a reaction to the initial envy with which the elder child receives the younger one". There grows up in a troupe of children a communal or group feeling based upon jealousy, further developed at school. The first demand made by this reaction-formation is for justice, for equal treatment of all. If one cannot be the favourite oneself, at all events nobody else shall be favourite.

Each individual subsequently develops a share in numerous group minds —those of his race, of his class, of his creed, of his nationality, etc.

Trotter's (3) view is that mental phenomena occurring in groups are due to the herd instinct (gregariousness), which is primary and not further reducible. The dread shown by small children is an expression of this herd instinct. The individual feels "incomplete" if he is alone.

Causes.

(a) *Home-sickness: Family and Herd Antagonisms Sharpened by Emigration.*

Emigration in times of stress and crisis merely anticipates the imminent break-up of that economic unit of modern society—the family. The move fulfils its purpose only through the forging of fresh social bonds in another country.

But family and herd are ever opposed. According to Freud, two people seeking solitude for sexual satisfaction demonstrate against the herd. "In order that a herd may form," says Engels (4), "family ties must be loosened and the individual be free. . . . The rising sense of cohesion in a herd cannot therefore have a greater enemy than consciousness of family ties."

Emigration, however, raises special problems of its own. In a strange new world, difficulties of translation attend not only speech but also objects of affection, conditions of work, conventions of custom and expression of ideas. (Marie and Godin (5) noted that among the special stresses suffered by North African natives living in France is their vexation at having to take off their national costume and don European dress.) Not only language, but life itself must be lived and practised in a different idiom. Mastery of the new grammar of living is most likely to be achieved when the sponsors of emigrants turn out also to be friends. Failure of group formations leads to loneliness, and forces the individual back to recollection of home. Such yearning is but an intense form of wishing, and while it directs attention homeward, social activity suffers neglect. The energy of pent-up longing for home, finding no outlet along social channels, may be released as symptoms of ordinary home-sickness, or transcending these limits, may be converted into those qualitatively different forms we recognize in psychosis.

Relatives, friends and employers of the patients repeatedly emphasized the importance of home-sickness. The patients themselves expressed their longings in different ways. One worried over a brother in Germany; another continually talked about a sister in Italy; yet a third became anxious as a result of not getting news of her mother in Austria. Home-sickness brought conflict even to those who were fond of England, as evidence from letters often revealed: "When people ask me whether I like being in England my conscience always says 'Yes'. Everything in England reminds me of home; the trees and the flowers and everything I see. . . ."

By the dialectics of psychological symbolism, hatred may be as suggestive of attachment as its opposite—love. According to the employers, one patient, when calm, thought highly of her parents and knitted socks for her father, who was "too good" to her. But at other times she levelled horrid accusations against them.

The direct appeal—"Please send me back to my own country"—was heard at some stage in most cases.

(b) *Loneliness and Expectation; Phantastic Identification of Thinking and Being.*

Loneliness creates an atmosphere conducive to phantasy formation. Expectation rouses the suggestibility apparatus, and excites pseudo-realization (Braun (6)). "If he is left to himself, a neurotic is obliged to replace by his own symptom-formations the great group formations from which he is excluded. He creates his own world of imagination for himself, his own religion, his own system of delusions, and thus recapitulates the institutions of humanity in a distorted way" (Freud). In phantasy, thinking and being tend to become identified unless *persistently* tested and corrected by practice. By ignoring the criterion of practice, the validity of the objective world becomes blurred.

Among the cases described here, the absence of close contact with other people was due in large measure to lack of opportunity. Language difficulties also added a barrier to communion. "I have almost forgotten how to talk. Have not seen or heard anything but just sat and thought of my past life," wrote one patient to her godmother. Morbid phantasy often filled an empty dwelling. "There are men in the house," said one; another thought, "There was a devil in the house".

According to Kretschmer (7), home-sickness may, through the experience of isolation, loneliness of the soul, pierce the psyche to its depths and cause, especially in young girls, "short-circuit" reactions, such as arson and infanticide.

My cases showed no instance of either infanticide or arson, but I noted in many cases that loneliness set the stage for suicide. In two instances, hanging

and gas-poisoning were attempted after the women had been left alone in the house several days.

(c) *Exhaustion and Lowered Resistance.*

Domestic work, all too often a drudgery, and long hours of fetching and carrying sap the strength. One nursemaid found it very hard that she was given much of the rough work of the house to do. Another servant described the work as hard, and felt she was not doing it well, and yet another realized she was no good as a cook. This note of conscientiousness and distress at inefficiency was frequently reiterated in case-histories. I quote a letter in which the additional responsibility of housekeeping in a parsimonious household proved too exacting: "I did not want to handle the housekeeping money. The first week I was there I asked the lady to keep a book for each separate tradesman. She couldn't do it; she said all this was a great trial. I was given a certain sum of money a week for all household expenses. When I found I could not make ends meet I paid out of my own purse. Anything to keep the peace. Then in December came the milk book. Inside was a leaflet with the words, 'Drink more milk and remain fat'. To see it was a bolt from the blue. The nurse ordered a pot of cream every day and two bottles of milk. Mr. B— had to have a pot of cream a day with milk as well and butter for cooking purposes. In the end they maintained that the cook had had it all. The lady refused to eat puddings without an egg. There were plenty of vegetables and fruit in the house, but none for me. All this made me mistrustful. Then we were overrun with mice. I asked for a food cupboard; they refused. The same thing happened with the laundry and the sewing-machine."

As between loneliness, home-sickness and exhaustion, it is not always possible to apportion the precise ætiological weight. Most psychological reactions spring not from *one* motive but from a *bundle* of motives (Kretschmer (8)). But in one case exhaustion alone was the probable exciting factor. A young girl of seventeen needed hospital care a few hours after arrival in London after a tiring, sight-seeing and exciting four days' motor journey from Vienna, across Germany to England.

(d) *Constitutional Elements.*

Information regarding family history was difficult to obtain. The new sterilization laws in Germany would, of course, deter many from giving frank reports. Nevertheless, a history of some sort was solicited wherever possible from employers, friends, relatives and the patients themselves. A psychiatric social worker's report was available in many cases, and efforts were always made to procure news from abroad. In one case a father had committed suicide; in two other instances the father had broken down mentally.

In three patients there was a history of previous mental hospital treatment.

(e) *Age, and Time Factors.*

The ages of the cases on admission were as follows (see Table I) :
Table II gives the length of stay in Britain before breakdown occurred :

TABLE I.

Age.	Number of cases.
16–20	3
21–25	9
26–30	16
31–35	5
36–40	4
41–45	2
Over 46	1
Total	40

TABLE II.—*Length of Stay in England Prior to Breakdown.*

Months.	Number of cases.
0–6	10
7–12	8
13–18	8
19–24	4
25–36	6
Over 36	3
Not known	1
Total	40

PSYCHOLOGICAL MECHANISMS AND INDIVIDUAL SYMPTOMS.

(a) *Identification in Group Formations.*

Identification is the earliest expression of an emotional tie with another person, according to Freud. A little boy, for example, will exhibit a special interest in his father ; he would like to grow like him and be like him and take his place everywhere. But the identification is ambivalent from the very first ; it can turn into an expression of tenderness as easily as into a wish for someone's removal. The boy's identification with his father may take on a hostile colouring, and become identical with the wish to replace his father in regard to his mother as well. Moreover, in a regressive way, identification becomes a substitute for a libidinal object tie. Every new perception of a common quality becomes a basis for a partial identification, and represents the beginning of a new tie.

Strangers, photographs, film characters were often claimed by my cases as kinsfolk. But it would be too facile to assume in every instance disturbance of visual perception as such.

(i) *Mistakes of identity; not always illusions of resemblance.*—Patients tended to see relatives everywhere. One woman claimed the relieving officer as her father. A second threw her arms round a nurse, claiming her for her mother. One employer said of a patient, "She claimed our Welsh maid as a school friend, and that my husband was her father's brother. She recognized every face in a picture paper or photograph as that of a friend or relative". Patient G. F— identified characters in the film "Episode".

It is extremely unlikely that any one person would have as many relatives as the total number of photographs that appear in a magazine full of pictures of film stars. Moreover, it is equally improbable that the likenesses should be sufficient to create the illusion of identity.

(ii) *Primitive notions of kinship.*—Observations showed that age stratified the degrees of kinship. Those of the same age were called sisters; the generation next above in age were claimed as mothers. Similar features characterized fraternal and paternal relationships.

In these respects there could be detected a similarity to those early notions of kinship common among primitive races. This followed the usage inevitable in societies still practising consanguine or punuluan group marriage. [Is this an example of "recapitulation" (Howe (9))? Were the patients living again in the racial past?] "Brothers and sisters, male and female cousins of the first, second and more remote grades, are all mutual brothers and sisters . . . " says Morgan (10). Even when the structure of the family first changed from a lower to a higher form, the original system of kinship sometimes persisted. "The consanguine family is extinct. But the Hawaiian system of kinship, in force to this day in all Polynesia, compels us to acknowledge its former existence, for it exhibits grades of kinship that could only originate in this form of the family" (Morgan, *loc. cit.*). The same authority stated that in certain parts of China and Hawaii, kinship was still determined by age levels.

(b) *The "Religious Reflex": Schizophrenic Duplication into Real and Imaginary Worlds.*

Fear created the gods. Primitive man, unable to understand the external forces which controlled his daily life, personified these forces. At the present time social forces are active; forces which present themselves to mankind "as equally extraneous and at first equally inexplicable, dominating them with the same apparent necessity as the forces of Nature themselves. The fantastic

personifications which at first only reflected the mysterious forces of Nature at this point acquire social attributes. . . . The actual basis of religious reflex action therefore continues to exist and with it the religious reflex itself" (Engels (11)).

In the *Theses on Feuerbach*, Marx (12) accepts Feuerbach's start from the fact of religious self-alienation, the duplication of the world into a religious imaginary world and a real one; and then goes on to state that the secular foundation of the religious world lifts itself above itself, and establishes itself in the clouds as an independent realm to be explained only by the "self-cleavage" and self-contradictoriness of this secular basis.

This penetrating analysis gives a schizophrenic interpretation to the origin of religious ideas—a mind-splitting operation, dependent upon the division existing between forces which *can* be controlled and those which, apparently, cannot.

Many cases suffering from a "home-sick psychosis" found themselves the victims of social forces they could neither understand nor alter. Religious delusions were therefore commonly expressed.

(i) *God the Father.*—A young girl was asked, "Do you want to go home to your father?" She replied, "I want to go to God". It seems that some such mechanism of identification of God with the father accounted for the frequency with which religious notions and practices were observed.

(ii) *Mystical-orgiastic prayers, ecstasies, fears and the devil.*—M. H—: Swiss pastor visitor considers there may have been some religious conflict; hence the fear that the devil was in her employers' house.

A. H—: Prays loudly to be forgiven.

A. M—: Constantly making the sign of the cross. Reported to be in a state of religious ecstasy, singing hymns and calling upon God.

E. M—: She imagines that she is going to save everybody and that Christ is coming at midnight. Sings hymns and prays. She says she has seen pictures of Christ, that she felt her heart was black and that she had the devil in it.

N. H—: She would stand in one position for hours reading religious books.

A. M—: She adopts a praying attitude.

(c) *Delusions about Royalty: King as Father.*

The most naïve substitution of the King as father was voiced by F. H—, who said to her employer, "You have had the father of my child here. You had royalty here".

A number of the women visited Buckingham Palace, and one was arrested by the police outside the building as she had come to see the King, with whom she was in love, and refused to go away. N. H— also went to Buckingham Palace and demanded to see Their Majesties.

The following bear out the general thesis:

T. L—: She imagines the King of England and the Queen of France talk about her and accuse her of immorality.

J. S—: She says she went to Buckingham Palace in response to an invitation and because there had been an accident to the King. The wish-fulfilment here implied revealed the ambivalence of the love-hate motif towards her father; the invitation and the accident.

The intrusion of sex love into this situation is merely another variant of the identification. The same patient wrote to the Duke of Gloucester daily because "life does not give me the opportunity to get married to other gentlemen".

G. F—: Wrote to "His Majesty the King. I am so sorry I have not written to you before my Gratulation, my affection. You will understand that all my thoughts have been with dear Edward. By God! I did not know it was the King. I promised myself to make his life to great happiness, love and comfort. Will you please send enclosed letter to dear Edward as soon as possible. I wish to you and your dear familie all the Best. Always your affectionate."

(d) *Stripping of Clothes; Making Oneself "At Home", or Sign of Rebelliousness, Exhibitionism.*

The symbolization of love by warmth and unfriendliness by cold may explain the rather frequent occurrence of stripping among these cases. Flugel (13) reminds us that "coldness" is a universal metaphor for lack of love. Flugel writes of clothes as being a protection against the general unfriendliness of the world as a whole, or a reassurance against the lack of love. In unfriendly surroundings we tend to button up, to draw our garments closely around us. There is definite evidence that "depression, anxiety, loneliness or home-sickness may coincide with a desire to be more warmly clad than usual". Reference is made by Flugel to a boy at home who refused to wear an overcoat, but at a boarding-school, when he was home-sick, would insist upon always going about in his overcoat.

But my cases showed the reverse of this, in that they stripped themselves naked of all clothing. Flugel provides us with a clue: with women in particular, the removal of outer garments signifies a condition of friendliness and of being "at home". Stripping of clothes was noted more frequently while the patients were in hospital, which may have represented a more welcome and homely atmosphere.

Alternatively, since clothes obviously protect us from cold, it is not surprising that they frequently become symbols of the protective function of the mother, who incidentally is associated with clothes from a very early age. A mother usually dresses and undresses her child; intends to show her love by

manifesting an anxiety lest her children should be inadequately clothed. Such consideration may become a source of worry and annoyance to children, and may arouse in them a spirit of rebellion, manifesting itself in a desire to wear as little covering as possible. It may be that those who belong to this *rebellious type* of Flugel free themselves from a mother-fixation by casting off the trammels ("swaddling clothes") to movement. Kraepelin (14), however, considers such nakedness as the sexual exhibitionism which is often noted as a reactive impulse in wandering states, fugues, automatism, and is also related to the frequent disturbance of menstruation.

(e) *Escape through Frequent Change of Employer.*

Attempts to escape from unhappy situations were often reflected in frequent changes of post. One woman had eight different mistresses within eighteen months. Flitting from one household to another provided some outlet for pent-up restraint. The moving was but one variant on a recurring theme—"only to get away". Though valuable as a safety-valve, each move spent considerable vitality, and contributed in no small measure to the general state of exhaustion. I do not consider that the changes were an expression of lability of mood. There was never any climax in elation—rather an anti-climax in relief of tension.

(f) *Escape through Sex Love.*

Though directly sexual tendencies are, as we have already noted, unfavourable to the formation of groups, yet to marry and bring up children would be a most satisfactory method of social readjustment—the most effective form of naturalization. "Love," says Freud, "breaks through the group ties of race, of national separation", and thus is an important factor in civilization. But the path of true love here did not always run smoothly. In one instance an illegitimate "black baby" was born during the patient's stay in England and the father had been lost sight of. Abortions had been procured in two other cases. Two others had languished after faithless lovers. One woman confessed to stress resulting from changing her "sir friends".

(i) *Love affairs: Imaginary.*—Failing real object-love, recourse was made in other instances to imaginary lovers. As already indicated, the subjects of these projected episodes might be pure and Christ-like, or more mundane, albeit exalted, royal personalities.

(ii) *Delusions of sexual assault.*—Alternatively, suspicions of intended sexual assault or fancies of actual impregnation were expressed. One woman became very apprehensive, and badgered her master to know when her mistress, away on holiday, would return. Another girl imagined she was pregnant by a cousin.

(g) *Escape through Suicide.*

Over 60% of the cases attempted or threatened suicide. Hanging, gas-poisoning, cut-wrist, drowning were the commonest modes of the actual efforts. If made during lucidity the effort was calculated; if during confusion the attempts were none the less deliberate. Can the suicidal effort be regarded as a short-circuit action?

Kretschmer applies the term "short-circuit actions" to reactions in which affective impulses elude the total personality and are directly translated into action. (Short-circuit reactions, however, differ from explosive reactions which take the form of primitive motor discharge, in that the former involve complex actions.) They may be accomplished after the fashion of normal actions, with deliberation, foresight and skill and fully consciously; or they can occur in an abnormal state, which is self-limited and circumscribed and apt to be accompanied by clouding of consciousness. In both cases, however, the short-circuit action is characterized by the factor epitomized by the words, "No other thought entered my mind". The action, along with the affective drive which generated it, together form an integrated whole possessed of meaning, but it is a unity which is split off from the rest of the personality—an independent action.

E. S— cut her wrist and was found hanging by a bandage in the lavatory.

T. S— severed an artery at the wrist.

A. K— attempted suicide by gas-poisoning.

Threats included precipitation in front of trains. Real danger to life arose from refusal to eat, and tube-feeding alone often saved life.

(i) *Hallucinatory promptings.*—It would be too great a simplification to assume that the efforts at self-destruction were answers to the question, "Is life worth living without companionship?" The mechanisms released by loneliness include not only fanciful brooding, but hallucinatory projection. "Voices were always telling me to do things . . . sometimes to kill myself."

J. L— admitted she attempted suicide and said she would do so again under the same circumstances. She said she heard people saying things about her.

A. F— admitted that a voice told her to kill herself and she would have thrown herself in front of a train a few nights previously, but she had not the courage.

A. M—: Saw visions of the dead and thought she was going to be killed.

A. H—: Complained of being affected by electricity and feared this might kill her. Attempted suicide by gas-poisoning.

(ii) *Ideas of unworthiness.*—Guilt ideas sometimes lay behind the threat of suicide. Dwelling upon God the symbolic Father, our patients had

become religion-conscious. Perhaps the harbouring of revengeful ideas against the parents, or the mere association of religion with sin, or the acceptance of unhappiness as a punishment brought notions of unworthiness to the fore.

A. L— said she was a very wicked woman and wished she were dead.

J. L— indicated definite ideas of unworthiness, and admitted in the same breath having suicidal tendencies.

Form of Disorder. (See Table III.)

Though mistakes of identity, religious delusions, ideas about royalty and suicide dominated the clinical picture, yet the cases grouped themselves into recognized syndromes. Among the younger cases (aged 20 to 30) acute toxic bodily conditions occurred frequently, and were associated with two main types of mental disorder. First, acute confusional states resembling acute delirious mania ; second, acute schizophrenic states.

Table III.—*Diagnosis. All Cases* (40).

Schizophrenia		16
Paraphrenia		9
Confusional states		7
Affective disorders :		
(*a*) Manic-depressive insanity	2	
(*b*) Involutional melancholia	3	
		— 5
Twilight state		1
Reactive depression		2
Total		40

Among older patients the more conventional paranoid and involutional forms were to be observed. Reactive depressions were uncommon.

(a) *Bodily Reactions; Vegetative Stigmata; Loss of Appetite; Toxæmia.*

A very low wall separates psychic from vegetative reactions and the one easily overflows into the other (Hoff und Werner (15)). Among the "vegetative stigmata" (Bergman (16)) which so commonly accompany psychological disorders, pallor, trophic changes and disturbances of the gastro-intestinal function figured prominently. Loss of appetite, however, was the most grave of such signs, for it often led to refusal of food—Adler's (17) "hunger-strike". Being fed is equivalent to being loved (Menninger (18)), and this infantile association may explain the nutritional disturbance noted.

Such vegetative-nervous manifestations of the biologico-somatic mechanism linked up with endocrine disturbances—19 out of 40 cases exhibited amenorrhœa or irregularity of menstruation.

Many patients were quite obviously ill—toxic and dehydrated. Sordes on the lips, hectic flush, dry furred tongue, foul breath, faucial infection, tonsillitis and pyrexia were frequently noted. Boils, carbuncles, bed-sores were common on admission. One gave a history of recent catarrhal jaundice; another who had recently recovered from influenza subsequently contracted pulmonary tuberculosis while in hospital. In one patient an appendicular abscess burst through the rectum and the same patient subsequently also passed a large tape-worm.

Another was admitted after a miscarriage and had bilateral tender tubes.

Almost all put on weight substantially before leaving hospital. In a number, of course, the symptoms were protean and, as in many cases of acute delirious mania, no focus of infection could be located.

(b) *Acute Confusional Mental States.*

Acute confusional states were common among those admitted in a toxic state. Clouding of consciousness was marked, with disorientation in time and place. Comprehension was poor, and in consequence no connected or relevant story could be elicited. Auditory and visual hallucinations, frequently of a terrifying nature, contributed to a general state of apprehension. Emotional instability gave evidence of preservation of affective tone. Thought and feeling showed relevant correlation whenever the observer could detect the intellectual process. For example, a patient mistook a nurse for a relative, and embraced her in an appropriate, affectionate manner.

Psycho-motor activity was usually increased. Goss (19) makes it clear that such psychic effects of toxic disturbances do not represent a *generation* of energy so much as a liberation amounting simply to a *displacement* of energy. Patients were admitted in a state of great restlessness, refusing to stay in bed, wandering about excitedly and resisting all attention. Sleeplessness was prominent; the patients' "night life" ("Nachtleben" of Kraepelin) was intense; a jumbled recapitulation of life-history or of the day's events often prevented sleep. Noisiness, refusal of food, loss of sphincter control, stripping and destruction of clothing completed the bird's-eye view, so to speak, of the picture.

It might be argued that the cases in this confusional group were in reality schizophrenic, whose very nature is to "tear thoughts apart" (Bleuler). Avoidance of reality takes the form of imperception. But the course of these confusional cases fitted better into the acute delirious mania group, with its better prognosis.

Moreover, periods of temporary lucidity, or the rapid emergence from the original state of confusion, threw a critical and diagnostic light upon the

emotional state. During the phases of lucidity, the patient's emotional life was active and the personality altogether intact. Lucidity brought with it a sense of relief; though there was partial or complete amnesia for the detailed events of the confused phase, there was considerable appreciation by the patients of the fact that they had not been very well. Insight and the quick realization of their whereabouts in a mental hospital were accompanied by a depression which was not, however, incommensurate with the existing situation and the past lot of the patient.

The patients, perhaps for the first time since arriving in England, began to clamour openly to go home. They wrote imploring letters to their friends and importunate notes to their medical officers. Progress was often delayed by impatience—at any rate in the early stages. It was then that phases of intense depression occurred. Nevertheless, progress was steady, habits became clean and there were no feeding difficulties. The patients soon washed and dressed, and quickly applied themselves to useful work. The prospect of repatriation acted as a great incentive towards the exercise of self-control and patience. In the end, with either some relative, or with a member of some religious or nursing order, the return home was accomplished.

(c) *Acute Schizophrenic Symptoms.*

In this group the outstanding signs were the mannerisms, the meaningless laughter and the emotional indifference. The personality was split and did not react as a whole in any given situation. Signs of affection towards staff and others were wanting. Declarations of death affecting near and dear relations evoked no corresponding affective display. There was not the relevant emotional interplay that was to be noted in the confusional group described above.

Emergence from confusion did not bring the same fleeting phase of total lucidity. Whereas lucidity in the confusional group revealed a lively emotional life and considerable insight and also restored ordinary cleanly personal habits, the schizophrenic group remained tearless, indifferent, without insight, negativistic and persistently defective in hygiene.

Finally, the prognosis in these schizophrenic cases, though relatively good, was not so favourable as in the confusional group.

(d) *Paraphrenic States More Common Among the Mature Cases.*

Among the older women (aged 30 to 40) mental breakdown proceeded along more conventional lines. The affective psychosis was still rarely seen; but paraphrenic and paranoid states more appropriate to the age were common.

The paranoid reaction in the more mature women was understandable. The escape from reality through persecution fitted better into the logic of failure. Fully adult personalities have had more practice than younger

people in facing up to reality, and there was no escape through blurring of perception. Reality could not be ignored or jumbled up ; but it could be given the twist of misinterpretation. Disappointment and failure gained full admission into consciousness ; there was no blinking of the fact, but there was distortion of the explanation.

Success and failure, in apparently unalterable sociological circumstances, appeared determined by competition among individuals. To fail, therefore, through no fault of one's own, implied malevolent intervention of other personalities. Ideas of persecution insidiously arose. Other people were planning harm; they gathered together, and speculation as to the nature of their conversation took concrete form in hallucinatory projection. " Voices " confirmed what the imagination feared.

Reaction to the paranoid state implied a struggle against one's persecutors and acts of violence were not uncommon.

Development through persecution to grandeur and an irrevocable alteration of personality seldom occurred. There was arrest at the persecuted stage. Admission to mental hospital removed the pressure of daily conflict with insoluble difficulties. The new reality of confinement within the limits of the hospital grounds raised a new issue which could be dealt with—by recovery. Discharge would not entail a return to the hardship of immigrant existence, but opened up the vista of the comfort of home life. Resolution spelt repatriation.

(e) *Involutional Forms in Menopausal Cases.*

Among women who became home-sick at about the time of the change of life, the intense melancholy coupled with a sense of the futility of things and a general nihilism served to mark the involutional colouring of the psychoses.

Such symptoms as mistaken identities, religious delusions and suicidal efforts recurred as in the other forms of home-sickness psychosis. With nostalgia as a precipitating cause, the epochal involutional psychosis followed a more favourable course than usual.

(f) *Miscellaneous ; Personality Reactions.*

Distinctive personality reactions were strikingly low. One instance of a twilight state was observed in a young girl aged 17, subject to such attacks (? epileptiform in this case) since about the age of ten. In another instance a woman had a first attack of melancholia at the age of 29, and it was felt legitimate to regard the breakdown as reactive to immigrant difficulties.

In 3 other cases a depressive attack occurred in patients with a previous history of manic-depresive insanity. It would be splitting hairs to decide whether the present attacks were reactive depressions of exogenous origin or merely incidents in an endogenous manic-depressive insanity. Bleuler does

speak of exogenous reaction types originating on different psychopathies, but believes that these rarely come to the psychiatrist except as partial manifestations of other diseases, especially of manic-depressive insanity.

Discussion.

(a) *Opinions of Braun and Kraepelin.*

Braun's contribution in Bumke's encyclopædic *Handbuch* places home-sickness among the psychogenic reactions. The content of a true reaction has some obvious connection with the provoking experience itself; and we speak, says Braun, of psychogenic reactions "when the emotional reaction to unaccustomed psychic experience leads to unusual, but on the whole, comprehensible reactions which can still in general be influenced psychically and which, especially after the disappearance of the causative psychic experience, usually disappear gradually without leaving any trace".

Braun proceeds to sub-classify home-sickness among the "personality reactions" rather than among the "milieu" or situation reactions. Personality is made up of a constellation of factors comprising constitutional elements (character qualities, race, sex), the milieu (social position, education, experience), and acquired characters (alcohol, etc.). A psychogenic reaction, therefore, regarded from the personality standpoint is the result of some change working on the disposition and on the tendency to a given psychic disturbance. Constitution determines, says Braun, the *form* of the reaction, and experience the *occasion*.

Braun divides personality reactions into the following four groups:

(1) Depressive reactions.
(2) Explosive reactions.
(3) Fits, twilight states, stupors and fugues.
(4) Bodily symptoms.

Though my cases do not, in my view, fall into the category of reactive depression, nevertheless some account must be given of the depressive reaction for purposes of comparison and discussion. Kretschmer and Bleuler (20), as will be seen later, consider home-sickness to be a depressive reaction, and Braun, though he uses another classification, believes that home-sickness "can" cause such a depressive reaction.

The symptomatology of the depressive reaction is, according to Braun (*loc. cit.*, *p.* 156), the prototype of psychogenic illness. But it is well to mark the differences which Braun emphasizes to distinguish reactive depression from the endogenous melancholy of manic-depressive insanity. The pure type of depressive reaction grows in a different psychopathic soil. Depressive reactions do not touch so much the cyclothyme; rather do they afflict the asthenic, sensitive, soft, weak, impressionable. It is the "near-to-hysterical" personalities which incline to the depressive reaction. To crystallize the difference

between endogenous melancholia and reactive depression, Braun quotes Kahn's classical phrase, "Der Melancholiker leidet; der reactiv Depressive tut sich leid" ("The melancholiac suffers; the reactive depressive is sorry for himself"). Finally, in general, surroundings play a much more important part in the case of reactive depressives than in the case of melancholics, who tend rather to be preoccupied with themselves.

Braun, as already mentioned, does not classify home-sickness with the depressive reactions. I incline to follow him in this. Hysterical phenomena (palsies, anæsthesiæ) were strikingly absent in my series of cases. Braun actually places homesick reactions among the group comprising twilight states, stupors and fugues (particularly the latter). Young homesick servant-girls react under the influence of the urge "to get away" ("*Nur fort*") and may kill their young charges or burn down the house of their employers as a means of escape. To this extent Braun agrees with Kraepelin, who brings together wandering states (fugues) and the impulse to set fire (pyromania) as typical of the behaviour of half-grown, weak-minded servant girls torn away from their family and unable to find emotional contact with the new place. Kraepelin, however, complicates terminological difficulties by ascribing such behaviour to "reactive impulses", among which he includes sexual exhibitionism.

(b) *Views of Kretschmer and Bleuler.*

Bleuler (*loc. cit.*), summing up the subject of home-sickness, accepts the account of Kretschmer that home-sickness is a reactive depression to be classified with exaggerated or false simple reactions like screaming, attacks of rage, affect stupor, prison crash and rare manic-like reactive states as a "primitive reaction". "Such cases are usually ushered in with deep disturbances of consciousness with or without hallucinations. They last a few minutes, at most a few weeks, and leave behind a pronounced or absolute amnesia and full insight" (Bleuler).

Nostalgia reactions, says Kretschmer, are typical in maidservants between the age of 14 and 17. The violent home-sickness reaction is manifestly due to the incomplete solution of the psychic attachment to the parents. In a lamb-like, timid and autistic way, such girls often exhibit schizoid features.

(i) *Clarification through the personality filter: "having a good cry".*—In the case of an ordinary servant-girl, nostalgia-governed impulses, according to Kretschmer, would pass through all the intercalated circuits connecting sentiments with personality, such as pity for employers, consideration for parents, fears of arrest and punishment, religious and moral scruples. The path taken through this maze would necessarily be long and tortuous, and the impulses would be so checked, inhibited and transformed by a dozen counter-impulses and resistances, that the final form of motor reaction would be quite harmless. The girl would "have a good cry" or take her employer into her confidence, or at worst give notice or run away.

(ii) "*Short-circuit reactions*": *arson*.—However, besides generating transitory reactive depression, the nostalgia impulse may pass *direct* to the psychomotor system without filtering through the total personality. That is what is termed a "short-circuit", resulting in such actions as arson and infanticide. The following is quoted from Kretschmer's work:

"A young maidservant, weakly, gentle and timid, arrives from the country to take up her first situation in the town. During the first few weeks she seems to be worried and in poor health, but she complains of nothing. Suddenly one morning the house is in flames, and her employer's children have been murdered. The evidence in court is as follows: She felt terribly home-sick and over-tired; everything was strange to her; she was at her wits' end; she did not dare to say anything to a soul. If nothing were left of the house or the children she would be free to go home. (This intermediate train of thought may or may not have been thought out after the event.) A heavy, insistent, unbearable obsession: 'Only to get away'! One morning her head feels muzzy and dizzy; she does not know what is happening to her." Or maybe, the deed is accomplished with a horrible clarity and obviousness. For example, in another case, Kretschmer's patient stated that no other thought entered her mind when she was beset with the idea of burning the place down.

(c) *Correlation with Present Series of Cases*.

My cases concerned rather older patients than those described by Kraepelin, Kretschmer, Bleuler and Braun. Only three, for example, of the cases described in this paper were between 17 and 20 years of age.

Moreover, the above authorities were describing cases of home-sickness occurring in young girls who, though torn from home, had not actually left their own country. The possibility of a return home by creating hysterical difficulties was more feasible for them. My cases had made a more irrevocable break with home ties, and dramatic hysterical modes of escape were not so practicable. The "shame" of failure and the "disgrace" of return to an impoverished family also made it harder for the immigrant cases. Finally, my cases were by no means weak-minded. On the whole, they were reasonably educated, some having reached high school or even university standard. Only one was illiterate.

Such factors, of course, may account for some of the differences to be observed between classical accounts of home-sickness and my own.

As already noted (Table III), schizophrenic (16 cases), paraphrenic (9 cases) and confusional states (7 cases) accounted for the bulk of my cases. Braun's twilight state (1 case) and reactive depression (2 cases) figured much less prominently. Affective (including involutional) disorders concerned only 5 cases.

On the other hand, certain resemblances with the accounts given by the authorities can be detected.

Many of the confusional cases in my series entered into dream-like ecstatic, contemplative phases suggestive of a twilight state (see Braun). The frequent running away and changes of post replaces the franker fugue-like states—though those of my cases arrested outside Buckingham Palace attempting to visit the King approached nearer to the wandering states. The stripping of clothes reproduced the exhibitionism of Kraepelin's fugues.

Though none of my patients attempted arson or committed child-murder, yet one of them did cut a cat's throat, and the short-circuit escape theme ("*Nur fort*"—only to get away) took shape as suicidal efforts.

With regard to bodily reactions, my observations more than tally with those of Braun and Kraepelin. The loss of appetite, the vegetative nervous changes (Braun) and the menstrual disturbances (Kraepelin) were reproduced in my cases, in which toxic, infective and nutritional disorders were commonly noted.

Of the broader correlation of the mental reaction with the type of bodily conformation (Kretschmer) I could see little striking evidence. I did not probe into the matter in detail, but I have the impression that my patients comprised all shapes and sizes, many being pyknic in physical type though the outstanding mental reaction was schizoid.

My view of the cases is the common-sense one that home-sickness is a "milieu" or situation reaction. Despite the diversity of personality types, there is a striking uniformity of symptomatology, course and prognosis—suicide, mistakes of identity, religious delusions—an immediate improvement once the situation is changed by hospital care, and a favourable course ending in repatriation.

No rigid separation of personality from milieu is, of course, permissible. The question, as always, is *how much* personality, *how much* situation? In assessing the relative importance of these factors, however, I incline to put most weight upon milieu.

Prognosis.

The outlook is usually fairly good. Of the 27 cases admitted between 1931–36, 8 were discharged recovered, 8 were repatriated relieved and 3 were sent home not improved. At the end of December, 1937, there were 8 cases of this group remaining in hospital, 6 of these having been under treatment less than 18 months.

The form of the disorder influences the prognosis to some extent.

All 6 confusional cases in the group under discussion were repatriated (3 having recovered and 3 discharged as relieved); whereas of the 9 schizophrenics, 3 had recovered, 2 were relieved, 2 were repatriated not improved and 2 remained in hospital. Of 7 paraphrenics, none had recovered, though 3 were sent home relieved, 1 was repatriated not improved and 3 remained in hospital.

Of those repatriated recovered or relieved, 6 had been in hospital less than

six months, 8 in hospital seven to twelve months, and 2 thirteen to eighteen months.

There seemed to be an inverse relationship between the length of stay in England before breakdown and the duration of hospital treatment. The longer the patients endured before breakdown the sooner they recovered. For example, two cases had been in England for twenty-four months before certification ; one recovered in two months, the other in four months. A case which was certified within five months of arrival in England remained in hospital for thirteen months. The rule is only very rough and there are exceptions to it, but I think it is useful as a guide.

Prophylaxis.

(a) *The Problem of Selection ; American and French Experience.*

Is migration synonymous with inferiority ? Clearly not, if we consider the big migrations of mankind along the river banks after the first discovery of the edibility of fish following the use of fire, and further migrations when mankind had discovered how to domesticate animals and then to cultivate cereals (Morgan). There were migrations through the various stages of savagery to barbarism which laid the foundation of civilization. These migrations were upward movements in the evolutionary scale.

But the modern movement of immigrants is not comparable with such historical marches of time. Put more simply the question is—Should there be any selection of immigrant domestic servants entering Great Britain ?

We can refer to American and French experience to assist us. The United States applies very stringent tests, demanding medical certificates, employing measurements of intelligence (? " educational opportunity ", Boody (21)), and even fining shipping companies which make inadequate inquiries about immigrants brought to America. As Kirkpatrick (22) says, the " new mercantilism " of America produced a zeal for high-grade immigrants of a different standard than the " gold supply " of the seventeenth century. But this rigid selection is avowedly designed to skim " the cream of Europe ". Are the same standards necessary for the domestic servants coming to Great Britain ?

It is by no means certain that the alleged higher incidence of mental disorder among foreign-born immigrants in the United States is either proved or accepted. Malzberg (23, 24, 25), discussing mental disease and the " melting-pot ", whittled down the statistical difference as to mental disease among native and foreign-born whites until there was little left.

Correction for age differences, for environmental, economic and occupational factors, combined with the degree of urbanization, reduced the difference from an alarming 100 to a bare 10%

In France, where there is a shortage of labour and where tradition of the right of political asylum persists, no such selection is applied—although some

medical authorities would like to enforce some scheme of exclusion. At the same time, however, the French have made a special study of the needs of the immigrants and how to make them contented. A certain mutuality applies to the immigrant and to the French Government—each has need of the other. The French are at pains to absorb the immigrant, who is encouraged to work according to the motto, "*Ubi bene ibi patria*". Dr. Martial (26), of the French Immigration Department, goes so far as to inquire how best to satisfy the dominant need of the immigrant. For the Poles, it is a question of religion; for the Dutch, it is a question of where to live; for the Czechs, it is a question of co-operative development; for the Italians, the opportunity to save.

(b) "*Institutionalization*" *of the Foreign Domestic Servant.*

Should the foreign domestic servant become a recognized "institution" in the present-day social organization of this country? The ultimate answer must depend upon politico-economical factors beyond the scope of this paper. From the point of view of the immigrants themselves, such an acceptance of their position would contribute much to their peace of mind and contentment. With some machinery for making their lot a happier one these immigrants would find it easier to adapt themselves, and would be less likely to hanker after home.

Dr. Martial very carefully insists that the immigrant should be encouraged to respect his mother tongue, and that nothing should be done to give the immigrant the feeling that one wishes him to forget it. Successful absorption and interracial grafting, however, do not necessitate a complete break with language and home ties. Moreover, it is well that the immigrant should retain some of his customs.

(c) *Supervision of Domestic Agencies.*

Some such sympathetic handling seems to me the correct approach. Some responsibility attaches to the domestic agencies which make a financial business of bringing foreign domestic servants to this country. At least one such agency, to my knowledge, takes special pains to meet incoming immigrants at the station on arrival in London; the personal touch is exercised, the immigrants are found comfortable lodgings, and as far as possible are placed in jobs in pairs, or where one girl is within easy reach of another. The girls are encouraged to visit the agency on their free afternoons to report progress, to make complaints, and to renew contacts with their fellow countrywomen. Surprisingly few cases of mental breakdown come from this particular agency. On the other hand, in the case of another registry office there is not the same consideration, and recurring instances of mental breakdown are recorded among girls sponsored by this concern. The girls arrive in London unwelcomed

at the station, and if the agency office is closed they have to fend for themselves in a strange big city. [Dr. Marie (27) in France collected cases of aphasia and amnesia among foreigners abandoned by an emissary on arrival at their station.] No care is taken in any way to place the girls near each other, or to introduce them to others of their own race or religion; and certainly there is no encouragement given to the girls to come back with their troubles.

It is possible that the position outlined in this paper may assist official authorities in their supervision of agencies which appear to have little sense of their responsibilities in this matter.

(d) *Renewal of Permits; Medical Opinion.*

As to what official steps could be taken to make these girls contented is another problem. One thing is clear: considerable anxiety attaches to the problem of the renewal of permits to stay. These are renewable every six or twelve months, and the girls have to report change of address to the police. There is no question here of absorption, and no hope of permanent settlement with their families, which is what most of the women really desire. A dilemma clearly exists—on the one hand a shortage of domestic servants, and on the other hand the risks of importing further labour in the face of an already high unemployment incidence.

It is pertinent to suggest that a medical history is as important as a police dossier when the official renewal of permits is under consideration.

MANAGEMENT.

Once mental breakdown has occurred, the management of the case raises legal and clinical considerations. When symptoms of abnormality begin to develop, the subsequent evolution of the mental disorder is usually quite rapid, and the problem of disposal becomes urgent.

(a) *Temporary Treatment Preferred to Certification.*

Segregation in a mental hospital appears essential. The high incidence of suicidal attempts renders enforced care necessary in the patient's own interests. Moreover, complete separation from unhappy surroundings is imperative.

As many of the cases in the present series recovered or were repatriated within a twelvemonth, it would seem that treatment as a temporary patient would meet the needs of the individual case. The stigma of certification has added terrors for the German cases in that the risk of sterilization would apply not only to them but possibly to their relatives. Unfortunately, only one of my cases was received as a temporary patient; in my view, all the acute confusional cases were unnecessarily certified.

(b) *General Measures.*

Food and rest constitute the immediate indications. Refusal of food occurs so frequently that patient hand-feeding, if not substantially successful, should be supplemented, or entirely replaced by tube-feeding. As soon as the confusion lifts, co-operation frequently returns, and patients readily consume what is offered. But in some obstinate cases forced feeding must be persisted in. Care must be taken to safeguard against vitamin deficiency, and I usually supplemented the daily milk and egg feeds with concentrates of vitamins A and D and orange-juice.

With regard to sleep, those patients who were excited and restless on admission were given hyoscine and morphine. For the milder cases such sedatives as paraldehyde, bromides and the barbiturates were tried. In some instances hydrotherapy was successful.

Despite recent strictures against "ritual purging" I always took care to keep the bowels free with enemata or aperients, especially in those confusional cases resembling acute delirious mania. Fluids were given freely as a precaution against the risks of dehydration.

Though amenorrhœa was probably part of a general toxic or nutritional upset, œstrogenic preparations were prescribed. It was not always possible to estimate how often resumption of menstruation was due to the general improvement in the bodily state and how much resulted from the exhibition of hormone substances, but I have the impression that the latter were useful.

Local measures for the alleviation of toxæmia were, of course, carried out. The mouth was kept clean and moist as far as possible; swabbing and painting of the throat were performed whenever the patients were unable to use gargles. Septic areas, sores, boils and carbuncles were dealt with on conventional lines. Often the patients needed treatment for bed-sores on admission. Whenever the pressure areas were healthy, every nursing attention was given to prevent trophic changes, especially liable to occur in restless, poorly nourished, faulty patients.

In some cases surgical intervention might be necessary, and in one case an anthelmintic was needed for the expulsion of a tape-worm.

(c) *Persuasion; Encouragement; Group Discussion.*

On admission most patients were inaccessible. The acute confusional cases responded, during intervals of lucidity, to persuasion and encouragement. So often were they beset with terrifying illusions and hallucinations that only the greatest kindness and reassurance on the part of the nursing staff would suffice to calm the patients.

When they became accessible, it was usually possible to get the patients to talk freely of their experiences. The emotional play was both varied and

intense, and despite the immediate distress, the patients were subsequently the better for expressing themselves. They derived much encouragement from the reiterated assurance that they were to return to their families as soon as they were well enough to make the journey. Letter-writing was a great indulgence, and no bar was set to this in the early stages of recovery, but later on there was sometimes a tendency to spend most of the day in epistolary self-indulgence.

It was usually possible to occupy the patients quite early on the return of lucidity, and once bodily health and strength permitted. Sewing, cooking, weaving, embroidery, painting, leather-work were all popular, especially if the work was done in concert with others. Group work provided opportunity for conversation and singing. The patients were particularly responsive when brought together with other Germans and Austrians. Each gave encouragement to the other, and there was no longer the sense of complete isolation from their kind. Without formally employing "group therapy", I found it a good thing to place the Austrians and Germans together in one ward. I encouraged them to gather about me in twos and threes to discuss the situation of foreign girls in Britain in general, and their individual experiences in particular. The patients were always amused to discover how similar had been their several histories. This made it more difficult for the paranoid patients to believe, with the same conviction, that each had been specially singled out for persecution. Group discussion, moreover, spread the opportunities for transference of affect. The "*ventil-mechanismus*" in these circumstances worked particularly well. Hostility, where it existed, was dissipated in many directions; new ties and friendships were fast cemented. These group meetings agreed upon the importance of loneliness as a factor in breakdown, and brought home to me that solution of this problem is the key to the prevention of breakdown in these cases.

Summary and Conclusions.

1. This study deals with 40 foreign domestic servants, mainly German and Austrian, suffering from mental disorder.

2. Whether innate or acquired, the need for companionship must be satisfied.

3. Conflict between family ties and herd or group feelings among immigrants excites home-sickness.

4. Home-sickness combined with loneliness and exhaustion comprise the principal ætiological factors producing psychoses among immigrants. Hereditary elements do not figure prominently.

5. (*a*) Psychological mechanisms brought into play centre strikingly around those identifications characteristic of group formations. Mistakes of identity are common, and illusions of resemblance appear to follow the stratifications peculiar to primitive notions of kinship. Claims of familial relationship are based not so much on superficial pictorial resemblance as upon age—persons of

the same age as the patient are regarded as sisters and brothers, and those a generation ahead are treated as parents.

(*b*) Circumstances compel a duplication of the world into real and imaginary. Religious ideas are therefore called into being. Identification of God with the father occurs frequently. Mystical rites, prayers, ecstasies, and fears associated with the devil feature strikingly.

(*c*) Delusions connected with Royalty arise and depend partly on the identification of the King as Father.

(*d*) Stripping of clothes is noted as a symptom, and this paper discusses the significance of this phenomenon.

6. Escape—"*Nur fort*"—the desire to get away lies at the bottom of the frequent change of employer, of the many attempts at suicide, of love affairs, real and imaginary, and of delusions of sexual assault.

7. The forms of mental disorder met with in the present series of cases comprise acute confusional states, acute schizophrenic conditions, paraphrenia, and involutional forms. Rarely reactive depressive and twilight states occur. Endogenous manic-depressive insanity is rarer still. Bodily reactions may be seen in all the above forms—loss of appetite, toxæmia, vegetative-nervous changes being among the most common, and being most likely to be found in the acute confusional and acute schizophrenic types of disorder.

8. The views of Braun, Kraepelin, Kretschmer and Bleuler are discussed.

9. American and French experience is referred to regarding the problem of selection of immigrants. The practical absence of political refugees among my group of cases tends to suggest that perhaps such refugees do not break down so frequently. Other prophylactic measures discussed are the question of "institutionalization" of foreign domestic servants, and the desirability of obtaining medical opinion before renewal of permits.

10. Temporary treatment is preferred to certification.

11. Apart from general measures in treatment, persuasion, encouragement and group discussion are valuable.

12. The prognosis is fairly good. About two-thirds of the cases recover or are repatriated within twelve months of hospital treatment.

Illustrative Case Histories.

For convenience the cases were divided into two groups:

SERIES A: deals with cases admitted between 1931–36, and provides scope for fuller histories. Of the 27 cases included in this group, 19 were repatriated, of whom 8 had recovered, 8 were relieved, and 3 were not improved. Of the 8 patients of this group remaining in hospital in December, 1937, 6 had been under treatment less than eighteen months.

SERIES B concerns cases admitted during 1937, and insufficient time has elapsed to give the fullest account; in some instances the history is deficient, in others the period of observation has been too short. Of the 13 cases included in this group, 3, having recovered, were repatriated during the same year. The remaining 10 were still under treatment at the end of December, 1937.

In this paper 17 cases have been selected for detailed description, of which 10 belong to Series A, and 7 to Series B.

Series A.

Schizophrenic and Paraphrenic Cases.

Case 1.—G. B—, single, aged 26; Austrian; Roman Catholic; domestic servant. Arrived in England in 1933. Diagnosis: *Schizophrenia*. Date of admission: February 27, 1935. Date of discharge: May 1, 1935. Recovered, repatriated. Duration of hospital stay, two months.

History.

Source of information.—Social worker's report from employer.

Family history.—Parents and three brothers alive and well. One brother in Munich, one with parents in Austria.

Personal history.—Patient states that she was born and brought up in Austria and went to school there; did not get along very well at school; not such a good scholar as her brother. Helped parents at their hotel. Came to England in 1933 alone. Wanted to learn English language and cooking. Found work; did not mind what she did, but never got along well; there was always something wrong, and she changed posts frequently. Recently patient seems to have been worrying about her relatives in Austria; is afraid that something may have happened to them. Thinks that they are being persecuted like the Jews. Mrs. E—, former employer, states that patient entered her service as a domestic servant in October, 1934; she was rather slow and dull, and not a great success. She did not mix with the other servants; the cook was also an Austrian woman, but patient did not like her. Menstruation normal

History of present illness.—Patient states that she was delicate as a baby, but has had no serious illnesses since, and cannot remember being in a hospital before. A few weeks ago patient grew neglectful of her work; she forgot things, seemed confused and absent-minded. This state of mind was put down to the fact that as she had given in her notice to leave, she was disinterested in her work, and little was said to her. She would hang odd curtains up at the windows, place pieces of furniture in inappropriate places, etc. She got silent and sullen, and latterly had been lying in bed for a greater part of the time, unknown to her employers. It was decided that medical advice must be obtained for the girl, and her admission to St. Stephen's Hospital was ultimately arranged. In the general ward she proved to be unsuitable; she was restless, and it is said that she jumped out of bed and attacked a nurse, and was also found with a stocking tied round her neck. She is said to have thought that another patient wished to poison her. She states that she is being killed, and that one side of her body is dead; she is also afraid that her parents have been killed by political enemies.

Reason for admission to Friern Hospital.—Medical certificate dated February 24, 1935: "She takes no interest in her surroundings, and does not try to occupy herself. She smiles and grins for no apparent reason. She does not control her sphincters. She imagines her head does not belong to her body."

Condition on admission.

Physical state: General physique good. She weighed 9 st. 6 lb. and was 5 ft. 4½ in. in height. *Heart and lungs:* No sign of abnormality. *Abdomen: Nil* abnormal detected. *Central nervous system:* No loss of power; no disturbance of sensation. *Reflexes*—unimpaired. *Pupils*—equal and react to light and accommodation. *Thyroid: Nil* abnormal detected. *Urine:* Not examined; subsequently *nil* abnormal found.

Mental condition on admission.—She is dull and slow, and has only a vague memory for her breakdown. She states that she knows she has had a nervous breakdown, but does not remember the things she is reported to have said and

done, and saying if true they must have occurred in her dreams. She appears to have been unhappy in her situation, and to have been worrying for no real reason about her relatives in Austria, to whom she is anxious to return. She states she has never had any previous breakdown. Since admission she has been quiet and well conducted in every way.

Progress.

March 13: She is improving. Her bodily ailments do not worry her so; she is cheerful and usefully occupied. Paranoid notions are not to the fore.

March 21: She is much improved and probably nearing her normal, though likely to have been always self-centred. One cannot say definitely that she is suspicious, but there is undoubted reserve, which borders on mistrust of one's motives. Here, too, though well conducted in every way, she is aloof, does not encourage advances, and does not join in social activities. Her anxiety about home conditions was probably not, as was first thought, unfounded, though as far as is known she has not been informed that her father is in prison. She, understands her position and, though she would much prefer to stay in England, realizes that this will probably not be permitted. However, she bolsters herself up with the hope that after spending a few months in Austria she may be allowed to return.

March 27: No further change to note. She is very well conducted, though rather solitary.

April 26: Discharged under Section 77 as " recovered, for repatriation ".

CASE 2.—G. G—, single, aged 25; Italian; Roman Catholic; student. Arrived in England February, 1935. Broke down 9 months later. Diagnosis: *Schizophrenia*. Date of admission: November 21, 1935. Date of discharge: December 3, 1936, relieved; taken home to Italy by her father. Duration of hospital stay, twelve months.

History.

Source of information.—Social worker's report from convent sister.

Patient is a dark, attractive Italian girl whose family live in Italy. She left home in March, 1934, and went to Paris to study French. In February, 1935, she came to England to learn English.

Family history.—Father, profession unknown, seems to be fairly well off, and has been keeping patient while in England. Has married a second time, and stepmother is not congenial to patient, and seems to have been partly the cause of her leaving home. Father now writes begging patient to come home and " forget the past ". Appears to be a good Catholic from his letters.

Mother dead. Cause unknown.

Siblings.—Two younger brothers.

Home.—There seems to have been friction at home. Patient was only to be six months in England, but when the time was up refused to go back to Italy in spite of her father's entreaties. She is still said to be opposed to returning home.

Personal history.—Nothing is known of patient's early life or development. She is said to have been studying French in Paris from March, 1934, to February, 1935, when she came to England, where she has been having English lessons.

Sex.—Patient does not seem particularly interested in the other sex, and as far as is known has no men friends. Is always in early at night. Mensuration normal.

Personality.—The convent sisters where patient stayed say she has always been peculiar since she came to them.

Illness.—Patient is always writing sheets of letters, which the father says have been sent to people in the village slandering him and the family.

Delusions.—Has always had the idea that people are robbing her and saying that she has reported them to the police. Quick-tempered, quarrelsome, obstinate.

Reserved and quiet about herself and her family affairs. No friends. Had *first attack* of hysterical behaviour in June, when she kicked the furniture about; would not stay in bed at night, but wandered about the house; stared at herself in the glass in the middle of the night, powdering and painting her face. Has had two or three of these attacks, and on the last occasion locked herself in the bathroom and announced her intention of sleeping in the bath. By strategy the sister got in, but patient said that if she was forced to leave she would throw herself out of the window. After long persuasion she consented to return to her room if she could barricade the door. She seemed afraid of something, but they did not know what. The doctor advised her removal to the local hospital. No known heredity.

Reason for admission to Friern Hospital.—Medical certificate dated November 19, 1935: "She is panting for breath and labouring under great nervous excitement. She said, "I've got the right name"; "they stole me" (referring to her parents). As examination proceeded she worked herself up, shouting, "I'll kill myself", "I'll finish". She was extremely agitated and restless, tearing up everything within reach of her fingers."

Condition on admission.

Physical state.—Her general physique was good. She weighed 8 st., and was 4 ft. 10½ in. in height. *Heart and lungs:* These appeared healthy. *Abdomen:* No abnormality detected. *Central nervous system:* No loss of power. No disturbance of sensation. *Deep reflexes*—exaggerated. *Pupils*—equal and react to light and accommodation. *Thyroid:* No abnormality detected. *Urine:* Acid, 1028; no albumen; no sugar.

Mental condition.—She is conscious of her surroundings and is correctly orientated. She left home in Milan in March, 1934, and went to Paris. She states that when she left home she had 10,000 francs. She came to England in February, 1935. She wanted to learn English and become a missionary. She seems to have spent all her money, to have been in touch with the Italian Consulate in London, to have tried to get more money from them and to have refused their offers to send her back to Milan. She has been living at a boarding-house, and has been doing nothing in particular. She denies having any male friends, she denies being ill; she alleges that she has constantly been robbed and persecuted by some unknown person. She admits threatening to kill herself because of her persecutions. She gives an involved account of herself. Her first attack. No insane family history.

Progress.

January 22, 1936: She is now occupying herself with work in the occupational class. Miss B— states that the patient writes to her and accuses some of her former friends of being in a plot against her. She is well conducted, moderately happy but constantly asking to go home.

April 21: She writes many letters; some of them have been interpreted, and most of their contents are nonsense.

June 22: She appears to be a hebephrene with hysteroid features. She decks herself in a bizarre fashion and looks like a pre-Raphaelite picture, in an affected sort of way. She is vain, and indulges in fantasies. Her conversation fragments to a surprising degree and she speaks in a garrulous, disjointed fashion.

October 30: She over-decorates herself and dresses quaintly. Her general appearance is bizarre and affected. Her conversation has tended to become incoherent through fragmentation of thought, though recently she is a little, but only a little, better in this respect. She indulges in phantasy, and is sometimes impulsive in consequence of ideas of persecution. As a rule she is unduly elated in view of her circumstances and has little real understanding of her position. She is in fair bodily health and condition.

December 12: Discharged Section 77. Taken home to Italy by her father. Relieved.

CASE 3.—C. H—, divorced, aged 42; Austrian; Roman Catholic; cook. Arrived in England May, 1936. Diagnosis: *Paraphrenia*. Date of admission: December 18, 1936. Date of discharge; September 6, 1937, relieved, for deportation to Austria. Duration of hospital stay, nine months.

History.

Source of information.—Social worker's report.

Description of patient.—Never showed any sign of being in the least home-sick. She said she liked England, but would prefer to work for English people as she would learn more, and not be so hard-worked. (Her employers were German.) Suffered from nervous twitching, headaches and absent-mindedness for two months. Breakdown sudden in other respects. No previous breakdown so far as is known. Patient has no parents alive. She has one sister, in service. She is said to be divorced, which is unusual for a Roman Catholic.

She was born at Möglin, near Vienna; she came to this country in May of this year to enter the services of Mrs. B—. She married in 1923, lived with her husband for three years and then they drifted apart; she has not seen him for three years. She states that no divorce has occurred.

Reasons for admission.—The medical certificate stated, "She was very depressed and anxious-looking, and said all the advertisements on the walls and in the papers were about her and telling nasty things about her and were 'all against her'. She complained that people were all pointing at her and saying nasty things about her. She would not go out of the house because she saw these advertisements which were against her and would hear the nasty things people were saying, and because they were trying to injure her and laughing at her. She said the secretary of the Austrian Club told her to read these advertisements about her." Her employer said the patient had been acting strangely for about ten days before admission, and imagined everybody was against her, and now complains about the people in the street and the advertisements on the walls and in the newspapers being against her and about her. He said that when instructed to cook certain food she cooked something quite different, and that she got up and walked about in the middle of the night.

Condition on admission.

Physical state: Her general physique was good. Weight 12 st. 3 lb., and 5 ft. 5 in. in height. Stocky. *Heart and lungs:* Healthy. *Abdomen:* No abnormality. *Central nervous system:* Normal. No loss of power. *Reflexes*—knee- and ankle-jerks present; plantar responses flexor. *Sight:* Impaired; bilateral opacities cornea. *Thyroid:* No abnormality. *Urine:* Acid 1020; no albumen; no sugar.

Mental condition.—On admission she was correctly orientated. She has been very much alone in service. She became anxious, and thought she was being filmed when she went out. Read advertisements in the paper, did not understand them properly and concluded that they must refer to herself. She is rather perplexed at being brought here; she fears a long period of detention and she wants to return to Vienna. Eating and sleeping well.

Progress.

January 16, 1937: Improved and anxious for discharge, but still retains her delusions, although she states no attempts are made to molest her here.

February 21: She has done fairly well, but she still retains strange ideas and she alludes to the way in which she used to be followed about. The language difficulty is of importance in this case.

May 18: She retains persecutory ideas relating to detectives and to the spying upon her which went on in the street, and which she says she is quite unable to understand.

September 9: Left under escort in accordance with arrangements for deportation made by the Home Secretary. Discharged under Section 77 (1) on August 8, 1937. Relieved.

CASE 4.—G. F—, single, aged 23; Austrian; Roman Catholic; domestic servant. Arrived in England August, 1935. Broke down sixteen months later. Diagnosis: *Schizophrenia*. Date of admission: December 22, 1936. Still in Hospital (December, 1937).

History.

Source of information.—Social worker.

Patient was brought in by the police as she has visited the Palace to make an attempt to see the King, with whom she had been in love for a long time; she refused to go away, so was taken into custody.

She is an Austrian girl, who has been in England about sixteen months.

Information from employer says that patient has been employed by her for about five weeks; that she obtained her from a bureau. About two days after her arrival she complained of a sore throat and was ill for two or three days. Soon after her arrival the police called on her employer and gave her to understand that patient was considered to be " rather eccentric ", and that they had had her examined by a woman psychologist; they did not show the report to the employer, but advised her to report to them if she noticed any abnormality in the girl.

The employer says that from the first patient seemed to consider herself rather " superior "; she said, " Of course I am not an ordinary servant "; but she did her work well and gave no trouble. She had some strange ideas from the first; she thought that if she went out into the street people took more than ordinary notice of her; she had a " definite idea that she was different, exalted ". But for the first month there was nothing to which her employer could take exception. She says, however, that her " charwoman, who had been a maid for two years at a mental hospital, said from the start that the girl was 'batty' ". Recently patient definitely became more abnormal; she told her employer that she must leave; that she had to return to Austria to prepare for her forthcoming marriage. She did not say to whom; employer questioned her as she was thought to have a young man in England; patient said she had written to her mother for her fare; a few days previously she was all packed up ready to go; she seemed very strange; refused to accept a week's wages in lieu of notice offered to her by her employer; went out of the house in the early afternoon to " go to the hairdresser " and actually went to the Palace. She had told her mistress that she had received a communication from Scotland Yard, and that she was to be deported immediately.

Ideas re *suicide*.—Employer states that patient said she would " kill herself " if her plans did not work out as she intended. She said she had " tried it before ".

Information given by patient to doctor, December 20, 1936.—Patient says that she was born in Austria; that her mother died when she was three years old; that she was brought up by her father and stepmother. She left school at 14, and after a time went to work in a shop in Vienna. She came to England in August, 1935. She had several posts as house-parlourmaid since being here, mostly for short periods. Last November, at B——, she left a post late at night; mistress could not take her back. She left because she could not have a bath. Slept out all night. She then got a post in K——. Has been mistress of a dog-racing bookmaker till recently. Has many ideas of reference; mistakes identities. Identified herself with Mrs. Simpson and went to the Palace because she thought she was to marry King Edward. Thinks child in former post might have been Prince Edward. Thinks Nurse H— is her mother. No insane heredity noted.

Reason for admission to Friern Hospital.—Medical certificate, dated December 21, 1936: " She is childish and mischievous in behaviour. She had many ideas of reference, e.g., she imagines the incidents in the film ' Episode ' are drawn from

her life story. She makes mistakes of identity, e.g., she imagines the ward nurse is her mother. She is without insight, and needs care and control for her own safety."

Condition on admission.

Physical state : General physique good. She weighed 8 st. 12½ lb. and was 5 ft. 0½ in. in height. *Heart and lungs :* Appeared healthy. *Abdomen :* No abnormality detected. *Central nervous system :* No loss of power. *Reflexes*—plantar responses flexor ; arm-jerks slightly depressed. *Pupils*—equal and react to light and accommodation. *Thyroid :* No abnormality. *Urine :* Acid 1022 ; no sugar ; trace of albumen.

Mental condition.—She is moderately well orientated, but she is much absorbed in phantasy and does not pay a great deal of attention to her present surroundings. She giggles and laughs in a silly manner. Bizarre delusions supported by hallucinations are much in evidence. She makes contradictory statements about her parents. She alludes to her recent visit to Buckingham Palace ; she frankly admits that she went to see the King ; she was in love with him ; had seen many things in the papers, and she thought that the King might like to have her at the Palace. She makes mistakes of identity ; she states that she saw her mother at F—— Hospital and that her " mother " keeps talking to her. Her mother is stated to have died when she was an infant.

Progress.

January 1, 1937 : Crepitations at right base and complaint of pain. Suggestive of influenzal pneumonia or tubercle.

January 6 : Temperature 100°, pulse 98, respirations. Right lower chest : some crepitations. Urine : Trace of albumen ; no sugar. Sputum : Blood-stained. No T.B. in sputum.

January 10 : Better in herself, but blood-stained sputum. Loose cough. Her case is suggestive of pulmonary tuberculosis.

February 2 : Bright, happy. Delusional ideas no longer present. Wants to go back to her own country. Helpful in the laundry and in her own ward. She is much better physically.

March 18 : Patient was sweeping the floor, felt sick, and went to the lavatory. She returned, saying that she had coughed up some blood and showed about an ounce of bright red blood intermingled with saliva. She also complained of a vague sensation in the interscapular region and thought that the blood came from the lungs.

April 3 : X-ray to-day. Suspicious mottling of the right hilum—peri-bronchial fibrosis.

May 5 : Consultant diagnoses *pulmonary tuberculosis*.

June 21 : Mentally relapsed. Threatened Miss F— on the verandah. Failed to stay in bed and has been quite irresponsible in behaviour. Transferred to Villa 7.

July 13 : No reaction following sanocrysin administration.

August 20 : Emotionally she is unstable and her mood quickly changes. Her behaviour is querulous and difficult and she remains devoid of insight. At times she requires washing, dressing and hand-feeding.

September 19 : She is now depressed and anxious to go to a villa and to work again. Attempts to explain her chest condition are of little use. She has been getting up, but her cough has again been worse during the past few days.

She is hallucinated, alludes freely to the way in which she alleges that all the other patients call her a " swine ", a " pig ", etc.

CASE 5.—L. H—, single, aged 26 ; Austrian ; Roman Catholic ; cook. Arrived in England January, 1936. Diagnosis : *Paraphrenia*. Date of admission : June 26, 1936. (Still in hospital, December, 1937.)

History.

Source of information.—Social worker's report.

Description of patient.—Has been in England this time since January, 1936; last year she says she also worked in England for a time and she was then also in the German Hospital.

She returned to England and obtained a post in Bedfordshire; she held this for two months, but was not happy there. Through a friend of hers she obtained a new position; she has been there about two months; the mistress says that from the beginning she was strange at times; but her friend from the country told the mistress she had had a lot of trouble in her life; that her parents were now dead and she only had a cruel elder brother and sister "who wanted to shut her up in an asylum". About a week ago the mistress was herself taken ill and patient was forced to go out of the house to do the shopping; she became very agitated from that time; she said that three young men in the post office where she was buying stamps said "There she is", and that these people, who followed her from place to place, had found her and meant harm to her; she did not want to go out into the street; she said they found her everywhere she went; she wanted to shut her window at night because a young man would come in and "give her a baby". From that time she had outbursts of excitement; when papers were shown her she said her pictures were in them; they had writings about her; if the wireless was turned on it referred to her. Employer made inquiries and found that she had apparently suffered from these persecutory ideas for some time. She accordingly arranged on Monday for patient to go to the German Hospital, as she was in a very agitated state, saying she did not know what to do; begging the employer to help her. Employer understood her to make some reference implying a desire to commit suicide, but says she thinks she may have understood patient imperfectly, as the doctor at the hospital did not think she would be suicidal.

Reason for admission to Friern Hospital.—Medical certificate, dated June 22, 1936: "She is depressed and agitated. She states she is under the influence of a man who 'mesmerized' her in Austria and who wanted her to become a prostitute. She adds that she is worried because she knows 'he wants me to go on the streets of London now that I am in this country'. She says she wishes she were dead and her troubles would be over."

Menstruation: Amenorrhœa (menstruated once in seven months).

Condition on admission.

Physical state: She weighed 7 st. 11½ lb. and was 5 ft. 2½ in. in height. *Heart and lungs:* These appeared healthy. *Abdomen:* No sign of abnormality was discovered. *Central nervous system:* No loss of power was detected. There was no disturbance of sensation. *Reflexes*—the knee- and ankle-jerks were normal and equal. The plantar responses were flexor. *Pupils*—the pupils were equal and reacted to light and accommodation. *Thyroid:* No abnormality was detected. *Urine:* Acid, 1030; no albumen; no sugar.

Mental condition on admission.—She is conscious, but only vaguely orientated in time. Comprehension fair. She is uncertain whether or not she was mesmerized. She hears many people talk to her and this confuses her. She is full of fears of an unspecified character and is extremely depressed. There is a "secret", and the patients appear to speak to her about this. She sighs, is agitated, and begs to be made well. She is clean, needs persuasion with her food; afraid to sleep well; she fears dangers beset her on all sides.

Progress.

July 23: She has settled down well. Working in the laundry.

August 28: She is tearful and depressed following the receipt of a letter from her relatives in Austria.

December 2: Last night she impulsively took up a chair to a fellow patient and tried to strike her, but was prevented from so doing by a nurse.

March 2, 1937: Improving and emerging from a state of stupor, but her paranoid attitude towards her late employer persists. She is less dependent and now well behaved.

June 1: She exhibits mannerisms, is solitary and introverted. She gives a poor account of herself and has no definite ideas regarding her own future. Phases of more or less marked confusion occur. Her behaviour is at times impulsive.

November 12: She is prone to sudden outbursts in which she is violent and impulsive. She throws chairs, crockery, etc., at those who offend her.

Confusional Cases.

Case 6.—H. M—, aged 20; Swiss; Roman Catholic; domestic servant. Arrived in England February 26, 1931. Broke down fourteen months later. Diagnosis: *Confusional state*. Date of admission: April 12, 1932. Date of discharge: November 25, 1932, recovered. Duration of hospital stay, seven months.

History.

Source of information.—Employer.

Her mistress states that the attack occurred suddenly, a few days before admission to hospital care. The patient thought that the devil was in the house and rushed off to the police. A Swiss pastor said that the patient appeared to be in conflict over some religious matters.

Menstruation: Regular for three months followed by amenorrhœa for four months.

Condition on admission.

Physical state: Weight 8 st. 11 lb. Height 5 ft. 2 in. The tongue was furred and the breath tainted. She appeared to be toxæmic. Sordes were present on the lips. *Heart and lungs:* Healthy. *Abdomen:* Nothing abnormal noted. *Central nervous system:* Power good; sensation not impaired. Deep reflexes brisk and equal. Plantar responses flexor. Pupils dilated, equal and react to light and accommodation. *Thyroid:* No enlargement. *Urine:* Acid, 1028; no albumen; no sugar.

Mental condition.—On admission she was acutely excited, terrified and fought and struggled. She resented attention, and satisfactory physical examination was impracticable. She was tube-fed with milk, sedative and aperient. During the first few days she spoke a few words only; she presented a vacant stare and smiled only occasionally. Her habits were defective, and she exhibited erotic behaviour in the presence of men.

One week later the patient was unable to recognize the nature of her surroundings, nor did she appear to comprehend what was said to her. Questions evoked no reply. At times she appeared terrified by alarming hallucinations.

Progress.

Confusion and inability to answer questions persisted. The patient continued to be restless and to need every nursing attention. One month later boils developed on cheek and leg. Within a further month signs of progress were noted. The patient was more settled and began to take interest in her surroundings, though she was still shy and had little to say for herself.

A relapse occurred on July 12, three months after admission, the patient being restless and destructive. A dental abscess was treated later in the month, and the patient again settled down, but later she began to exhibit mannerisms and to grimace, and senseless laughter burst from her accompanied by gesticulation.

However, six months after admission definite signs of improvement were recorded. The patient attended the " art class " and was tidy and attentive to her needs. By this time it emerged that her knowledge of English, though limited, permitted her to express herself sufficiently well.

Her improvement was rapidly consolidated. She had very little memory for the acute phase of her illness, and perhaps for this reason she did not fully appreciate the gravity of her position. Nevertheless, she had sufficient understanding to express the hope that she would not break down again.

She was discharged recovered on November 25, 1932.

CASE 7.—A. W—, single, aged 26 ; German ; Roman Catholic ; domestic servant. Arrived in England November 9, 1931. Broke down six weeks later. Admitted in a *confusional state*. Date of admission: December 31, 1931. Date of discharge: March 22, 1932, relieved. Returned to Germany, c/o brother, under Section 77 of the Lunacy Act. Duration of hospital stay, three months.

History.

Source of information.—Brother living in Baden.

Past history.—Patient was reported to have been born " four months before time ". She was quick to learn at school and reached the eighth standard, being one of the best pupils.

In Germany she worked in an office as a shorthand-typist. She was always a willing worker, a little excitable when teased, but very sensible and kind. The brother suggested " home-sickness " as a cause of breakdown.

Family history.—The father broke down mentally eighteen months ago.

Present condition.—The certificate stated that the patient broke down one week before admission. At the St. Marylebone Institution she was reported to be in a state of religious ecstasy, singing hymns and calling upon God.

Condition on admission.

Physical condition.—The patient weighed 8 st. 8 lb., but appeared toxic, with coated tongue and was constipated. *Heart, lungs and abdomen :* Appeared healthy. *Central nervous system :* No abnormal sign was detected. Knee-jerks were present and equal. Both plantar responses were flexor. Pupils were medium, equal and reacted to light and accommodation. *Thyroid :* No abnormality was noted.

Mental condition.—The patient was excited, noisy and restless on admission. She destroyed her clothing and her habits were faulty. There was difficulty in feeding. Her conversation was an incoherent mixture of German and English. She complained of being hypnotized.

Progress.

The patient did not menstruate for two months after admission. The first period was noted on February 19, 1932, and lasted four days.

She made rapid progress, and within a fortnight became quiet, more settled and clean in her personal habits.

Within another week she began to appreciate her circumstances and commenced to write letters. Vague ideas about " spiritism " were expressed by her.

Her letters became more and more numerous ; she was trying to arrange to go to some friends rather than back to her employers, who appear to have expected a great deal of hard work from her.

She had progressed so far as to have emerged from her initial state of confusion, but she was continually thereafter inclined to be overactive, and towards the end of her stay even impulsive and disturbing to others.

March 22, 1932 : She became well enough to go home in the care of her brother under Section 77 of the Lunacy Act. She was considered as " relieved " on departure.

AFFECTIVE AND INVOLUTIONAL DISORDERS.

CASE 8.—O. B—, single, aged 35 ; Austrian ; Roman Catholic ; cook. Arrived in England August, 1935. *Manic-depressive insanity.* Date of admission: December 22, 1936. Still under treatment (December, 1937).

History.

Source of information.—Social worker's report.

Description of patient.—She is an Austrian who came to England fourteen months ago to work as a cook-general. Her employers state that she had a ten years' reference from a previous employer, and that during the fourteen months she had given them every satisfaction. They talk of occasional "outbursts of excitement". This they attributed to her lack of understanding of some English things and ways.

Patient had been very depressed for a few days at her place of work ; she had constantly burst into tears. She could not say what was the cause of her depression. It is understood from patient that she had been in a nerve clinic in Austria before she came to England, and that her reference belonged to a time previous to treatment in this nerve clinic ; her employers were much annoyed by this and have sent by air mail to Vienna for full particulars.

Information from patient.—Patient has since stated that she made two previous attempts at suicide ; first in 1934 (?), and was one week under observation at the Sophienspital in Vienna. She then went to a home which her sister had ; but (?) four months later, June to July, 1934, she again attempted suicide, this time by cutting her wrist ; she was then under treatment in a nerve hospital (Steinhof, Nervenheilanstalt) for ten months. She came out of this hospital in April, 1935 ; returned to her sister's house, and in September, 1935, she came to England. She has liked her work in England and has not changed her job. Patient does not disclose the reason for two suicidal attempts, or the cause of her present depression.

Family history.—Parents : Father and mother are dead ; mother in 1918 from tuberculosis ; father in 1924 (?) same cause. Mother 54 at time of death. *Siblings :* One sister, Emma, aged 34, unmarried, (?) has a child. Also in domestic service as a cook. Patient says she had "other brothers and sisters", but does not know or will not say what happened to them.

She says that menstruation has always been regular, and did not cease during the period of her treatment in the nerve hospital.

She does not wish to return to Austria ; has had her first year's permit extended for a further period of two years, and wishes to work in England when she feels better.

Reason for admission to Friern Hospital.—Medical certificate dated December 18, 1936: "She is extremely depressed and tearful. She imagines she hears voices discussing her previous mental treatment in Vienna. She says she is tired of life and will commit suicide."

Condition on admission.

Physical state : She weighed 7st. 12 lb. *Heart and lungs :* These appeared healthy. *Abdomen :* No sign of abnormality was detected. *Central nervous system :* No loss of power. *Reflexes*—knee- and ankle-jerks were exaggerated. The plantar reflexes were flexor. *Pupils*—regular and equal and reacted to light and accommodation. *Thyroid :* No abnormality was detected. *Urine :* Acid, 1016 ; no albumen ; no sugar.

Mental condition on admission.—She understands and speaks English moderately well. She states that she has always suffered from periods of depression and of excitement. She admits having been under treatment for nerves in Austria. She admits suicidal attempts, but will not discuss them or give any reason why she made them. She admits hearing voices speaking to her, but beyond saying that

it is the devil she will give no information. She is quiet and reserved, seldom speaks to her fellows and takes little interest in her surroundings. She is less depressed than when she was admitted.

Progress.

January 27, 1937: Much better; able to give a good account of herself. Working in the laundry.

March 25: Still without insight into her acute phase. Obviously requires sheltered conditions. Well behaved and works well.

May 20: She discusses with a considerable amount of reserve the question of her possible return to her own country. As to how she might behave on a journey is still very uncertain.

June 28: Not so well, but just manages to maintain self-control. States she would like to return to Austria, but denies that recent phases of depression ever occurred.

September 3: Miserable yesterday and to-day, probably because she was unable to return with another patient to her own country. Mute when seen to-day.

November 19: She is moody, prone to frequent phases of severe depression and less acute periods of excitement. She has no real insight, and continues to require control and supervision.

March 14, 1938: In a better phase at present.

March 28: Refused all food yesterday and to-day. Tube-fed. Resistive and negativistic. Will not speak.

CASE 9.—E. S—, single, aged 51; German; Protestant; cook. Arrived in England March 2, 1933. Broke down 3½ years later. *Involutional melancholia.* Date of admission: September 9, 1936. Date of discharge: September 24, 1937, recovered and discharged for deportation. Duration of hospital stay, twelve months.

History.

Source of information.—Social worker's report. (Patient is the fourth case of mental breakdown among people brought to England through the X—— Employment Agency that worker has dealt with during the last few weeks.)

Reason for admission.—Attempted suicide by hanging. Patient is a German woman who belongs to a good family; but owing to inflation the fortunes of the family were ruined and patient and her sister were forced to earn their living; they had lived in their younger days on a big farm. Patient came to England about three years ago. She was a very good cook, but she never kept her jobs very long; friends think that she spoke so little English that there was always a language difficulty to be got over; and also that she "did not see very well and perhaps made mistakes".

She was afraid that her permit in England would not be indefinitely extended and had nowhere she felt she could go; so she was much worried over this; she had not been registering properly as an alien in the places where she had been working, and there was some trouble with the police over this.

She was unemployed at the moment and therefore depressed, but was told that she would be helped. She gave no warning of the suicidal attempt. She was discovered because someone had tried the door of the lavatory and found it locked for a long period, became suspicious and sent for help. The door was then broken in. The people who found her were not at home when worker visited, but a note on the case-paper says she was found hanging "by a bandage round her neck in the lavatory at her lodgings and was able to walk a little when cut down". (Worker was told the agency was no longer officially recognized by the German Government.)

Reason for admission to Friern Hospital.—Medical certificate dated September 10, 1936: "She is extremely depressed and introverted, taking no interest in her

surroundings, and only replying to questions in monosyllables and then infrequently. She has recently attempted to end her life by cutting her wrist and by hanging, and is still considered to be actively suicidal."

Condition on admission.

Physical state: Physique obese. She weighed 12 st. 11½ lb., and was 5 ft. 3½ in. in height. *Heart and lungs:* Healthy except for some fatty changes. *Abdomen:* No signs of abnormality. *Central nervous system:* Gait natural. Speech, mute. *Reflexes*—knee- and ankle-jerks present. Plantar responses flexor. *Pupils*—equal and react to light and accommodation. *Thyroid:* No abnormality. *Urine:* Acid, 1030; no albumen; no sugar.

Mental condition on admission.—She is conscious. She is extremely retarded and takes an unconscionably long time to answer questions. Vaguely orientated in time. She is preoccupied, profoundly depressed and full of inexplicable fears. She feels there is nothing to live for and admits a suicidal attempt by hanging. She lacks spontaneity in speech and action and lies with her head buried beneath bed-clothes. Clean, but needs nursing attention.

Progress.

October 2: Restless. Gets out of bed.

November 4: She has been very much better recently, getting up and going into the gardens. Now happy and sociable. Eats well. Works in the ward. She gives no cause for anxiety.

December 21: Complained of a sore throat yesterday. Throat clean this morning. Says that she feels quite all right. No rise of pulse or temperature.

January 1, 1937: She has been unsettled recently, having been worried by another patient who has become excited and restless.

February 3, 1937: Hallucinated. Pulled down the wireless leads because she said the radio was talking about her.

March 16: Better, but still hallucinated and irresponsible. Cannot give any account of herself on account of the language difficulty. Over-active.

April 30: Vivid auditory hallucinations.

May 22: She attacked another patient and scratched her face in a fit of pique because this patient failed to bring her an envelope.

June 7: Her behaviour has been good, but she still requires close observation and control owing to temperamental outbursts. Her general attitude is paranoid; she has no insight and required tactful handling.

August 27: She is now emerging from a phase in the course of which she was excited, noisy and violent towards other patients. She considered that the wireless was speaking to her personally.

September 14: At her best just now and says she is very anxious to return to her own country.

September 24: Discharged recovered under Section 77 (1) of the Lunacy Act. Deported September 28, 1937.

Reactive Depression.

Case 10.—A. R—, single, aged 29; Pole; Protestant; domestic servant. Arrived in England December, 1935. Diagnosis: *Reactive depression.* Date of admission: December 8, 1936. Still under treatment (December, 1937).

History.

No history obtained.

Reason for admission to Friern Hospital.—Medical certificate dated December 4, 1936: "This patient appears to be depressed; she lies in bed on her back with eyes shut and will make no attempt to answer questions. She resists when an attempt is made to move her arms."

Condition on admission.

Physical state: Her general physique was good, but she was sallow complexioned, and her throat was red and injected; slight cervical adenitis. She weighed 9 st. 3½ lb., and was 5 ft. 2 in. in height. *Heart and lungs:* No abnormality detected. *Abdomen:* No sign of abnormality was discovered. *Central nervous system:* No loss of power. No disturbance of sensation. *Reflexes*—the knee- and ankle-jerks were brisk and equal. The plantar responses were flexor. *Pupils*—the pupils were equal and reacted to light and accommodation. *Thyroid:* No abnormality was detected. *Urine:* Acid, 1012; no albumen; no sugar.

Mental condition on admission.—She is disorientated and confused. She seems to have come to England about a year ago, to have worked here as a domestic servant, and about two weeks prior to certification to have suddenly become unable to work. She is frightened and apprehensive; she frequently says that she wants to die; she seems to think that everything is hopeless. She is able to give a very limited account of herself. She weeps readily. At first difficult with food she is now better from this point of view, but she still has to be hand-fed at times. She gazes about the ward in a vacant manner. Habits are clean.

Progress.

December 12, 1936: Temperature 101·2°, pulse 120, respirations 22. Throat red and injected. No rash; no vomiting.

December 15: Throat not much less injected. Slight cervical adenitis. Nil in chest, heart, abdomen. Tongue moist, slightly furred.

December 15: She is profoundly depressed, shows little interest in her surroundings, and can with difficulty be induced to converse. Though since admission she has repeatedly expressed a desire to die, to-day she only whispers a few disjointed words. It is difficult to induce her to take food. Well nourished and in fair health apart from mild pharyngitis.

February 11, 1937: Does some work in the ward. Eats and sleeps well. Still solitary in her habits.

April 8: She does not really want to return to Poland, but says when asked, "It is all the same to me". Language difficulties make obstacles for her here, but she does mix with her German-speaking fellows.

August 4: She lacks confidence in herself. Her knowledge of English is poor but she speaks German quite well. She does not know whether she wishes to stay or go. She is mildly depressed, but appears better than on admission. Occupied and clean.

December 6: She remains quiet and well behaved. She is solitary, and says little to the other German and Austrian women. During the present interview she refused to give an account of herself.

Series B.

Schizophrenic and Paraphrenic Cases.

Case 11.—I. S—, single, aged 35; native of Free State of Danzig; Roman Catholic; parlour-maid. Arrived in England April 22, 1937. Diagnosis: *Schizophrenia.* Date of admission: June 10, 1937. Still a patient (December, 1937).

History.

Source of information.—sister (inquiry form): "My sister wished to go to England to learn the English language. She would change her profession and become an English correspondent in Danzig. After a sojourn of one or two years in England, she was not long able to be a teacher at a primary school. I have

observed that she is quite well if no difficult work was asked of her and she was in our own family or with relations. But in England the foreign country, the new language, strange circumstances etc., must have puzzled her. When she got her fits of illness in 1931 at home she had a very difficult post at a primary school with a great many lessons and many children in one form. In the long leave from school between the two fits of 1931 and 1935, she seemed to be quite healthy. In 1935 she had to go to a teacher's camp for some days, which was the cause of the second fit. It lasted three weeks. After some weeks of leave she went to school again but her profession was too hard for her and therefore she helped in the household of our relatives. From there she went to England."

Reason for admission to Friern Hospital.—Medical certificate dated June 8, 1937: " She is in seclusion—is excited, confused and deluded—at intervals bursts into loud laughter and when asked why she does it replies, ' I hear voices telling me to laugh '—is quite lost to her surroundings ".

Condition on admission.

Physical state: Her physique was fair. Height 5 ft. 3¾ in., weight 8 st. 13½ lb. *Heart and lungs:* Appeared healthy. *Abdomen:* No abnormality detected. *Central nervous system:* No loss of power. No disturbance of sensation. *Reflexes*—knee- and ankle-jerks present and equal. Plantar responses flexor. *Pupils*—equal and reacted to light and accommodation. *Thyroid:* No abnormality detected. *Urine:* Acid, 1014; albumen, trace; no sugar.

Mental condition.—She is in an excited, restless state. Bursts of laughter are frequent, she gazes around herself as though hallucinated. She talks much nonsense in German. She is able to express herself quite well in English, but is inattentive to what is said to her. She seems to be resentful at coming here. She says she will not pay a penny.

Progress.

June 24: She is full of trivial complaints and chatters querulously about trivialities, claiming that she has not been allowed to have handkerchiefs, that she cannot have a belt, that she is not allowed to work, to run about barefooted, etc. All these complaints have no foundation in fact as regards articles of clothing. As regards work she declares she is tired the moment she is started on any.

June 25: Was in hospital in Danzig she says, but escaped because she feared " Hitler's operation " (sterilization). She still fears to go back there owing to the risk of having to undergo this operation.

September 3: She claims that the charge nurse came in this morning and tried to have " ovaric " with her. Actually the nurse was examining her sheets as she had been faulty. These homosexual fantasies are probably the basis of her impulsive hostile conduct.

October 5: She remains devoid of insight and complains bitterly about the dirty habits of the other patients. During conversation she grimaces to herself. She is in need of nursing supervision.

November 10: She is much concerned with religion, the welfare of the soul and the anti-semitic problem. She cannot be persuaded to work in the Art class. She is a solitary woman who is much worried about abstract problems.

December 13: She is still in a paranoid state, particularly grieved about the medical and nursing staffs of this hospital. Though there is probably some foundation for certain of her grievances she greatly exaggerates these, and readily displays unnecessary heat in conversation, thus making it very difficult to reason with her. She seems very anxious to return first to Germany and then to Danzig.

January 11, 1938: She is very talkative at present and at slight provocation indulges in rhetoric. Her sister arrived here on the 31st ultimo to take her home; patient went into an acute schizoid phase when faced with the prospect of returning

to Danzig to undergo sterilization. Reasoning was of no avail and at first she refused to see her sister again, but did so on the 4th instant. She is now, she says, prepared to go with her sister. She dreads sterilization.

CASE 12.—F. R—, single, aged 26; Austrian; Roman Catholic; domestic servant. Arrived in England October 15, 1935. Diagnosis: *Schizophrenia*. Date of admission: April 24, 1937. Date of discharge: October 23, 1937, by operation of law, her six months' treatment as a temporary patient having terminated. Sent under escort to St. Pancras Hospital. Readmitted as a certified patient October 26, 1937. Still under treatment (December, 1937).

History.

Source of information.—Social worker's report.

Description of patient.—Date of breakdown—a few days before her admission to hospital. Said to be sudden. Her sister saw her the previous week and thought her quite normal, though a little nervous and tired from overwork. The sister is of the opinion that she did not thoroughly break down until she found herself in hospital. Not home-sick. Her twin sister was with her in England and they spent their free time very happily together. Chief cause of breakdown thought to be that her work was too hard and uninteresting, and that her mistress, who herself suffered from nerves, was a very exhausting person to be with. Her mistress gave her notice, and she was to leave in a month. Suddenly, a few days later, the ambulance was sent for and patient whisked into hospital without her sister's knowledge.

Education.—Patient and her sister were at school until they were 18. They are refined in manner and have quite intellectual tastes. They learnt music, needlework, and the care of children during the later years of school life. The school was a convent. Parents both living and in fair health. No history of mental trouble in the family. Mother is not very strong now, and is inclined to worry about patient. Patient is one of four sisters. There are no brothers. The two elder sisters are married. They found on coming to England that the only work open to them was domestic service, and they have found this dull and hard work. They were also disappointed to find that they could not save much, owing to the higher cost of living.

Reasons of admission to Friern Hospital.—Application by sister for *temporary* treatment. Dr. C— states: "She lies in bed curled up, whispering to herself and refusing to speak or to give her attention to those questioning her. She is obviously acutely hallucinated. At times she becomes frenzied and is difficult to control. She strips herself naked from time to time."

Condition on admission.

Physical state: On admission spare and in poor health, with sordes and other evidence of a toxic state. *Heart and lungs:* Appeared healthy except for some shallow vesicular breathing. *Abdomen:* Nil abnormal detected. *Central nervous system* (patient appears to be under sedative): *Reflexes*—knee- and ankle-jerks present and equal. *Pupils*—equal, reacted to light and accommodation. *Urine:* Acid, 1026; no albumen; sugar present.

Mental condition.—She is confused and disorientated, apprehensive and worried. She picks at her fingers and looks about her in an agitated manner. She has been resistive to attention and is difficult with her food. It is very difficult to re-assure her. She has been faulty in her habits.

Progress.

Menstruation: Regular first two months after admission, amenorrhœa six months since.

April 27: She does not realize her condition and is unable to give any clear statements. From her few utterances and conduct she appears to be continuously in a state of apprehension. All nursing attention is resisted. She refuses food and

has required to be fed by tube. She is quite incapable of attending to any of her personal needs. Sparely nourished and in poor health with sordes and other evidence of a toxic state.

May 2: She is emerging from her confused state, but is still very uncertain of herself. Even with the aid of an interpreter her answers are confused and irrelevant.

June 6: Morose and mute. At times she wakes up to threaten her fellows.

July 26: When visited by her sister on July 14 much difficulty was found in getting her to leave the ward to be visited.

August 8: Patient was very unsettled and threw her tea down the ward.

September 20: She is quite inaccessible in conversation. When seen by the Commissioners last week she mentioned that she would go to Parliament. To-day she just grins foolishly and expresses no preference as regards staying here or leaving. She cannot be regarded as being volitional just now.

October 23: Discharged by operation of law, her six months' treatment as a temporary patient having terminated and not being extended. Sent by ambulance under nursing escort to St. Pancras Hospital.

October 26: *Readmitted as a certified patient.*

November 2: At present in a catatonic state, completely preoccupied with phantasies. She cannot be induced to speak and shows no concern about her condition. Periods of partial stupor alternate with periods of restless and mischievous conduct. She is very dirty in her ways and resists necessary attention. Sparely nourished and in fair health.

November 20: She impulsively put her fist through a pane of glass in the dormitory this morning. There is a wound of the left wrist about 1 in. long. To remain in bed.

November 24: She is very confused, and if she speaks at all, her remarks are quite at random. She smiles fatuously when questioned and obviously fails to realize her position.

CASE 13.—H. M—, aged 37, single; German; Church of England; student. Arrived in England November, 1935. Diagnosis: *Paraphrenia*. Date of admission: June 18th, 1937. Still in hospital (December, 1937).

History.

Source of information.—By social worker.

Patient has lived in England for fifteen months. She left Germany of her own accord as she felt there was no opening for women. The professor she was studying under was expelled as a Jew and she was very upset at this. She was studying philosophy, comparative religion, etc. She came to England with letters to influential people. On account of these recommendations she obtained grants from the York Trust and the British Federation of University Women for maintenance and tuition while she studied for a Ph.D. She arrived in England with only two pounds and stayed at a Y.W.C.A. hostel, where she was kept free for several months. She has stayed at this house all her time in England and became very attached to the warden. After eight months she was able to start work and was coached at Bedford College. The patient found that she had to take all the English examinations, and that her German qualifications were of no use in helping her to get exemption from the lower examinations. She worked extremely hard, allowed herself no free time for exercise or relaxation and failed in her preliminary exam. While staying at the hostel she made many violent friendships and seemed to demand a great deal of attention; she was easily hurt, quick to take offence. Her paranoid tendencies and delusions developed very quickly before her admission to hospital. She announced that people were trying to poison her friends, and said that it would be better that it should be done by someone who loved them rather than by one who hated them. She threatened to commit suicide.

The patient is an orphan; her mother died in 1916, her father in 1918; she is an

only child and has no relatives in Germany. Her permit to stay in England lasts till January, 1938, when it will be renewable, but the conditions are that she shall not take any form of employment, paid or unpaid.

Reason for admission to Friern Hospital.—Medical certificate dated June 15, 1937: "She is pale, restless and apprehensive—eyes downcast—at first talks quickly and disjointedly, and then suddenly drops her voice almost to a whisper and stares vacantly."

Condition on admission.

Physical state: Her general physique was good. She weighed 7 st. 11½ lb., and was 5 ft. 2½ in. in height. *Heart and lungs:* Appeared healthy. *Abdomen:* No sign of abnormality. *Central nervous system:* No loss of power. No disturbance of sensation. *Reflexes*—knee- and ankle-jerks present. *Pupils*—equal and react to light and accommodation. *Thyroid:* No abnormality. *Urine:* Acid, 1010; no albumen; no sugar.

Mental condition.—She gives a limited account of herself and is evasive. She denies she made statements attributed to her in the social worker's report, but admits that she frequently expressed the desire to die. She states that she had a hard time and overworked in her efforts to pass examinations in her philosophical studies. It appears probable that economic stress and overwork with subsequent failure in examinations are responsible for her condition.

Progress.

July 11: Restless; appears frightened; is hallucinated. Needs hand-feeding.

August 18: Patient will not reply to questions and gazes at the floor.

October 18: She remains agitated. Her behaviour is unreliable.

November 17: She is still disorientated and confused and refuses to answer most questions, saying she is afraid of the consequences. She is manneristic and hallucinated. Does a little ward work.

December 14: She is a great deal better and is again thinking of resuming her studies, but states that it is immaterial whether she does so in England or elsewhere.

Confusional Cases.

Case 14.—W. G—, single, aged 21; Austrian; Roman Catholic; cook. Arrived in England, June, 1937. Diagnosis: *Confusional state.* Date of admission: September 7, 1937. Still under treatment (December, 1937).

History.

Source of information.—Social worker's report.

Description of patient.—Patient is a single woman, whose family live in Austria, and who has come to England as a domestic servant. Her family is not a very happy one.

Personal history.—Birth and infancy normal.

Education.—Secondary. Patient did normally well. She was at school till she was 16.

Work.—Helped at home until she went into domestic service. Patient's home is in the country. The family appear rather of the peasant type.

Health.—Has been very good up to the present. Menstruation regular.

Sex.—Patient has a man friend in Austria who wishes to marry her. She also had a brief love affair in Vienna with another young man.

England.—Patient came to England three months before her breakdown. She had found difficulty in getting work, and the family were hard up. She was very shy and quiet when she first arrived, but she was placed with very kind and friendly people. At first the lady found patient unsatisfactory, but after a few weeks she liked patient and would have kept her.

Family history.—Father : Deserted the family recently with a woman. Patient was fond of him. *Mother :* She is said to be a very good woman, much respected in her neighbourhood. *Siblings :* Patient appears to be the second in a large family. Sister, the eldest, is a curious unstable girl, who has also been abroad in domestic service. Younger children all said to be normal. There is said to be no history of mental illness in the family.

History.—From employer : Her father was involved in political affairs and lost his property, which led to the children having to earn their own living.

Patient has been employed in England for three months. Three weeks ago said she had had a letter saying her grandfather was dying ; this statement was untrue, but she had had news of her sister being in difficulties. Complained of headaches for three days. Last Monday week went to bed, said she felt ill, "fainted" (?) and afterwards declared her employer's husband was very ill, which was not the case. Hallucinations of sister's voice.

Reason for admission to Friern Hospital.—Medical certificate dated September 3, 1937 : " Her verbal output consists of illogical and unintelligible German ; she refuses to speak English. She is disorientated in space and time. She is violent and resistive to nursing attention ".

Condition on admission.

Physical state : General physique fair. Height and weight not taken. *Heart and lungs :* Appeared healthy. *Abdomen :* No abnormality detected. *Central nervous system :* Patient resistive to examination. *Reflexes*—knee- and ankle-jerks not obtained. *Pupils*—equal and reacted to light and accommodation. *Thyroid :* No abnormality detected. *Urine :* Acid, 1020 ; no albumen ; no sugar.

Mental condition.—She is acutely confused and grossly disorientated. She is violently resistive to attention, and destructive to clothing. Her habits are very faulty, she refuses her food ; she is resistive to all nursing supervision. She strips herself, stands up and shouts in German and in broken English. She makes few coherent statements. Her pupils are widely dilated, and at times she appears to be in a state of terror. No information regarding her illness can be obtained from her even with the aid of an interpreter.

Progress.

October 8 : Is now taking her food well and on the whole has improved, although still resistive to necessary attention. She scratched a nurse's wrist last night when an enema was being administered.

November 11 : Quiet but very inaccessible. Eats well but needs a good deal of supervision. She is impulsive in response to hallucinations.

December 18 : She tries to give a limited account of herself. She says she had a baby in August and that her sister is looking after him. This is quite at variance with history given, but an abortion may have occurred.

Affective Disorders.

Case 15.—F. A—, single, aged 36 ; Austrian ; Roman Catholic ; cook-general. Arrived in England May 16, 1934. Broke down three years later. Diagnosis : *Melancholia.* Date of admission : March 10, 1937. Date of discharge : September 10, 1937, recovered. Duration of hospital stay, six months.

History.

Very poor, except that it is known that the father committed suicide.

Reason for admission.—Medical certificate dated March 6, 1937, stated : " This girl is deluded and depressed. She admits that a voice tells her sometimes

to kill herself, and she would have thrown herself under a train a few nights ago but she had not the courage. Voices are always telling her to do things."

Condition on admission.

Physical state: Her general physique was moderate. She weighed 7 st. 11 lb. (9 st. 8 lb. on discharge) and her height was 5 ft. 3¼ in. *Heart and lungs:* No abnormality. *Abdomen:* No abnormality detected. *Central nervous system:* Loss of power diminished in arms. Sensation not tested. *Reflexes*—knee- and ankle-jerks present. Plantars no response. *Pupils*—equal and react to light and accommodation. *Thyroid:* Enlargements of right lobe and isthmus. *Urine:* Acid, 1030; no albumen; no sugar.

Mental condition.—On admission she was fully conscious, but her confusion, agitation and depression together with her faulty English make her difficult to understand. She appears to be an Austrian who has been employed as a domestic for the past three years. She states she was happy in her employment, but that recently she became anxious as result of not getting news of her mother in Austria. A further stress resulting from changing her "sir friends". An acute phase then supervened; she wandered about and was urged by hallucinatory voices to kill herself, but resisted their promptings. These events led to her certification. She is now less depressed, but is anxious not to be detained here indefinitely. She would like to return to her mother in Austria, and realizes her chances of further employment here are poor.

Progress.

March 24: She is still emotional rather than depressed and has no desire to kill herself. She seems to have resisted this impulse in the past when it was possible for her to yield to it, and it now seems to be to her benefit to withdraw the restrictions entailed in suicidal caution.

April 9: Better than she was. Not so depressed; working in the ward. No evidence now of hallucinations.

June 10: Very much better. Her emotional control is now good. She has a considerable amount of insight. An excellent worker and very pleasant and happy in the ward.

September 10: Discharged recovered. To return to Austria in the care of public assistance officer.

Reactive Depression.

Case 16.—L. S—, single, aged 26; German; Church of England; companion. Arrived in England in 1934. Diagnosis: *Reactive depression.* Date of admission: March 31, 1937. Date of discharge: October 8, 1937, recovered, to the care of sister to return to Germany. Duration of hospital stay, five months.

History.

Source of information.—Social worker's report.

Description of patient.—She is a German said to have undergone a full period of training (five years) in a German Red Cross Hospital, and to have come to England three years ago to learn the language and also to study differences in diet. She went to work in a domestic capacity at Beckenham. The employer, a Mr. G—, moved to Cheshire, but some time in the summer of 1936 the patient left his employment and came to London again. The reason given by a friend is that she was asked to appear more completely in a domestic capacity in Cheshire. She appears to have had one or two places when she returned to London, and is said to have gone to Germany for a holiday in the autumn of 1936; she returned t

study diets professionally. Patient read of a vegetarian guest house which gave tuition and applied to be taken as a pupil, but there was no vacancy. The head of the guest house offered patient work in a domestic capacity, as companion to one of her guests.

Recent conduct.—At first patient was very happy and extremely satisfactory, though she was reluctant to go out of the house in her free time, and seemed to have no friends in London.

In January, 1937, patient began to have moody turns, one coinciding with menstruation. She had a " sulky fit " in which she " glowered at everyone ". She cried, saying that she did not know what was wrong. She " felt psychic " and thought " something must be wrong at home ". Patient then remained quite her normal self for about five weeks, when she had another attack of " moodiness " followed by a slight hysterical outburst. Employer felt that the depression must be associated with sex, as patient had told her in a serious conversation that she " never meant to marry, never wanted any children, nor to go out with any men " ; employer felt that this was abnormal in one of her age.

On Wednesday before Good Friday, 1937, patient suddenly at lunch-time burst out crying and then went perfectly rigid ; " unable to move ". She was carried to bed and then laughed and screamed alternately for about two hours. She seemed after this quite natural again, and was most distressed by the attack, again begging her employer to tell her what was wrong with her. Thursday she came down to breakfast with the " same sulky look back again " ; as the head of the house was leaving for the Easter holiday, she " thought patient was playing up a bit because I was going away " ; the employer then left. On Good Friday morning patient walked round the house naked except for her dressing-gown, and was found lying on her bed entirely unclothed. Persuaded to dress, she did so and the doctor came and talked with her, but later she stripped again. Became extremely difficult and noisy and she was accordingly admitted to hospital in the absence of her employer.

Reason for admission to Friern Hospital.—Medical certificate dated March 29, 1937 : " She is in a manic state, extremely restless and impulsive. She exposes herself and is faulty in her habits. At times she becomes frenzied, apparently as the result of auditory hallucinations. At such times she attacks those attending on her ".

Condition on admission.

Physical state : Her general physique was good, but she was toxic on admission. Too resistive for examination. *Urine :* Acid, 1030 ; no albumen ; no sugar.

Mental condition on admission.—She presents a picture of misery and retardation to-day, but this seems to be a pose. With considerable retardation and following close questioning, she confirmed the history given in the social worker's report, but added that she was in love with " Jim ", a scullery worker at her place of employment, and wanted a baby by him. She does not appear to have received any encouragement from him, but made the most of his chance remarks. She seems to have interpreted his behaviour as a tacit admission of his regard for her. On admission she was resistive, negativistic and hostile. She now asserts she wants to get well, but is adamant on the point that a baby is necessary to her happiness. She is now quieter, but remains in need of every nursing attention.

Progress.

April 16 : She is now quite lucid, and discusses with " la belle indifference " her feelings during her acute phases, explains nonchalantly that her feelings were natural, and that she had been very repressed, and that she now felt her affection for " Jim " was entirely one-sided.

May 4 : Pulling at her hair. Noisy, restless. Faulty. In bed.

May 7 : This morning she tried to get out of the lower opening of the side-room

window. She got her pelvis out but could not get her chest out. Noticed by Nurse F—. The top stops of the window were removed, the window opened and the patient drawn back. Bruises both arms; superficial abrasions below breasts, on back in lumbar region; swelling over lumbar spine.

May 16: Restless, hallucinated. Mistakes identities.

June 25: She says, "I have no secrets but it can't be told". She asserts that she is anxious to return, where she promises to work hard. A few days ago her attitude towards return was quite different.

September 2: She has been looking much better for some time and is looking forward to repatriation.

September 19: She had a slight emotional outburst yesterday following receipt of a letter from her sister hinting that a Frankfort Assurance Society had been approached to defray her travelling expenses. To-day she seemed quite stable again.

October 10: She was this day discharged by the sub-committee as recovered.

Twilight State.

Case 17.—S. M—, single, aged 17; Austrian; Hebrew. Date of arrival in England: January 31, 1937. Diagnosis: *Twilight state*. Date of admission: February 12, 1937. Date of discharge, August, 1937—relieved. Duration of hospital stay, six months.

History.

Source of information.—Employer.

Parents.—Both living. They used to be well-to-do retail merchants in Budapest. They lost all their money and went to Vienna, where they make a living as best they can. The father sells papers, though well educated.

There are several brothers, two younger than patient. It is not known whether patient was a twin.

Education.—Well educated; attended high school in Vienna, where she did well. Later became a children's governess in Hungary.

Onset of illness.—"During the journey from Vienna patient spoke repeatedly of the freshness and oppressiveness of the air; the light air in the plains; invigorating air of mountains. Could not stay because of the heat of her room, but did not open the window. On Friday, February 5, 1937, during the course of the afternoon walk, we passed the front of the house where we lived; I pointed this out. She refused to believe it and seemed very suspicious. Two hours later she appeared and declared that she was no actress and was leaving this place immediately. She tried to run away with all her luggage, knowing no English and not having been in London 2½ hours. Later she could give no reason for the outburst; said she was not home-sick and wished to remain here. She then levelled various horrid accusations against her parents, some of which we knew to be quite untrue and without foundation. She cried and complained of the oppressive air and pressure in the head. In the evening she said she knew she was her father's dead brother.

"Complained of oppressive air and pain in the head. Odd behaviour, suspicious and refused to eat food. During onset her limb control was quite accurate. She walked clumsily and was rather bent. Seemed to have difficulty in breathing when walking up hill. On Saturday the 6th she paced through the flat and wandered about all night. On Sunday morning she claimed our Welsh maid as school friend. She was very distressed, and later rolled on the ground weeping and praying. She shuddered occasionally. She appeared to have a small amount of pain in the abdomen. This phase passed and she became quite calm. She was then taken to Marylebone Institution. She stated that my husband was her father's brother who died in Budapest. She put cold cream on the faces in an illustrated magazine, recognizing them as friends. She recognized every face in picture papers, or in

photographs, as that of a friend or relation. She hinted that her mother's paying guests paid attention to her; that her father had sent her to England ' for reasons ' ; that her father took drugs because he is an active man though elderly ; that he disowned her and that he was ' too good ' to her. Later at the institute when she was calm the first thing she asked for was wool and needles to knit him socks. When calm she thinks very highly of her parents.

"On Sunday morning her behaviour was such that I felt she needed skilled attention and I could not possibly nurse her in my small flat. The maid was upset, frightened and in tears ; the baby screamed every time he saw her, which made her worse. I rang up Dr. B— and he communicated with the relieving officer.

"She seemed prepared for an attack, as we discovered she had had powders to take on the journey ' to kill pain '."

No insane heredity.

Reason for admission to Friern Hospital.—The medical certificate stated : " Patient was in seclusion and looked up to ceiling in praying attitude. Patient was asked, ' Do you want to go home to your father ? ' She replied, ' I want to go to God '. Patient stated that her name was not S—, which is not true. Patient when asked where she was said that she was in Palestine, which is not the case."

Condition on admission.

Physical state : Her general physique was good. She weighed 7 st. 8 lb. on admission but 8 st. 9 lb. on discharge. Height 5 ft. 1½ in.—medium. *Heart and lungs :* No abnormality. *Abdomen :* No abnormality detected. *Central nervous system :* No loss of power. No disturbance of sensation. *Reflexes*—knee- and ankle-jerks present. Plantar responses flexor. *Pupils*—equal, react to light and accommodation. *Thyroid :* No abnormality detected. *Urine :* Acid, 1020 ; no albumen ; no sugar.

Mental condition.—Her present attack commenced with an acute confusional state two days after reaching England on January 31, 1937. She says she was very happy with her new employers, but she thinks that the long journey upset her. No doubt adolescence and language difficulties played an important part. She is rapidly emerging from her acute state ; is now pleasant and appreciative, eating and sleeping well.

Progress.

February 17 : She appears to be emerging from an acute confusional state of which she has little recollection. Though unable to speak English she is able to tell, through an interpreter, that she vaguely recalls having been unable to control her actions, and admits having been restless, divested herself of her clothing, etc., for no known reason or motive. At the present time she is lucid and correct in conduct.

February 19 : She is emerging rapidly from her illness. Writes good letters, pleasant and co-operative.

March 15 : She attributes her breakdown to fatigue and the excitement of her long journey. She would not prefer to stay in England. She appears to be stabilizing well now.

April 13 : She is happy and contented. She may now be considered to have recovered. Mr. and Mrs. P— are anxious to have her discharged to their care, and they have agreed to send her back under proper care to her parents in Vienna.

June 1 : Rushed outside the laundry garden this morning. Stripped herself. Confused, restless, resistive. She seemed as if in a dream.

July 11 : Improving steadily. Starting to work again. Says she realized that she stripped herself, but says she does not know why.

August 12 : She maintains her improvement and is now attending the work-room. She has not much to say for herself and most of her replies are platitudes.

August 13 : She was discharged as relieved.

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