MENTAL HYGIENE AND CONSTITUTION IN SCHIZOPHRENIA.
AN INVESTIGATION OF FIFTY CASES.

by

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INTRODUCTION.

Most studies relative to the causation of mental disorder commence with unfailing regularity by honouring the past with at least some slight, and frequently scathing, reference to the historical aspect of the subject. I make no excuse for being prosaic in this matter, for doubtless like many others I find in this way a suitable mode of introduction.

At least I will attempt to be brief, and merely mention "demoniacal possession", passing from that line of thought to the even more fatalistic attitude of unwavering belief in "heredity" and "tainted stock".

With the advent of Mendelian theories, it was hoped that the solution of heredity was near to being solved, but alas, what was valid with simpler organisms was found to be greatly lacking in the intricacies of human transmission. Present day opinion is exceedingly chary of coming to any definite conclusion in the matter, and with regard to mental disorder the position is summed up quite adequately in the following passage, taken from Henderson's and Gillespie's Textbook of Psychiatry (I):

"The quantitative difference between the inherited total taint in the psychotic and the mentally normal is surprisingly low. There is, however, a considerably greater direct inheritance of actual mental disorder in the psychotic, while in the normal the indirect inheritance of all types (psychoses, organic nervous conditions etc.) was greater than in the psychotic."

These remarks indicate how indecisive the position remains, and how meagre is our knowledge of hereditary transmission. It may be that scientific progress will elucidate the complexity of a subtle transmission of "genes", and reveal the exact extent of how individual differences depend on the composition of the germplasm, in distinction to the part played by the individual's environment.

This paramount problem of why all men are not alike, and yet displaying common characteristics, requires further consideration. Woodworth (2) outlines how psychological statistical studies indicate quite conclusively that a clearly differentiated "type" theory is untenable, and that there
is a distinct "unimodal" distribution curve, although the extremes may bear little resemblance. It is, however, the extremes of human personality which provide, at least, a relative preponderance of material for psychiatric investigation, and if merely for convenience of description they may be divided empirically into types. The temperamental attribute of personality has long been subject to such a division, and reference to the sanguine, the choleric, the phlegmatic and the melancholic "humoral" types is found in many books relating to Psychology and Psychiatry.

Among the more modern and scientific attempts to group personalities and types of mental disorder, and lastly to correlate the prepsychotic personality with the type of disorder ensuing, is the work of Kraepelin; a notable milestone in the advance of Psychiatry, which leads to a general acceptance of the distinction between dementia praecox and manic-depressive types of "biogenetic" psychoses.

Meyer (3), and later Hoch, indicated the prepsychotic type of personality in Schizophrenia, and more recently Kretschmer (4) postulates a correlation between physical stature and mental constitution. Kretschmer's work may have far-reaching effects, and eventually lead to a scientific and rational link between Physiology and Psychology. At present, Kretschmer is not without critics, who accuse him of dogmatising on restricted evidence, of reverting to "type" theory, and if not the latter, by including in his "asthenic", and "athletico-somatic" scales of physique, which are associated with Schizoid personalities, all manner of men except a few round tub-like individuals, whom he terms "pyknic" and cyclothymic! In defence of his system, Kretschmer indicates in the preface of his book ("Physique and Character") that he is referring to certain "extremes" of associated human physique and mentality. His contribution to the problem of hereditary influence is that, by the studies of the ancestors and collaterals of his patients, he shows the tendency for the cyclothymic or schizoid personality to preponderate with occasional recurrence of that peculiarity beyond the bounds of what is considered "normal".

We must acquiesce to the fact that, at least, some of the types of mental disorder are reactions occurring in corresponding varieties of personality, and a study of the "Mental Hygiene" of these patients, and their lives in general, may help us in arriving at certain decisions. Perhaps the most important fact to be ascertained is whether the individual's personality is purely inborn and constitutional, or whether personality develops solely as the result of environmental influence, or, as might be expected, is the result of the sum total of these factors.
To such ends is this thesis devoted; not through any new and untried method of approach, not in the hopes of obtaining devastating results, but merely as a small contribution to our accumulating store of evidence, which must yet be amplified, in the cause of Psychiatric progress.
CLINICAL MATERIAL.

The clinical material for this thesis is provided by a series of fifty cases admitted to Ewell Mental Hospital during the last three or four years. These cases were not chosen on account of any special clinical interest, but are merely those among the Schizophrenic admissions during that period about which it was possible to obtain a fuller "life history", although even the best of these contain many regrettable omissions. These omissions, and the difficulty in general of obtaining the required information, emphasise the urgent need for some central authority equipped with psychologists, to record the personality and other facts of psychological import in the case of every child; to preserve these records until the occasion for their use might arise, such as ascertaining suitability for employment and, in the more unfortunate cases, for the convenience of the psychiatrist. As it is, there are only a few selected cases whose personalities have been scientifically studied from infancy onwards, and in such an investigation as this we can only hear a lay, and frequently biased, opinion, and are left, in many cases, with inferences and not facts. The material for this study was obtained through the usual avenue of interviews with the patient's relatives and friends, and with the aid of reports from that very valuable assistant - the Social Worker.

For convenience in tabulating results etc., I have made a rough division into "age groups", the first three years being considered as "Infancy"; from four years to a period corresponding to puberty, usually between twelve and fourteen years, as "Childhood"; and from there to the late "teens", the exact age depending on individual circumstances, as "Adolescence"; and the remaining period as "Adult" life. Environmental circumstances are bound to differ to a considerable extent in a qualitative fashion in these different periods of life, but at the same time certain influences, such as the parental attitude, may be present throughout, and therefore, as far as possible, the environmental factors considered in each group are the same as in the other groups with certain inevitable omissions and additions. In each case, a fixed scheme has been employed to tabulate the results of the enquiries; the scheme itself having no special characteristics, but is merely a personal variation of the type used in case records in many mental hospitals. At the end of each case thus dealt with, certain provisional conclusions, pertaining to the individual case, are noted for convenience in drawing up the collective result.
The question of heredity in relation to mental disorder has already been referred to, and in a study of environmental factors as possible causative, or at any rate precipitating agencies in the breakdown of mental health, the influence of abnormality in the family stock is only considered where it might have a direct effect, in other words where continual contact with an abnormal personality might well be regarded as having an adverse effect on the individual's mental equilibrium. This attitude is, of course, in concordance with Janet's well known hypothesis.

Recognising the contingency of damage to the unborn germplasm, the maternal health during pregnancy, the nature and duration of the labour and delivery, have been enquired into, and are grouped as "Eugenic" factors; but it was impossible to include a study of more distant events in the lives of the parents and earlier generations, which, according to some authors, e.g. Stockhard (5), are calculated to produce an indelible effect on the constitution of the offspring.

After birth, the individual is almost inevitably exposed to psychic trauma, both in direct participation, or merely as a witness of distressing situations, to a variable degree depending on circumstances. Thus the extent to which an individual encounters adverse factors depends not only upon the adjustment which he or she is able to make to their environment, but also involves the reactions of other individuals who form an essential part of that environment. The latter component of the mental hygiene of the individual can well be expressed as the one word - "atmosphere", and it is easily comprehensible how this psychic "atmosphere" is certainly one of the most important factors, as it is rarely absent throughout the individual's life, being thrust upon him in the home, at school, and at work. The scheme used in this series of cases is accordingly designed to record both those classes of factors: the direct and the indirect, and is subdivided in order to distinguish those arising at home, in the school, at work, and in connection with various outside social activities.

Furthermore, in each of the empirical age groups a brief description of the individual's personality, with special reference to any recognisable "Schizoid" traits, is made. In this way the constitutional and environmental factors are tabulated side by side, to facilitate the examination of their possible interactions and relative importance in the production of Schizophrenia.
Together with the tentative results in each individual investigation, a short statement pertaining to the clinical features of the case is appended, and without resorting to any symbolic or analytical interpretations, mention is made of any obvious correlation between clinical and aetiological findings, and insight shown by the patient into the presumably adverse factors in the mental hygiene of his past existence.

A copy of the case scheme just described will be found overleaf.
Case No.: Name:

DIAGNOSIS:

Age at onset: Date of onset:
Age on admission: Date of admission:


(1). Pregnancy: (Normal or abnormal - clinical evidence)
(2). Birth: Type (normal or abnormal, Prolonged labour, Instrumental Birth Trauma)
(3). Feeding: Type.
(4). Age of Parents:
   Father.
   Mother.
(5). Spacing of pregnancies - (in years e.g. 2, 1, 3, etc)
(6). Illnesses, including fits.
(7). Development (age on teething, walking, talking, etc.)
(8). Peculiarities of temperament, disposition, etc. (Personality).
(9). Material home conditions.
(10). Attitude of parents to infant.
(11). Attitude of siblings and other associates to infant.
(12). Attitude of parents to each other and other members of the family, etc. (i.e. "atmosphere" in home).
(13). Shocks, frights, etc.

(B). Childhood.

(1). Illnesses.
(2). Development.
(3). Peculiarities of temperament, disposition, etc. (Personality).
(4). Material home conditions.
(5). Attitude of parents to child (and vice versa).
(6). Attitude of siblings etc. to child (and vice versa).
(7). Family relations (i.e. "atmosphere" in home).
(8). School.
   Age of entry.
   Age of leaving.
   Relative standard of achievement.
   Attitude to teachers and school mates (and vice versa).
(9). Shocks or frights.
(C). ADOLESCENCE.

(1). Illnesses.
(2). Development.
(3). Peculiarities of temperament, disposition, etc. (Personality).

(4). Material home conditions.
(5). Attitude of parents.
(6). Attitude of siblings.
(7). Family relationships ("atmosphere" in home).
(8). Work: Type - involving physical or mental strain. Casually or deliberately chosen. Material conditions at work. Attitude towards employers and fellow workers and vice versa. Suitability. Unemployment - calendar and psychological relationship to breakdown.

(9). Shocks or frights.
(10). Social activities, including recreations, hobbies, etc.
(11). Sex life:
    Attitude towards (a) Same sex. (b) Opposite sex.
    Sexual knowledge etc. Abnormal sexual habits. Abnormalities of menstruation (in F.)

(D). ADULT.

(1). Illnesses.
(2). Development.
(3). Peculiarities of temperament, disposition, etc. (Personality).

(4). Material home conditions.
(5). Attitude of parents.
(6). Attitude of siblings.
(7). Family relationships ("atmosphere" in home).
(8). Marriage Factors:
    (a) Material home condition compared with former home.
    (b) Attitude of and to wife.
    (c) Attitude of and to children.
    (d) Relationships between the two families.

(9). Work: Type - involving physical or mental strain. Casually or deliberately chosen. Material conditions at work. Attitude towards employers and fellow workers and vice versa. Suitability. Unemployment - calendar and psychological relationship to breakdown.
(D). ADULT (Cont'd.)

(10). Shocks or frights.
(11). Social activities, including recreations, hobbies etc.
(12). Sex life:
   Attitude towards (a) Same sex.
   (b) Opposite sex.
   Sexual knowledge etc.
   Abnormal sexual habits.
   Abnormality of menstruation (in F.)
   Climacteric changes.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT IN HOME, SCHOOL OR WORK.

(F). HEREDITY. Insanity or nervous disorder in
   (a) Parents.
   (b) Siblings.
   (c) Offspring.

(G). CONCLUSIONS.

(1). Chief factors in environment (mental hygiene)
   (a). Mental.
   (b). Physical.
   (c). Material.
(2). Principal manifestations of mental disease.
(3). Correlation of clinical manifestations and environmental factors.
(4). Insight regarding these environmental factors during remission or recovery.
(5). Continuation of these environmental factors after discharge, etc.
RESULTS OF THE INVESTIGATION

ANALYSIS OF "EUGENIC" FACTORS.

These factors were chosen by a purely "rule of thumb" method, and can be divided into three main classes:–

(a) Illness of the mother during pregnancy.
(b) Prolonged or "difficult" labour.
(c) Cases occurring within, or at the end of, a rapid succession of pregnancies, which for lack of a better term might be named "unsatisfactory spacing".

There were eighteen cases in all, of which one (No.756, Miss R.B.) was unfortunate enough to be included in all three classes, while the others enter only into one class each. Excluding case No. 756, there was one case in class (a), seven cases in class (b), and nine cases in class (c). The analysis of these numbers is quite inconclusive, for if prenatal injury alone is to be held responsible for the eventual Schizophrenia it is justifiable to suppose that early indications of this fate would be apparent in a greater proportion than in the total cases of the series. Actually, the percentage (38.8%) of the cases in this group which appear to have been Schizoid from Infancy onwards is only very slightly greater than the percentage (36.6%) occurring in the whole series. (See section on "Prepsychotic Personality"). Furthermore, with regard to the third class (c), all the siblings born under equally unsatisfactory, or even worse, circumstances have survived without any ill effect, except in one case (No.600, Miss D.T.) where there is evidence of mental abnormality in two of her sisters.

It is interesting to note, however, that out of a total of four, or possibly five, (the fifth case, No.770, suffered from sufficiently severe myopia to warrant her attendance at a special school for this defect) cases in which general intellectual deficiency had been recognisable prior to the onset of Schizophrenia, three cases (Nos. 179, 591 and 600) are included in this "Eugenic" factor group.
## Eugenic Factors

<table>
<thead>
<tr>
<th>(a) Illness of mother during pregnancy</th>
<th>(b) Prolonged or difficult labour</th>
<th>(c) &quot;Unsatisfactory spacing&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. 179 Mr. B.R.</td>
<td>No. 203 Mr. T.R.</td>
<td>No. 179 Mr. B.R.</td>
</tr>
<tr>
<td></td>
<td>No. 339/723 Miss F.B.</td>
<td>No. 591 Miss B. C.</td>
</tr>
<tr>
<td></td>
<td>No. 590 Miss F.T.</td>
<td>No. 595 Miss D.L.S.</td>
</tr>
<tr>
<td></td>
<td>No. 614 Miss F.T.</td>
<td>No. 600 Miss D. T.</td>
</tr>
<tr>
<td></td>
<td>No. 732 Miss W.J.</td>
<td>No. 604 Miss M. N.</td>
</tr>
<tr>
<td>No. 756 Miss R.B.</td>
<td>No. 756 Miss R.B.</td>
<td>No. 622 Miss M.M.J.</td>
</tr>
<tr>
<td></td>
<td>No. 761 Miss H.K.</td>
<td>No. 631 Miss E. S.</td>
</tr>
<tr>
<td></td>
<td>No. 771 Miss F.M.</td>
<td>No. 655 Miss A. L.</td>
</tr>
<tr>
<td></td>
<td><strong>TOTAL 8</strong></td>
<td><strong>TOTAL 8</strong></td>
</tr>
<tr>
<td></td>
<td>TOTAL 8</td>
<td>TOTAL 10</td>
</tr>
</tbody>
</table>

TOTAL No. of cases involved: 17.
PREPSYCHOTIC PERSONALITY.

The individual characteristics of Schizoid personalities undoubtedly vary to a very great extent, and perhaps it is not so much the analysis of the different elements which leads to the recognition of the Schizoid, but rather the synthesis of these qualities dimly illuminating a personality, which "instinctively" makes the observer feel that he has seen the surface and very little else. There is something intangible, "cold", or unreal about the Schizoid, which becomes more noticeable the longer one knows him, instead of that warm familiarity which develops with the acquaintance of the average man. This recognition of the general atmosphere which the Schizoid creates has its chief value in the consulting room, but is too abstract in its consistence to provide a methodical study of the Schizoid's career. Therefore, we must try and distinguish the various "traits" which constitute the superficial aspect of the Schizoid personality.

As Kretschmer (6) puts it: "the Schizoid temperament lies between the extremes of excitability and dullness", and, as may be expected, the individual traits are correspondingly numerous. Much work has been done in recent years, especially in America, listing these traits and formulating "psychographs". A single glance at most of these studies, such as Bowman's (7), will reveal how extraordinarily complicated and extensive the analysis may become. For the purpose of this thesis I have been less ambitious, and have contented myself with making use of a rather simpler scheme, borrowed from Kretschmer (8), who outlines the more frequent combinations of the multiple characteristics which may present themselves. He divides these characteristics into three main groups, in order of their relative frequency, as follows:-

I. Unsociable, quiet, reserved, serious (humourless), eccentric.

II. Timid, shy, with fine feelings, sensitive, nervous, excitable, fond of nature and books.

III. Pliable, kindly, honest, indifferent, dull witted, silent.

The first group is the obvious Schizoid, with his undemonstrative exterior; an exterior which is an effectual barrier between the affective turmoil of his inner mental life and a world of reality which affords no palatable outlet for his emotions. He is regarded by the world as apathetic and "cold", as he is indeed towards it. In the second group the barrier is not so complete, and there is direct evidence of the real "hyperasthetic" qualities of the Schizoid, and, instead of perpetual affective
"coldness" and apathy towards his environment, he finds certain outlets for the ideals of his autism, and thus possibly is less prone to develop a Schizophrenic illness. The third group has, in some respects, an appearance of general mental deficiency, and it is well within the bounds of possibility that this group accounts for at least part of that not inconsiderable proportion of Schizophrenics who are classified as having a "background" of partial Amentia. Kretschmer (9) and Kraepelin suggest that the origin of this last group may be postpsychotic; that it consists of children who have undergone a Schizophrenic illness in the first few years of life, and who are left in a state which corresponds, in a lesser degree, with the "affective imbecility" (Kraepelin) of the more severe and advanced psychotic cases.

I have taken characteristics which correspond, more or less, to those contained in Kretschmer's Group I, as a standard whereby to estimate the presence or absence of a Schizoid personality, but it must be understood that the existence of these traits in each case is, for the most part, according to the opinion of the friends and relatives of the patient, and unfortunately not determined by unbiased and experienced scientific observation. Fortunately, a discrepancy is likely to lie on the side of omission, and thus the value of positive facts is maintained. In an overwhelming majority of cases of Schizophrenia there is undeniable evidence of Schizoid tendencies in the later years of prepsychotic life, usually occurring as an abnormal survival of the natural "shyness" manifesting itself at puberty; but, as will be shown by the figures obtained from this series, and by certain references from the observations of other writers, exploration of the patient's earlier life will also yield Schizoid traits in a considerable proportion of cases.

It is rather difficult to estimate the real existence of a definable Schizoid personality in Infancy, as the organism is bound to be still in a rather amorphous, malleable state, owing to its limited reactions with a confined environment. At any rate, in support of the hypothesis that Schizoid characteristics may be evident in the first few years of the child's life, the testimony of the parents is that, even then, the children were "different" from other infants, and that difference lay, almost universally, in an abnormally quiet, shy and placid nature. I have been unable to find any suitable references recording actual figures of Schizoid personality in Infancy, but remarks such as the following, made by Kasanin and Rosen (10), are frequently encountered. These authors state that, in one series of nineteen cases, "in eleven (57.9%) of these cases the personality has been considered "different" from early childhood".
Thereafter, even in the minds of biased parents, there usually lurks a suspicion that the child, apart from any definite characteristics, is rather "strange", and at times baffling. The existence of this indefinable peculiarity, which is so readily distinguished by the trained observer, is rarely a spontaneous admission on the part of the parents, but is usually conceded on further questioning.

The figures yielded by this investigation are as follows:—

Schizoid Traits (corresponding to Kretschmer's Group I) existed -

(a) In Infancy and onwards, in 18 cases (36%)
(b) " Childhood " " 12 " (24%)
(c) Since puberty " 9 " (18%)

Thus the total number estimated to be definitely Schizoid prior to the onset of the actual psychosis is 39 (78%). This is a fraction more than the "three-fourths" quoted by Bleuler (11), and also in excess of 51% and 68% which are the figures given by Hoch (12) as the result of two separate investigations. It will also be noted that the addition of the first two (a and b) groups, i.e. 60%, approximates closely to the 57.9%, already mentioned as the result given by Kasanin and Rosen for "early childhood".

Of the remaining eleven cases in this series, two (Nos. 802 and 884) were certainly endowed with "normal" personalities, and one (No. 596) was probably normal, although this possibly merited inclusion as Schizoid, if Kretschmer's Group II had been taken as standard. This leaves eight cases not considered "normal", and yet not belonging to the definite Schizoid (Group I) category, of which two (Nos. 250 and 592) have been generally "emotionally unstable", and another (No. 593) is described as "nervous and hypochondriacal". Both these cases might be included as Schizoid within Kretschmer's second group. However, the "emotionally unstable" type has been recognised as a separate prepsychotic entity, and at this point I will compare my figures with those of Bowman and Raymond (13), which are the result of an investigation upon over two thousand Schizophrenics, collected during the space of four years:—

<table>
<thead>
<tr>
<th></th>
<th>&quot;Normal&quot;</th>
<th>&quot;Emotionally unstable&quot;</th>
<th>&quot;Seclusive&quot; (B. &amp; R.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. &amp; R.</td>
<td>22 - 26%</td>
<td>15 - 24%</td>
<td>50 - 59%</td>
</tr>
<tr>
<td>A. J. G.</td>
<td>4% (6%)</td>
<td>(?6%) 4%</td>
<td>78%</td>
</tr>
</tbody>
</table>

No. 596
A diagnosis of a varying degree of Mental Deficiency had been made in the remaining five cases (10%), and, as I have previously remarked, might correspond to Kretschmer's third group.

Prepsychotic Schizoid characteristics are certainly represented in 78%, and possibly these figures may be legitimately extended to cover no less than 96% of these cases.

The problem of constitution, however, still remains, and it is feasible that the explanation lies in the direction of the physio-psychological affective mechanisms. The James-Lange theory of Emotions postulates the conscious psychic component as secondary to certain physiological reactions, possibly centred in the Endocrine and Autonomic systems. Mott attempted to ascribe Schizophrenia to pathological changes ("regressive atrophy") in certain of the Endocrine glands, but his evidence was far from being conclusive. Of more recent years, research has advanced our knowledge of emotional "centres" in the brain, and their connections within, and without, the central nervous system, including those with the Autonomic and Hormonic systems. It may be that the constitutional factor in the Schizoid is a dynamic disturbance of this hormonic and neuronic chain, and that an extension of the James-Lange theory can be applied to explain the pathology of the Schizoid's affective reactions. In this way it may become demonstrable that the Schizoid relapses into autism simply because he is incapable (by virtue of his physiological defect) of experiencing satisfactory emotions from his interaction with the environment.
### PERSONALITIES

<table>
<thead>
<tr>
<th>SCHIZOID during and since:</th>
<th>&quot;NORMAL&quot;</th>
<th>OTHER ABNORMALITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>(I) Infancy</td>
<td>(C) Childhood</td>
<td>(A) Adolescence</td>
</tr>
<tr>
<td>No. 203</td>
<td>No. 179</td>
<td>No. 371</td>
</tr>
<tr>
<td>&quot; 223</td>
<td>&quot; 205</td>
<td>&quot; 590</td>
</tr>
<tr>
<td>&quot; 339/723</td>
<td>&quot; 237</td>
<td>&quot; 595</td>
</tr>
<tr>
<td>&quot; 580/690</td>
<td>&quot; 239</td>
<td>&quot; 610</td>
</tr>
<tr>
<td>&quot; 597</td>
<td>&quot; 599</td>
<td>&quot; 614</td>
</tr>
<tr>
<td>&quot; 604/729/753</td>
<td>&quot; 732</td>
<td>&quot; 755</td>
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<tr>
<td>&quot; 619</td>
<td>&quot; 751</td>
<td>&quot; 824</td>
</tr>
<tr>
<td>&quot; 620</td>
<td>&quot; 754</td>
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<tr>
<td>&quot; 622</td>
<td>&quot; 771</td>
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<td>&quot; 623</td>
<td>&quot; 780</td>
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<td>&quot; 631</td>
<td>&quot; 756</td>
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<td>&quot; 662</td>
<td>&quot; 759</td>
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<td>&quot; 719</td>
<td>&quot; 761</td>
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<td>&quot; 756</td>
<td>&quot; 830</td>
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<tr>
<td>&quot; 761</td>
<td>&quot; 832</td>
<td></td>
</tr>
<tr>
<td>&quot; 898</td>
<td>&quot; 898</td>
<td></td>
</tr>
<tr>
<td><strong>Total 18</strong></td>
<td><strong>Total 12</strong></td>
<td><strong>Total 9</strong></td>
</tr>
<tr>
<td>(36%)</td>
<td>(24%)</td>
<td>(18%)</td>
</tr>
<tr>
<td>No.</td>
<td>Infancy</td>
<td>Childhood</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>203</td>
<td>Quiet and placid.</td>
<td>Shy, timid and solitary.</td>
</tr>
<tr>
<td>205</td>
<td>-</td>
<td>Quiet and reserved.</td>
</tr>
<tr>
<td>223</td>
<td>Rather quiet and placid.</td>
<td>Quiet and reserved.</td>
</tr>
<tr>
<td>237</td>
<td>&quot;Normal.&quot;</td>
<td>Excitable, mischievous and boisterous in early childhood. Later quiet.</td>
</tr>
<tr>
<td>239</td>
<td>&quot;Normal&quot;</td>
<td>Reserved. Made no friends outside own family.</td>
</tr>
<tr>
<td>250</td>
<td>&quot;Normal&quot;</td>
<td>Quick-tempered, eccentric and fastidious.</td>
</tr>
<tr>
<td>339/723</td>
<td>Quiet, shy and docile.</td>
<td>Shy and quiet.</td>
</tr>
<tr>
<td>371</td>
<td>&quot;Normal&quot;</td>
<td>&quot;Normal&quot;</td>
</tr>
<tr>
<td>590</td>
<td>&quot;Normal&quot;</td>
<td>-</td>
</tr>
<tr>
<td>591</td>
<td>Extremely retarded but quite happy.</td>
<td>Dull, but apparently happy.</td>
</tr>
<tr>
<td>No.</td>
<td>Infancy</td>
<td>Childhood</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>592</td>
<td>Fits of weeping and &quot;tantrums&quot;.</td>
<td>As in Infancy</td>
</tr>
<tr>
<td>593</td>
<td>&quot;Nervous&quot;</td>
<td>Nervous and hypochondriacal.</td>
</tr>
<tr>
<td>595</td>
<td>Quiet, but somewhat precocious.</td>
<td>Slightly precocious.</td>
</tr>
<tr>
<td>596</td>
<td>Precocious</td>
<td>&quot;Normal&quot;</td>
</tr>
<tr>
<td>597</td>
<td>Quiet and contented</td>
<td>Quiet and rather timid.</td>
</tr>
<tr>
<td>598</td>
<td>&quot;Normal&quot;</td>
<td>Normal until 13.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Became quiet and timid following accident.</td>
</tr>
<tr>
<td>599</td>
<td>&quot;Normal&quot;</td>
<td>Rather quiet and timid.</td>
</tr>
<tr>
<td>600</td>
<td>Dull and often had &quot;tantrums&quot;.</td>
<td>Dull but cunning.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Held distinct views of her own.</td>
</tr>
<tr>
<td>610</td>
<td>&quot;Normal&quot;</td>
<td>&quot;Normal&quot;</td>
</tr>
<tr>
<td>614</td>
<td>&quot;Normal&quot;</td>
<td>&quot;Normal&quot;</td>
</tr>
<tr>
<td>615</td>
<td>Rather backward.</td>
<td>Dependent and retarded.</td>
</tr>
<tr>
<td>620</td>
<td>Quiet and placid.</td>
<td>Quiet and shy.</td>
</tr>
<tr>
<td>622</td>
<td>Slow, &quot;dreamy&quot; and placid.</td>
<td>Shy and quiet.</td>
</tr>
<tr>
<td>No.</td>
<td>Infancy</td>
<td>Childhood</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>623</td>
<td>Shy, quiet and timid.</td>
<td>Shy, timid and retiring. Intelligence good.</td>
</tr>
<tr>
<td>631</td>
<td>Quiet and placid.</td>
<td>Reserved, but self-willed.</td>
</tr>
<tr>
<td>655</td>
<td>&quot;Normal&quot;.</td>
<td>&quot;Normal&quot;.</td>
</tr>
<tr>
<td>662</td>
<td>Quiet and solitary.</td>
<td>&quot;Nervous&quot; and hysterical.</td>
</tr>
<tr>
<td>729/753</td>
<td>-</td>
<td>Sullen and resentful. Had fits of temper.</td>
</tr>
<tr>
<td>732</td>
<td>&quot;Normal&quot;.</td>
<td>Rather unstable. Worried over trifles.</td>
</tr>
<tr>
<td>737</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>751</td>
<td>-</td>
<td>Quiet and dependent.</td>
</tr>
<tr>
<td>754</td>
<td>-</td>
<td>Quiet. Did not &quot;mix&quot; well. Sometimes unstable.</td>
</tr>
<tr>
<td>755</td>
<td>&quot;Normal&quot;.</td>
<td>&quot;Normal&quot;.</td>
</tr>
<tr>
<td>756</td>
<td>Shy and quiet</td>
<td>Shy and sensitive.</td>
</tr>
<tr>
<td>761</td>
<td>Quiet and placid.</td>
<td>Quiet and shy.</td>
</tr>
<tr>
<td>770</td>
<td>-</td>
<td>Docile and contented.</td>
</tr>
<tr>
<td>771</td>
<td>-</td>
<td>Solitary and quiet.</td>
</tr>
<tr>
<td>780</td>
<td>-</td>
<td>Shy and sensitive.</td>
</tr>
<tr>
<td>No.</td>
<td>Infancy</td>
<td>Childhood</td>
</tr>
<tr>
<td>------</td>
<td>---------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>802</td>
<td>&quot;Normal&quot;</td>
<td>&quot;Normal&quot;</td>
</tr>
<tr>
<td>824</td>
<td>&quot;Normal&quot;</td>
<td></td>
</tr>
<tr>
<td>830</td>
<td>Quiet and placid</td>
<td>Quiet and timid</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Did not &quot;mix&quot;</td>
</tr>
<tr>
<td>832</td>
<td>Quiet and shy</td>
<td>Quiet and shy</td>
</tr>
<tr>
<td>884</td>
<td>&quot;Normal&quot;</td>
<td>&quot;Normal&quot;</td>
</tr>
<tr>
<td>898</td>
<td>Rather quiet</td>
<td>Quiet, over-tidy and particular over details</td>
</tr>
<tr>
<td>900</td>
<td>&quot;Normal&quot;</td>
<td>Rather quiet but &quot;mixed&quot; fairly well</td>
</tr>
</tbody>
</table>
In this somewhat summary fashion the problem of the Schizoid's mental constitution has been discussed, and the remainder of the investigation is devoted to the external factors of the "Mental Hygiene" of the individual.

In the majority of cases, the unfortunate person destined to become Schizophrenic has already shown tendencies in that direction, and the search for adverse external factors will be made upon rather preconceived lines. Realising that he is at least potentially autistic in his mental life, the factors which are likely to be detrimental are those which either encourage him, or force him, to become increasingly introverted. Within the first category are likely to be those influences which tend to shelter him from the world at large, and thus he must resort to autism, or else be eternally bored with an atmosphere from which he has long since absorbed all interest. The second group constitutes all those unpleasant and rude rebuffs from which the Schizoid, by virtue of his very nature, must surely shrink, and then supplant them in his mind by more acceptable autistic thoughts.

Furthermore, environmental influences are derived mainly from three great sources, whose relative importance depends upon the age of the individual. In this way the Home and all its associates forms the world for the Infant, but in later years his horizon is extended to the School, and to other situations in the outside world.

The importance of the environment and "environmental stress" in the production of mental disorder was unfortunately long delayed in its general acceptance. This fact is strikingly portrayed by figures given by Macfie Campbell (13a) concerning Schizophrenic patients at the Boston Psychopathic Hospital. In the year 1923 the factor of "environmental stress" was recorded as "unknown" in 98% of the male cases, and in 75% of the female cases. In 1926 the figures were respectively 57% and 55%.
THE EFFECT OF "OVERPROTECTION".

I will deal first with those influences which naturally tend to encourage already existing autism and a shrinking fear of emancipation from the closed circle of the home. The chief offenders in this respect are undoubtedly the parents, but in their defence I would suggest that it is brought about in a well meaning way. The situation may be summarised by reference to the following passage by Gillespie (14): "But it is not surprising to learn that seclusiveness in children is favoured by parental influences. The readiest form is the injunction not to play with rough boys, but it is doubtful whether such an instruction alone would have any effect on the otherwise happy child. Too much devotion of a parent to a child fosters its separation from its coevals;".

Unfortunately, the facts procured in relation to parental and general familial over-protection in this series are insufficiently detailed to show definitely whether this attitude is adopted prior to, or following, the appearance of Schizoid tendencies in the child, but it seems highly probable that the latter situation is more frequent than the former. Kasanin and Rosen (15) also support this view, as will be evident from the following extract from their writings: "would lead us to suspect that overprotection is a function of the weak child who requires special attention because of a defect either of personality or physical build, or of both." It is easy to imagine how the parents, and especially the mother, finding her offspring quiet and sensitive, readily allows her maternal instincts to overcome her better judgment, and encourages the child to avoid the "rough and tumble", so that they may devote themselves to each other. The Schizoid child no doubt readily accepts this invitation to avoid reality, and live a sheltered life, with more than adequate opportunities to become increasingly shy and introverted.

The figures relating to overprotection in this series are, as I have said, inconclusive, being partly in agreement with the hypothesis that over-protection results from, and is not the cause of, Schizoid characteristics, but if accepted literally also contradict this suggestion. Of the total number of patients showing a definite Schizoid personality previous to the onset of the mental illness, 51.2% have been overprotected either from Infancy or at some period during their lives. The cases which did not appear to be Schizoid until Childhood are only preceded in 16.6% by overprotection; whereas the cases in which the appearance of the Schizoid personality was delayed until adolescence, were preceded in 55.5% by overprotection.
"OVERPROTECTED"

<table>
<thead>
<tr>
<th>During and since Infancy</th>
<th>During and since Childhood</th>
<th>During Adolescence</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.179 (C)</td>
<td>No.203 (I)</td>
<td>No.780(C)</td>
</tr>
<tr>
<td>223 (I)</td>
<td>237 (C)</td>
<td></td>
</tr>
<tr>
<td>250 (&quot;Emot.unstable&quot;)</td>
<td>339/723 (I)</td>
<td></td>
</tr>
<tr>
<td>590 (A)</td>
<td>371 (A)</td>
<td></td>
</tr>
<tr>
<td>593 (Nervous&quot;)</td>
<td>592 (&quot;Emot.unstable&quot;)</td>
<td></td>
</tr>
<tr>
<td>597 (I)</td>
<td>737 (A)</td>
<td></td>
</tr>
<tr>
<td>604 (I)</td>
<td>761 (I)</td>
<td></td>
</tr>
<tr>
<td>610 (A)</td>
<td>824 (A)</td>
<td></td>
</tr>
<tr>
<td>614 (A)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>615 (&quot;Ment.defect.&quot;)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>619 (I)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>620 (I)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>732 (C)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>756 (I)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>770 (&quot;Ment.defect.&quot;)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>830 (I)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>832 (I)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>884 (&quot;Normal&quot;)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>900 (&quot;Ment.defect.&quot;)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total 19  Total 8  Total 1
Schizoids 13  Schizoids 7  Schizoids 1

Percentage of Total Schizoids overprotected ..... 51.2%

Number of cases where overprotection preceded the appearance of Schizoid traits in Childhood: 2.
i.e. Percentage of "C" preceded by overprotection 16.6%

Number of cases where overprotection preceded the appearance of Schizoid traits in Adolescence: 4.
i.e. Percentage of "A" preceded by overprotection 55.5%

I = Schizoid during and since Infancy.
C = " " " " Childhood.
A = " " " " Adolescence.
Total C = 12.
Total A = 9.
Total Schizoids = 39.
THE RELATIONSHIP OF PHYSICAL ILLHEALTH TO THE
DEVELOPMENT OF SCHIZOPHRENIA.

This aspect in the mental hygiene of an individual may have, at first sight, little connection with the previous factor of overprotection, but is conveniently recorded in this position because certain of the results do demonstrate a connecting link between the two factors.

In seventeen cases there is a history of chronic illhealth, or at least some abnormal physical character resulting from disease. In thirteen of these sixteen cases the importance seems to lie not in the actual physical disability, but in the unfortunate sequelae resulting directly from such disabilities. Thus in five cases (Nos. 593, 756, 761, 770 and 832) the patient forthwith became the victim of undue overprotection, and in two cases (Nos. 597 and 600) the opposite effect resulted, i.e., antagonism and contempt. In two cases (Nos. 600 and 620) where the child had evidently been of average ability, "backwardness" consequently developed, resulting in psychic strain, both in and out of school. Three cases (Nos. 371, 596 and 719) show evidence of disturbing "selfconsciousness" as the result of physical stigmata due to disease, and one other case (No. 592) was one of complete deaf-mutism following Scarlet Fever.

An acute physical disturbance appears to have been the precipitating factor in two cases. Thus Schizophrenia followed upon: - (a) Dental extraction under local cocaine anaesthesia (No. 619), and (b) a "boil" (No. 830). The first of these two cases eventually recovered, although she had evidently been Schizoid since Infancy. The second has been Schizoid since Infancy, and has not recovered.
<table>
<thead>
<tr>
<th>Chronic physical illhealth.</th>
<th>Mental sequelae.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.371 Chronic upper respiratory catarrh in childhood. Psoriasis.</td>
<td>Selfconsciousness.</td>
</tr>
<tr>
<td>No.591 Congenital Syphilis.</td>
<td>Mental deficiency.</td>
</tr>
<tr>
<td>No.592 Severe illness (? Scarlet Fever) aet 1 year. Since then has been deaf and dumb, and asthenic.</td>
<td>Deaf mutism.</td>
</tr>
<tr>
<td>No.593 Infantile malnutrition, &quot;delicate&quot; since.</td>
<td>Maternal over-protection.</td>
</tr>
<tr>
<td>No.596 Infantile rickets with residual deformity.</td>
<td>Selfconsciousness.</td>
</tr>
<tr>
<td>No.597 &quot;Delicate&quot; since infancy.</td>
<td>Maternal antagonism.</td>
</tr>
<tr>
<td>No.600 Tubercular adenitis aet 5, followed by chronic ill-health.</td>
<td>&quot;Backwardness&quot; Despised by mother.</td>
</tr>
<tr>
<td>No.604 &quot;Goitre&quot; (during two years previous to mental illness)</td>
<td>Manifestations of hyperthyroidism.</td>
</tr>
<tr>
<td>No.620 Chronic illhealth since infancy. Recently diagnosed as Tubercular (Phthisis).</td>
<td>Backwardness.</td>
</tr>
<tr>
<td>No.662 Chronic intestinal trouble, terminating in appendicitis during the year previous to mental breakdown.</td>
<td>?</td>
</tr>
<tr>
<td>No.719 Acne Vulgaris.</td>
<td>Selfconsciousness.</td>
</tr>
<tr>
<td>No.729 &quot;Encephalitis&quot; aet 12. Followed by frequent headaches.</td>
<td>?</td>
</tr>
<tr>
<td>No.751 Middle ear disease and chronic deafness.</td>
<td>?</td>
</tr>
<tr>
<td>No.756 &quot;Delicate&quot; during infancy and childhood.</td>
<td>Overprotection.</td>
</tr>
<tr>
<td>No.761 Chronic &quot;illhealth&quot; from infancy onwards.</td>
<td>Overprotection.</td>
</tr>
<tr>
<td>No.770 Congenital Syphilis - &quot;delicate&quot;.</td>
<td>Overprotection.</td>
</tr>
<tr>
<td>No.832 Rickets and general ill-health during infancy.</td>
<td>Overprotection.</td>
</tr>
</tbody>
</table>
The adverse factors hitherto considered have been mainly those which have tended to draw the Schizoid into a more seclusive life, and thereby enhance the existence of autism. The remaining factors are chiefly those of a repellent nature which force, rather than encourage, the individual to seek refuge in autistic processes. They are essentially the unpleasant circumstances which are bound to be encountered, if reality is not ignored absolutely.

UNHAPPINESS IN THE HOME.

The Home is naturally the first environment where unpleasantness is liable to occur, and the atmosphere of the home may be rendered unhappy, as far as the patient is concerned, either by his being directly involved in the cause of the disturbance, or he may only be the unfortunate witness of the strife between others.

In this series, I found that in twentyseven cases (54%) there was evidence of a persisting unhappy atmosphere within the precincts of the home. Of these twentyseven cases, the patient had been directly involved in fourteen cases, and there is little doubt that in the majority the disturbance originated due to a lack of insight on the part of the relatives into the nature of the patient. The shy, or rather "dull", child was regarded as lazy and "worthless", and illconceived attempts were made to "bully" him or her into activity and sociability. This attitude appears to be adopted more often by the father and siblings, in contrast to the frequent overprotection on the mother's part, and when both factors are present simultaneously the situation is correspondingly complex and unbearable. The "bullying" at first is met with open resistance, but later the victim eventually adopts the alternative, and becomes more heedless and introverted.

In sixteen cases, the patient was indirectly involved, including three cases (Nos. 339/723, 593 and 597) in which there was also direct participation in the cause of the turmoil. In this indirect group, the commonest cause of the unhappiness was marital incompatibility of the parents, which was evident in ten cases (see Table).
## UNHAPPY HOME ENVIRONMENT.

<table>
<thead>
<tr>
<th>Patient directly involved</th>
<th>Patient indirectly involved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No.339/723 Sister's antagonism.</strong></td>
<td>No.339/723 Father's infidelity, leading to disruption of home</td>
</tr>
<tr>
<td><strong>No.593 Father's cruelty.</strong></td>
<td>No.593 Friction between parents.</td>
</tr>
<tr>
<td><strong>No.597 Mother's contempt.</strong></td>
<td>No.597 Father's intemperance.</td>
</tr>
<tr>
<td>Overprotected by siblings.</td>
<td>No.179 Strife between parents.</td>
</tr>
<tr>
<td>No.580/690 Misunderstood and &quot;bullied&quot; by mother and sisters.</td>
<td>No.203 Strife between parents.</td>
</tr>
<tr>
<td><strong>No.592 Mother disliked patient.</strong></td>
<td>No.205 Much worry over financial troubles.</td>
</tr>
<tr>
<td>Overprotected by Grandmother.</td>
<td>No.239 Strife between parents.</td>
</tr>
<tr>
<td>No.598 Perpetual unhappiness involving whole family.</td>
<td>No.250 Father's intemperance</td>
</tr>
<tr>
<td><strong>No.600 Both parents harsh and contemptuous to patient.</strong></td>
<td>No.590 Father's delinquencies</td>
</tr>
<tr>
<td><strong>No.604 Father harsh and sisters critical towards patient.</strong></td>
<td>No.591 Strife between parents.</td>
</tr>
<tr>
<td><strong>No.662 Neglected by both parents.</strong></td>
<td>No.596 Strife between sisters.</td>
</tr>
<tr>
<td>No.719 Perpetual unhappiness involving whole family.</td>
<td>No.599 Strife between parents.</td>
</tr>
<tr>
<td><strong>No.729/753 Unhappy institution life.</strong></td>
<td>No.622 Strife between parents.</td>
</tr>
<tr>
<td><strong>No.756 Quarrelled with sisters.</strong></td>
<td>No.631 Strife between parents. Father's incest with sister.</td>
</tr>
<tr>
<td><strong>No.824 Unhappy marriage.</strong></td>
<td>No.732 Strife between parents.</td>
</tr>
<tr>
<td><strong>No.830 Father unstable and harsh.</strong></td>
<td>No.737 Father's infidelity, and death of mother.</td>
</tr>
</tbody>
</table>

**Total 14.**

**Total 16.**

* Associated with overprotection.

Marital Incompatibility: 10 cases.

**Total number of cases involved = 27.**
THE INFLUENCE OF RELATIVES AND OTHER CLOSE CONTACTS
SUFFERING FROM MENTAL ILLNESSES, OR CONSIDERED TO
HAVE DEFINITELY ABNORMAL PERSONALITIES.

In concordance with Janet's proposal that contact with abnormal personalities is itself inducive to mental illness, an investigation into the occurrence of this factor is suitably made at this juncture, as it is found to bear a considerable influence on the question of unhappy home atmospheres.

A total of fourteen cases in this series record the existence of mental abnormalities among the relatives of the patient. The types which occurred most frequently are as follows:

"Emotional instability" 5 cases.
Alcoholism 4 cases (+ G.P.I. in 1 case).
Sexual perversity 2 cases (one also emotionally unstable).

It is noteworthy that twelve out of these fourteen cases are also included in the previous figures for "unhappy homes", which is fairly direct evidence of the deleterious effect of continual contact with persons who are themselves abnormal, although in most cases not considered to be suffering from actual mental illnesses. Indeed, it is these less pronounced and illdefined cases of mental abnormality, including alcoholics, who restrain themselves sufficiently to escape detection outside their own homes, who are liable to create more misery and anxiety for their unfortunate relatives than do those suffering from more obvious mental illnesses, and who are generally recognised as abnormal, and receive appropriate treatment.

"Emotional instability", occurring in siblings in the two remaining cases (Nos. 595 and 802) of this section, was evidently insufficient to upset the general atmosphere of the home.
MENTAL "ABNORMALITY" AMONG RELATIVES

<table>
<thead>
<tr>
<th>Mental Unstability</th>
<th>Sexual Perversity</th>
<th>Alcoholism</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. 179 Father.</td>
<td></td>
<td>No. 250 Father.</td>
<td>No. 590 Father, a recidivist.</td>
</tr>
<tr>
<td>No. 239 Father.</td>
<td></td>
<td>No. 591 Both parents.</td>
<td>No. 593 Mother, &quot;hypochondriacal&quot;.</td>
</tr>
<tr>
<td>No. 595 Two sisters.</td>
<td></td>
<td>No. 596 Father (+G.P.I.)</td>
<td>No. 596 Sister, &quot;neurasthenic&quot;</td>
</tr>
<tr>
<td>No. 600 Father.</td>
<td>No. 600 Father, incest on patient's sister.</td>
<td>No. 599 Father.</td>
<td>No. 598 Both parents, &quot;ill-tempered and antagonistic&quot; to everybody.</td>
</tr>
<tr>
<td>No. 602 Two sisters.</td>
<td>No. 631 Father, incest on patient's sister.</td>
<td></td>
<td>No. 604 Father, harsh &quot;bully&quot; type.</td>
</tr>
</tbody>
</table>

Total 5. Total 2. Total 4. Total 5.

Total cases involved 14.

*Associated with "Unhappy homes" - 12.*
MATERIAL CONDITIONS IN THE HOME.

One further aspect of the environment of the home remains to be considered, and that is the existing material conditions.

The effects of poverty are twofold, namely overcrowding and the inadequate provision of nutritional requirements, and in an urban population, to which the cases in this series belong, these two factors are generally both represented simultaneously. As a large majority of these cases are drawn from the "lower classes", the prevalence of unsatisfactory material conditions is considerable. Indeed, no less than half (i.e. 25) of these patients had lived all their lives, or for considerable periods, at such a disadvantage. The existence of such squalor and semistarvation must surely enhance the possibility of the general psychic atmosphere of the home becoming "strained" and unhappy, and again to force the Schizoid child to seek refuge from reality.

An unhappy home atmosphere was recorded in sixteen of these instances of poverty, whereas only nine were associated with homes having a satisfactory psychic atmosphere.
In the foregoing sections an attempt has been made to analyse the environment of the home into the various adverse factors which may, and frequently do, exist. Furthermore, it has been shown that several of the separate factors are undoubtedly interconnected, both in their causal and resultant relationships. Thus the existence of unsatisfactory emotional bonds within the home may be caused to a great extent by the presence of mental abnormality, apart from the Schizoid under consideration, within the family. These lesser anomalies of psychic constitution may themselves be enhanced by the disturbances which they promote, and in this way a vicious circle is produced, entailing an environment which is progressively unsuitable for the salvation of the Schizoid child, and enhancing the growth of economic chaos which again tends to lead to a further disturbance of the psychic equilibrium within the home. The situation is still more complex when each of the parents adopts an entirely different attitude towards the unfortunate Schizoid child. Maternal overprotection and paternal severity or contempt are not infrequently directed simultaneously towards the child, and this in itself may lead to dissatisfaction and strife between the parents. When readjustment is to be made, the relationship of the separate factors to the entire situation must receive searching examination and consideration.
**UNSATISFACTORY MATERIAL HOME CONDITIONS**

<table>
<thead>
<tr>
<th>Associated with unhappy &quot;atmosphere&quot;</th>
<th>Associated with satisfactory &quot;atmosphere&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. 203</td>
<td>No. 614</td>
</tr>
<tr>
<td>&quot; 250</td>
<td>&quot; 623</td>
</tr>
<tr>
<td>&quot; 339/723</td>
<td>&quot; 655</td>
</tr>
<tr>
<td>&quot; 580/690</td>
<td>&quot; 751</td>
</tr>
<tr>
<td>&quot; 590</td>
<td>&quot; 761</td>
</tr>
<tr>
<td>&quot; 591</td>
<td>&quot; 770</td>
</tr>
<tr>
<td>&quot; 593</td>
<td>&quot; 780</td>
</tr>
<tr>
<td>&quot; 597</td>
<td>&quot; 802</td>
</tr>
<tr>
<td>&quot; 598</td>
<td>&quot; 900</td>
</tr>
<tr>
<td>&quot; 600</td>
<td></td>
</tr>
<tr>
<td>&quot; 622</td>
<td></td>
</tr>
<tr>
<td>&quot; 631</td>
<td></td>
</tr>
<tr>
<td>&quot; 719</td>
<td></td>
</tr>
<tr>
<td>&quot; 737</td>
<td></td>
</tr>
<tr>
<td>&quot; 824</td>
<td></td>
</tr>
<tr>
<td>&quot; 830</td>
<td></td>
</tr>
<tr>
<td><strong>Total 16.</strong></td>
<td><strong>Total 9.</strong></td>
</tr>
</tbody>
</table>
THE INFLUENCE OF THE SCHOOL.

During the period of Childhood, the individual's environment becomes considerably extended, and of the extension the School represents a highly important section. Reports from teachers and other educational officers are not entirely satisfactory in offering insight into the life of the prepsychotic, as they are, in many cases, chiefly concerned with the purely intellectual capacities, at their surface value, of the child. However, the influence of Psychology in the training curriculum of the teacher is beginning to bear fruit, and more notice is being taken of "personalities", although examination results still figure largely in the teacher's estimation of the child. Furthermore, the "smattering" of Psychology which the embryo teacher may acquire is more often of the "pure" and more academic nature than of a knowledge of the application of psychological principles to mildly abnormal and problematic cases. The teacher may well recognise the grosser anomalies, but his psychiatric education is rarely capable of recognising the importance of some of the less evident deviations of personality. Unfortunately, the Schizoid child frequently belongs to the latter category, and consequently escapes notice at a time when intervention might prove most successful.

Rosen and Veo (16) studied the school life of a series of psychotics, and I have summarised a part of their results to indicate the types of abnormal personality which pass unrecognised in the schoolroom. These figures are of American origin, where the influence of Psychology and "Mental Hygiene" is probably much more widespread than in the educational communities in this country, and thus minimise the lack of unskilled observation in the school.

<table>
<thead>
<tr>
<th>Group</th>
<th>Obvious peculiarities</th>
<th>Slight personal deviations, e.g., slight shyness</th>
<th>Sociable type</th>
<th>&quot;Brilliant&quot; type</th>
<th>Extremely shy type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>8</td>
<td>10</td>
<td>2</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Others</td>
<td>4</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>
Of the above, the first and last groups were recognised as being abnormal by the School teachers, and no surprise was felt when it was learnt that these children had become psychotic, but such a fate had never been suspected in the case of the three other groups. It remains to be seen whether the less obvious personal peculiarities can be identified, but the school room certainly does provide the ideal situation for systematic observation. Let us hope that in the future more use will be made of this opportunity, and that psychological medicine will have its rightful place in the routine examination of school children.

In this series I have reports of sixteen cases who were "subnormal" in varying degrees from "backwardness" to such a pronounced defect which required special schooling. This number includes six cases where a diagnosis of mental deficiency has been made, but where unresponsiveness may, as previously mentioned, have been truly schizoid in character. The remaining ten cases are typical examples of the "dreamy" Schizoid child, who undoubtedly possesses the ability, but fails to apply himself in directions which do not appeal to him. The social proclivity of the Schizoid child at school is next studied, and, as far as I can ascertain, the number of children in this series who were considered asocial at school is eleven, which compares favourably with the total number of thirty who were Schizoid at this age. Even allowing for those teachers whose reports are mainly the observance of scholastic success, these figures are impressive, and indicate that the atmosphere of the schoolroom is a better setting for the Schizoid child than the majority of the homes which have been studied. The influence of other children, beyond the "coddling" or harshness of misguided parents, may well be an effective means of finding suitable outlets for the Schizoid's mind, and in general a healthier contact with his environment.

The final observation of the School lives of these cases concerns the incidence of "behaviour" disorders, arising from their relationships with other scholars or with teachers. There are only four examples belonging to this category, and with nothing outstanding or peculiar to Schizoid tendencies, as compared with the occurrence of similar events in "normal" children, except in the last instance. Thus we find one case (No.610) of infatuation over a teacher, another (No.662) of "sexplay" with children of the opposite sex, one (No.754) was abnormally mischievous, and the fourth (No.900) child's quiet, and possibly defective, nature led to definite over-protection by the teacher, which was greatly resented by the other members of the class, who made the unfortunate child the victim of their vindictiveness.
Little, as yet, has been said about active hygienic methods in the school, but undoubtedly the nature of the "soil" must be thoroughly understood before attending to the "seed". Behaviour disorders have received considerable, and well merited, attention of recent years by the co-operation of the school authorities and child guidance clinics, but as yet the Schizoid child is either unnoticed, or insufficiently troublesome, to receive psychological treatment in the majority of cases. Once again a thorough comprehension of his delicate mental constitution is the first essential, and adjustment of the school curriculum to stimulate his interests and develop his special abilities would seem to be the broad general principles upon which the "mental hygiene" of the Schizoid in school must be built. This probably involves considerable deviation from the routine academic studies, and their substitution by a more artistic and yet practical education, and above all a gradual and skilful method of enhancing the child's contact with reality. We have special classes and schools for the education of the mental defective, but as yet the facilities for helping the Schizoid to develop to an optimum capacity are lacking.

"Character" education is a subject which involves the Schizoid as well as many other types of personality, and Beckham (17) has summarised the situation in a concise and yet comprehensive manner in the following paragraph: "Character building begins far back in the life of the individual; indeed, according to most specialists, the first three years lay the foundation of character so firmly that later training merely modifies, without materially changing, the emotional habits formed during those years. The importance of the proper type of education at the outset is, therefore, stressed by educators and psychologists alike. Any power whatsoever of the individual, physical or mental, may become an asset or a liability from the standpoint of character education. It is the aim of mental hygiene to make these powers, both mental and physical, assets in the character of the individual. The objectives of character education, from the standpoint of mental hygiene, are to secure the highest development of the personality and to make the child a strong and thoroughly socialised individual."
### TRAITS IN RELATION TO SCHOOL LIFE

<table>
<thead>
<tr>
<th>No.</th>
<th>Backward</th>
<th>Asocial</th>
<th>&quot;Behaviour&quot; disturbances</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.179</td>
<td>🆕</td>
<td>🆕</td>
<td>🆕</td>
</tr>
<tr>
<td>&quot;223&quot;</td>
<td>🆕</td>
<td>🆕</td>
<td>🆕</td>
</tr>
<tr>
<td>&quot;237&quot;</td>
<td>🆕 (above average)</td>
<td>🆕</td>
<td>🆕</td>
</tr>
<tr>
<td>&quot;239&quot;</td>
<td>🆕</td>
<td>🆕</td>
<td>🆕</td>
</tr>
<tr>
<td>&quot;371&quot;</td>
<td>🆕</td>
<td>🆕 (?)</td>
<td>🆕</td>
</tr>
<tr>
<td>&quot;580/690&quot;</td>
<td>🆕 (good at &quot;art&quot;)</td>
<td>🆕</td>
<td>🆕</td>
</tr>
<tr>
<td>&quot;591&quot;</td>
<td>🆕</td>
<td>🆕</td>
<td>🆕</td>
</tr>
<tr>
<td>&quot;593&quot;</td>
<td>🆕</td>
<td>🆕</td>
<td>🆕</td>
</tr>
<tr>
<td>&quot;600&quot;</td>
<td>🆕 (special class)</td>
<td>🆕</td>
<td>🆕</td>
</tr>
<tr>
<td>&quot;604&quot;</td>
<td>🆕</td>
<td>🆕 (?)</td>
<td>🆕</td>
</tr>
<tr>
<td>&quot;610&quot;</td>
<td>🆕</td>
<td>🆕</td>
<td>(Infatuation for teacher)</td>
</tr>
<tr>
<td>&quot;615&quot;</td>
<td>🆕</td>
<td>🆕 (?)</td>
<td>🆕</td>
</tr>
<tr>
<td>&quot;619&quot;</td>
<td>🆕</td>
<td>🆕</td>
<td>🆕 (&quot;Sex play&quot;)</td>
</tr>
<tr>
<td>&quot;622&quot;</td>
<td>🆕 (?)</td>
<td>🆕</td>
<td>🆕</td>
</tr>
<tr>
<td>&quot;655&quot;</td>
<td>🆕</td>
<td>🆕</td>
<td>🆕 (mischievous)</td>
</tr>
<tr>
<td>&quot;662&quot;</td>
<td>🆕</td>
<td>🆕</td>
<td>🆕</td>
</tr>
<tr>
<td>&quot;719&quot;</td>
<td>🆕</td>
<td>🆕</td>
<td>🆕</td>
</tr>
<tr>
<td>&quot;737&quot;</td>
<td>🆕</td>
<td>🆕</td>
<td>🆕</td>
</tr>
<tr>
<td>&quot;751&quot;</td>
<td>🆕</td>
<td>🆕</td>
<td>🆕</td>
</tr>
<tr>
<td>&quot;754&quot;</td>
<td>🆕</td>
<td>🆕</td>
<td>🆕</td>
</tr>
<tr>
<td>&quot;771&quot;</td>
<td>🆕</td>
<td>🆕</td>
<td>🆕</td>
</tr>
<tr>
<td>&quot;780&quot;</td>
<td>🆕</td>
<td>🆕</td>
<td>🆕</td>
</tr>
<tr>
<td>&quot;830&quot;</td>
<td>🆕 (special school)</td>
<td>🆕</td>
<td>🆕</td>
</tr>
<tr>
<td>&quot;832&quot;</td>
<td>🆕</td>
<td>🆕</td>
<td>🆕</td>
</tr>
<tr>
<td>&quot;900&quot;</td>
<td>🆕</td>
<td>🆕</td>
<td>🆕</td>
</tr>
</tbody>
</table>

Total Schizoid during school age - 30.
definite precipitating factors. It must be borne in mind, however, that the outcome of unemployment in the average healthy individual may bear little resemblance to these results found in the undermined Schizoid constitution. Lewis (18) in a recent study on "Neurosis and Unemployment" has also emphasised the necessity for this latter remark.

Finally, there are two cases where "upsets" at work appeared to have exerted a considerable adverse effect on the individual. One of those (No.596) received promotion and thereby aroused the jealousy of the other employees, who vented their spite on the unfortunate girl. In the other case (No.599), there was considerable unhappiness over an unfounded accusation of theft. Both these incidents were regarded as precipitatory to the ensuing mental illness, although the mechanism of the second in this respect is doubtful, and might have been delusional in character, within the actual Schizophrenia.
MENTAL HYGIENE AND EMPLOYMENT.

Employment is the natural sequence of the termination of the school career, and one which presents multiple problems and difficulties. In the first place there is the question of the choice of a career, and its suitability in each individual case. Secondly the relationship of unemployment to mental hygiene and mental breakdown must receive consideration.

With regard to the former, there is evidence of unsuitability to the particular employment in eighteen cases in this series, and on reviewing these figures one finds that, of the eighteen, two-thirds of the individuals have been engaged in occupations of a decidedly "unimaginative" and "semi-automatic" order, features which might not in themselves constitute unsuitability in relationship to the "average" individual, but which are obviously adverse when considered in connection with the Schizoid, as they tend to produce further apathy or distaste towards the environment of reality, and provide the opportunity for relapse into phantasy. The types of employment belonging to this order are represented in this series in three chief varieties, namely, factory work (five cases), clerical work (four cases), and domestic service. The situation in these cases is not difficult to understand, and although the relative scarcity of employment, during the past ten years, has often necessitated the exclusion of any choice in the matter, vocational guidance to provide work more in keeping with the artistic and idealistic nature of the potential Schizophrenic might be of great assistance in averting the onset of mental illness. One particular case (No.590) is worthy of further mention in this respect. This girl had been employed as a kennel maid, and evidently was well suited to her occupation and happy at her work. Then unfortunately, through no fault of her own, she became unemployed, and later started to work in a factory. This environmental change proved her undoing, and it was not long before she became definitely Schizophrenic.

I have considered the question of unemployment from one simple aspect, which undoubtedly does not nearly cover the complex relationships of that state with the mental hygiene of the individual. The particular point which I have noted is the incidence of obvious psychic trauma as the result of unemployment. This only includes those cases who made it clear that they underwent considerable worry and anxiety, and thereby provided direct evidence of the trauma, although doubtless there were others who suffered in silence. There are six cases in the group, and in four of these the psychic trauma coincided sufficiently with the development of the mental breakdown that such traumata can be regarded as
EMPLOYMENT AND MENTAL HYGIENE

<table>
<thead>
<tr>
<th>No.</th>
<th>Unsuit</th>
<th>Unemploy</th>
<th>Upsets at work</th>
</tr>
</thead>
<tbody>
<tr>
<td>179</td>
<td>Coach building</td>
<td></td>
<td>X P</td>
</tr>
<tr>
<td>205</td>
<td>Postman</td>
<td></td>
<td>X P</td>
</tr>
<tr>
<td>223</td>
<td>Carpet beating ?P</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>237</td>
<td>Shop assistant and domestic Clerk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>239</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>339/723</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>371</td>
<td>Dressmaker</td>
<td></td>
<td>X P</td>
</tr>
<tr>
<td>580/690</td>
<td>Factory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>590</td>
<td>Domestic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>591</td>
<td>Shop assistant</td>
<td></td>
<td>X P</td>
</tr>
<tr>
<td>595</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>596</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>597</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>599</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>600</td>
<td>Factory Clerk</td>
<td></td>
<td>X P</td>
</tr>
<tr>
<td>604</td>
<td>Factory Clerk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>610</td>
<td>Domestic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>623</td>
<td>Various Clerk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>655</td>
<td>Factory Clerk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>732</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>780</td>
<td>Factory Clerk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>832</td>
<td>Factory Clerk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>900</td>
<td>Factory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total 18</td>
<td>Total 6</td>
<td>Total 2</td>
<td></td>
</tr>
</tbody>
</table>

P = Precipitating factor.
MENTAL HYGIENE AND SOCIAL INTERESTS.

During the adolescent period the individual usually begins to develop specialised or generalised interests in the social sphere, or may devote leisure hours to the study and practice of some particular hobby. On examining these cases, of which the majority, at this phase of life, are now frankly Schizoid, one finds further evidence of their introverted and asocial habits. Thus in 27 cases (54%) such interests both within and outside the home appear to have been entirely lacking. Nineteen (38%) are recorded as having various outside interests, while the remaining four patients (8%) indulged in reading as their sole form of recreation, one of whom specialised in religious study. Hinsie (19) on the diagnosis of incipient Schizophrenia emphasises this "generalized retraction of interests from environmental situations", but his findings differ in one respect from the data of this series, in that he maintains that the Schizoid devotes himself to literature. "It is very probable that his books are his closest companions.... The library is a favourite haunt." This statement would certainly contradict the small numbers I have found who took solace in reading.

The progressive nature of Schizoid tendencies is now quite evident, and the occurrence of social activities, and other realistic forms of recreation, is less frequent in those individuals who were recognisable as Schizoids during Infancy than in the cases where this personality disorder was delayed in its development. Thus of the first group 72.7% had no outside interests, as compared with 50.0% and 55.3% of the cases becoming Schizoid during Childhood and Adolescence respectively. This progressiveness in the Schizoid personality is also indicated by Bowman (20) who supplies the following figures:

<table>
<thead>
<tr>
<th>Recreations</th>
<th>&quot;With others&quot;</th>
<th>&quot;Average&quot;</th>
<th>&quot;Solitary&quot;</th>
<th>Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood</td>
<td>26</td>
<td>81</td>
<td>38</td>
<td>6</td>
<td>151</td>
</tr>
<tr>
<td>Adult</td>
<td>18</td>
<td>52</td>
<td>54</td>
<td>1</td>
<td>125</td>
</tr>
</tbody>
</table>

It will be seen that from Childhood to Adult life there is an increase in the incidence of "solitary" amusements, and a corresponding decrease in the cases who frequently indulged in communal recreation.
The above information concerns Schizoids previous to their being placed under observation and treatment, and it is entirely a matter for conjecture as to whether the advancement of social recreation in these cases would have been beneficial. The same difficulty arises as in the case of the school child; the entire, or almost entire, lack of systematic and skilled observation to distinguish these Schizoids at a time when much might be accomplished in the direction of their socialisation.
### SOCIAL INTERESTS

<table>
<thead>
<tr>
<th>No interests</th>
<th>Outside Interests</th>
<th>Reading</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.179 (C)</td>
<td>No.205 Outdoor games</td>
<td></td>
</tr>
<tr>
<td>&quot; 203 (I)</td>
<td>&quot; 237 Dancing</td>
<td>No. 239</td>
</tr>
<tr>
<td>&quot; 223 (I)</td>
<td>&quot; 239 Cinema</td>
<td></td>
</tr>
<tr>
<td>&quot; 339/723 (I)</td>
<td>&quot; 250 Various</td>
<td></td>
</tr>
<tr>
<td>&quot; 371 (A)</td>
<td>&quot; 595 &quot;Pleasure seeking&quot;</td>
<td></td>
</tr>
<tr>
<td>&quot; 580/690 (I)</td>
<td>&quot; 596 Often out with friends</td>
<td></td>
</tr>
<tr>
<td>&quot; 590 (A)</td>
<td>&quot; 597 Dancing etc.</td>
<td></td>
</tr>
<tr>
<td>&quot; 591(&quot;ment.defect&quot;)</td>
<td>&quot; 599 Church social club</td>
<td></td>
</tr>
<tr>
<td>&quot; 593 (&quot;Nervous&quot;)</td>
<td>&quot; 604 Girl Guides (not keen)</td>
<td>No. 604</td>
</tr>
<tr>
<td>&quot; 598 (C)</td>
<td>&quot; 610 Various</td>
<td>No. 622</td>
</tr>
<tr>
<td>&quot; 600(&quot;ment.defect&quot;)</td>
<td>&quot; 614 Various (Religion)</td>
<td></td>
</tr>
<tr>
<td>&quot; 619 (I)</td>
<td>&quot; 615 Various</td>
<td></td>
</tr>
<tr>
<td>&quot; 620 (I)</td>
<td>&quot; 729/953 Various</td>
<td></td>
</tr>
<tr>
<td>&quot; 631 (I)</td>
<td>&quot; 756 Religious</td>
<td></td>
</tr>
<tr>
<td>&quot; 655 (A)</td>
<td>&quot; 770 Church social</td>
<td></td>
</tr>
<tr>
<td>&quot; 662 (I)</td>
<td>&quot; 802 Various</td>
<td></td>
</tr>
<tr>
<td>&quot; 719 (I)</td>
<td>&quot; 824 Dancing</td>
<td></td>
</tr>
<tr>
<td>&quot; 737 (A)</td>
<td>&quot; 884 Various</td>
<td></td>
</tr>
<tr>
<td>&quot; 751 (C)</td>
<td>&quot; 900 Church choir</td>
<td></td>
</tr>
<tr>
<td>&quot; 754 (C)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot; 755 (A)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot; 761 (I)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot; 771 (C)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot; 780 (C)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot; 830 (I)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot; 832 (I)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot; 898 (I)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total - 27.**

**Total - 19.**

**Total - 6.**

Reading only - 4.

Percentage of cases Schizoid from Infancy (I) with no outside interests ... ... ... ... 72.2%

Percentage of cases Schizoid from Childhood (C) with no outside interests ... ... ... ... 50.0%

Percentage of cases Schizoid from Adolescence (A) with no outside interests ... ... ... ... 55.3%
SEXUAL FACTORS.

Much has been written concerning the inter-relationships of the psychological and physical attributes of sexual life, with both normal and abnormal mental processes. The Freudian approach is perhaps the most characteristic and extensive in this respect, but the importance of this sphere is also recognised by the majority of other schools of thought.

For the purpose of this thesis I have only studied the more superficial and restricted aspects of the subject, as a discussion on the more intricate and deeper mechanisms of sexual psychopathology would greatly exceed the material hitherto displayed, and would distort the rather simple approach which has been employed in the preceding sections. In the first place I have confined the term to those manifestations appearing in the adolescent and adult phases of life, leaving the infant and child in an enviable state of "innocence". As I have already hinted, this is not the result of any heretical disbelief in the analytical theories of sexuality, but merely because it is the superficial and obvious aspects of sex, appearing after puberty, which are most easily correlated with personality as a whole.

Similarly with regard to psychic traumata arising in the sexual sphere, I have only enquired into obvious situations which may be added to, and combined with, general factors in psychic traumata. In this way I have sought additional evidence of the existence of Schizoid characteristics, and explored further territories for psychic factors which might influence the evolution of personality in an adverse direction, or possibly account for the precipitation of a psychosis. Such adverse factors have not been listed separately, but are included among the other faults of mental hygiene, and are referred to elsewhere.

As might be expected, the Schizoid is as seclusive in his sexual relationships as he is in the other aspects of his social existence. In the earlier stages of his disability he is too shy and self-conscious to commune with the opposite sex, and excuses himself by expressing a dislike for what he may, at heart, desire. Later his apathy prevents him from embracing reality in this direction, as in other spheres, but throughout, if the surface be penetrated, he is idealistic and eventually turns to phantasy. These remarks are hoped to convey the personal impression which the study of these cases has made, and they coincide to a considerable degree with the observations made by Hinsie (21) on "Heteroerotic Behaviour" in incipient Schizophrenia. In this series I have recorded twenty-seven cases (54%) where the opposite sex was avoided in the
manner described above, and I have listed the descriptive remarks made by the relatives, and in a few cases by the patient, on the subject, as typical of the superficial, and infrequently the real attitude, of the Schizoid towards the opposite sex.

The Schizoid does not encourage confidences, and this probably accounts for the rather remarkable fact that, of these fifty patients, I could only discover four (No. 597, 600, 619 and 623) who had received anything approaching adequate instruction in sexual matters. Only one (No. 619) of these four remained Schizoid in his attitude towards the opposite sex, following such instruction. This is yet another example of the need for a widespread understanding of the Schizoid, so that parents and others might provide guidance and other hygienic measures to encourage extroversion and thereby enhance the Schizoid's contact with reality and a healthier mental existence.

Finally, the occurrence of Masturbation in the Schizoid is recognised as a frequent event, and in the past undue stress has been laid upon such practices as being inducive to mental illness. It is now generally recognised that masturbation, or at least excessive masturbation, is rather the result than the cause of mental abnormality. Regarding the problem of the sexual life of the Schizoid from the simplest viewpoint, masturbation is merely a further manifestation of his seclusiveness. This seclusiveness in itself may possibly account for the rather low recorded incidence of masturbation occurring in the cases of this series. There are only five cases (No. 179, 614, 737, 864 and 900) where it was admitted to exist in presychotic life. In a similar number of Schizophrenics, Bowman and Raymond (22) give the following figures for the occurrence of masturbation.

<table>
<thead>
<tr>
<th></th>
<th>Present</th>
<th>None</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood</td>
<td>13</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Adult</td>
<td>14</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Number</td>
<td>Description</td>
<td></td>
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<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>179</td>
<td>&quot;Shunned&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>203</td>
<td>&quot;Avoided&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>205</td>
<td>&quot;Shy&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>223</td>
<td>&quot;Shy&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>239</td>
<td>&quot;Had no use for&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>250</td>
<td>&quot;Not interested in&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>339/723</td>
<td>&quot;Does not mix with opposite sex, but looks forward to marriage&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>580/690</td>
<td>&quot;Shunned&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>590</td>
<td>&quot;No friends&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>591</td>
<td>&quot;No interests in&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>593</td>
<td>&quot;Had one friend, but association did not last&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>599</td>
<td>&quot;Expressed dislike&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>610</td>
<td>&quot;No interest in&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>619</td>
<td>&quot;Timid towards&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>622</td>
<td>&quot;Did not associate with&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>655</td>
<td>&quot;Shunned&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>719</td>
<td>&quot;Reserved towards&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>732</td>
<td>&quot;No friends&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>751</td>
<td>&quot;Little interest in&quot;. (Was once engaged)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>755</td>
<td>&quot;No interest in&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>761</td>
<td>&quot;Shunned, but anxious to marry&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>770</td>
<td>&quot;No interest in&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>780</td>
<td>&quot;Did not mix with&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>832</td>
<td>&quot;Shunned&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>884</td>
<td>&quot;Hated&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>900</td>
<td>&quot;Disliked, but afterwards admitted desire, but was too selfconscious.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total 27
MENTAL TRAUMA AS A PRECIPITATING AGENT TO MENTAL BREAKDOWN.

Throughout this investigation, the prominent features which have been encountered can be separated into two distinct classes, namely the evidence of a constitutional "inferiority", and environmental factors which at least seem to promote the progressiveness of such an inherent defect. The insidious onset may veil the importance of similar factors in precipitating Schizophrenia, and the fact that the majority of Schizophrenics develop their mental illnesses during the adolescent years may make it appear that the actual breakdown is the result of the strain of physiological and psychic adjustments taking place at this time. Nevertheless, precipitating factors, both mental and physical, have received merited attention, without losing sight of the predisposition, both constitutional and acquired, to such an illness. As Bleuler (23) puts it: "We must assume that the disease is not engendered by such conditions (external factors) but only made manifest."

The evil consequences of sudden and dire mishaps are more easily recognised, but psychic trauma of a more prolonged and "subacute" nature may eventually culminate in the breakdown of mental health. In the consideration of these facts, I have divided the possible precipitating factors into two groups: (a) Sudden "Shocks", and (b) Prolonged mental trauma. Both these groups contain a variety of unfortunate circumstances. The actual contact of such factors may be of supreme importance to the individual concerned, but it would seem to serve no practical purpose to attempt to generalise, and consequently I have made no attempt to compare these results with any other findings. The situation must be treated at its face value in each individual case. Bleuler (24) has said: "...... any psychic factor, especially an unfortunate love-life."; let that suffice.

The results in this series are outlined as follows:

(a) (Sudden "Shocks") comprises twelve cases, of which two were of sexual assault, two of uncertain sexual assault (? delusional at onset of illness), two of the sudden and unsatisfactory termination to a love affair, three were directly involved in an accident, and one was hastily summoned to his brother who had been involved in an accident, and the remaining case was apparently precipitated into Schizophrenia by finding a lump (afterwards proved to be a cyst) in her breast.
(b) In twenty-one cases, more prolonged psychic traumata appear to have been precipitating factors, the more frequent of which were:

Strain at work - chiefly the result of unsuitability (6 cases)
Unemployment ... ... ... (4 cases)
Unsatisfactory love affairs (4 cases)

It has been shown hitherto that only three (6%) (Nos. 596, 802 and 884) of the total cases in this series were apparently of "normal" personality until the onset of their mental illnesses, and all these three individuals have endured mental trauma, evidently sufficient to precipitate a psychosis, from which they have since recovered. This seems to indicate that psychic shock may precipitate a benign Schizophrenic illness in an individual of normal personality, and therefore adds considerable importance to the external factor.
### PRECIPITATING FACTORS

<table>
<thead>
<tr>
<th>(a) Sudden shocks</th>
<th>(b) Prolonged mental trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.239 Accident at work.</td>
<td>No.239 Unhappiness at home, due to father's misconduct.</td>
</tr>
<tr>
<td>No.737 ? involved in a case of sexual assault by a man against the patient's sister.</td>
<td>No.737 Breaking up of home after death of mother and introduction of stepmother.</td>
</tr>
<tr>
<td>No.237 Accident to brother.</td>
<td>No.205 Unemployment.</td>
</tr>
<tr>
<td>No.598 Accident; Birth of illegitimate child and desertion by father of child.</td>
<td>No.223 Unemployment. Inadvertently in trouble with police.</td>
</tr>
<tr>
<td>No.614 Sexual assault.</td>
<td>No.591 Worry over religious matters. (patient brought up in a convent.)</td>
</tr>
<tr>
<td>No.623 Sexual assault.</td>
<td>No.590 Worry over sexual matters, regarding which patient was ignorant.</td>
</tr>
<tr>
<td>No.651 Sudden death of two fellow workers.</td>
<td>No.596 Unsatisfactory love affair. Strain of employment.</td>
</tr>
<tr>
<td>No.655 Sexual assault.</td>
<td>No.597 Unemployment.</td>
</tr>
<tr>
<td>No.754 Broken engagement.</td>
<td>No.599 Unhappiness at work.</td>
</tr>
<tr>
<td>No.771 &quot;Deserted&quot; by boy friend.</td>
<td>No.600 Strain of employment.</td>
</tr>
<tr>
<td>No.884 Motor accident.</td>
<td>No.604 Financial worries.</td>
</tr>
<tr>
<td>No.898 Shock of finding &quot;lump&quot; (cyst) in breast.</td>
<td>No.719 Unsatisfactory love affair.</td>
</tr>
</tbody>
</table>

Total - 12.  
Total - 21.  
(including 2 also in (a))
CORRELATION OF CLINICAL FEATURES AND DETRIMENTAL EXTERNAL FACTORS.

Without resorting to analytical or other "translations" of the mass of clinical features presented in these fifty cases of Schizophrenia, I have found that direct representation of the detrimental incidents in the pre-psychotic mental hygiene of these patients is relatively infrequent. In seven cases only do the superficial aspects of the mental illness bear any obvious resemblance to such incidents, in a way which enables the observer of the clinical features to hazard an opinion as to the likely preceding traumata. This is unfortunate, but is not unexpected in a disease such as Schizophrenia, where the clinical features are merely superficial and disorganised offshoots from the remainder of the hidden mental processes. In the cases where the correlation is obvious, the adverse factors are directly represented within the content of delusions appearing during the course of the illness.

A short description of these delusions and mention of their connection with environmental factors are included in the individual case records of the following patients: Nos. 223, 595, 597, 598, 600, 761, 884 and 900.
"RECOVERIES" AND THE INCIDENCE OF "INSIGHT" DURING RECOVERIES OR PHASES OF REMISSION.

In this series of fifty cases, slightly more than half (i.e. 26) of the patients recovered sufficiently to leave hospital, after varying periods of treatment; but unfortunately several (i.e. 7) of these "recovered" cases subsequently relapsed, and are still undergoing hospital treatment, either at Ewell Mental Hospital or elsewhere.

In consideration of the more permanent recoveries, the chief source of interest undoubtedly lies in the relationship of the recovery rate to the duration of pre-psychotic Schizoid tendencies. Thus the percentage of recoveries in the group of patients who were Schizoid in Infancy and onwards is 22.2. The Childhood group gives a recovery rate of 33.3% and the Adolescent group 77.7%, while the three patients who were apparently "normal" prior to the actual illness all recovered, i.e. 100%. These figures displayed in graphic form (see overleaf) make a very striking illustration, which I feel must have a decided value in the estimation of prognosis in Schizophrenia. Among the other types of abnormal personalities there were two "permanent" recoveries and two "temporary" recoveries, giving a true recovery rate of 25.0%. When discussing these other abnormalities, I made a suggestion that they might also be Schizoid in origin, and as their individual peculiarities all date from an early age, may possibly furnish additional evidence of a less favourable prognosis in cases where Schizoid traits are of prolonged duration.

Insight into adverse hygienic factors, in their respective cases, was only evident in five patients (Nos. 205, 371(?), 614, 631, 802), so that apparently little assistance is provided by the patients themselves, either through the medium of their clinical features (V.S.), or by their insight into adverse factors.
**"RECOVERED" CASES**

<table>
<thead>
<tr>
<th>Infancy Group (I)</th>
<th>Childhood Group (C)</th>
<th>Adolescent Group (A)</th>
<th>&quot;Normal&quot;</th>
<th>Other Abnormalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.339/723R</td>
<td>No.205</td>
<td>No.371</td>
<td>No.596</td>
<td>No.591</td>
</tr>
<tr>
<td>&quot;580/690R&quot;</td>
<td>&quot;598&quot;</td>
<td>&quot;590&quot;</td>
<td>&quot;802&quot;</td>
<td>&quot;593R&quot;</td>
</tr>
<tr>
<td>&quot;597&quot;</td>
<td>&quot;599&quot;</td>
<td>&quot;595&quot;</td>
<td>&quot;884&quot;</td>
<td>&quot;615&quot;</td>
</tr>
<tr>
<td>&quot;619&quot;</td>
<td>&quot;729/753&quot;</td>
<td>&quot;610&quot;</td>
<td></td>
<td>&quot;770R&quot;</td>
</tr>
<tr>
<td>&quot;620R&quot;</td>
<td>&quot;732R&quot;</td>
<td>&quot;614&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;631&quot;</td>
<td>&quot;756&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total 7</td>
<td>Total 5</td>
<td>Total 7</td>
<td>Total 3</td>
<td>Total 4</td>
</tr>
</tbody>
</table>

Relapsed 3 Relapsed 1 Relapsed - Relapsed - Relapsed 2

Total of "true" recoveries 4 Total of "true" recoveries 4 Total of "true" recoveries 7 Total of "true" recoveries 3 Total of "true" recoveries 2

Total I 18 Total C 12 Total A 9 Total "Normal" 3 Total "other" abnormalities 8

% "Recovered" 22.2 % "Recovered" 33.3 % "Recovered" 77.7 % "Recovered" 100 % "Recovered" 25.0

R = Relapsed.
Recovery Rate in Personality Groups.

Percentage of Recoveries:

- Schizoid in Infancy
- Schizoid in Childhood
- Schizoid in Adolescence
- Normal
- Other Abnormalities
READJUSTMENT OF THE MENTAL HYGIENE IN "RECOVERED" CASES.

The discharge of the more fortunate Schizophrenics, who make sufficient readjustment to permit their departure from hospital, should undoubtedly be preceded by a survey of the previous adverse factors in their lives, and an attempt made to eliminate these factors from the environment to which the patient returns. This necessitates the co-operation, in most cases, of both the family and the individual. Faulty parental attitude and other anomalies in the home must be dispersed; failing this they must be avoided by the patient. In this series, as the direct result of advice from the hospital authorities, a successful alteration was achieved in the home, whereby parental overprotection, family quarrels, etc., were ended prior to the return of the patient, in six cases (Nos. 205, 371, 596, 610, 615 and 756). The alternative course was resorted to in three cases (Nos. 598, 614 and 729/753), where the patient, in each instance, entered domestic service, by no means an ideal occupation, but undoubtedly preferable to remaining in their previous environments. In addition, advice was given to the parents or other close contacts, regarding the gradual "exteriorising" of the discharged patient, and it was emphasised that gentle persuasion, and never "moral" force, must be used. Any convenient avenue should be employed, and such organisations as the "Girl Guides", "Scouts", and other social clubs seem suitable means of stimulating palatable interests, and a reintroduction into the wider spheres of the outside world.

It would appear that, whenever possible, the discharged patient should remain under skilled observation for a considerable period after leaving the hospital, so that advice as to environmental difficulties could be given without unnecessary delay, and thereby enhance the existence of a permanent "recovery". A recent study by Wootton and Armstrong (25) on the after-histories of a series of patients discharged from Ewell Mental Hospital indicates the "danger periods" when relapse most frequently occurs. Observation and advice should obviously be intensified at such times. (With the kind permission of the authors I have included a copy of a graph which illustrates the occurrence of these "danger periods".

(P.T.O.)
To recapitulate the results of the investigation into the after-histories of discharged patients belonging to this present series: twenty-six patients eventually departed from the hospital, and of these, twenty remain, at least, in a comparatively satisfactory mental state, but six (Nos. 339/723, 580/690, 593, 620, 732 and 770) have relapsed and are still receiving hospital treatment. In two (Nos. 339/723 and 580/690) of these relapsed cases there is clear evidence that the patient returned to an environment which had not improved, while in two others (Nos. 732 and 620) new pitfalls were encountered.
CONCLUSIONS.

1. "Eugenic" factors were present in seventeen cases, but no definite conclusion could be brought forward upon their occurrence.

2. Prepsychotic Personality - Abnormalities were denoted in a large proportion of these cases. Schizoid tendencies were present in at least 78%, while other abnormalities, also possibly Schizoid in origin, accounted for a further 16%, leaving only 6% (3 cases) presumably "normal" previous to the onset of the actual mental illness. Furthermore, the Schizoids could be divided into three groups:-

(a) Those in whom Schizoid traits were present during and since Infancy (I), of whom the "quiet and placid" baby is a typical example.
(b) Those in whom Schizoid traits were present during and since Childhood (C).
(c) Schizoid during Adolescence (A).

Of the minimum total (78%) of Schizoids, 36% were of the group I, 24% group C, and 18% group A.

3. The adverse factors in the Mental Hygiene of these cases were in part the direct or indirect result of their Schizoid personalities, and could be separated into two main subdivisions, viz., (a) Influences which encouraged further autism, and (b) Influences which tended to force the individual to avoid reality, because of the latter's unpleasant nature.

4. The Home environment provided several adverse factors, viz.:-

Parental "Overprotection" (especially by the mother) - possibly the result rather than the cause of the patient's introverted personality.

Family quarrels.

Mild degrees of mental abnormality among the relatives, emotional instability and alcoholism being the types which created most disquiet within the home.

Poor material conditions (Overcrowding and Malnutrition).

These adverse factors within the home were shown to be inter-related, and frequently formed the links in a "vicious circle" of events.

Lastly, in very few instances was there any proper recognition and understanding of the patient's Schizoid personality.
5. Physical ill-health proved to have an adverse effect in several instances. Thus chronic maladies were present in seventeen cases, and led to faulty psychological attitudes, such as "over-protection" and further "selfconsciousness". An acute physical disturbance acted as a "precipitating" agent in two cases.

6. The School seems to provide an ideal situation for observation and recognition of Schizoid children, but, in this country at least, there is probably very little provision made for observation by skilled psychologists. Even so, school records did give further evidence of the existence of Schizoid tendencies in these patients, although in several cases the child was less introverted than at home.

7. Employment. Unsuitability (as the result of Schizoid personality) and unemployment were the main adverse factors in this sphere.

8. Social interests were found to be conspicuously lacking during the adolescent years in the lives of these patients. This was particularly so in those cases who had been Schizoid since Infancy. Reading was much less indulged in than might be supposed.

9. The Sexual (Adolescent) lives of these patients also emphasised their "seclusiveness", and in some cases an idealistic but intensely reticent attitude. A history of masturbation was infrequent, but may have been more common than actually recorded.

10. Mental trauma appeared to precipitate the actual Schizophrenia in thirtyone cases (62%). These precipitating factors can be divided into two groups, viz., (a) Sudden, acute incidents ("Shocks") present in twelve cases, and (b) More prolonged trauma in twentyone cases (including two cases where there was also an acute incident).

11. Clinical features of the ensuing Schizophrenia, viewed from a simple "nonanalytical" standpoint, gave very little assistance in verifying the previous adverse factors.

12. Insight during "recoveries" or remissions into previous adverse factors was also uncommon, but undoubtedly helpful in maintaining satisfactory mental health when it did occur.
13. The recovery rate showed a remarkable inverse relationship to the duration of prepsychotic Schizoid tendencies. This would appear to be most helpful in estimating prognosis.

14. Mental hygiene in the postpsychotic phase would appear to be an extremely important consideration, and involves a continuance of skilled observation and guidance, in addition to the co-operation of the patient and his family, in order to promote the patient's interests in a palatable reality.

Thus, in the majority of the cases which have been studied, the mental constitution of the individual has been impaired for a considerable period before the actual illness commences. Unfortunately, this is rarely recognised, and consequently prophylactic measures are neglected. During childhood, both the parents and the school authorities have ample opportunity for observing the malignant changes which are taking place, and, if it is unlikely that the majority of parents could be enlightened in this respect, surely the time has come for the educational centres to realise the situation, and institute the necessary skilled attention as is provided for the maintenance of physical health in school children? Child guidance centres and clinics fulfil this duty to a certain extent, but unfortunately the quiet, unobtrusive Schizoid rarely comes their way. He gives little trouble to his family until Schizophrenia has set in, and escapes the attention bestowed upon his illbehaved brother. Were the Schizoid recognised in the early stages of his disability, then, and then only, could the adverse environmental factors, which endanger his mental health, be circumvented.

In conclusion, I have to thank Dr. L. H. Wootton, Medical Superintendent of Ewell Mental Hospital, for permission to investigate these patients under his care. I am also indebted to the Social Workers, Miss Lilley and Miss McAllister, for the valuable information provided by their reports.
LIST OF REFERENCES


No:179. MR.B.R.

DIAGNOSIS: Hebephrenic Schizophrenia.
Mental deficiency - mild degree.

Age at onset: 19 Date of onset: 1929
Age on admission: 22 Date of admission: 26.4.32.

(A). PRENATAL - INFANCY.
(1). Pregnancy: Premature birth. (7 months). (Much mental and physical stress imposed on Mother through marital maladjustment).
(2). Birth: Normal apart from prematurity.
(3). Feeding: Bottle fed 18 months.
(4). Age of parents at time of patient's birth:
   Father: 32
   Mother: 33
(5). Spacing of pregnancies:
   Male, 1 yr, Female, 1 yr, Female, 1 yr, Male, 1 yr, miscarriage, 1 yr, Male, 2 yrs, Twins (still birth) 1 yr, Patient, 3 yrs, Male, 3 yrs, Male.
(6). Illnesses, including fits: Measles, Chicken-pox and whooping cough before age 5.
(7). Development: Normal.
(8). Temperament and peculiarities of disposition:
   Backward and dependant.
(9). Material home conditions: Fair.
(10). Attitude of Parents to infant: Mother overprotective; ? Father's attitude.
(11). Attitude of siblings and other associates to infant: Normal.
(12). Attitude of parents to each other and other members of the family: Very unhappy owing to maladjustment between parents.
(13). Shocks, frights etc., Unknown.

(B). CHILDHOOD.
(1). Illnesses: -
(2). Development: Mental development retarded.
(3). Temperament and peculiarities of disposition:
   Shy and timid. Lacking in initiative and ambition.
(4). Material home conditions: Institutional at age of six for few months and then removed by father to a home away from the mother. Material conditions probably poor.
(5). Attitude of parents to child and vice versa:
   Parents separated when patient was six. Father and his second partner are said to have been cruel to patient.
(7). Family relations: Most unhappy.
(8). School: Entered L.C.C School at 9 and left at age 14. On entering he was found to be backward but on leaving he was up to standard. Required supervision and prompting. Not a good "mixer!"
(9). Shocks or frights: Separated from mother at 6.
No: 179. Mr. B.R.

(C). ADOLESCENCE.

(1). Illnesses: Nil.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Shy, timid and dull. No initiative or ambition.
(4). Material home conditions: Poor to 17 with Father. After 17 good with Mother.
(5). Attitude of Parents: Illtreated by Father with whom patient lived till aet 17.
(6). Attitude of siblings: Ignored by siblings because of dullness.
(7). Family relationships: Unhappy till he left Father at aet 17.
(8). Work: Carefully chosen. Apprenticed to coach builder. No aptitude for work and was discharged as hopeless after five years apprenticeship - three years before admission and has done no work since.
(9). Shocks or frights:
(10). Social activities: Opportunities present but not made use of.
(11). Sex life:
   Attitude towards same sex: Normal but did not make friends.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

School -
Work - Patient's first definite symptoms were related to his work where he appeared to be confused.
Home -

(F). HEREDITY:

(a). Parents: Father had violent temper and his behaviour was sadistic and erratic.
(b). Siblings: One brother imprisoned for indecent behaviour.

(G). CONCLUSIONS:

(1). Chief Factors:
   (a). Mental trauma. Unhappy home life chiefly on account of maladjustment between parents. Unsuitable to his work where he became confused. Patient appears to have been a dull retarded child and the attitude of his father and siblings was extremely misunderstanding.
   (b). Principal manifestations of mental disease. Patient is dull and apathetic. Solitary and appears to have little initiative or ambition. Mildly retarded and this is regarded as the result of slight mental defect.
(3). Correlation of clinical manifestations and environmental factors: Nil obvious.

(4). Insight regarding these environmental factors during remission or recovery. Nil.

(5). Environment after discharge: Patient is still in hospital (3.12.34), and there is very little change in his mental condition.
No. 203.  MR.  T.R.

DIAGNOSIS:  Catatonic Schizophrenia.

Age at onset: 18.  Date of onset: Oct.-Nov., 1933
Age on admission: 19.  Date of admission: 27.3.34.

(A).  PRENATAL - INFANCY.

(2).  Birth:  Prolonged labour.
(3).  Feeding:  Bottle fed.
(4).  Age of parents at time of patient's birth:
   Father: 25.
   Mother: 25.
(5).  Spacing of pregnancies:
   The patient is the only child.
(6).  Illnesses, including fits:
   Abscess in arm at the age of 12 months.
(7).  Development:  Normal.
(8).  Temperament and peculiarities of disposition:
   Quiet and placid.
(9).  Material home conditions:  Fair.
(10).  Attitude of parents to infant:  Probably over-
   protected - only child.
(11).  Attitude of siblings and other associates to
   infant:  None.
(12).  Attitude of parents to each other and other
   members of the family:  Fairly happy.
   Occasional unpleasantness between the parents.
(13).  Shocks, frights etc.:  Nil.

(B).  CHILDHOOD.

(1).  Illnesses:  Diphtheria at 6 years.  Chickenpox
   and measles.
(2).  Development:  Normal.
(3).  Temperament and peculiarities of disposition:
   Shy, timid and solitary.
(4).  Material home conditions:  Poor - overcrowded
   district.
(5).  Attitude of parents to child:  Overprotected,
   especially by mother.
(6).  Attitude of siblings to child:  No siblings.
   Mixed very little with other children.
(7).  Family relations:  Fairly happy.  Query trouble
   between parents.
   Scholarship and behaviour of average standard.
(9).  Shocks or frights:  Nil.

(C).  ADOLESCENCE.

(1).  Illnesses:  Nil.
(2).  Development:  Normal.
(3).  Temperament and peculiarities of disposition:
   Solitary and shy.
No. 203.

(Adolescence - Cont'd.)

(4). Material home conditions: Poor.
(5). Attitude of Parents: Overprotected by parents.
(6). Attitude of Siblings: None.
(7). Family relationships: Mother and patient appeared to be deeply attached to each other, while the father kept rather aloof.
(8). Work: Fitter. Deliberately chosen. Conditions good. The patient left of his own accord, as he felt inefficient (at the onset of his illness - no trouble with his employers).
(9). Shocks or frights: Nil.
(10). Social activities: Little participation.
(11). Sex life:
   Attitude towards same sex: No friends, but fairly normal attitude.
   Attitude towards opposite sex: Avoided by the patient.
   No information regarding sexual knowledge.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

Onset of illness related to work, which he left because he felt inefficient, but there is no evidence of any precipitating factor in relation to his work.

(F). HEREDITY:

Nil.

(G). CONCLUSIONS:

(1). Chief Factors.
   (a). Mental trauma: Overprotected by mother from infancy onwards.
      Query unhappiness in home because of mal-adjustment between parents.
   (b). Physical trauma: Nil.
   (c). Material conditions: Poor material conditions - overcrowded dirty district - throughout the patient's life.

(2). Principal manifestations of mental disease.
   Typical picture of catatonic schizophrenia - mute and resistive.

(3). Correlation of clinical manifestations and environmental factors. No obvious correlation.

(4). Insight regarding these environmental factors during remission or recovery. No insight gained.

(5). Environment after discharge. Patient improved to a slight extent, and would obey simple commands and answer simple questions in a mechanical sort of way. He was discharged 8.9.34 at the request of his parents before he was properly recovered, and soon relapsed and was removed to another hospital.
No. 203.

(Conclusions - Cont'd.)

(5). Environment after discharge (Cont'd.)

This is a case where a schizoid personality appeared to exist from a very early age, and where the parental attitude did not help to "exteriorise" the patient.
No. 205. MR. G.S.E.

DIAGNOSIS: Schizophrenia - probably of Simplex variety.

Age at onset: ? Date of onset: ?
Age on admission: 29 Date of admission: 4.5.34

(A). PRENATAL - INFANCY.

(2). Birth: Normal.
(3). Feeding: No information.
(4). Age of parents at time of patient's birth: No information.
(5). Spacing of pregnancies: Patient - 4 years - Female.
(6). Illnesses, including fits: None.
(7). Development: No information.
(8). Temperament and peculiarities of disposition: No information.
(9). Material home conditions: Very good.
(10). Attitude of parents to infant: Normal.
(11). Attitude of siblings and other associates to infant: Normal.
(12). Attitude of parents to each other and other members of the family: Happy atmosphere.
(13). Shocks, frights etc.: Nil.

(B). CHILDHOOD.

(1). Illnesses: Nil.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Quiet and reserved.
(5). Attitude of parents to child: Normal.
(6). Attitude of siblings to child: Good relationship.
(7). Family relations: Happy.
(8). School: Secondary school education.
   Age of entry, 5. Age of leaving, 16.
   Standard: Average scholar. Quite companionable with the other pupils.
(9). Shocks or frights: Nil.

(C). ADOLESCENCE.

(1). Illnesses: Nil.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Quiet, reserved and serious minded.
(5). Attitude of Parents: Normal relationship. His parents were ambitious for the patient.
(6). Attitude of Siblings: Sister very sociable and vivacious.
(7). Family relations: Happy, but a certain amount of worry over financial difficulties.
No. 205.

(Adolescence - Cont'd.)

(8). Work: Secretarial. Deliberately chosen. Conditions were good and the patient was quite successful, although he became unemployed six months before admission to hospital, through no fault of his own.

(9). Shocks or frights: Nil.

(10). Social activities: He was fond of outdoor games, and had ample opportunities.

(11). Sex life:
   Attitude towards same sex: Normal.
   Attitude towards opposite sex: Shy towards opposite sex.

No abnormal behaviour.

(D). ADULT.

(1). Illnesses: None.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Quiet and reserved.
(5). Attitude of Parents: Normal.
(6). Attitude of Siblings: Normal.
(7). Family relationships: Happy, but there were still financial worries.
(9). Work: As in adolescence.
(10). Shocks or frights: Nil.
(12). Sex life: As before.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

Onset of illness was related to increasing financial difficulties in the home, and also to the loss of the patient's own employment.

(F). HEREDITY:

Nil.

(G). CONCLUSIONS.

(1). Chief Factors:
   (a). Mental trauma: Worry in the home over financial problems.
   Loss of work.
   (b). Physical trauma: -
   (c). Material conditions: -
(Conclusions - Cont’d.)

(2). Principal manifestations of mental disease.
Apathetic and mildly depressed, with commencing disintegration of personality.

(3). Correlation of clinical manifestations and environmental factors. The patient partially realised that his mental condition during remission or recovery.

(4). Insight regarding these environmental factors appeared to be the result of worry in the family.

(5). Environment after discharge.
Discharged 30.8.34. The parents realised that their son's personality was not altogether normal, and that they would have to try and promote his interests without undue stimulation and avoid as far as possible involving him in any of the family's worry.
No. 223. MR. J.J.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: 24.  Date of onset: ? May 1935
Age on admission: 24.  Date of admission: 19.7.35.

(A). PRENATAL - INFANCY.

(2). Birth: Normal.
(3). Feeding: Breast fed 9 months. Easily weaned.
(4). Age of parents at time of patient's birth:
   Father: 25.
   Mother: 24.
(5). Spacing of pregnancies:
   Patient - 2 years - Female.
(6). Illnesses, including fits: Nil.
(7). Development: Normal.
(8). Temperament and peculiarities of disposition:
   Rather quiet, placid baby.
(9). Material home conditions: Good.
(10). Attitude of parents to infant: ? overprotected.
(11). Attitude of siblings and other associates to
    infant: Normal.
(12). Attitude of parents to each other and other
    members of the family: Happy.
(13). Shocks, frights etc.: Nil.

(B). CHILDHOOD.

(1). Illnesses: Measles and chicken pox.
(2). Development: He had a slight "stutter" which
    disappeared soon after going to school.
(3). Temperament and peculiarities of disposition:
    Quiet and reserved.
(4). Material home conditions: Good.
(5). Attitude of parents to child: Overprotected by
    parents.
(6). Attitude of siblings to child: Good relation-ship with his sister.
(7). Family relations: Happy.
    Standard, average.  No troubles.
    He was inclined to keep to himself, and took
    no interest in sports.
(9). Shocks or frights: Nil.

(C). ADOLESCENCE.

(1). Illnesses: Mumps, aet 20.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition:
    Quiet and reserved.
(4). Material home conditions: Good.
No. 223.

(Adolescence - Cont'd.)

(5). Attitude of Parents: Overprotected.
(6). Attitude of Siblings: Good relationship with his sister.
(7). Family relationships: Happy.
(8). Work: Electric Lift Co. for 7 years. He liked his work.
(9). Shocks or frights: Nil.
(10). Social activities: He had no outside interests. At home he did odd jobs and made bird cages.
(11). Sex life:
   Attitude towards same sex: Normal.
   Attitude towards opposite sex: Shy of opposite sex.
   No abnormal habits.

(D). ADULT.

(1). Illnesses: Nil.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Quiet and reserved.
(4). Material home conditions: Good.
(5). Attitude of Parents: Overprotected.
(6). Attitude of Siblings: Good relationship with his sister.
(7). Family relationships: Happy.
(8). Marriage: Not married.
(9). Work: Two years ago he lost his work with the Electric Lift Co. because he asked for a "rise". Since then he has only had irregular employment.
(10). Shocks or frights: Four months ago the patient was worried about a police case, in which detectives were looking for a street bookmaker who was very like the patient in physical appearance, and on several occasions he was mistaken for the "wanted" man.
(11). Social Activities: No outside interests.
(12). Sex life: As in adolescence.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.
  No definite relationship.

(F). HEREDITY:
  Nil.
No. 223.

(G). CONCLUSIONS:

(1). Chief Factors:
   (a). Mental trauma: Disappointment and worry over his unemployment.
       Worry over the police case - this appears to have been a precipitating factor.
       Overprotected by parents. His personality was the exact opposite of his sister's, and the parents appear to consider that he required much more care and attention than the rationally extroverted sister.
   (b). Physical trauma: -
   (c). Material conditions: -

(2). Principal manifestations of mental disease.
   About 2 months before admission he became unusually quiet and appeared depressed. He developed ideas of reference and other persecutory delusions. At present his delusions are less obvious, but he is a typical early Hebephrenic, showing a mild degree of emotional incongruity.

(3). Correlation of clinical manifestations and environmental factors:
   Direct relationship between the police case and his ideas of reference.

(4). Insight regarding these environmental factors during remission or recovery.
   No insight.

(5). Environment after discharge:
   He is still in hospital. Condition as above.
No. 237. MR. J.G.B.

**DIAGNOSIS:** Hebephrenic Schizophrenia.

Age at onset: 18. Date of onset: July 1935
Age on admission: 19. Date of admission: 20.9.35.

(A). **Prenatal - Infancy.**

(1). Pregnancy: Normal (although mother was said to be "nervous" owing to air raids).
(2). Birth: Normal.
(3). Feeding: Breast fed. Weaned 16 months. No difficulties.
(4). Age of parents at time of patient's birth:
   Father: 31.
   Mother: ? about 30.
(5). Spacing of pregnancies:
   Patient, 3 years, Male, 2 years, Female, 4 years, Male.
(6). Illnesses, including fits: Nil.
(7). Development: Normal.
(8). Temperament and peculiarities of disposition: Normal.
(9). Material home conditions: Rather poor.
(10). Attitude of parents to infant: Apparently normal.
(11). Attitude of siblings and other associates to infant: Apparently normal.
(12). Attitude of parents to each other and other members of the family: Apparently normal.
(13). Shocks, frights etc.: Nil.

(B). **Childhood.**

(1). Illnesses: Measles and whooping cough aet 5.
   Chickenpox aet 7.
   Mumps aet 11.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition:
   Excitable, mischievous and boisterous in early childhood, but later in childhood became very quiet.
(4). Material home conditions: Rather poor.
(5). Attitude of parents to child: Overprotected by mother.
(6). Attitude of siblings to child: Apparently normal.
(7). Family relations: Apparently normal.
   Standard: Above average (top of the class). Good at games. Popular with school fellows and teachers.
(9). Shocks or frights: Nil.
(C). **ADOLESCENCE.**


(2). Development: Normal.

(3). Temperament and peculiarities of disposition: Quiet. Always had "big ideas".

(4). Material home conditions: Rather better - moderately satisfactory.

(5). Attitude of Parents: Overprotected by mother.

(6). Attitude of Siblings: Normal.

(7). Family relationships: Normal.

(8). Work: Postman. He never liked the work, and constantly complained about it.

(9). Shocks or frights: A few weeks before his first breakdown, he was summoned to see his brother who had been involved in an accident and had been taken to hospital. He appeared to be greatly distressed at the time. (July, 1934).

(10). Social activities: Danced, but had few outside interests.

(11). Sex life:
   - Attitude towards same sex: Normal.
   - Attitude towards opposite sex: Normal.

(E). **RELATIONSHIP OF ONSET TO ENVIRONMENT.**
Second breakdown associated with return to work.

(F). **HEREDITY:**
Father - "nervous worrying temperament".

(G). **CONCLUSIONS.**

(1). Chief Factors:
   (a). Mental trauma:
       Shock of brother's accident - precipitating factor.
       Uncongenial work.
   (b). Physical trauma: -
   (c). Material conditions: -

(2). Principal manifestations of mental disease.
First breakdown in July 1934 with fairly typical hebephrenic manifestations. Treated at Hanwell Mental Hospital and discharged "recovered" in 8 months. Remained well for a time after his discharge, but on return to work (message boy at a shop) which again he disliked, he gradually became "moody" and introverted. He is now dissociated from reality, is manneristic and has bizarre delusions.
(Conclusions - Cont'd.)

(3). Correlation of clinical manifestations and environmental factors.  
Nil obvious.

(4). Insight regarding these environmental factors during remission or recovery.  
Nil.

(5). Environment after discharge:  
Still in hospital.
No. 239. MR. W.J.B.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset : 21. Date of onset : 14.9.35.
Age on admission: 21. Date of admission: 23.9.35.

(A). PRENATAL - INFANCY.

(2). Birth: Very easy.
(3). Feeding: Breast fed.
(4). Age of parents at time of patient's birth:
    Father: 29.
    Mother: 30.
(5). Spacing of pregnancies:
    Female, 10 months, Female, 14 months, Male,
    3 miscarriages, 3 years, Patient, 2 years,
    Male, 3 years, Male, 2 years, Female.
(6). Illnesses, including fits: Measles, aged 2 yrs.
(7). Development: Forward in teething, walking and
talking.
(8). Temperament and peculiarities of disposition:
    Normal.
(9). Material home conditions: Overcrowded - poor
    financial circumstances.
(10). Attitude of parents to infant: Normal.
(11). Attitude of siblings and other associates to
    infant: Normal.
(12). Attitude of parents to each other and other
    members of the family: Unhappy owing to father's
    infidelity.
(13). Shocks, frights etc.: Nil.

(B). CHILDHOOD.

(1). Illnesses: Scarlet Fever at 7 years. Was
    very ill and left with a discharging ear, which
    has never cleared.
(2). Development: Apparently normal.
(3). Temperament and peculiarities of disposition:
    Quiet and inclined to be taciturn.
(4). Material home conditions: Father deserted the
    family when the patient was 7 years old.
    Financial difficulties - mother had separation
    allowance, and worked to keep the children.
(5). Attitude of parents: Normal.
(6). Attitude of siblings: Normal.
(7). Family relations: Better after the father left
    home.
(8). School: Age of entry - 5 years. Age of leaving
    14 years. Standard - Below the average.
    Was not a good scholar.
(9). Shocks or frights: Nil.
(C). ADOLESCENCE.

(1). Illnesses: Nil.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Reserved. He made no friends outside his own family.
(4). Material home conditions: Mother was divorced and remarried when the patient was 14. Still overcrowded.
(5). Attitude of Parents: Normal.
(6). Attitude of Siblings: A very united family, even after marriage.
(7). Family relationships: Amicable. The stepfather got on well with the rest of the family.
(8). Work: Errandboy, vanboy and carpet-beater. Employed by carpet-beating firm during summer months only. Unable to find other work during winter months. Hardworking during periods of employment. His work made him "fed-up", and he disliked the foreman intensely. Was latterly irritated by the monotonous and nerve-racking clanking of one of the machines.
(9). Shocks or frights: Nil.
(10). Social activities: He made no outside contacts. Was very fond of going to the cinema, also reading, and enjoyed the 'bloodthirsty' types of films and books.
(11). Sex life:
   Attitude towards same sex: Normal.
   Attitude towards opposite sex: Not interested in girls.

(D). ADULT.

(1). Illnesses: Nil.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Quiet and taciturn.
(5). Attitude of Parents: Normal.
(7). Family relationships: Amicable.
(8). Marriage: Unmarried.
(9). Work: Carpet-beater. He did not like his work.
(10). Shocks or frights: He got a severe shock in May, 1935, when his foreman collapsed amongst the machinery. The patient dragged him out, and was afterwards much worried by constant interrogation in connection with the accident.
(11). Social Activities. No outside interests.
(12). Sex life: As in adolescence.
(E).  RELATIONSHIP OF ONSET TO ENVIRONMENT.

Patient appeared to be upset by his work at the factory.

(F).  HEREDITY:

Father unstable and lascivious.

(G).  CONCLUSIONS.

(1). Chief Factors.
   (a). Mental trauma: Strife between parents, ending in divorce. (patient aet 14).
       Dislike of his work.
       Witness to severe accident, 4 months before onset of illness (? precipitating factor).
   (b). Physical trauma: -
   (c). Material conditions: -

(2). Principal manifestations of mental disease.
   Typical Schizophrenic reaction commencing with a depressed phase, and now showing great emotional incongruity, and irrational rather disjointed thought processes.

(3). Correlation of clinical manifestations and environmental factors:
   Nil obvious.

(4). Insight regarding these environmental factors during remission or recovery.
   Nil.

(5). Environment after discharge:
   Still in hospital.
No. 250. MR. J.E.W.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: 23. Date of onset: Sept., 1935. 
Age on admission: 23. Date of admission: 3.12.35.

(A). PRENATAL - INFANCY.

(2). Birth: Normal.
(3). Feeding: Normal.
(4). Age of parents at time of patient's birth:
   Father: 41.
   Mother: 40.
(5). Spacing of pregnancies:
   Half-brother, 2 years, Half-sister, 2 years,
   Half-brother, 9 years, Brother, 2 years, Patient.
(6). Illnesses, including fits: Measles and
   Pneumonia - 11 months. Slight rickets in
   infancy.
(7). Development: Normal.
(8). Temperament and peculiarities of disposition:
   Normal.
(9). Material home conditions: Poor.
(10). Attitude of parents to infant: Mother over-
    protective. Father indifferent.
(11). Attitude of siblings and other associates to
    infant: Normal.
(12). Attitude of parents to each other and other
    members of the family: Father ignored and
    despised by mother because of his laziness.
    Father alcoholic. Strife between the parents.
(13). Shocks, frights etc.: Nil.

(B). CHILDHOOD.

(1). Illnesses: Minor accidents at school.
   (? head injury)
(2). Development: Normal.
(3). Temperament and peculiarities of disposition:
   Quick tempered, rather eccentric and fastidious,
   but sociable.
(4). Material home conditions: Poor.
(5). Attitude of parents to child: Mother over-
   protective. Father indifferent.
(6). Attitude of siblings to child: Normal.
(7). Family relations: Strife between the parents.
   Standard: Above the average.
   He was popular with both masters and other
   scholars.
(9). Shocks or frights: Nil.
No. 250.

(C). ADOLESCENCE.

(1). Illnesses: Nil.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition:
As in childhood - excitable and eccentric, but sociable.
(4). Material home conditions: Poor.
(5). Attitude of Parents: Over-protected by mother.
Father indifferent.
(6). Attitude of Siblings: Normal.
(7). Family relationships: Strife between the parents.
(8). Work: Shoe factory. No strain. He got on well at work.
(9). Shocks or frights: Nil.
(10). Social activities: Varied outside interests, including Boys' Club.
(11). Sex life:
Attitude towards same sex: Normal.
Attitude towards opposite sex: Not interested.
No abnormal habits.
? knowledge.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

First signs of mental disorder noticed at work.

(F). HEREDITY:

Father - ? alcoholic.
Half-sister - Epileptic. She did not live in the home.

(G). CONCLUSIONS:

(1). Chief Factors:
(a). Mental trauma: Mother's overprotection.
(c). Material conditions: Poor material conditions throughout life.
(2). Principal manifestations of mental disease.
Typical hebephrenic. He is manneristic, fatuous and his behaviour is mischievous and unreliable.
(3). Correlation of clinical manifestations and environmental factors: Nil.
(4). Insight regarding these environmental factors during remission or recovery: Nil.
No. 339 & 723. MISS F.B.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: 21. Date of onset: 1928.
Age on admission: a) 21. Date of admission: a) 10.3.28.
               b) 26. Date of admission: b) 4.4.33.

(A). PRENATAL - INFANCY.

(1). Pregnancy: 7 months pregnancy.
(2). Birth: Difficult prolonged labour.
               Instruments used.
(3). Feeding: Bottle fed.
(4). Age of parents at time of patient's birth:
               Father:) Both between
               Mother:) 25 and 30.
(5). Spacing of pregnancies:
               Female, 3 years, Patient, 2 years, Female.
(6). Illnesses, including fits: Very delicate,
               always ailing. Had eye trouble from infancy.
               Operation to feet during infancy.
(7). Development: Teeth - normal age.
               Talked - 2 years old.
               Walked - 2 years old. (Delayed by
               foot trouble and operation.)
(8). Temperament and peculiarities of disposition:
               Quiet, shy and docile.
(9). Material home conditions: Good.
(10). Attitude of parents to infant: Normal.
(11). Attitude of siblings and other associates to
               infant: Normal.
(12). Attitude of parents to each other and other
               members of the family: Unhappy family atmosphere.
(13). Shocks, frights etc.: Nil.

(B). CHILDHOOD.

(1). Illnesses: Delicate. Measles and whooping
               cough.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition:
               Shy and quiet.
(5). Attitude of parents to child: Patient was spoilt
               by her father.
(6). Attitude of siblings to child: Siblings
               antagonised towards the patient, because of the
               father's attitude.
(7). Family relations: Unhappy. Father unfaithful
               to his wife.
               Standard: Average scholar. No details.
(9). Shocks or frights: Nil.
No. 339 & 723.

(C). ADOLESCENCE.

(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Shy and timid. Resentful and jealous of others' successes.
(4). Material home conditions: Poor. (Mother left father, and took the patient and her elder sister.)
(5). Attitude of Parents: Parents separated when the patient was aged 16. The patient went with her mother.
(6). Attitude of Siblings: Siblings despised the patient because of her inability to "get on".
(7). Family relationships: No regular home life.
(8). Work: Shop assistant and domestic service. Casually chosen. The patient lacked the capacity to fill either of these positions satisfactorily, and had much unemployment. She disliked domestic work.
(9). Shocks or frights: Nil.
(10). Social activities: She was not interested in social life.
(11). Sex life:
   Attitude towards same sex: Normal.
   Attitude towards opposite sex: She does not mix with the opposite sex, but looks forward to marriage.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

No direct relationship to any particular situation.

(F). HEREDITY. Nil.

(G). CONCLUSIONS.

(1). Chief Factors:
   (a). Mental trauma: Unhappy home life, owing chiefly to the father's infidelity which led to the dissolution of the home. Her sisters were antagonised towards the patient because her father had "spoilt" her, and latterly despised her because of her failures at work.
   (b). Physical trauma:
       Poor physical health from infancy.
   (c). Material conditions:
       Home conditions poor during latter years.
(Conclusions - Cont'd.)


(3). Correlation of clinical manifestations and environmental factors. Nil obvious.

(4). Insight regarding these environmental factors during remission or recovery. No insight.

(5). Environment after discharge: Improved sufficiently to be discharged from hospital (3.3.32) and returned to face the same adverse environmental conditions as before. Soon relapsed and was readmitted on 4.4.33, has been in hospital since and has not improved.
No. 371. MISS A.D.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: 15. Date of onset: 1927.
Age on admission: 15. Date of admission: a) 1928.  b) 16.5.29.

(A). PRENATAL - INFANCY.

4. Age of parents at time of patient's birth:
   Father: 23.
   Mother: 23.
5. Spacing of pregnancies:
   Female, 1 year, Patient, 9 years, Male.
6. Illnesses, including fits: Nil.
8. Temperament and peculiarities of disposition: Normal.
10. Attitude of parents to infant: Normal.
11. Attitude of siblings and other associates to infant: Normal.
12. Attitude of parents to each other and other members of the family: Happy.
13. Shocks, frights, etc.: Nil.

(B). CHILDHOOD.

5. Attitude of parents to child: Possibly spoilt by parents.
6. Attitude of siblings to child: Normal (? some jealousy).
7. Family relations: Happy.
9. Shocks or frights: Nil.

(C). ADOLESCENCE.

1. Illnesses: Frequent "colds". Psoriasis.
3. Temperament and peculiarities of disposition: Reserved. Sensitive about her Psoriasis.
4. Material home conditions: Good.
(Adolescence - Cont'd.)

(5). Attitude of Parents: Probably overprotected by parents.

(6). Attitude of Siblings: Some jealousy between the patient and her sister.

(7). Family relationships: Happy.

(8). Work: Clerical. Carefully chosen, but did not get on too well. She tried manual work, but disliked that also. Poor general adjustment to work.

(9). Shocks or frights: Nil.


(11). Sex life:
   Attitude towards same sex: ) Not known.
   Attitude towards opposite sex: ) Not known.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

No definite relationship.

(F). HEREDITY:

Nil.

(G). CONCLUSIONS:

(1). Chief Factors:
   (a). Mental trauma: Sensitive about her skin trouble.
       Parents overprotective.
       Maladjustment at work.
   (b). Physical trauma: -
   (c). Material conditions: -


(3). Correlation of clinical manifestations and environmental factors. Nil obvious.

(4). Insight regarding these environmental factors during remission or recovery. Query some insight gained.

(5). Environment after discharge:
    The patient remained stationary for a considerable time, but eventually improved sufficiently to be discharged (12.10.33). Since then she has remained well. The parental attitude is considerably changed - as the result of advice - and the patient has found a simple type of factory work which she likes, and appears to be quite happy among her fellow workers.
NO: 580 ) MISS. J.H.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: 19  Date of onset: 
Age on admission: 19  Date of admission: 11.6.31.

(A). PRENATAL - INFANCY.
(2). Birth: Normal.
(3). Feeding: No information.
(4). Age of parents at time of patient's birth:
   Father: 20.
   Mother: 27.
(5). Spacing of pregnancies:
   Patient, 2 yrs, Female.
(6). Illnesses, including fits: Nil.
(7). Development: Retarded - no details.
(8). Temperament and peculiarities of disposition:
   Quiet and shy.
(9). Material home conditions: Very poor.
(10). Attitude of parents to infant: Possibly rejected by dominant mother.
(11). Attitude of siblings and other associates to
   infant: Sister quiet but alert and ignored patient.
(12). Attitude of parents to each other and other
   members of the family: Mother and sister devoted
   to each other. Father was dispised by mother for
   his lack of success. Patient was neither
   understood nor appreciated by the other members
   of the family.
(13). Shocks, frights etc., Unknown.

(B). CHILDHOOD.
(1). Illnesses: Nil.
(2). Development: Slow
(3). Temperament and peculiarities of disposition:
   Shy, solitary, self resourceful. Had plenty of
   imagination; whimsical.
(5). Attitude of parents to child and vice versa:
   Rejected by parents.
(6). Attitude of siblings to child: Dispised by more
   active sister.
(7). Family relations: Indifferent - as before.
(8). School: Age of entry: 5.
   Age of leaving: 14.
   Below standard in ordinary academic subjects.
   Extremely good at drawing and painting. Got on
   well with certain teachers who "understood" her.
   Did not "mix" with schoolmates.
ADOLESCENCE.

(1). Illnesses: Nil.
(2). Development: Normal.
(5). Attitude of Parents: Rejected, especially by Mother.
(6). Attitude of siblings: Dispised by sister.
(7). Family relationships: Indifferent home atmosphere. Mother and sister congenial Father unsuccessful and patient was classed with father as a "failure".
(8). Work: Dressmaking. Casually chosen. No strain. Material conditions: Work was most uncongenial to patient - no scope for her artistic abilities. She was found fairly capable but below average.
(9). Shocks or frights: Nil.
(10). Social activities: Opportunities present but not accepted as patient had little interest in social activities.

RELATIONSHIP OF ONSET TO ENVIRONMENT.
Onset of illness not definitely related to any special environment. She was unhappy both at home at at her work.

HEREDITY. Nil.

CONCLUSIONS.

(1). Chief Factors:
(a). Mental trauma. Atmosphere at home. Patient not understood or appreciated by mother or sister. School and work - no opportunity for development of the patient's artistic capacity and forced to do uncongenial work.
(b). Physical trauma.
(c). Poor home conditions.
(2). Principal manifestations of mental disease. Patient admitted in a state of acute katatonic excitement.
(3). Correlation of clinical manifestations and environmental factors: Nil.
(4). Insight regarding these environmental factors during remission or recovery: Nil.
(5). Progress: Patient gradually settled down and eventually recovered sufficiently to be discharged. (23.4.32). She returned to her former occupation in which she had no real interest, and at home her mother again showed very little understanding regarding the patient's condition. She gradually deteriorated and had to be readmitted (14.12.32). She is still in hospital and her mental condition is unimproved.
MISS. F.T.

DIAGNOSIS: Catonic Schizophrenia.

Age at onset: 16     Date of onset:     16     Date of admission: 2.10.31.

(A) PRENATAL - INFANCY.

(1) Pregnancy: Normal.
(2) Birth: Labour prolonged and difficult. No instruments or anaesthetic.
(3) Feeding: Breast fed until 10 months. Weaned easily.
(4) Age of parents at time of patient's birth.
   Father: 18
   Mother: 17.
(5) Spacing of pregnancies: First of family of two.
   (Patient, one year, male, 15 mths).
(6) Illnesses, including fits: Nil.
(7) Development: Walked 10 months
   Talked: 12  Commencement.
   Teething 5
(8) Temperament and peculiarities of disposition: Normal.
(9) Material home conditions: Satisfactory working class home.
(10) Attitude of parents to infant: Child liked but not spoiled by both parents.
(11) Attitude of siblings and other associates to infant:
(12) Attitude of parents to each other and other members of the family: No known disturbances.
   Father away at the war.
(13) Shocks, frights etc., Unknown.

(B) CHILDHOOD.

(2) Development: Normal bright child.
(3) Temperament and peculiarities of disposition: Nil.
(4) Material home conditions: Satisfactory although frequently faced with poverty.
(5) Attitude of parents to child and vice versa: Liked by parents but not spoiled.
(6) Attitude of siblings to child:
(7) Family relations: Happy. Only disturbance was that father was frequently in trouble with police
   and in jail several times. Patient had a sheltered life and was not encouraged to mix with outsiders.
(8) School: Entry; 3 yrs. Leaving: 12 yrs. Normal standard until last year or so when she
   appeared rather dull. Enjoyed school and its association.
(9) Shocks or frights: Unknown.
(C) ADOLESCENCE.

(1) Illnesses: Nil. Health good.
(2) Development: Normal.
(3) Temperament and peculiarities of disposition: Solitary in type and this attitude was encouraged by her mother.
(4) Material home conditions: Fairly good in spite of instances of privation.
(5) Attitude of Parents: Liked by parents and vice versa.
(6) Attitude of siblings:
(7) Family relationships: Unhappiness at home owing to father's terms in prison. (v.i).
(8) Work: One year after leaving school worked as kennel maid. Liked this work and gave satisfaction. Thereafter had to work in factory, work which she did not like. She seemed out of her element and became dull and confused.
(9) Shocks or frights:
(a) Worried and shocked regarding the lurid explanation given to her by fellow factory worker, while previously she had no instruction or knowledge of sexual affairs.
(b) Shame attached to father's delinquencies and consequent fabrication. She learnt the truth about her father's absences from home about one year before the onset of her illness and was greatly upset at the time.
(c) Electric shock at onset of illness.
(10) Social activities: Secluded and solitary by nature. Could not adjust herself to communal factory life.
(11) Sex life:
Attitude towards same sex: No special friends.
Attitude towards opposite sex: No male friends.
No correct sexual instruction. Just before onset of illness she was worried because her menstruation period was slightly delayed.

(E) RELATIONSHIP OF ONSET TO ENVIRONMENT:
Onset definitely related to change of work from kennel maid to factory hand.

(F) HEREDITY: Nil.

(G) CONCLUSIONS.
(1) Chief Factors:
(a) Mental trauma. Solitary secluded type, partly due to parents' attitude, suddenly thrust into factory life which was a drastic change of environment. Worries:
   (a) Ignorant of sexual matters until eventual and unfortunate enlightenment which perturbed her greatly.
   (b) Shame over father's life.
No: 590.

Conclusions cont'd.


(c). Material home conditions were undoubtedly poor from time to time corresponding to the father's terms of imprisonment.

(2). Principal manifestations of mental disease.
Acute catatonic excitement - noisy, restless.
Aurally and visually hallucinated - "sees God and angels in her room".
Faulty in habits and masturbates freely and openly.

(3). Correlation of clinical manifestations and environmental factors:
Mental manifestations roughly indicate the state of conflict and confusion resulting from the reaction of a girl living in ignorant bliss of worldy and sexual matters, suddenly thrust into an atmosphere of communal activity where sexual matters were freely and immorally discussed.

(4). Insight regarding these environmental factors during remission or recovery. Nil.

(5). Environment after discharge.
Gradually became quiet and less confused. Mentally she was found to be simple and childish. Discharged 29.4.32 "recovered". Reintroduced into the environment of the outside world through the less disturbing channels of the Girl Guides and her work as a nursery maid.
No: 591. MISS B.C.

**DIAGNOSIS:** Congenital Mental Deficiency, and Hebephrenic Schizophrenia.

**Age at onset:** 17  **Date of onset:**

**Age at admission:** 17  **Date of admission:** 14.10.31.

(A). PRENATAL - INFANCY:


(2). Birth: Labour stated to be difficult. (? veracity of this statement).

(3). Feeding: Breast fed 9 months. Weaned easily.

(4). Age of parents at time of patient’s birth:
   
   Father: 33
   
   Mother: 31.

(5). Spacing of pregnancies: 10th of 14 pregnancies:
   
   Female, 2 yrs, Male, 1 yr, Male, 1 yr, Male, 2 yrs,
   
   Female, 1 yr, Female, 1 yr, Female, 1 yr, Female,
   
   1 yr, Male, 1 yr, Patient, 1 yr, miscarriage,
   
   six yr, Female, three yrs, Female.

(6). Illnesses, including fits: Whooping cough 18 mths.
   
   Congenital Syphilis. 1 fit, 18 months.
   
   Measles 2 years, Chicken pox 2½ years.

(7). Development: Feeding began four months.
   
   Walking began 12 months. Speech very retarded.
   
   Could not make herself understood till age of 6-7.

(8). Temperament and peculiarities of disposition: Extremely retarded but quite happy.

(9). Material home conditions: Very poor.

(10). Attitude of parents to infant: Normal.

(11). Attitude of siblings and other associates to infant: Normal.

(12). Attitude of parents to each other and other members of the family: Constant strife and unhappiness between parents.

(13). Shocks, frights, etc.,

(B). CHILDHOOD.

(1). Illnesses: Tonsils and adenoids removed at 12.
   
   Congenital Syphilis. Suffered from deafness.

(2). Development: Slow and backward.

(3). Temperament and peculiarities of disposition: Dull but apparently happy.


(5). Attitude of parents to child and vice versa: Normal.

(6). Attitude of siblings to child: Normal.

(7). Family relations: Constant strife between parents.
   
   Legal separation between parents when patient at 13. Father given custody of child.

   
   Extremely backward. (at age of 14 was in class where average age was 9). Attended ordinary school - was never in a special school for defectives. Liked and treated kindly by teachers. Never made friends or mixed much with other scholars.
ADOLESCENCE. (C).

(1). Illnesses: Congenital Syphilis.
(2). Development: Slow and backward.
(3). Temperament and peculiarities of disposition: Dull but apparently happy.
(4). Material home conditions: Material conditions after leaving school were better as she no longer stayed at home.
(5). Attitude of Parents: "NORMAL" { NOT MUCH CONTACT (V.) }
(6). Attitude of Siblings: "NORMAL" }
(7). Family relationships: (Strife between parents).
quite happy in Convent.
(8). Work: Kitchen maid after leaving school, quite incapable.
(9). Shocks or frights: Age 16. Mother went to Court to try and regain custody of child (patient), and this worried the patient greatly as she evidently was much happier where she was in the Convent. Just before onset of mental illness the patient became greatly worried over religious matters.
(10). Social activities: Nil.
(11). Sex life: No instruction. No apparent interest on opposite sex and little interest in her own sex.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.
Onset of illness occurred in Convent where she had been kept since age of 14 after she had been found incapable of working and living in outside world. Actual onset was related to worry over religious matters, which she could not comprehend.

(F). HEREDITY:
Parents: Both parents alcoholic.
Maternal aunt suffered from delusional insanity.
History of alcoholism in both families.

(G). CONCLUSIONS:
(1). Chief Factors:
(a). Mental trauma. Constant strife between parents in home and consequent unhappiness.
Worries: (a). Fear of being discharged into custody of mother (age 16).
(b). Worry over religious matters prior to onset of illness.
Dull mentally defective child (result of congenital Syphilis) having to compete in school with children of usual intelligence.
(c). Home conditions very poor up to age of 14.

(2). Principal manifestations of mental disease.
General mental defect. Apathetic and introverted.
To begin with often appeared terrified.
(Conclusions - cont'd).

(3). Correlation of clinical manifestations and environmental factors:
Mental defect associated with congenital Syphilis. Terrified attitude probably related to worry, fear and uncomprehension over religious matters which occurred just previous to mental breakdown.

(4). Insight regarding these environmental factors during remission or recovery.
Nil.

(5). Environment after discharge.
Discharged 12.10.33. "Improved". Sent to suitable Institution for defectives, where she will no encounter the psychic strain engendered by having to complete with normal intellects.
No: 592. MISS D.A.

DIAGNOSIS: Catonic Schizophrenia.

Age at onset: ?/6  Date of onset: ?
Age on admission: 17  Date of admission: 30.10.31.

(A). PRENATAL - INFANCY.

(2). Birth: Normal.
(3). Feeding: No details obtainable.
(4). Age of parents at time of patient's birth: Not known.
(5). Spacing of pregnancies: Patient only child by mother's first union.
(6). Illnesses: Severe illness at 12 months, nature unknown. (?) Scarlet fever. Patient left marasmic, deaf and dumb.
(7). Development: No details obtainable.
(8). Temperament and peculiarities of disposition: History of fits of weeping and "tantrums".
(9). Material home conditions: No details obtainable.
(10). Attitude of parents to infant: Father was killed in war and was never known by patient. Mother was disinterested, even antagonistic towards the child.
(11). Attitude of siblings and other associates to infant:
(12). Attitude of parents to each other and other members of the family: Patient brought up by her Grandmother. Mutually devoted and patient apparently "spoilt" by the latter.
(13). Shocks, frights etc.: Unknown.

(B). CHILDHOOD.

(1). Illnesses: No further illnesses, apart from mumps (at 14) but remained undernourished, although in fairly good health.
(2). Development: Undernourished but not retarded.
(3). Temperament and peculiarities of disposition: Frequent fits of weeping and "tantrums". Otherwise a gentle affectionate child. Spoilt by grandmother.
(4). Material home conditions: No details of grandmother's home. Went to live with her mother after grandmother's death, when patient was aged 10. In mother's home conditions were poor.
(5). Attitude of parents to child and vice versa: Disinterest and antagonism of mother.
(6). Attitude of siblings to child:
(7). Family relations: Devotion and spoiling by grandmother.
(8). School: Entry to special deaf and dumb school at 10. Age of leaving - 15. Achieved average standard. Reported as being bright, observant and intelligent. Although inclined to be sensitive and reserved her attitude to her schoolfellows was quite normal.
(9). Shocks or frights: Greatly disturbed by grandmother's death. (At age of 10).
(C). **ADOLESCENCE.**

(1). Illnesses: Deaf and dumb.

(2). Development:

(3). Temperament and peculiarities of disposition: Still had fits of depression and weeping.

(4). Material home conditions: Poor.

(5). Attitude of Parents: Mother disinterested and antagonistic.

(6). Attitude of siblings:

(7). Family relationships: Patient did not know the same happiness after she went to live with her mother, following the grandmother's death.

(8). Work: After leaving school she lived at home for five months and then went to work as kitchenmaid. Good at her work and got on well with individual members of the household. Became more depressed and lacrymose for no apparent reason, apart from the fact that she imagined that the other members of the domestic staff were "talking about her".

(9). Shocks or frights:

(10). Social activities: Fond of reading and doing "cross-word" puzzles. No intimate friends or special outside interests.

(11). Sex life:

Attitude towards same sex: Normal, but no intimate friends.

Attitude towards opposite sex: Normal.

No instruction by relatives.

(E). **RELATIONSHIP OF ONSET TO ENVIRONMENT.**

Onset of illness related to her work as domestic servant when she became "suspicious" of her fellow-workers and had more frequent weepings and tantrums and there is also mention of an "hysterical faint".

(F). **HEREDITY.** Nil.

(G). **CONCLUSIONS.**

(1). Chief Factors:

(a). Mental trauma. Patient "spoilt" by grandmother and then at age of 10 had to live with her mother who was antagonistic towards her.

(b). Physical trauma. Severe illness (?) Scarlet Fever) in infancy which left the patient with serious physical affliction, deafness and dumbness.

(c). Material conditions certainly poor during her five months stay with her mother.

(2). Principal manifestations of mental disease. Onset of "ideas of reference" and suspicion. Emotional instability - weeping and "tantrums". Obsessed with dread of corporal punishment. After admission to hospital was introverted and inaccessible with period outbursts of catatonic excitement.
(3). Correlation of clinical manifestations and environmental factors:
Fears and suspicions resulting from harsh attitude of mother towards a child who had been thoroughly "spoiled" up to the age of 10.

(4). Insight regarding these environmental factors during remission or recovery.
Nil.

(5). Environment after discharged:
Transferred to another mental hospital - "not improved".

_________________________
MISS I.G.

DIAGNOSIS:  Hebephrenic Schizophrenia.

Age at onset:  24  Date of onset:  11.10.29
Age on admission:  26  Date of admission:  10.11.31.


(2). Birth:  Normal.
(3). Feeding:  Breast fed for nine months. Did not thrive till weaned when she was put straight on to a cup and spoon.
(4). Age of parents at time of patient's birth.
   Father  39
   Mother  41
(5). Spacing of pregnancies:
   Female, 4 yrs, Male, 3 yrs, Female (died at 3 yrs "heart trouble"), Patient.
(6). Illnesses, including fits:  Jaundiced at birth, lasted three months. Suffered from malnutrition till she was weaned at 9 months and thereafter improved but general health was poor.
(7). Development:  Very retarded. Talked 7 years.
   Walked 2 years. Teeth unknown.
(8). Temperament and peculiarities of disposition:
   Nervous infant.
(9). Material home conditions:  Rather poor owing to father's neglect.
(10). Attitude of parents to infant:  Mother over protective. Father uninterested and tended to be harsh.
(11). Attitude of siblings and other associates to infant:  Unknown.
(12). Attitude of parents to each other and other members of the family:  Considerable friction between the parents.
(13). Shocks, frights etc.,  Unknown.

(B). Childhood.

(1). Illnesses:  General health poor - illnourished etc. Measles, Chickenpox, Scarlet Fever.
(2). Development:  Very retarded. Could not talk properly till at 7 years.
(4). Material home conditions:  Poor till at 9, thereafter more satisfactory.
(5). Attitude of parents to child and vice versa:  Overprotective mother - child sheltered and hypochondriacal. Father rather harsh.
(6). Attitude of siblings to child:  Unknown.
(7). Family relations:  Friction between parents.
   Father died when patient at 9; mother remarried one year later and since father's death the atmosphere in the home has been quite pleasant.
(Childhood - cont'd).

   Age of leaving: 14.
   Definitely retarded - average age in patient's last class was 11. Although she found school work difficult she seemed quite happy.

(9). Shocks or frights: Father's death, patient aged 9, but latter apparently unaffected.

(C). ADOLESCENCE.

(1). Illnesses: Poor general health but by now disability was chiefly the result of "nerves".

(2). Development: Certainly retarded during the earlier years of adolescence.

(3). Temperament and peculiarities of disposition: Nervous and hypochondriacal.


(7). Family relationships: Harmonious.

(8). Work: Since leaving school (aged 14) patient has been employed as a canvasser by a trading company. Seemed to like the work and was fairly efficient.

(9). Shocks or frights: Nil.

(10). Social activities: Little outside interest. (confined, sheltered home life).

(11). Sex life:
   Attitude towards same sex: No special friends.
   Attitude towards opposite sex: Had one man friend but the association did not last.
   Menstruation started at age of 13 and she has always has a chronic brown discharge which seems to have been a great source of perturbation to the patient.

(D). ADULT.

(1). Illnesses: Hypochondriacal but latterly her physical condition has been quite satisfactory.

(2). Development: Now normal.

(3). Temperament and peculiarities of disposition: "Nervous" and hypochondriacal.


(7). Family relationships: Harmonious.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.
   Symptoms related to both home and work (v.i.)

(F). HEREDITY:
   Nil.
(G). CONCLUSIONS:

(1). Chief Factors:

(a). Mental trauma: Prolonged overprotection by and association with a hypochondriacal mother. Unhappy home environment up to age of 9 due to father's harsh nature and neglect of his home. Strain imposed upon a person who in childhood was certainly defective and retarded, coming in contact with outside world. Worry concerning vaginal discharge.

(b). Physical trauma. General debility in infancy and early childhood. Extension of this true physical debility into one with a marked psychic determination, probably the result of the overattention bestowed by a hypochondriacal mother. Chronic vaginal discharge since puberty.

(c). Material conditions moderately poor for first nine years of life.

(2). Principal manifestations of mental disease. Patient became confused and had delusions of a persecutory type i.e. that people were following her about outside with intent to kidnap her. She also believed that her cousin and her stepfather had an affair. Also numerous hypochondriacal symptoms. Recovered sufficiently to be discharged (4.4.30) but relapsed in 1931 with a more advanced schizophrenic reaction and is still in hospital. This appears to be a case of schizophrenia developing on top of a hypochondriacal neurosis which had existed from early childhood.

(3). Correlation of clinical manifestations and environmental factors:

Fear by the overprotected hypochondriacal child of the outside world translated into persecutory delusions. (Jealousy of stepfather was apparently also a basis for delusions but this jealousy had not previously been apparent).

(4). Insight regarding these environmental factors during remission or recovery. Nil.
Diagnosis: Schizophrenia (? Catatonic Type)

Age at onset: 23 (? 21). Date of onset: ?
Age on admission: 23 Date of admission: 20.11.31.

(2). Birth: Normal.
(3). Feeding: Breast fed. (Time of weaning not known.)
(4). Age of parents at time of patient's birth:
   Father: 38.
   Mother: 36.
(5). Spacing of pregnancies:
   Female, 1 yr, Male, 1 yr, Male, 2 premature births (in four years) Female, two miscarriages (in two years) Female, 2 yrs, Male, 1 yr, Female, 1 yr, Male, 1½ yrs, Patient.
(6). Illnesses, including fits: No serious illnesses. No fits.
(7). Development: Slight precocity. Walked 9 months, talked 9 months.
(8). Temperament and peculiarities of disposition:
   Quiet but slightly precocious and would sing for the company at age of three years.
(9). Material home conditions: Good.
(10). Attitude of parents to infant: Normal affection.
(11). Attitude of siblings and other associates to infant: Normal affection.
(12). Attitude of parents to each other and other members of the family: Chiefly undisturbed but two sisters are quick tempered and used to have violent quarrels with father.
(13). Shocks, frights etc., Unknown.

(B). Childhood.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition:
   Slightly precocious but otherwise no peculiarities.
(4). Material home conditions: Good.
(5). Attitude of parents to child and vice versa:
   Normal affection.
(6). Attitude of siblings to child: Normal affection.
(7). Family relations: Chiefly undisturbed with the exception of sisters' quarrels with father.
(8). School:
   Age of entry: (?)
   Age of leaving: 15.
   Achieved good average standard. Enjoyed school.
(9). Shocks or frights: Unknown.

(C). Adolescence.
(1). Illnesses: Nil. (Slight "mental breakdown" 1929, aet 21.)
(2). Development: Normal.
(3). Temperament and peculiarities of disposition:
   Reserved but friendly. Inclined to be fastidious, e.g. disliked mother's grammatical mistakes and father's loud voice.
(Adolescence - cont'd).

(4). Material home conditions: Good.
(5). Attitude of parents: Normal affection.
(6). Attitude of siblings: Normal affection.
(7). Family relationships: Probably undisturbed as quarrels between sisters and father seem to have died out.
(8). Work: Age 15-21 - stage dancing. Probable physical strain. Deliberately chosen but probably influenced by the fact that other members of the family were similarly occupied. Material conditions at work satisfactory. Suited to and liked stage work. Age 21-23; Travelled for "Hoovers".
Unemployment: Unemployed for one year previous to "breakdown" in 1929; Three months unemployed previous to onset of present illness. Unemployment seems to have disturbed the patient immensely.
(9). Shocks or frights: Nil.
(10). Social activities: Pleasure seeking.
(11). Sex life:
   (a). Attitude towards same sex: Normal. Had one intimate friend on the stage.
   (b). Attitude towards opposite sex: Normal. Had two intimate friends on the stage.
Patient appears to have had strict ideas on sexual relationships with opposite sex but nevertheless had illicit affair with a married man during the year previous to her first breakdown (1929). This seems to have worried her a great deal and she had definite ideas of unworthiness based on this misdemeanour. Sexual knowledge: well informed. No abnormal habits.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.
Onset of present illness related to period of unemployment.

(F). HEREDITY: Nil.

(G). CONCLUSIONS:
(1). Chief Factors:
   (a). Mental trauma: Worry and feeling of guilt regarding sexual misconduct. Worry regarding unemployment.
(2). Principal manifestations of mental disease.
   Depression. Feelings of guilt and unworthiness. Later confusion and disorientation added to the above.
(3). Correlation of clinical manifestations and environmental factors: Depression, guilt and unworthiness associated with her sexual lapse which was much contrary to her high moral ideals.
No: 595.

(Conclusions - cont'd).

(4). Insight regarding these environmental factors during remission or recovery.

(5). Environment after discharge:
Made gradual recovery and was discharged 28.4.32. "Recovered". Went to live at home and is anxious to get work as soon as possible.
31.5.32. Married to her brother-in-law.
Material conditions good.
21.9.33. Conditions satisfactory. Patient has made good adjustment. Has just had a baby.

This patient possessed an energetic nature and high moral ideals. The two chief factors (unemployment and illicit sexual relationship) were adversely related to these characters. Both the patient and her mother seem to have an almost obsessed fear of unemployment. Since her marriage the patient seems contented and well adjusted. Marriage as an employment, being likely to last, without idle periods, will probably suit the patient's temperament without causing or giving access to overactivity and strain.
No. 596. MISS. V.P.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: 20  Date of onset:  
Age on admission: 20  Date of admission: 20.11.31.

(A). PRENATAL - INFANCY.

(2). Birth: Difficult but non instrumental.
(3). Feeding: Breast fed three months.
(4). Age of parents at time of patient’s birth:
   Father 25  
   Mother 26
(5). Spacing of pregnancies:
   Female, 2 yrs, Female, 1 yr, Female 1 yr,  
   Patient, 3 yrs, Female, 2 yrs, Female, 2 yrs, Male.
(6). Illnesses, including fits: Suffered from Rickets.
(7). Development: Developed more quickly than average  
   but exact time of teething etc forgotten.
(8). Temperament and peculiarities of disposition:  
   described as being a precocious infant.
(9). Material home conditions: Satisfactory.
(10). Attitude of parents to infant: Father alcoholic  
     and described as having a jealous disposition  
     which frequently led to strife and unhappiness.  
     (Contrasted Syphilis at age of 20 and died of  
     G.P.I aet 36).
(11). Attitude of siblings and other associated to  
     infant: not known.
(12). Attitude of parents to each other and other  
     members of the family: Sisters frequently  
     quarelled and the home atmosphere seems to have  
     been definitely unrestful.
(13). Shocks, frights etc.: Not known.

(B). CHILDBOOD.

(1). Illnesses: Apart from residual rachitic  
   deformalities patient was healthy.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition:  
   No abnormalities noted.
(5). Attitude of parents to child and vice versa:  
   Jealous alcoholic father - consequent strife  
   and unhappiness.
(6). Attitude of siblings to child: Mutual liking  
   between patient and sisters.
(7). Family relations: Uneasy atmosphere due to  
   quarrelling between the patient's sisters  
   and to father's habits and temperament.
     Age of leaving: 14.  
     Reached top standard and had above average ability.  
     Enjoyed school life.
(9). Shocks or frights: unknown.
(C). ADOLESCENCE.


(2). Development: Normal.

(3). Temperament and peculiarities of disposition: Gentle and affectionate. Always anxious to please others. Easily upset.


(5). Attitude of Parents: Unrestful atmosphere at home due to father's

(6). Attitude of siblings: Jealousy etc and sisters' quarrels but nevertheless the various members of the family appeared to like each other. Patient had to act as peacemaker to her sisters.

(8). Work: Stationers shop. No evidence of strain. Liked work and got on well until three to four weeks before onset of illness when she was transferred to another branch of the firm and was unhappy there because of unkind treatment meted out by the other shop assistants who were jealous of the patient's promotion and she worried because she found her new job difficult.

(9). Shocks or frights: Shock and disappointment over love affair (v.i.)

(10). Social activities: Fond of reading and went out a lot with her friends.

(11). Sex life:

(a). Attitude towards same sex: Numerous companions but no particular friend.

(b). Attitude towards opposite sex: During the three months prior to her mental illness she became very attached to a young Jew. One week before her illness started the Jew broke off the relationship and this upset the patient very much.

No instruction given by mother.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

Onset chiefly related to her work where she was worried and confused.

(F). HEREDITY.


(b). Siblings: One sister has "neurasthenia".
CONCLUSIONS.

(1). Chief Factors:

(a) Mental trauma. Unrestful home atmosphere which had existed all her life, chiefly the result of her sisters' quarrelling. G.P.I. Father. Patient was often worried and upset by these disturbances and took on the role of peacemaker.

Unhappy love affair with abrupt termination.

Change of environment in her work from an easy position to one which taxed her ability and in which she encountered personal jealousy and antagonism.

(The latter two factors appear to be the precipitating agents which unbalanced a rather sensitive nature, which had been strained by the long standing unrestful atmosphere at home).

(b) Physical trauma. Residual rachitic deformities resulting from Infantile Rickets. (Also a psychic factor - stigma of deformity).

(c) Material conditions; Nil abnormal.

(2). Principal manifestations of mental disease.

Gradual onset of depression, anxiety and confusion dating from change in employment.

Admission to hospital because of acute attack of maniac excitement. Thereafter affective state chiefly one of depression with short periods of excitement. Introverted and hostile attitude. No improvement until 20.8.32 (Adm.20.11.31) when she became more settled and less confused.

Discharged "Relieved" 13.10.32.

(3). Correlation of clinical manifestations and environmental factors:

Affective state of anxiety, depression with excited periods and hostile attitude to others combined with apparent confusion indicate the reaction of the unhappy jealous environment of her last situation at work.

There was no direct evidence of the effect of her unhappy love affair.

(4). Insight regarding these environmental factors during remission or recovery.

None apparent up to the time of discharge.

(5). Environment after discharge.

Patient settled down at home and gradually returned to her "normal self". Her sisters seemed inclined to withdraw personal animosities out of anxiety to help and look after the patient. Patient seems content to lead a sheltered life at home - no strain on a sensitive nature. Later (11.4.34) Patient reported to be in good health and working in a factory for the past four months.
MISS U.C.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: 20 1st attack. Date of onset: 1929.
22 2nd attack.
Age on admission: 22. Date of admission: 24.11.31.

(A). PRENATAL - INFANCY.

(2). Birth: Normal.
(3). Feeding: Breast fed 10 months. Weaned easily.
(4). Age of parents at time of patient's birth:
   Father: about 26.
   Mother: 23.
(5). Spacing of pregnancies:
   Female, 1 year, male, 3 years, Patient, 3 years,
   male, 3 years, female.
(6). Illnesses, including fits: Nil serious.
(7). Development: Normal. Walked 12 months.
    Talked 12 months. Teethed normal.
(8). Temperament and peculiarities of disposition:
    Quiet and contented. Stable.
(9). Material home conditions: Poor - owing to
    financial difficulties as a result of the
    father's intemperance.
(10). Attitude of parents to infant: Liked and
    "petted" - owing to solemn rather frail "make
    up".
(11). Attitude of siblings and other associates to
    infant: Liked and "petted".
(12). Attitude of parents to each other and other
    members of the family: Unhappy, owing to the
    father's intemperance.
(13). Shocks, frights, etc.: Nil.

(B). CHILDHOOD.

(1). Illnesses: No serious illnesses.
(2). Development: After infancy she became rather
    frail and delicate looking, but there is no
    history of retardation, etc.
(3). Temperament and peculiarities of disposition:
    Quiet and rather timid.
(4). Material home conditions: Never more than
    moderate. 1914 to 1918, satisfactory while
    the father was at the war. After mother's
    second marriage conditions have been rather
    poor, owing to periods of unemployment of
    stepfather.
(5). Attitude of parents to child: Mother pities
    and despises the patient. She has never
    considered the patient to be as good as her
    siblings.
(Childhood - Cont'd.)

(6). Attitude of siblings to child: Brothers and sisters fond of the patient.
(7). Family relations: After father's death, home atmosphere was satisfactory.
(8). School: Age of entry, 5. Age of leaving, 14½. Standard: Rather backward latterly, but this was considered to be the result of numerous changes of school rather than to any dulness on the part of the patient. Psychological environment at school: Satisfactory except for one year when aged 8, when she was associated with children of a lower social class and these disturbed her sensitive nature and made her unhappy.
(9). Shocks or frights: Father's death occurred when aged 8, but did not appear to affect the patient.

(C). ADOLESCENCE.

(1). Illnesses: Nil serious. Still rather "frail".
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Patient now definitely of sensitive, nervous self-centred personality. (Nervousness increased to stage of mental breakdown when aged 15.)
(4). Material home conditions: As in childhood.
(5). Attitude of Parents: Mother pitied and despised the patient. Stepfather felt normal affection.
(6). Attitude of Siblings: She was liked by brother and sister, but the patient was jealous of her sister's popularity and ability to find work.
(7). Family relationships: No other disturbances apart from above.
(8). Work: The patient has always found difficulty in finding and doing work, in fact she has had very little employment and this has always depressed her and made her jealous of the comparative success of her brother and sister. Depression over unemployment seemed to be the precipitating cause of mental breakdown in 1929 (aged 20). After her breakdown (aged 15) she was under the care of M.A.C.A. who interested her in gardening which she liked and which did not worry her.
(9). Worry over religious controversy when aged 15 - preceded first breakdown.
(Adolescence - Cont'd.)

(10). Social activities: Fond of dancing and other social activities.

(11). Sex life:
   - Attitude towards same sex: Normal.
   - Attitude towards opposite sex: Normal.
   Adequate instruction.
   When aged 16 had a great disappointment when she fell in love with a man whom she afterwards discovered to be married.
   Menstruation - started 13½ years - normal.
   No abnormal sexual habits.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

At home she became restless and excited, and attacked mother with a pair of scissors.

(F). HEREDITY:

Father intemperate. History of mental illness during adolescence.

(G). CONCLUSIONS:

(1). Chief Factors.
   (a). Mental trauma: Attitude of mother - patient being rather frail physically and of a quiet rather sensitive nature from early childhood, mother being robust and extrovertive did not understand the patient and despised her, and always belittled her compared with the brother and sister. This attitude was definitely present before the patient's personality became frankly abnormal.
   Unemployment and jealousy of brothers' and sisters' ability to find and keep work. This is only a subsidiary factor, as it did not arise until after the patient had shown signs of a psychopathic nature.
   Unhappy home atmosphere during infancy, due to father's intemperance.
   Various minor worries - Disappointing love affair (aet 16) and religious worry (aet 15). These again acted in an already disturbed personality.
   (b). Physical trauma: Delicate from infancy onwards.
   (c). Material conditions: Poor during infancy.
(Conclusions - Cont'd.)

(2). Principal manifestations of mental disease. Restless and excited at home. She attacked her mother with a pair of scissors. Removed to hospital. On admission to Ewell Mental Hospital she was apathetic, introverted, foolish and impulsive in her behaviour, and had persecutory delusions concerning nearly everybody, but especially directed towards her mother.

(3). Correlation of clinical manifestations and environmental factors. Schizophrenic reaction with persecutory reference to mother, who had never understood her sensitive nature and treated her accordingly.

(4). Insight regarding these environmental factors during remission or recovery. Query insight.

(5). Environment after discharge. Gradual improvement, and was discharged 28.4.32. This is a clear case of maladjustment between mother and daughter (patient) where the former had little or no insight into the requirements of such a personality as that of her daughter.
No: 598. MISS D.K.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: 19. Date of onset: 1929

(A). PRENATAL - INFANCY.

(1). Pregnancy: No details obtainable. (Presumably within limits of normality).
(2). Birth: 
(3). Feeding: 
(4). Age of parents at time of patient's birth:
   Father: 36
   Mother: 30
(5). Spacing of pregnancies:
   Male, 2 yrs, Female, 3 yrs, Female, 1 yr, Patient, 2 yrs, Female, three yrs, Male, 2 yrs, Male, 3 yrs, Female.
(6). Illnesses, including fits: No details. No history of serious illness.
(7). Development: No details of any abnormality.
(8). Temperament and peculiarities of disposition: Normal.
(9). Material home conditions: Squalor of poverty.
(10). Attitude of parents to infant: Mother probably overbearing. Both parents are antagonistic and ill-tempered to everybody.
(11). Attitude of siblings and other associates to infant: No details.
(12). Attitude of parents to each other and other members of the family: Perpetual state of disharmony and unhappiness.
(13). Shocks, frights etc: No details.

(B). CHILDHOOD.

(1). Illnesses: No history of serious illness. Accident at 13, knocked over by taxi. No details as to type and extent of injury(v.i.)
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Normal until age of 13 when after accident patient became quiet and timid.
(5). Attitude of parents to child and vice versa: Antagonistic and ill-tempered.
(6). Attitude of siblings to child: No details.
(7). Family relations: Disharmony and unhappiness.
   Standard slightly below average. Teacher's report states that patient was quite bright and intelligent but that progress was retarded owing to dreadful home conditions.
(9). Shocks or frights: No details.
No: 598.

(C). ADOLESCENCE.

(1). Illnesses: Fainting fit after confinement aged 19.

(2). Development: Physical development normal.

(3). Temperament and peculiarities of disposition: Became quiet and timid after accident (aet 13) and since birth of illegitimate child has been sullen and morose.


(5). Attitude of Parents: Antagonistic and ill-tempered.

(6). Attitude of siblings: No details.

(7). Family relations: Disharmony and unhappiness.

(8). Work: Continued to live at home and went out doing charring. This type of work was too much in keeping with home conditions. Working capacity?

Unemployment: Was dismissed a few months before admission but this was quite evidently the effect and not the cause of her mental breakdown.

(9). Shocks or frights: Birth of illegitimate child with disappearance of the father (aet 19).

(10). Social activities: Nil.

(11). Sex life:

Attitude towards same sex: Normal.
Attitude towards opposite sex: From age of 17 kept company with man who was father of her child at age of 19. Attitude to child - liked child.

Sexual knowledge etc: (?) but concerned with the stigma of illegitimacy.

Menstruation normal.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

Seen chiefly during patient's working hours but probably also present at home although no information forthcoming or admitted.

(F). HEREDITY. Nil.

(G). CONCLUSIONS.

(1). Chief Factors:

(a). Mental trauma. Home conditions both material and psychological were sordid and unhappy. No release from this atmosphere when the patient started work. Precipitating factors were:

(1). Shock of accident, aet 13, followed by change of disposition to undue timidity and quietness.

(2). Birth of illegitimate child and decampment of father (aet 19) followed by further change of disposition to one of moroseness and sullenness.


(c). Material conditions very bad all her life.

This case is a striking illustration of a child of normal temperament developing dementia praecox during adolescence, apparently the result of psychic trauma on two occasions with a background of a/
(Conclusions - cont'd).

1/ persistently bad environment. The patient might have been able to accommodate herself to the environment but the two grave shocks overcame her resistance with consequent deterioration of personality. The deterioration was accomplished in two distinct stages with acute psychic trauma heralding their onset.

2. Principal manifestations of mental disease. Sullen, evasive and hostile. Says she does not know the Christian names of either of her parents.

3. Correlation of clinical manifestations and environmental factors: Defensive relation to bad treatment she received by her parents and others. Denial of knowledge of the names of her parents indicates a wish to sever her association with them.

4. Insight regarding these environmental factors during remission or recovery. Nil.

5. Environment after discharge. Discharged 26.5.32. "Recovered". Returned home to live with her mother and child. Seems to have been rather unhappy and apathetic as long as this arrangement proceeded but became quite cheerful and bright when some months later she found employment as a kitchen maid and left the mother to look after her child with a view to having him sent to an Institution if an opportunity for his reception should occur. Since discharge she was rather disinterested in her child and the best plan seems to be that he should be sent to an Institution as suggested above. Although the mother's antagonism towards the patient has been modified since her mental breakdown, a certain antipathy remains and of which the patient is fully aware and hence became much improved after she had left home to go to work.
NO: 599. MISS I.N.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: Date of onset
Age on admission: Date of admission, 8.12.31.

(A). PRENATAL - INFANCY.

(1). Pregnancy: Normal
(2). Birth: Normal
(3). Feeding: Unknown.
(4). Age of parents at time of patient's birth:
   Father:
   Mother:
(5). Spacing of pregnancies:
   Male, one year, Female, one year, male, two years, Patient.
(6). Illnesses, including fits: Nil.
(7). Development: No details but no obvious abnormality.
(8). Temperament and peculiarities of disposition:
    No peculiarities.
(9). Material home conditions: Lived with mother when latter was in service - Satisfactory.
(10). Attitude of parents to infant: Child is illegitimate and mother left father during patient's infancy owing to his cruelty and intemperance. Father's attitude unknown but patient seems to have preferred him to the mother.
(11). Attitude of siblings and other associates to infant: Normal.
(12). Attitude of parents to each other and other members of the family: Unhappy relationship and eventually mother left taking child with her.
(13). Shocks, frights etc., Unknown.

(B). CHILDHOOD.

(1). Illnesses: Nil.
(2). Development: Normal
(3). Temperament and peculiarities of disposition:
    Rather quiet and timid.
(4). Material home conditions: As before until age of nine when patient went to live at an Institution where conditions were quite satisfactory.
(5). Attitude of parents to child and vice versa:
    Patient ashamed of her unsatisfactory family relationship.
(6). Attitude of siblings to child: Normal.
(7). Family relations: Since separation of parents no trouble in home.
(8). School:
    Age of entry: 5
    Age of leaving: 15.
    Relative standard - average. Attitude normal. Patient had one particular girl friend at the Institution but did not make many friends.
Childhood (Cont'd).

(9). Shocks or frights: Unknown.

(C). ADOLESCENCE:

(1). Illnesses: Nil.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Still quiet and timid.
(4). Material home conditions: quite good at Institution.
(5). Attitude of Parents: ) Nothing
(6). Attitude of Siblings: ) abnormal
(7). Family relationships: ) known.
(8). Work: Housemaid - no particular physical strain. Choice not known but probably the result of her mother having been in service. Attitude quite happy and satisfactory until six weeks previous to the onset of her illness during which time she worked as a "family help" to a Jewish family where she was most unhappy. She did not like the work or her employers and there is also some doubt as to whether she was paid her proper wages and also was accused (?) falsely) of petty theft by her employers. Earning capacity: ?
(9). Shocks or frights:
(a). During adolescence she was constantly worried and ashamed of her illegitimacy and to cover this "invented" more satisfactory family relationships.
(b). Worried and unhappy in her last position owing to the unsatisfactory attitude of her employers.
(c). Also during her last position she regretted not being able to attend her former Church and Church Social Club; also from the religious standpoint she was uncertain of the ethics of a Christian living with Jews.
(10). Social activities: Few friends but had one particular girl friend whom she met in the Institution during her school days and whom she continued to see after they left school. After school social life was chiefly centred in Church Social Club.
(11). Sex life:
Attitude towards same sex: One particular girl friend.
Attitude towards opposite sex: No boy friends, expressed dislike for the opposite sex.
RELATIONSHIP OF ONSET TO ENVIRONMENT:
Onset of illness definitely related to her last situation at work.

HEREDITY:
Normal, except for Father's intemperance.

CONCLUSIONS:
(1). Chief Factors:
   (A). Mental trauma: Unhappiness concerning illegitimacy. This led to fabrications about her parents and family. Unhappiness in last position as domestic (see above). Again evidence of lying - gave her age incorrectly when she applied for the job. Also may have lied about her wages not having been given to her and may have been guilty of stealing.
   (B). Physical trauma: Nil.
   (C). Material: Nil.

(2). Principal manifestations of mental disease.
Schizophrenic reaction of fairly acute onset. Attempted suicide and mental picture dominated by delusions of guilt and unworthiness.

(3). Correlation of principal factors in previous mental hygiene and symptomatology is obvious.
   - Inferiority - Fabrication - Guilt.

(4). Insight: Nil.

(5). Discharged 8.12.32. "Recovered".
No details of environment etc after discharge.
DIAGNOSIS: Hebephrenic Schizophrenia. (Mental Deficiency).

No: 600. MISS. D.T.


(2). Birth: Normal.
(3). Feeding: No details.
(4). Age of parents at time of patient's birth:
   Father: 32
   Mother: 32

(5). Spacing of pregnancies:
   Male, 1 yr, Female, 1½ yrs, Male (died convulsions)
   1½ yrs, Female (In asylum - insanity definitely
dates from incest by father 11 yrs ago) 3 yrs,
   Male, 2 yrs, Male, 1 yr, Patient, 2 yrs, Male (?)
   Male (died convulsions) (?) Female (nervous),
   5 yrs, Male.

(6). Illnesses: Healthy until aet 5. (Aet 5 measles,
   followed by T.B. Adenitis - operation and since
   then has suffered from cardiac oedema).

(7). Development: Even in infancy patient is described
   as being "not sharp". Talked and walked 15 months.

(8). Temperament and peculiarities of disposition:
   Dull and often had "tantrums".

(9). Material home conditions: Until term of father's
   imprisonment, 11 years ago, the family was fairly
   well off, but judging from present conditions house
   was probably always rather dirty and illkept.

(10). Attitude of parents to infant: Father quite
    disinterested in the children and was disliked
    and mistrusted by the children. Mother liked
    children but her attitude towards patient has
    always been one of disinterest and contempt
    because of her backward mentality.

(11). Attitude of siblings and other associates to
    infant: As with Mother.

(12). Attitude of parents to each other and other
    members of the family: (Home environment has been
    exceedingly unhappy since disgrace of father's
    conviction and imprisonment for incest with
    daughter Violet 11 years ago.). Both before and
    since that event his outbursts of bad temper were
    also causes for unhappiness. Patient openly
    acknowledged as being M.D. by the rest of the family.

(B). Childhood.

(1). Illnesses: Chronic illhealth since aet 5. Measles,
   T.B. adenitis - operation - cardiac oedema.

(2). Development: Retarded.

(3). Temperament and peculiarities of disposition:
   Dull but "cunning" and frequent outbursts of
   temper.
(Childhood - cont'd).


(5). Attitude of parents to child and vice versa: Father disinterested and disliked. Mother disinterested.

(6). Attitude of siblings to child: As with mother.

(7). Family relations: As in Infancy.

(8). School: Age of entry: 5.
   Age of leaving: 14.
   Kept in special class for backward children.

(9). Shocks or frights: disgrace of father's incest etc with older daughter. (Patient aged 9 at the time).

(C). ADOLESCENCE.

(1). Illnesses: Chronic ill health (v.s).

(2). Development: Retarded.

(3). Temperament and peculiarities of disposition: Dull. Now definitely becoming "foolish" and "confused". Memory bad. During the last two years she was in Church Army Home and they found that she was quite likeable and appreciated kindness and responded if treated as a child).

(4). Material home conditions: Poor.

(5). Attitude of Parents: Father and mother disinterested.

(6). Attitude of siblings: Disinterested.

(7). Family relationships: As in Infancy and Childhood.

(8). Work: Factory work after leaving school. Dismissed from several works as being hopelessly incompetent. Domestic training centres since 1930 - again found to be incompetent.

(9). Shocks or frights: Nil. (Continued disgrace of father's misconduct.).

(10). Social activities: N/L.

(11). Sex life:
   Attitude towards same sex: (?)
   Attitude towards opposite sex: (?) Found to have V.D. shortly before admission. Sexual knowledge said to have been relatively advanced. Menstruation started 16. Irregular.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.
   Gradual onset of symptoms since she started work and chiefly related to work.

(F). HEREDITY:
   "Moral defective"). Apart from father's mental instability and elder sister's insanity there is no previous history.
CONCLUSIONS:

(I). Chief Factors:

(a). Mental trauma: Mental deficiency - evident from infancy. Several unhappy home conditions chiefly result of father's bad temper and disgrace of his misconduct. Attitude of rest of family towards patient "open acknowledgment of M.D etc", no doubt at least part origin of the patient's "tantrums". Precipitating cause of frank psychosis was the prolonged attempt to make patient tackle work which she was intellectually incapable of performing.


(c). Poor Material home conditions.

To sum up - here is a case of a mentally defective girl whose upbringing in view of her defect was grossly unsuitable, and who also was subjected to the mental strain of having to share in the disgrace brought on the family by the father's sexual crime which evidently led straight away to the sister's insanity. (Sister was the victim of father's incest).

(2). Principal manifestations of mental disease.

Generalised intellectual defect.

Introverted, manneristic and foolish.

Persecutory delusions - e.g. "that people were trying to crucify her".

(3). Correlation of clinical manifestations and environmental factors:

Persecutory delusions related to the attitude of her family towards her.

(4). Insight regarding these environmental factors during remission or recovery:

Nil.

(5). Environment after discharge:

Transferred 18.6.32 to another mental hospital. "Not improved".
No: 604. MISS M.N.

DIAGNOSIS. Hebephrenic Schizophrenia.

Age at onset: 18 Date of onset: October 1931. 
Age on admission: 18 Date of admission: December 1931.

(A) PRENATAL - INFANCY.
(2). Birth: Normal.
(3). Feeding: Breast fed till two years.
(5). Spacing of pregnancies: 
   Female, 1 yr, Female, 1 yr, Female 1 yr, 
   Female, 2 yrs, Patient, 5 yrs, Male.
(6). Illnesses, including fits: None.
(7). Development: Normal.
(8). Temperament and peculiarities of disposition: Quiet and rather nervous.
(9). Material home conditions: Fairly good.
(10). Attitude of parents to infant: Mother protective to balance father's rather harsh attitude.
(11). Attitude of siblings and other associates to infant: Unknown.
(12). Attitude of parents to each other and other members of the family: Satisfactory.
(13). Shocks, frights etc.: Nil.

(B) CHILDHOOD.
(1). Illnesses: Measles. Myopia - worn glasses since 2.
   Enlarged thyroid 1929 (16). "Nervous twitchings" during her school life.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Still quiet, reserved and rather nervous but had distinct views of her own which she expressed from time to time. (Regarding school work - liked literature and dramatic work but disliked and disposed technical subjects).
(5). Attitude of parents to child and vice versa: Mother protective. Father harsh and had no insight into differences in personality and temperament.
(6). Attitude of siblings to child: Elder sisters were critical, chiefly on account of patient not acquiring their all round ability.
(7). Family relations: Harmonious, except for attitude of father and elder sisters towards the patient. Financial instability impressed on all members of the family.
   Standard above average. Relatively poor at such subjects as mathematics and science. No disharmony between patient and teachers and school mates but although patient took part in the corporate life of the school she was not enthusiastic.
No: 604.

(Childhood - cont'd).

(9). Shocks, worries etc:
   Failed matriculation examination May 1930.
   Worry over School fees, Oct-Dec.1930.

(C). ADOLESCENCE.

(1). Illnesses: Thyroid enlargement at 16.
   Improved by avoidance of strenuous exercise.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition:
   Still quiet and rather nervous.
(5). Attitude of Parents: Mother protective, but
   Father still harsh.
(6). Attitude of siblings: Elder sisters critical.
(7). Family relationships: Harmonious except for
   attitude of Father and elder sisters towards
   patient.
(8). Work: Post Office Clerk. No strain. Own
   choice but not patient's ideal and further
   she was disappointed over the purely mechanical
   nature of her duties. Material conditions good.
   Attitude normal till onset of illness which was
   ushered in by "ideas of reference" about her
   fellow workers. Earning capacity 30/- per
   week. Capable at her work but was not suited
   to it. No unemployment.
(9). Shocks, worries etc., As above.
(10). Social activities: Fond of reading - chiefly
   early literature - Shakespeare etc., quite good
   at games but not enthusiastic. Became a Girl
   Guide but again there was lack of enthusiasm,
   for which she was criticised by her sisters.
(11). Sex life: No special friends of either sex.
   Sexual knowledge ?. Menstruation at 11.
   Slight menorrhagia till after treatment for
   thyroid condition.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.
   Onset definitely related to work. Breakdown
   commenced with slight confusion during which
   patient appeared to be desirous of going home at
   an hour before she was free to go. Confusion
   followed by persecutory delusions definitely
   related to her fellow workers.

(F). HEREDITY. Nil.

(G). CONCLUSIONS:
   (1). Chief Factors:
      (a). Mental trauma: Critical and misunderstanding
         attitude of Father and sisters throughout
         the whole of the patient's life. These
         members of the family were possessed of an
         entirely different temperament to the
No. 604.

(Conclusions - cont'd).

The patient and could not appreciate her outlook. Employment quite unsuited to the patient's artistic tastes.

Various worries during the year previous to breakdown e.g. failure in exam, financial difficulty of class fees etc.,

(b) Physical trauma. Thyroid enlargement with hyperthyroidism, possibly resulting from the same factors responsible for the mental illness and in turn an additional factor in the causation of the latter.

(c) Material conditions: Throughout her life it was obviously a case of forcing a square peg into a round hole!

(2) Principal manifestations of mental disease. Mild confusion. Ideas of reference and persecutory delusions associated chiefly with her former fellow workers.

(3) Correlation of clinical manifestations and environmental factors: Uncongenial employment resulting in a desire to "escape" from that life. Subsequent rationalisation through delusions of persecution regarding her fellow workers.

(4) Insight regarding these environmental factors during remission or recovery. Nil.

(5) Environment after discharge: Condition of patient has steadily deteriorated both intellectually and regards her personality. She is now mute and inaccessible.
No. 610. MISS M.B.

DIAGNOSIS: Schizophrenia.

Age at onset : 17  Date of onset : 1929.
Age on admission: 17  Date of admission: 1) 1929.
                      2) 11.7.30
                      3) 2.2.32.

(A). PRENATAL - INFANCY.

(2). Birth:  Normal.
(3). Feeding: Breast fed 5 months. Easily weaned.
(4). Age of parents at time of patient's birth:
    Father: 37.
    Mother: 34.
(5). Spacing of pregnancies:
    Female - 9 years - female - 2 years - female -
    1 year - miscarriage - 1 year - patient - 1 year-
    male.
(6). Illnesses, including fits:  Nil.
(7). Development:  Normal.
(8). Temperament and peculiarities of disposition:  Normal.
(9). Material home conditions:  Fair.
(10). Attitude of parents to infant:  Parents over-
      protective.
(11). Attitude of siblings and other associates to
      infant:  Elder siblings protective.
(12). Attitude of parents to each other and other
      members of the family:  Happy.
(13). Shocks, frights etc.:  Nil.

(B). CHILDHOOD.

(2). Development:  Normal.
(3). Temperament and peculiarities of disposition:  Normal.  (Nocturnal enuresis, age 8 - 10.)
(5). Attitude of parents to child:  Parents protective and "spoiling".
(6). Attitude of siblings to child:  Siblings protective and "spoiling".
(7). Family relations:  Happy.
(8). School:  Age of entry, 5.  Age of leaving, 14.  Standard:  Below the average.  Satisfactory relationships up to the age of 13, when she became infatuated with one of her teachers.
(9). Shocks or frights:  ? accident, aged 11.
No. 610.

(C). ADOLESCENCE.

(1). Illnesses: Mastoid operation, aged 18.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Reserved and quiet.
(5). Attitude of Parents: Overprotective.
(6). Attitude of Siblings: Overprotective.
(7). Family relationships: Happy.
(8). Work: Factory work (manual), aged 14 - 16. She became a little depressed about her work, and was promptly removed by her parents.
(9). Shocks or frights: Nil.
(10). Social activities: School socials, etc.
(11). Sex life: Attitude towards same sex: She became infatuated with members of the same sex. Attitude towards opposite sex: No interest in opposite sex.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

Nil obvious.

(F). HEREDITY:

Nil.

(G). CONCLUSIONS:

(1). Chief Factors:
   (a). Mental trauma: Overprotected and spoilt at home, and so unable to make satisfactory adjustment in the outside world (e.g. at work).
   (c). Material conditions: -
(2). Principal manifestations of mental disease. Schizoid personality became obvious when she went to work in factory. She gradually became definitely schizophrenic, and has had three attacks and intervening remissions since 1929. Last discharge - 1932. The parental attitude has changed for the better, and there is no information of any further trouble.
(3). Correlation of clinical manifestations and environmental factors: Nil.
(4). Insight regarding these environmental factors during remission or recovery. Nil.
(5). Environment after discharge: See (2) above.
No: 614. MISS. F. T.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at Onset: 16  Date of onset: February 1932
Age on admission: 16  Date of admission: 1.3.32.

(A). PRENATAL - INFANCY.

(3). Feeding: Bottle fed.
(4). Age of parents at time of patient's birth.
   Father: 24
   Mother: 37
(5). Spacing of pregnancies:
   Patient, 5 yrs, miscarriage, 2 yrs, Female,
   1 yr, Male, 3 yrs, Female.
(6). Illnesses, including fits: Nil.
(7). Development: Normal.
(8). Temperament and peculiarities of disposition:
   Cheerful, bright and active.
(9). Material home conditions: Poverty in slummy home.
(10). Attitude of parents to infant: Normal (first child - given much attention).
(11). Attitude of siblings and other associates to infant: -
(12). Attitude of parents to each other and other members of the family: Happy.
(13). Shocks, frights etc: Nil.

(B). CHILDHOOD.

(2). Development: Normal.
(3). Temperament and peculiarities of disposition:
   Active, bright and sociable.
(5). Attitude of parents to child and vice versa: Normal.
(7). Family relations: Happy and congenial.
(8). School: Age of entry: 5
   Age of leaving: 14.
   Average standard. Normal attitude towards other pupils.
(9). Shocks or frights: Nil.

(C). ADOLESCENCE.

(2). Development: Normal.
(3). Temperament and peculiarities of disposition:
   Sensitive, conscientious, self centred.
   Rather emotional and excitable. Religiously minded.
No: 614.

(Adolescence - cont'd).

(5). Attitude of Parents: Overprotective.
(6). Attitude of siblings: Good relationship.
(7). Family relationships: Happy.
(9). Shocks or frights: ? sexual assault five weeks previous to admission to hospital. (? delusion). Worries over religious matters.
(10). Social activities: Good opportunities and participation.
(11). Sex life:
   Attitude towards same sex: Normal.
   Attitude towards opposite sex: Normal.
   Had practiced masturbation for several years. Menstruation irregular.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.
Onset while at work as domestic, associated with attempted sexual assault or commenced with delusion of a sexual assault.

(F). HEREDITY: Nil.

(G). CONCLUSIONS:
   (1). Chief Factors:
      (b). Physical trauma.
      (c). Material conditions poor during infancy and early childhood.
   (2). Principal manifestations of mental disease. Depressed and lachrymose. Delusions of guilt and unworthiness. Believed that her food was poisoned. Faulty habits.
   (3). Correlation of clinical manifestations and environmental factors. Guilt and unworthiness possibly associated with religious worries.
   (4). Insight regarding these environmental factors during remission or recovery. Gained good insight and apparently realised that a sheltered home life is not conducive to self-confidence in the outside world.
   (5). Environment after discharge. Discharged 15.9.32. "Recovered". Since then has apparently been quite normal. She indicated frankly that she no longer wanted to be
No: 614.

(Environment after discharge - cont'd).

be/ "tied to her mother's apron strings" and is engaged in numerous social activities. Found domestic work which she likes and seems to be satisfactorily employed.
No: 615. MISS K.G.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: 17 Date of onset:
Age on admission: 18 Date of admission: 3.3.32.

(A). PRENATAL - INFANCY.

(1) Pregnancy: Normal.
(2) Birth: Normal.
(3) Feeding: Breast fed 18 months. No difficulties.
(4) Age of parents at time of patient's birth:
   Father: 35
   Mother: 28
(5) Spacing of pregnancies:
   Female, 3 yrs, Male, six yrs, Patient.
(6) Illnesses, including fits: Measles.
(7) Development: Walked 18 months, talked 18 months.
    Teething unknown.
(8) Temperament and peculiarities of disposition:
(9) Material home conditions: Good.
(10) Attitude of parents to infant: Parents overprotective.
(11) Attitude of siblings and other associates to infant: Normal.
(12) Attitude of parents to each other and other members of the family: Happy atmosphere. (But possible underlying anxiety over financial affairs).
(13) Shocks, frights etc., Unknown.

(B). CHILDHOOD.

(1) Illnesses: None.
(2) Development: Normal.
(3) Temperament and peculiarities of disposition:
    Dependent. Retarded.
(4) Material home conditions: Good.
(5) Attitude of parents to child and vice versa:
    Overprotective.
(6) Attitude of siblings to child: Good.
(7) Family relations: Happy.
(8) School: Age of entry: 5.
    Age of leaving: 14.
    Standard below average. Considered dull. Found difficulty in "getting on" at school to begin with.
(9) Shocks or frights: Nil.

(C). ADOLESCENCE.

(2) Development: Normal.
(3) Temperament and peculiarities of disposition:
    Simple, childish, immature. Lacking in judgment.
    Makes friends with older or younger people. Bites her nails.
(4) Material home conditions: Good.
(5) Attitude of parents: Overprotective.
(Adolescence - cont'd).

(6). Attitude of siblings: Patient jealous of her brother and sister.

(7). Family relationships: Happy.

(8). Work: At home. Deliberately chosen. No physical or mental strain. Conditions good. Received pocket money.

(9). Shocks or frights: Unknown.

(10). Social activities: Ample social interests.

(11). Sex life:
- Attitude towards same sex: Normal.
- Attitude towards opposite sex: Never had any boy friends and stated that she did not want any as long as she had her mother. No abnormal habits. Menstruation normal.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

(F). HEREDITY.

- Brother mental defective (died).

(G). CONCLUSIONS:

(1). Chief Factors:
   (a). Mental trauma: Overprotective attitude of parents throughout patient's life. No normal sexual attachments during adolescence, all her love still directed towards her mother.
   (b). Physical trauma: Nil.

(2). Principal manifestations of mental disease.
- Dull and apathetic. Lacking in initiative and ambition. Vague ideas of reference (e.g., children talking about her in the street).

(3). Correlation of clinical manifestations and any environmental factors:
- Mental symptoms indicate inability to face the outside world, corresponding to the extremely "sheltered" life she had led. Ideas of reference may indicate mild paranoid reaction, with a basis of homosexuality, the direction being towards the mother.

(4). Insight regarding these environmental factors during remission or recovery; Nil.

(5). Environment after discharge:
- Eventually became brighter and more interested in her surroundings. Discharged "Recovered" 23.1.33. Went home and her family appear to have been continually agitated about patient and acted like jailors which she resented and in consequence began to stay out at nights when she had the chance and her mental condition eventually relapsed and she had to be readmitted. Again improved and was sent home and by this time the parents had been persuaded to relax their vigilance and not attempt to keep the patient under such close observation. Since then her condition has been satisfactory.
NO: 619. MISS. L.P.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: 21  Date of onset: January 1932
Age on admission: 21  Date of admission: 11th Mar. 1932

(A). PRENATAL - INFANCY.

(1). Pregnancy: Normal
(2). Birth: Normal
(3). Feeding: Breast fed 12 months.
(4). Age of parents at time of patient's birth:
   Father: 20
   Mother: 19
(5). Spacing of pregnancies: No siblings.
(6). Illnesses, including fits: Measles at 1½ years.
   Ulcer on eye following measles.
(7). Development:
   Walked 15 months.
   Talked 18 months.
   Teething normal.
(8). Temperament and peculiarities of disposition: Shy and quiet.
(9). Material home conditions: Fair.
(10). Attitude of parents to infant: Protective.
(11). Attitude of siblings and other associates to infant: None.
(12). Attitude of parents to each other and other members of the family: Happy relationship.
(13). Shocks, frights etc.: Unknown.

(B). CHILDHOOD.

(1). Illnesses: Influenza at 10. Severe attack lasting 3 weeks.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Shy, timid and solitary.
(5). Attitude of parents to child and vice versa: Protective.
(6). Attitude of siblings to child: None.
(7). Family relations: Happy.
(8). School: Age of entry: 5
    Age of leaving: 14.
    Standard below average. Good contact with teachers and school fellows but shy and retiring.
(9). Shocks or frights: None.

(C). ADOLESCENCE.

(1). Illnesses: None. Mental illness obviously precipitated by extraction of teeth under cocaine.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Quiet, unassuming, solitary.
No: 619.

(Adolescence - cont’d).

(6). Attitude of siblings: None.
(7). Family relationships: Happy.
(8). Work: Printing operator. No physical or mental strain. Deliberately chosen. Poor material conditions. Not a good mixer with fellow employees. Well liked by both employers and employees. 30/- per week; suitable work. No unemployment.
(9). Shocks or frights: None.
(10). Social activities: N/L.
(11). Sex life:
  Attitude towards same sex: Normal.
  Attitude towards opposite sex: Timid, not a mixer.
  Sexual knowledge normal. No abnormal habits.
  Menstruation normal and regular.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.
  Apparently some slight relationship between work and breakdown. Patient had been worrying for some weeks about the routine nature of her work.

(F). HEREDITY. Nil.

(G). CONCLUSIONS.
  (1). Chief Factors:
    (a). Mental trauma: Sheltered life, overprotected by parents, especially mother.
    (b). Physical trauma. Precipitating factor was idiosyncrasy to cocaine.

  (2). Principal manifestations of mental disease.
    Acute delirium. Much clouding of consciousness. (Toxic psychosis).

  (3). Correlation of clinical manifestations and environmental factors:
    Cocaine - toxic psychosis.

  (4). Insight regarding these environmental factors during remission or recovery.

  (5). Environment after discharge:
    Made apparently complete recovery. Discharged 15.9.32 "Recovered". Mental condition has remained normal up to the present time.
No: 620. MISS V.P.

DIAGNOSIS: Catatonia. Schizophrenia.

Age at onset: 15 Date of onset: Jan. 1929
Age on admission: 15 Date of admission: 15.1.29.

(A) Prenatal - Infancy:
(1) Pregnancy: Normal. Mother had previously suffered from malaria.
(2) Birth: Normal.
(3) Feeding: Breast fed three months.
(4) Age of parents at time of patient's birth:
   Father: ?
   Mother: 37.
(5) Spacing of pregnancies:
   Male, 6 yrs, Female, 3 yrs, Patient, miscarriage, miscarriage.
(6) Illnesses, including fits: Delicate. Accident at 9 months - fell on head, but no obvious ill-effects.
(7) Development: Walked 15 months, Talked 14 months, Teeth very slow.
(8) Temperament and peculiarities of disposition:
   Quiet, placid and good tempered.
(9) Material home conditions: Good.
(10) Attitude of parents to infant: Very protective.
(11) Attitude of siblings and other associates to infant: Patient youngest, "babied" by siblings.
(12) Attitude of parents to each other and other members of the family: Happy.
(13) Shocks, frights etc: Unknown.

(B) Childhood:
(2) Development: Normal.
(3) Temperament and peculiarities of disposition:
   Quiet, shy.
(4) Material home conditions: Good.
(5) Attitude of parents to child and vice versa:
   Protective. ? attitude of Father.
(6) Attitude of siblings to child: Ignored or spoilt.
(7) Family relations: Happy.
(8) School:
   Age of entry: 5.
   Age of leaving: 14.
(9) Shocks or frights: None.

(G) Conclusions:
(1) Chief Factors:
   (a) Mental trauma, Overprotective attitude of parents and siblings. Strain at school of a mildly mentally defective child to maintain an average standard. (Case suitable for special school).
No:620.

(Conclusions - cont'd).

(b). Physical trauma; Chronic ill health.
(Recently definite diagnosis of Pulmonary Tuberculosis.

(2). Principal manifestations of mental disease.
Patient is hospital on three occasions between 1929 and 1932. On each occasion she was received in a state of acute katatonic excitement, was extremely confused and was aurally hallucinated.
Mental symptoms on each occasion gradually subsided. Last discharged on 2.2.33 "Recovered".

(3). Correlation of clinical manifestations and environmental factors:
Nil definite.

(4). Insight regarding these environmental factors during remission or recovery.

(5). Environment after discharge.
On last discharge parents were warned not to "shelter" the patient so much and to encourage her to take an interest in outside affairs. Recently became worried regarding unemployment and her mother took her to a "faith healer" (against advice). The latter reported that "the poison is slowly leaving the body and is emerging at the feet"!! Relapsed and readmitted to another hospital in July 1934.
No: 622. MISS M.M.J.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: 21 Date of onset: March 1932
Age on admission: 21 Date of admission: 17.3.32.

3. Feeding: Breast fed 9 months.
4. Age of parents at time of patient's birth:
   Father: 30.
   Mother: 30.
5. Spacing of pregnancies:
   Male (died in infancy) 2 yrs, Female, 3 yrs,
   Male (died in infancy) 3 yrs, Female, 1 yr,
   Patient, 3 yrs, Male, 3 yrs, Male.
6. Illnesses, including fits: Nil.
7. Development: Walked 15 months, Talked 15 months,
   Teething normal.
8. Temperament and peculiarities of disposition:
   Slow, dreamy and placid.
10. Attitude of parents to infant: Mother showed usual
    affection. Father indifferent.
11. Attitude of siblings and other associates to
    infant: Normal affection.
12. Attitude of parents to each other and other
    members of the family: Unhappy home atmosphere-
    parents did not agree. (Father's affections said
    to be elsewhere).
13. Shocks, frights etc: -

(B). Childhood.
1. Illnesses: Delicate - whooping cough, measles and
   chicken pox between age 5 - 14.
3. Temperament and peculiarities of disposition:
   Shy, quiet, lacking in initiative and in ability
   to assert herself.
4. Material home conditions: Poor. (Father deserted
   family when patient was 6).
5. Attitude of parents to child and vice versa:
   Normal affection between mother and patient.
6. Attitude of siblings to child: Feared and roughly
   handled by siblings and often did not retaliate.
7. Family relations: Home atmosphere very unhappy
   until father deserted and thereafter the mother
   had a struggle to maintain the family.
   Erratic but of good average standard. Normal
   relationship towards teachers and schoolmates.
9. Shocks or frights: -
(C). ADOLESCENCE.

(1). Illnesses: Frequent minor ailments from age of 14, e.g. indigestion and general debility.

(2). Development: Normal.

(3). Temperament and peculiarities of disposition: Quiet, reticent and generally introverted and passive. Interested in religion.


(5). Attitude of Parents: Mother normal.

(6). Attitude of Siblings: Normal affection.

(7). Family relationships: Happy.


(9). Shocks or frights: -

(10). Social activities: Plenty of opportunities but patient indifferent except towards religious matters.

(11). Sex life:

Attitude towards same sex: Normal but not a good "mixer".

Attitude towards opposite sex: Had one boy friend but refused to entertain the idea of marriage. In general did not associate with opposite sex to any extent.

Menstruation normal. Sex knowledge and instruction - unknown.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

Nil. Was unhappy as a child owing to uncongenial home atmosphere but no direct relationship of home environment to onset of present illness.

(F). HEREDITY. Nil.

(G). CONCLUSIONS.

(1). Chief Factors.

(a). Mental trauma: Extremely unhappy home environment during childhood.

(b). Physical trauma: Health slightly but chronically impaired since puberty.

(c). Material conditions: Slight degree of poverty between 6 - 14.

(2). Principal manifestations of mental disease. Apathetic, solitary, foolish and manneristic. Her only interest seems to be in her bible which she reads for hours on end.

(3). Correlation of clinical manifestations and environmental factors: Only obvious correlation is her continued interest in religious matters.

(4). Insight regarding these environmental factors during remission or recovery: -

No: 623. MISS L.K.

DIAGNOSIS: Katatonic Schizophrenia.

Age at onset: 24  Date of onset: Feb. 1932.
Age on admission: 24  Date of admission: 18.3.32.

(A) PRENATAL- INFANCY.

(2). Birth: Normal.
(3). Feeding: Combined breast and bottle feeding for six months.
(4). Age of parents at time of patient's birth:
   Father 32.
   Mother 33.
(5). Spacing of pregnancies:
   Patient, 1 yr, Male, 1 yr, Female, 2 yrs, Male.
(8). Temperament and peculiarities of disposition:
   Shy, timid and quiet.
(10). Attitude of parents to infant: Normal affection for grandparents with whom patient lived.
(11). Attitude of siblings and other associates to infant: -
(12). Attitude of parents to each other and other members of the family: Home atmosphere happy.
(13). Shocks, frights etc.: -

(B). CHILDHOOD.

(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Shy, timid and retiring but had good judgment and intelligence.
(4). Material home conditions: Poor.
(5). Attitude of parents to child and vice versa: Normal.
(7). Family relations: Happy.
(9). Shocks or frights: -
(C) **ADOLESCENCE.**

(1). *Illnesses:* Nil.

(2). *Development:* Normal.

(3). *Temperament and peculiarities of disposition:* Quiet and shy but self assured with considerable initiative and judgment. Solitary habits and tastes.

(4). *Material home conditions:* Poor.

(5). *Attitude of Parents:* Normal.

(6). *Attitude of siblings:* Normal.

(7). *Family relationships:* Happy.

(8). *Work:* Domestic work. Deliberately chosen but chiefly through lack of other openings. No strain and conditions good but the work was not congenial to patient.

(9). *Shocks or frights:* Nil.

(10). *Social activities:* Plenty of solitary activities, indulged in - reading, walking etc., Not a good "Mixer."

(11). *Sex life:* 

   - **Attitude towards same sex:** Normal attitude
   - **Attitude towards opposite sex:** but did not make friends easily.

   Sexual knowledge - well informed. No abnormal habits.

(D) **ADULT.**

(1). *Illnesses:* -

(2). *Development:* Normal.

(3). *Temperament and peculiarities of disposition:* Quiet and shy but self assured with considerable initiative and judgment. Solitary habits and tastes.


(5). *Attitude of Parents:* Normal.

(6). *Attitude of siblings:* Normal.

(7). *Family relationships:* Happy.

(8). *Marriage factors:* Nil.

(9). *Work:* As before. Patient discharged because of association with fellow man servant.

(10). *Shocks or frights:* Patient became infatuated with young man (fellow servant) who attempted to have sexual intercourse with patient which she resented. Later she lost her job owing to this attachment and at same time became separated with object of her affections.

(11). *Social activities:* Good opportunities.

(12). *Sex life:* Normal - as before.

(E) **RELATIONSHIP OF ONSET TO ENVIRONMENT.**

Onset of illness related to loss of employment and separation from her lover.

(F) **HEREDITY.** Nil.

(G) **CONCLUSIONS.**

(1). **Chief Factors:**


(G). CONCLUSIONS (Cont'd).

(c). Rather poor material conditions during childhood.

(2). Principal manifestations of mental disease. Since admission patient has been completely inaccessible. She is resistive and is faulty in her habits.

(3). Correlation of clinical manifestations and environmental factors: Nil.

(4). Insight regarding these environmental factors during remission or recovery. Nil.

(5). Environment after discharge. Patient in hospital (3.12.34) and her mental condition is unchanged except that she occasionally responds to questioning but her answers are off-hand and frequently irrelevant.
No. 631. MISS E.S.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: 22  Date of onset: 
Age on admission: 22  Date of admission: 15.4.32.

(A). PRENATAL - INFANCY.

(1). Pregnancy: Normal
(2). Birth: Normal
(3). Feeding: Breast fed for six months. Weaned easily.
(4). Age of parents at time of patient's birth:
   Father: 38
   Mother: 37
(5). Spacing of pregnancies:
   Miscarriage, one year, Male, one year, female, one year, Male, one year, miscarriage, one year, Patient, one year, female, one year, female.
(6). Illnesses, including fits: Convulsions due to worms, Nutrition and general health good.
(7). Development:
   Teeth: 1st 7 months, others normal.
   Walked: 11 months
   Talked: 12 months.
(8). Temperament and peculiarities of disposition: Quiet and placid. No abnormal habits.
(9). Material home conditions: Poverty stricken.
(10). Attitude of parents to infant: not known.
(11). Attitude of siblings and other associates to infant: not known.
(12). Attitude of parents to each other and other members of the family: Unhappy home atmosphere owing to constant strife between the parents, and the disgrace brought upon the entire family by the father's "moral deficiency" - incestuous interference with daughter of the first marriage and unfaithfulness to his wife.
(13). Shocks, frights etc., Unknown.

(B). CHILDHOOD.

(1). Illnesses: Scarlet fever, measles and whooping cough before age of six, but general health was good.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Inclined to be reserved but quite self-willed.
(4). Material home conditions: Poverty at home. In Orphanage from age of 6 to 16, where material conditions deplorable.
(5). Attitude of parents to child and vice versa: Mother neurotic and obsessed by father's "wickedness" about which she constantly reminded the family.
(6). Attitude of siblings to child: Not known.
No. 631.  
(B) Childhood (Cont'd).

(7). Family relations: Home atmosphere was that of the Orphanage where the Master appears to have been a "sexual pervert" - exposed himself to the girls etc., This latterly worried and shamed the patient a great deal.

Age of leaving: 16.  
Attained relatively high standard and was bright and happy at school.

(9). Shocks or frights: Worry about behaviour of Orphanage Master.

(C). ADOLESCENCE.

(1). Illnesses:  
Tonsillitis aet 18  
Nasal catarrh aet 18  
Influenza aet 18  
Septic finger aet 20

"Nervous breakdown" for week's duration while in domestic service. Recovered without removal to hospital.

(2). Development: Normal.

(3). Temperament and peculiarities of disposition: Quiet and reserved but self willed and ambitious.

(4). Material home conditions: Domestic work and latterly nursing. Material conditions satisfactory.

(5). Attitude of Parents: Mother neurotic and obsessed by father's wickedness" about which she constantly reminded the children.

(6). Attitude of siblings: Not known.

(7). Family relationships: Patient rather ashamed of the family relationships.

(8). Work: Domestic service aet 16 to 18, which was casually chosen. The conditions were satisfactory and there is no history of unhappiness. Her work was also satisfactory.  
Nursing aet 18 to 22. This was deliberately chosen as a result of her ambitions. The conditions were satisfactory and she was proficient.

(9). Shocks of frights:  
(a). Suicide of fellow nurse  
(b). Death by accident of fellow nurse.

The above shocks occurred during year previous to onset of mental illness.  
Worries: Ashamed of her family relationships.  
Unhappy love affair at commencement of her nursing training.

(10). Social activities: No outside interests.

(11). Sex life:  
Attitude towards same sex: Normal.  
Attitude towards opposite sex: Normal.  
RELATIONSHIP OF ONSET TO ENVIRONMENT:
Onset of illness related to work, during nursing training. Onset of "nervous breakdown" at 16 while doing domestic work.

HEREDITY.
(a) Parents: Father probably moral defective. Mother neurotic.
(b) Siblings: Half brother in mental hospital Half sister in mental hospital.

CONCLUSIONS:
(a) Mental trauma: Psychological environment up to age of 16 detrimental. This was result of association with a neurotic mother who was obsessed about the father's wickedness and who was never tired of impressing on her family that the bad "taint" would probably be inherited. Also association during school days with the Master of the Orphanage who was a sexual pervert and who worried the patient considerably. Perturbation and shame regarding her fathers behaviour. Worry caused by Master of Orphanage. Unsatisfactory love affair (age 18). Shocks caused by sudden deaths of two fellow nurses (age 21-22).
(b) Physical trauma: Born in middle of quick succession of pregnancies.
(c) Material environment up to age of 16 was definitely poor.

Principal manifestations of mental disease. Confusion and agitation were foremost. Complete amnesia for acute period of her illness. Later confusion became replaced by evasiveness on the subject of herself and her illness. Gradually recovered and was discharged 5.1.33. Recovered.

Correlation of clinical manifestations and environmental factors:
Numerous worries with which patient had to contend throughout her life brought about a state of conflict. Evasiveness indicated shame regarding her past life and environment.

Insight regarding these environmental factors during remission or recovery. After discharge there was much strife at home and patient told her mother that it was she (mother) who was the insane member of the family and not the father.
(Conclusions - Cont'd).

(5). Environment after discharge.
After discharge had one slight relapse but since then has been engaged in nursing and has kept well. Her family connections were obviously the chief cause for the patient's worry, mental conflict and illness and if she can avoid close contact with them she ought to progress satisfactorily.
DIAGNOSIS:  Hebephrenic Schizophrenia.

Age at onset: 16  Date of onset: March 1931
Age on admission: 17  Date of admission: 8.8.32

(A) PRENATAL - INFANCY.
(2). Birth:  Normal.
(3). Feeding: Breast fed 2 years.

(5). Spacing of pregnancies:
   Male, 2 yrs, Male, 4 yrs, 2 males (twins)  
   3 yrs, 2 females (twins) 2 yrs, Female, 4 yrs, 
   Patient.

(6). Illnesses, including fits: Nil.
(7). Development: Walked 12 months, talked 14 months, 
   teething normal.

(8). Temperament and peculiarities of disposition:
   Normal. Cheerful, alert and sociable.
(9). Material home conditions: Poor.
(10). Attitude of parents to infant: Normal for class. 
    Parents poor and ignorant.
(11). Attitude of siblings and other associates to 
    infant: Normal affection.
(12). Attitude of parents to each other and other 
    members of the family: Congenial, although 
    affected by poverty and overcrowding.
(13). Shocks, frights etc.: Unknown.

(B) CHILDHOOD.
(1). Illnesses: Measles and whooping cough between 
    ages 5-14.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition:
    Normal.
(4). Material home conditions: Poor.
(5). Attitude of parents to child and vice versa: 
    Normal.
(6). Attitude of siblings to child: Normal affection.
(7). Family relations: Congenial but affected by poverty 
    and overcrowding.
(8). School: Age of entry: 8 yrs 
    Age of leaving: 14 yrs. 
    Standard below average. Got on well with both 
    teachers and schoolmates.
(9). Shocks or frights: Unknown.

(C) ADOLESCENCE.
(1). Illnesses: Nil.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: 
    Quiet, solitary and dependent.
(4). Material home conditions: very poor. gross 
    overcrowding.
(C) Adolescence - cont'd.

(5). Attitude of Parents: Mother ignorant. Father apparently indifferent.
(6). Attitude of siblings: Normal affection.
(7). Family relationships: Congenial but affected by poverty and overcrowding.
(8). Work: Numerous employments. No strain. Unskilled and poorly adjusted to work. Conditions at work often poor.
(9). Shocks or frights: Attempted sexual assault immediately prior to onset of illness.
(10). Social activities: Few opportunities and patient showed little interest in outside affairs.
(11). Sex life:
  Attitude towards same sex: Normal.
  Attitude towards opposite sex: Shunned opposite sex.
  No proper instruction. Menstruation normal.
  (Had severe shock as result of attempted sexual assault).

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.
  Unhappy at work as result of poor adjustment.

(F). HEREDITY.

(G). CONCLUSIONS.
  (1). Chief Factors:
      (a) Mental trauma: Shock of sexual assault - precipitating factor. Maladjustment to outside world as result of association with poor and ignorant parents and siblings.
      (b) Physical trauma: ? malnutrition. Born after prolonged and rapid succession of pregnancies.
      (c) Poverty associated with gross overcrowding.
  (2). Principal manifestations of mental disease:
  Admitted in a state of katatonic stupor, exhibiting marked flexibilitas cerae. Occasional attacks of katatonic excitement. Eventually improved and was discharged "Recovered" on 25.5.33. Latterly has been much more of a hebephrenic type than the original katatonic state.
  (3). Correlation of clinical manifestations and environmental factors: N/L.
  (4). Insight regarding these environmental factors during remission or recovery. N/L.
  (5). Environment after discharge.
  After discharge attempts were made to find more congenial work for patient but she made poor adjustment and became apathetic and katatonic again and required readmission (18.12.33) and is still in hospital.
DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: 13 Date of onset: 1931
Age on admission: 14 Date of admission: Sept. 1932.

(A). PRENATAL - INFANCY.
1. Pregnancy: Normal
2. Birth: Normal
3. Feeding: Breast fed 3 months and then bottle fed.
4. Age of parents at time of patient's birth:
   Father: 35
   Mother: 28
5. Spacing of pregnancies: Patient only child.
6. Illnesses including fits: Nil.
8. Temperament and peculiarities of disposition:
   Quiet and solitary.
10. Attitude of parents to infant: Unwise and unbalanced upbringing by parents. At times "fussed" over the child too much and at other times were quite neglectful.
11. Attitude of siblings and other associates to infant: -
12. Attitude of parents to each other and other members of the family: Apparently happy.

(B). CHILDHOOD.
3. Temperament and peculiarities of disposition:
   Nervous and "hysterical". Lacking in sense of responsibility. ? precocious.
4. Material home conditions: Good.
5. Attitude of parents to child and vice versa:
   As above. Child often alone and apparently neglected.
6. Attitude of siblings to child:
7. Family relations: No unhappiness - no disharmony between parents.
   Attendance very irregular and frequent changes of school. Standard below average because of irregular attendance and changes. Intelligence quite normal. Satisfactory relationships with teachers but apparently unable to "mix" with her schoolfellows and consequently subjected to "teasing". Found to have indulged in sex play with boys in school and was consequently expelled.
No:662.

(E) RELATIONSHIP OF ONSET TO ENVIRONMENT.
Maladaptation and unhappiness chiefly related to school life.

(F) HEREDITY:

(G) CONCLUSIONS:
(1) Chief Factors:
(a) Mental trauma: Unwise, unbalanced and chiefly neglectful attitude of parents made the child solitary and unfitted to adjust herself to outside environment, especially in this case, her school life.
(b) Physical trauma: Mild chronic ill health - neglect on parents part to attempt to have this remedied. On admission was found to be suffering from slight chorea.

(2) Principal manifestations of mental disease.
Hebephrenic reaction. Inaccessible, manneristic and apathetic. Frequently impulsive and mischievous.

(3) Correlation of clinical manifestations and environmental factors: N/L.

(4) Insight regarding these environmental factors during remission or recovery. N/L.

(5) Environment after discharge.
Unimproved. Is still in Ewell Mental Hospital.
No: 719. MISS. M.C.

**DIAGNOSIS:** Hebephrenic Schizophrenia (and Congenital Mental Deficiency).

Age at onset: 20  Date of onset: March 1932.
Age on admission: 21  Date of admission: 18.3.33.

(A). **Prenatal - Infancy.**

(2). Birth: Normal.
(3). Feeding: Bottle fed.
(4). Age of parents at time of patient's birth:
   Father: 30.
   Mother: ? 26

(5). Spacing of pregnancies:
   Male, 1 yr, Female 2 yrs, Female 1 yr, Patient.
   (Followed by six other siblings).

(6). Illnesses: Measles (? age).

(7). Development:
   - Walked 18 months.
   - Talked 18 months.
   - Teethed normally.

(8). Temperament and peculiarities of disposition:
   Shy, quiet and sensitive.

(9). Material home conditions:
   Very poor. Overcrowded slummy locality.

(10). Attitude of parents to infant: Normal. (Patient one of a large family).

(11). Attitude of siblings and other associates to infant: Normal.

(12). Attitude of parents to each other and other members of the family:
   Poor material conditions "got on all their nerves" and there was much unrest and quarrelling in the home.

(13). Shocks, frights etc: Unknown.

(B). **Childhood.**

(1). Illnesses:
   - Acne started at 14, which caused patient much worry because of disfigurement.

(2). Development: Normal.

(3). Temperament and peculiarities of disposition:
   Shy, quiet, sensitive. Solitary and self-conscious. Often "gigly" at school.


(5). Attitude of parents to child and vice versa: Normal.

(6). Attitude of siblings to child: Normal.

(7). Family relations:
   Much unrest and quarrelling due to very poor material conditions.

(8). School:
   - Age of entry: 5.
   - Age of leaving: 14.
   - Average standard in a school populated by poor backward children. Satisfactory relationship with teacher but apparently asocial towards her school fellows.

(9). Shocks or frights: Nil.
(C). ADOLESCENCE.

(1). Illnesses:
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Introverted type.
(5). Attitude of Parents: Normal.
(6). Attitude of siblings: Normal.
(7). Family relationships: Much unrest and quarrelling due to very poor material conditions.
(9). Shocks or frights: Worried about the acne disfigurement. Lost the affections of her boy friend and this seemed to perturb her greatly.
(10). Social activities: Few opportunities owing to poverty.
(11). Sex life:
   Attitude towards same sex: ) Normal, but
   Attitude towards opposite sex: ) general reserved attitude.
   No abnormal habits. Menstruation normal.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.
Seemed to be chiefly affected by impoverished, uncongenial home conditions.

(F). HEREDITY.
Father "neurasthenic".

(G). CONCLUSIONS:
(1). Chief factors:
   (a). Mental trauma: Mentally defective and received no proper attention. Uncongenial squallid home atmosphere all her life. Worry regarding acne since age 14. Recent worry over disappointment in love affair.
   (b). Physical trauma. ? general malnutrition as result of poverty.
   (c). Material: Greatly impoverished home conditions existing since birth.
(2). Principal manifestations of mental disease: Introverted, manneristic and childlike. Solitary and unsociable.
(3). Correlation of clinical manifestations and environmental factors: N/L.
(4). Insight regarding these environmental factors during remission or recovery: N/L.
(5). Environment after discharge: Unimproved. Is still in Ewell Mental Hospital.
Miss P.G.

No: 729)  733.

DIAGNOSIS. Hebephrenic Schizophrenia.

Age at onset:  16  Date of onset:  April 1933.
Age on admission:  (a) 16. Date of admission: (a) 2.5.33.
(b) 16. Date of admission: (b) 26.8.33.

(A). PRENATAL - INFANCY.

(1). Pregnancy:  No information (Illegitimate).
(2). Birth:  No information.
(3). Feeding:  No information.
(4). Age of parents at time of patient's birth:
   Father: ? (Killed during war)
   Mother: About 38.
(5). Spacing of pregnancies:
   Patient, two years, Stepbrother.
(6). Illnesses, including fits:  No information.
(7). Development:  No information.
(8). Temperament and peculiarities of disposition:
   No information.
(9). Material home conditions:  Patient was born in an
   Institution and thereafter lived with her foster-
   parents.  No information regarding home conditions.
(10). Attitude of parents to infant:  Mother not in touch
   with patient.  Foster parents apparently good and
   kind to her.
(11). Attitude of siblings and other associates to
   infant:  -
(12). Attitude of parents to each other and other
   members of the family:  (?):
(13). Shocks, frights etc.:  Separation from mother
   during infancy.

(B). CHILDHOOD.

(2). Development:  Normal.
(3). Temperament and peculiarities of disposition:
   After about age of 12 she was described as being
   sullen, resentful and subject to fits of depression.
(4). Material home conditions:  Institutional after age
   of 12.
(5). Attitude of parents to child and vice versa:
   No parents.  (Foster parents died when patient
   aged 12).
(6). Attitude of siblings to child:  Patient did not get
   on well with her fellow inmates.
(7). Family relations:  Patient unhappy in institution.
   Above average.  On good terms with teachers and
   schoolmates.
(9). Shocks or frights:  -
(C). ADOLESCENCE.

(1). Illnesses: Frequent headaches (following 'Encephalitis').

(2). Development: Normal.

(3). Temperament and peculiarities of disposition: Sullen and resentful with some people but pleasant tempered at school and with the Matron at the Institution, during the latter part of her life there (age 15-16).


(6). Attitude of siblings: Now on fairly normal terms with other children in home.

(7). Family relationships: Satisfactory.

(8). Work: Clerk. Deliberately chosen by patient.

(9). Shocks or frights: -

(10). Social activities: Good opportunities which she made use of - girl guides etc.

(11). Sex life:

Attitude towards same sex: Normal.
Attitude towards opposite sex: Not much opportunity of mixing with opposite sex but apparently normal relationship for a girl of her age.

Sex knowledge etc.?

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

No special relationship.

(F). HEREDITY. No information.

(G). CONCLUSIONS.

(1). Chief Factors:

(a). Mental trauma. Separation from mother in infancy. Loss of foster parents with whom patient had been very happy, aged 12. Institutional life, after being left destitute among people she could not understand and who showed little sympathy.

(b). Physical trauma. "Encephalitis" aged 12 and history of headaches following this illness.

(2). Principal manifestations of mental disease. On addition was almost remote and entirely inaccessible. She became more communicative and it was discovered that she suffered from aural hallucinations and vague bizarre delusions of a persecutory nature.

(3). Correlation of clinical manifestations and environmental factors. Nil.

(4). Insight regarding these environmental factors during remission or recovery: ?

(5). Environment after discharge: Improved rapidly and was discharged "recovered" in 20.7.33 but relapsed soon afterwards and was readmitted 16.8.33 in a similar condition as on the/
No: 729,753.

The first admission. Again made good progress and was discharged on 2.3.34 to go into domestic service, in which occupation she has made a good adjustment and remained mentally well.
MISS W.J.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: 20  Date of onset: 1931.
Age on admission: 22  Date of admission: 19.5.33.

(A). PRENATAL - INFANCY.

(3). Feeding: Breast fed nine months.  Easily weaned.
(4). Age of parents at time of patient's birth:
   Father: 32  Mother: 31
(5). Spacing of pregnancies:
   Female - 6 years - patient.
(6). Illnesses, including fits: No serious illness.
(7). Development: Normal.
(8). Temperament and peculiarities of disposition: Normal.
(9). Material home conditions: Satisfactory.
(10). Attitude of parents to infant:  "Spoilt" by father.
(11). Attitude of siblings and other associates to infant: Normal.
(12). Attitude of parents to each other and other members of the family: Unhappy because of very frequent quarrels between parents.
(13). Shocks, frights etc.: Nil.

(B). CHILDHOOD.

(1). Illnesses: Nil.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Rather unstable and apt to worry over trifles.
(5). Attitude of parents to child:  "Spoilt" by father.
(6). Attitude of siblings to child: Normal.
(7). Family relations: Unhappy because of very frequent quarrels between parents.
   Standard: Above average.  Liked both her lessons and games.
(9). Shocks or frights: Nil.

(C). ADOLESCENCE.

(1). Illnesses: Nil serious.  Said to be "anaemic".
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Worries unduly, and is apt to brood over her difficulties.
No. 732.

(Adolescence – Cont’d.)

(5). Attitude of Parents: "Spoilt" by father.
(6). Attitude of Siblings: Normal.
(7). Family relationships: Non-legal separation between parents when patient was 16.
(8). Work: Numerous jobs – mostly clerical, but she appeared to find the work difficult and trying. During the year before admission she has been unemployed, although she has tried repeatedly to get work.
(9). Shocks or frights: Father leaving the home.
(10). Social activities: Normal interests.
(11). Sex life:
   Attitude towards same sex: Normal.
   Attitude towards opposite sex: No male friends.
   No abnormal habits.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

No direct relationship.

(F). HEREDITY.

Nil.

(G). CONCLUSIONS.

(1). Chief Factors:
   (a). Mental trauma: Onset precipitated by father leaving home, the father having always spoilt the patient.
      Unhappy home atmosphere due to parents' quarrels.
      Worry over unemployment. (The cause of the unemployment seems to have been her health – she actually displayed marked neurasthenic traits at the commencement of her present illness.)
   (b). Physical trauma: –
   (c). Material conditions: –

(2). Principal manifestations of mental disease: Admitted to another Mental Hospital in 1931 in a typical Hebephrenic state, and such was her condition on admission to Ewell Mental Hospital in 1933.

(3). Correlation of clinical manifestations and environmental factors: Nil.

(4). Insight regarding these environmental factors during remission or recovery: No insight.

(5). Environment after discharge: Patient improved and was discharged (18.8.33). Remained fairly well until she had an unhappy love affair which precipitated a further Schizophrenic reaction, commencing with a well marked neurasthenic state. Readmitted 14.6.35. Still in hospital.
No. 737. MISS M.C.

DIAGNOSIS: Dementia Paranoïdes.

Age at onset: 28 Date of onset: 1933
Age on admission: 28 Date of admission: 7.6.33

(A). PRENATAL - INFANCY.

(1). Pregnancy: No information.
(2). Birth: No information.
(3). Feeding: No information.
(4). Age of parents at time of patient's birth: No information.
(5). Spacing of pregnancies:
   14 children in all, 7 of whom died in infancy.
   Female - (?) - Female - (?) - Patient - 2 years
   Male - 5 years - Female - (?) - Female (?) Male.
(6). Illnesses, including fits: Nil serious.
(7). Development: Normal.
(8). Temperament and peculiarities of disposition: No information.
(9). Material home conditions: Poor. Poverty and overcrowding.
(10). Attitude of parents to infant: Normal and happy.
(11). Attitude of siblings and other associates to infant: Normal and happy.
(12). Attitude of parents to each other and other members of the family: Normal and happy.
(13). Shocks, frights etc.: Nil.

(B). CHILDHOOD.

(1). Illnesses: Measles, whooping cough and chickenpox.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: No information.
(4). Material home conditions: Poor.
(5). Attitude of parents to child: From about the age of 5 the father became indifferent and the mother overprotective. (The mother died when the patient was aged 11.) Stepmother came when the patient was aged 12.
(6). Attitude of siblings to child: Normal.
(7). Family relations: Unhappy, owing to father's indifference and infidelity. The patient lived with an aunt from the age of 14.
(9). Shocks or frights: The mother's death.
   (Patient aged 11.)
No. 737.

(C). ADOLESCENCE.

(1). Illnesses: Nil.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Reserved, obstinate and introspective. Overconscientious.
(5). Attitude of Parents: The father was not in close touch with the patient, while the patient was hostile towards her father.
(6). Attitude of Siblings: Normal.
(7). Family relationships: The patient lived alone from the age of 18.
(8). Work: Printing works. She liked her work and was efficient. No troubles.
(9). Shocks or frights: Unhappy love affair at the age of 20.
(10). Social activities: Little participation. She lived a solitary life.
(11). Sex life:
  Attitude towards same sex: Normal outlook
  Attitude towards opposite sex: but not a good mixer.
  Unhappy love affair.
  Inclined to be prudish over sexual matters.
  ? masturbated.

(D). ADULT.

(1). Illnesses: Nil serious, but frequent minor complaints.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: As in adolescence. Solitary.
(5). Attitude of Parents: No family life.
(6). Attitude of Siblings: The patient was living alone.
(7). Family relationships: alone.
(8). Marriage: Not married.
(9). Work: Printing works.
(10). Shocks or frights: Shortly before the onset of her illness, the patient's sister was involved in a sexual assault in which the patient interfered. The incident seemed to worry and upset the patient greatly.
(11). Social Activities: The patient lived a solitary life.
(12). Sex life: Normal outlook.
(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

The patient's personality seemed to undergo a change after her mother died and her father married again, and the home life became broken up, the patient preferring to live alone rather than share the family home.

(F). HEREDITY.

Nil.

(G). CONCLUSIONS:

(1). Chief Factors:
   (b). Physical trauma: -
   (c). Material conditions: -

(2). Principal manifestations of mental disease. Fairly sudden onset, with rather bizarre self-accusatory delusions. She has gradually improved, but her personality is still abnormal.

(3). Correlation of clinical manifestations and environmental factors: Nil obvious.

(4). Insight regarding these environmental factors during remission or recovery. No insight.

(5). Environment after discharge: Still in hospital.
No. 751. MISS M.B.

DIAGNOSIS: Catatonic Schizophrenia.

Age at onset : 24 Date of onset : 5.5.33
Age on admission: 24 Date of admission: 25.7.33

(A). PRENATAL - INFANCY.

(1). Pregnancy: No information.
(2). Birth: Normal.
(3). Feeding: No information.
(4). Age of parents at time of patient's birth:
   Father: 43
   Mother: 25
(5). Spacing of pregnancies: Patient was born in the latter half of a family of 16. Exact spacing unknown.
(6). Illnesses, including fits: Nil.
(7). Development: Normal.
(8). Temperament and peculiarities of disposition: Unknown.
(9). Material home conditions: Very poor.
(10). Attitude of parents to infant: Unknown.
(11). Attitude of siblings and other associates to infant: Apparently normal.
(12). Attitude of parents to each other and other members of the family: Apparently normal.
(13). Shocks, frights etc: Nil.

(B). CHILDHOOD.

(1). Illnesses: Accident to nose - aged 5.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Quiet and dependent.
(5). Attitude of parents to child: Mother died when patient was aged 4. Father (apparently normal).
(6). Attitude of siblings to child: Apparently normal.
(7). Family relations: Apparently normal.
(9). Shocks or frights: Accident, aged 5.

(C). ADOLESCENCE.

(1). Illnesses: Nil.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Quiet and solitary.
(5). Attitude of Parents: )
(6). Attitude of Siblings: Happy poor family type.
(7). Family relationships: )
(Adolescence - Cont'd.)

(8). Work: Domestic service.
Satisfactory relationship and good conditions.

(9). Shocks or frights: ? broken engagement, set 17.

(10). Social activities: Few opportunities, and not taken.

(11). Sex life:
Attitude towards same sex: Normal.
Attitude towards opposite sex:
Engaged when 17, but since that was broken off she has shown little interest in the opposite sex.
No abnormal habits.

(D). ADULT.

(1). Ear trouble and deafness, aged 20.
(?) result of accident at work.

(2). Development: Normal.

(3). Temperament and peculiarities of disposition:
Quiet and dependent.

(4). Material home conditions: ) Not much contact
(5). Attitude of Parents: ) with family.
(6). Attitude of Siblings: ) Patient in domestic
(7). Family relationships: ) service.
(8). Marriage: Not married.

(9). Work: Satisfactory relationship and good conditions.

(10). Shocks or frights: Nil.

(11). Social Activities: Few opportunities.
Patient solitary.


(E). RELATIONSHIP OF ONSET TO ENVIRONMENT:
No obvious relationship.

(F). HEREDITY:
Nil.

(G). CONCLUSIONS:

(1). Chief Factors:
(a). Mental trauma: Handicap of deafness from age of 20.
Unsatisfactory love affair.
(b). Physical trauma: -
(c). Material conditions: Poor until patient went into service.

(2). Principal manifestations of mental disease.
Acute onset. Patient agitated, noisy and obviously hallucinated.

(3). Correlation of clinical manifestations and environmental factors: Nil.

(4). Insight regarding these environmental factors during remission or recovery.
Remained in an advanced Schizophrenic state, till she died suddenly (18.6.34). Post Mortem showed only some myocardial degeneration.
No. 754. MISS V.H.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: 25     Date of onset: 1928.
Age on admission: 25   Date of admission: 9.10.28 & 19.8.33.

(A). PRENATAL - INFANCY.

(2). Birth: Normal.
(3). Feeding: No details.
(4). Age of parents at time of patient's birth:
   Father: 27
   Mother: 25
(5). Spacing of pregnancies:
   Female, (?) Patient, (?) Female, (?) Male, (?)
   Female, (?) Female.
   Actual spacing unknown. Patient is 10 years older than youngest sister.
(6). Illnesses, including fits: Nil.
(7). Development: Teeth - 11 months; Walked - 14 months; Talked - 2 years.
(8). Temperament and peculiarities of disposition: Normal.
(9). Material home conditions: Good.
(10). Attitude of parents to infant: Normal. Not
(11). Attitude of siblings and other contacts to infant: Beyond family
(12). Attitude of parents to each other and other members of the family:
(13). Shocks, frights etc: -

(B). CHILDHOOD.

(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Did not "mix" much with people outside the family. Quiet but at the same time was rather emotionally unstable.
(4). Material home conditions: Good.
(5). Attitude of parents to child: Normal.
(6). Attitude of siblings to child: Normal.
(7). Family relations: Normal.
(8). School: Age of entry, 5. Age of leaving, 14. Standard: Average. She liked school, but is reported to have been "mischievous and easily excited".
(9). Shocks or frights: Nil.
(C). ADOLESCENCE.

(1). Illnesses: Nil.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Quiet, but emotionally unstable. Rarely went beyond the family circle.
(4). Material home conditions: Good.
(6). Attitude of Siblings: ) patient's sisters married it broke up the family, and patient appeared to be much affected by this.
(7). Family relationships: ) patient's sisters married it broke up the family, and patient appeared to be much affected by this.
(8). Work: Clerk. No troubles until after onset of illness.
(9). Shocks or frights: Broken engagement appears to have been the precipitating cause of her illness.
(10). Social activities: Few outside interests.
(11). Sex life: Attitude towards same sex: Normal - although she had few friends.
Attitude towards opposite sex: Normal - became engaged (V.S.)
No abnormal habits.

(D). ADULT.

(2). Development: Normal.
(3). Temperament and peculiarities of disposition: As in childhood and adolescence.
(4). Material home conditions: Good.
(5). Attitude of Parents: Normal.
(6). Attitude of Siblings: Normal.
(7). Family relationships: Normal.
(8). Marriage: Not married.
(9). Work: Clerk.
(10). Shocks or frights: Nil.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT:

No obvious relationship.

(F). HEREDITY:

Nil.
No. 754.

(G). CONCLUSIONS:

(1). Chief Factors:
   (a). Mental trauma: Patient's family was a very close circle, and she felt the effects of this being broken when her sisters were married.
   Broken engagement - probable precipitating factor.

   (b). Physical trauma: -

   (c). Material conditions: -

(2). Principal manifestations of mental disease.
Patient had been emotionally unstable since childhood, but actual mental illness commenced with persecutory delusions. Is now a typical Hebephrenic.

(3). Correlation of clinical manifestations and environmental factors:
Persecutory delusions appear to be the direct result of her broken engagement.

(4). Insight regarding these environmental factors during remission or recovery.
No insight.

(5). Environment after discharge: Still in hospital. Is visited frequently by her elder sister, who is distinctly dominating in her manner, and probably had been dominating and protective to the patient all her life.
No. 755. MISS A.B.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: 22  Date of onset: 1930
Age on admission: 25  Date of admission: 1) 1930  2) 1933
(In West Park Mental Hospital aged 22)

(A). PRENATAL – INFANCY.

(2). Birth: Normal.
(3). Feeding: Breast fed 3 months. Easily weaned.
(4). Age of parents at time of patient's birth:
   Father: 23  Mother: 25
(5). Spacing of pregnancies:
   Male - 2 years  Patient - 5 years  Male.
(6). Illnesses, including fits: Nil.
(7). Development: Normal.
(8). Temperament and peculiarities of disposition:
   Normal.
(9). Material home conditions: Very good.
(10). Attitude of parents to infant: Normal.
(11). Attitude of siblings and other associates to infant: Normal.
(12). Attitude of parents to each other and other members of the family: Happy.
(13). Shocks, frights etc.: Nil.

(B). CHILDHOOD.

   Nil serious.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition:
   Normal.
(5). Attitude of parents to child: Normal.
   Father died when patient aged 7.
(6). Attitude of siblings to child: Normal.
(7). Family relations: Happy.
(8). School: Age of entry, 5. Age of leaving, 16.
   Standard: Average.
   Normal relationship with others.
(9). Shocks or frights: Nil.

(C). ADOLESCENCE.

(1). Illnesses: Nil.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition:
   She became serious and sensitive. Identified herself with other people's troubles, although she remained aloof and solitary.
No. 755.

(Adolescence - Cont'd.)

(4). Material home conditions: Good, although some financial difficulties.

(5). Attitude of Parents: Mother normal.

(6). Attitude of Siblings: Normal.

(7). Family relationships: Happy.
Mother kept a boarding house, and the patient appeared to be very sensitive about this and ashamed to admit it to her school friends.

(8). Work: Training for secretarial work.
Carefully chosen. Satisfactory relationships, and appeared well suited, although the patient herself was ambitious and not satisfied with her position.

(9). Shocks or frights: -

(10). Social activities: Ample opportunity, but no participation.

(11). Sex life:
   Attitude towards same sex: Normal.
   Attitude towards opposite sex: No interest in opposite sex.

Otherwise nil abnormal.

(D). ADULT.

(1). Illnesses: Nil.

(2). Development: Normal.

(3). Temperament and peculiarities of disposition: Becoming increasingly sensitive and aloof.

(4). Material home conditions: Good.

(5). Attitude of Parents: Normal.

(6). Attitude of Siblings: Younger brother was not sympathetic towards the patient.

(7). Family relationships: Good on the whole.

(8). Marriage: Not married.

(9). Work: Secretarial. Satisfactory circumstances, but patient was ambitious and dissatisfied.

(10). Shocks or frights: -

(11). Social Activities: No participation in opportunities presented.

(12). Sex life: No contact with opposite sex.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

Onset of first breakdown seemed to be concerned with her work, in which she was disappointed.

(F). HEREDITY:

Nil.
No. 755.

(3). CONCLUSIONS:

(1). Chief Factors:
   (a). Mental trauma: No outstanding factors - Patient was ambitious, and her home and work circumstances rather worried her.
   (b). Physical trauma: -
   (c). Material conditions: -

(2). Principal manifestations of mental disease. Sudden onset of typical hebephrenic reaction. Had persecutory delusions in which the wrongs perpetrated by employers in general on the workers was a prominent feature. Her first breakdown was at the age of 22, and the patient recovered, but relapsed 3 years later. She again recovered sufficiently to be discharged, obtained employment and has made a satisfactory adjustment.

(3). Correlation of clinical manifestations and environmental factors: Unsatisfied ambitions and content of delusions. (V.S.)

(4). Insight regarding these environmental factors during remission or recovery. No insight.

(5). Environment after discharge: Discharged 24.5.34. (V.S.)
No. 756.  MISS R.B.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset : 21  Date of onset:  - .5 .33
Age on admission: 21  Date of admission: 21 .9 .33

(A). PRENATAL - INFANCY.

(1). Pregnancy:  Mother in poor health during pregnancy.
(2). Birth:  Difficult.
(3). Feeding:  Bottle fed (Mother ill).
(4). Age of parents at time of patient's birth:
   Father: 44
   Mother: 39
(5). Spacing of pregnancies:
   9 years  10 years  6 years
(6). Illnesses, including fits:  Delicate. Bronchitis.
(7). Development: Normal.
(8). Temperament and peculiarities of disposition:
   Shy and quiet.
(9). Material home conditions: Good.
(10). Attitude of parents to infant:  Overprotected by parents.
(11). Attitude of siblings and other associates to infant:
      Overprotected by elder siblings.
(12). Attitude of parents to each other and other members of the family:
      Happy atmosphere.
(13). Shocks, frights etc.: Nil.

(B). CHILDHOOD.

(1). Illnesses:  Measles, whooping cough, ? scarlet fever. Tonsillectomy, age 9. Diphtheria, age 12, followed by "heart trouble".
(2). Development: Normal.
(3). Temperament and peculiarities of disposition:
   Shy and dependent.
(4). Material home conditions: Good.
(5). Attitude of parents to child:  Overprotective.
(6). Attitude of siblings to child:  Overprotective.
(7). Family relations:  Family very united, to the exclusion of outside persons and ideas.
(9). Shocks or frights: Nil.

(C). ADOLESCENCE.

(1). Illnesses: None.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition:
   Shy and submissive.
(4). Material home conditions: Good.
(Adolescence - Cont'd.)

(5). Attitude of Parents: Parents very protective.
(6). Attitude of Siblings: Elder siblings very protective.
(7). Family relationships: Happy (see above).
(8). Work: Stayed at home from 14 to 17, where she was happy, as she liked working with her mother. Shop assistant from 17 to 19. Casually chosen but apparently quite well suited. Conditions good. At home from 19 to 21.
(9). Shocks or frights: Nil.
(10). Social activities: Religious interests, but otherwise little participation in outside social affairs.
(11). Sex life:
   Attitude towards same sex: Shy
   Attitude towards opposite sex: Both sexes.
   Aged 19 she met her fiancé, to whom she became very much attached.

(D). ADULT.

(1). Illnesses: "Fits" when aged 20. Debilitated and history of "fits" from May 1933. When in hospital she had no "fits", but these recurred at home where she was treated as an invalid.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Quiet and reticent.
(4). Material home conditions: Good.
(5). Attitude of Parents: Parents very protective.
(6). Attitude of Siblings: Elder siblings very protective, but the patient had frequent quarrels with her sisters.
(7). Family relationships: Self sufficing and united.
(8). Marriage: Not married.
(9). Work: Working at home.
(10). Shocks or frights: Appeared to be greatly perturbed by her fiancé's more progressive ideas than those held by her own family. This led to much controversy between the two parties.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

Onset of illness was related to the trouble at home as the result of the difference of opinion between her fiancé and the patient's family and herself.
No. 756.

(F). HEREDITY:

Patient - Nil.
Siblings "all neurotic".

(G). CONCLUSIONS:

(1). Chief Factors:
   (a). Mental trauma: Conflict arising between loyalty to her fiancé on the one hand and to her family on the other. This naturally arose in a girl who had been protected within the family circle all her life, when she came in contact with outside opinion. Her father was dominating and tried to separate her from her fiancé.
   (b). Physical trauma: Poor health during infancy and childhood. This increased the protective attitude of the rest of the family. She was born after a prolonged series of pregnancies.
   (c). Material conditions: -

(2). Principal manifestations of mental disease. The "fits" prior to the onset of the present illness appear to have been either hysterical or conscious malingering. On admission she was clearly a case of Schizophrenia, being mute, faulty in her habits and probably hallucinated.

(3). Correlation of clinical manifestations and environmental factors: Nil obvious.

(4). Insight regarding these environmental factors during remission or recovery. ? some insight gained.

(5). Environment after discharge: The patient recovered sufficiently to be discharged (4.1.34) and returned home. The situation having been discussed with the parents, there is less likelihood of conflict, and they are more ready to listen to others' opinions on life, including those of the patient's fiancé.
DIAGNOSIS: Dementia Paranoides.

Age at onset: 25 Date of onset: 1927
Age on admission: 31 Date of admission: 5.10.33.

(A). PRENATAL - INFANCY.
(2). Birth: "difficult" - in hospital.
(3). Feeding: Bottle fed (Mother developed puerperal fever).
(4). Age of parents at time of patient's birth:
   Father: 41.
   Mother: 34.
(5). Spacing of pregnancies:
   Male, 1 year, Male, 4 years, miscarriage, 4 years miscarriage, 3 years, Patient.
(6). Illnesses, including fits: Frail child. Abnormally upset by vaccination. Suffered from vulvo-vaginitis.
(7). Development: Normal.
(8). Temperament and peculiarities of disposition: Quiet and placid.
(9). Material home conditions: Good.
(10). Attitude of parents to infant: At first the child was unwanted being a girl but afterwards appears to have been welcomed.
(11). Attitude of siblings and other associates to infant: Both brothers very fond of patient.
(12). Attitude of parents to each other and other members of the family: Happy.
(13). Shocks, frights etc., -

(B). CHILDHOOD.
(1). Illnesses: Frail and always ailing. Had mumps, measles and diptheria during school age. Still suffered from vaginal discharge.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Quiet, shy and unassuming.
(4). Material home conditions: Good.
(5). Attitude of parents to child and vice versa: Possibly overprotected.
(6). Attitude of siblings to child: "spoilt" by brothers.
(7). Family relations: Happy.
(9). Shocks or frights: Nil.

(C). ADOLESCENCE.
(1). Illnesses: Frail but no serious illnesses.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Quiet, sensitive and had intellectual interests.
No:761.

(A) ADOLESCENCE (CONT'D).

(4). Material home conditions: Good.
(5). Attitude of Parents: Mother possibly closely identified with patient. Father rather aloof.
(6). Attitude of siblings: Brothers still idolised patient.
(7). Family relationships: Happy on the whole but with some estrangement between the parents.
(8). Work: Clerk. No strain. Good conditions. Patient well suited to her work and was in the same post for 10 years.
Unemployment: No regular work for five years owing to illhealth.
(9). Shocks or frights: Nil.
(10). Social activities: Had opportunities but did not make use of them.
(11). Sex life:-
   Attitude towards same sex: Normal.
   Attitude towards opposite sex: Shy and self-conscious with men and shunned their company; although apparently anxious to marry. Was interested in the subject of sex but there is no evidence as to the extent of her knowledge.

(B). ADULT.

(1). Illnesses: Rheumatic Fever aet 20.
   Tonsillectomy " 21
   Sustained cuts to head when she fell from a bus aet 26. (Actual mental illness apparently started when she was 25).
(2). Development: Normal.
(3). Temperament and peculiarities of disposition.
   Quiet, sensitive and had intellectual interests.
(4). Material home conditions: Fair financial position but the home was small and cramped and in a neighbourhood which was deteriorating.
(5). Attitude of Parents: Mother over protective.
(6). Attitude of Siblings: Brothers over protective.
(7). Family relationships: Fairly happy but patient's poor health was a source of anxiety to the mother and brothers, but the father was disinterested and unsympathetic. One brother had left the home to be married.
(8). Marriage factors: -
(9). Work: No regular work after age of 25.
(10). Shocks or frights: -
(11). Social activities: Patient too delicate to be able to take part in any social life.
(12). Sex life:
   Attitude towards opposite sex: Patient shunned opposite sex. Considerable conflict in her mind over sexual matters.
   Attitude towards same sex: Few friends, patient being an invalid.
No: 761.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.
No direct relationship.

(F). HEREDITY. Nil.

(G). CONCLUSIONS:
(1). Chief Factors:
(a). Mental trauma. Overprotected by mother and brothers. Frustration of her desires and ambitions, including those pertaining to marriage by the ill state of her health.
(b). Physical trauma. Chronic illhealth from infancy onwards.
(c). Material. Home conditions becoming worse during latter years owing to the rapid deterioration of the neighbourhood.
(2). Principal manifestations of mental disease.
Bizarre hallucinations and delusions, chiefly of a persecuted nature but also including the belief that she was married to a certain doctor and later Prince George was deemed to have asked for her hand in marriage.
(3). Correlation of clinical manifestations and environmental factors:
Obvious connection between the frustration of her desire to marry and her delusional beliefs that she was married etc.
(4). Insight regarding these environmental factors during remission or recovery.
Nil.
(5). Environment after discharge.
Still in hospital.
Diagnosis: Catatonic Schizophrenia

Age at onset: 17  Date of onset: 12.12.33
Age on admission: 17.  Date of admission: 16.12.33


(2). Birth: Normal.
(3). Feeding: No details.
(4). Age of parents at time of patient's birth:
   Father: 38
   Mother: 33
(5). Spacing of pregnancies:
   Male - 3 years - Male - 7 years - Patient - 8 years - Male.
(6). Illnesses, including fits: Delicate, ailing infant.
(7). Development: Normal. (?backward)
(8). Temperament and peculiarities of disposition:
   Fretful.
(9). Material home conditions: Poor. Overcrowded district.
(10). Attitude of parents to infant: Parents overprotective.
(11). Attitude of siblings and other associates to
     infant: Elder brothers overprotective.
(12). Attitude of parents to each other and other
     members of the family: Happy, although living in poor district.
(13). Shocks, frights etc.: Nil.

(B). Childhood.

(1). Illnesses: Delicate. Poor eyesight (myopia).
(2). Development: Normal. (?backward)
(3). Temperament and peculiarities of disposition:
   Docile and contented.
(4). Material home conditions: Poor.
(5). Attitude of parents to child: Parents overprotective.
(6). Attitude of siblings to child: Brothers overprotective.
(7). Family relations: Happy.
   Standard: - In special school for myopics.
(9). Shocks or frights: Nil.

(C). Adolescence.

(1). Illnesses: Delicate. (Diagnosed and treated as congenital syphilitic.)
(2). Development: Normal.
(3). Temperament and peculiarities of disposition:
   Childish. Contented with sheltered life.
(Adolescence - Cont'd.)

(5). Attitude of Parents: Parents very protective.
(6). Attitude of Siblings: Brothers very protective.
(7). Family relationships: Happy, but poverty stricken.
(8). Work: Children's nurse. She liked her work and got on well.
(9). Shocks or frights: Nil.
(10). Social activities: Social activities in connection with church. Spent her holidays away from home - arranged by church and school.
(11). Sex life:
    Attitude towards same sex: Normal.
    Attitude towards opposite sex: Never showed any interest in boys.
    ? very little knowledge about sex.
    No worries or abnormal habits.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.
    No definite relationship.

(F). HEREDITY:
    Nil.

(G). CONCLUSIONS:

(1). Chief Factors:
    (a). Mental trauma: Overprotected by parents and siblings, chiefly on account of ill health.
    (b). Physical trauma: Severe myopia. General debility from infancy. (? Congenital Syphilis.)
    (c). Material conditions poor throughout her life.

(2). Principal manifestations of mental disease.
    Rather acute onset, being excited, restless and noisy.

(3). Correlation of clinical manifestations and environmental factors:
    Nil obvious.

(4). Insight regarding these environmental factors during remission or recovery.
    Nil.

(5). Environment after discharge:
    Gradually improved. Discharged 6.5.34.
    At first she appeared to make satisfactory adjustment, but subsequently relapsed and was admitted to another hospital (May 1935).
No. 771. MISS F.M.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: 16  Date of onset: 1932
Age on admission: 17  Date of admission: 16.12.33

(A). PRENATAL - INFANCY.

(2). Birth: Long and difficult labour, but actual birth normal.
(3). Feeding: No information.
(4). Age of parents at time of patient's birth:
   Father: 27
   Mother: 23
(5). Spacing of pregnancies:
   Patient - 3 years - Female - 6 years - Male - 4 years - Female.
(6). Illnesses, including fits: Nil.
(7). Development: Backward. Teething - 2 years.
   Walking - 2 years.
   Talking - 2 years.
(8). Temperament and peculiarities of disposition: No information.
(9). Material home conditions: Rather poor.
(10). Attitude of parents to infant: Normal.
(11). Attitude of siblings and other associates to infant: Normal.
(12). Attitude of parents to each other and other members of the family: Happy atmosphere.
(13). Shocks, frights etc.: Nil.

(B). CHILDHOOD.

(1). Illnesses: Age 5 - Tonsillitis followed by Rheumatic heart disease.
(2). Development: Slightly backward.
(3). Temperament and peculiarities of disposition: Inclined to be solitary and quiet.
(5). Attitude of parents to child: Normal.
(6). Attitude of siblings to child: Normal.
(7). Family relations: Happy.
   Standard: Below average.
   She kept much to herself and made few friends.
(9). Shocks or frights: Nil.

(C). ADOLESCENCE.

(1). Illnesses: Sydenham's chorea for some years before onset of mental illness.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Quiet and solitary.
(Adolescence - Cont'd.)

(5). Attitude of Parents: Normal.
(6). Attitude of Siblings: Normal.
(7). Family relationships: Happy.
(9). Shocks or frights: The patient's boy friend deserted her a year before admission to hospital. This upset her very much.
(10). Social activities: No definite outside interests.
(11). Sex life:
   Attitude towards same sex: Normal, but made few friends.
   Attitude towards opposite sex: Very fond of one boy (see above).
   Sexual knowledge probably deficient.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT:

   No definite relationship.

(F). HEREDITY:

   Nil.

(G). CONCLUSIONS:

(1). Chief Factors:
   (a). Mental trauma: Patient was probably a high grade mental defective, and found competition against normal people a strain. Trouble with boy friend - this appears to be a definite precipitating factor.
   (b). Physical trauma: ? Rheumatic heart and chorea producing general physical debility.
   (c). Material conditions: -

(2). Principal manifestations of mental disease. The patient, as well as being mentally backward, had long shown a schizoid personality. Her mental illness started with attacks of screaming, and the onset was definitely related to her desertion by her boy friend. On admission and since, she has been a typical introverted manneristic schizophrenic, and her screaming attacks are probably the result of aural hallucinations.

(3). Correlation of clinical manifestations and environmental factors:
   No direct correlation.

(4). Insight regarding these environmental factors during remission or recovery: No insight.

No. 780. MISS E.S.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: 17½  Date of onset: June 1933.
Age on admission: 18  Date of admission: 5.1.34

(A). PRENATAL - INFANCY.

(1). Pregnancy: No information.
(2). Birth: No information.
(3). Feeding: No information.
(4). Age of parents at time of patient's birth:
    Father: 24
    Mother: 23

(5). Spacing of pregnancies:
    Female, (?) Male, (?) Male, (?) Female, 3 years
    4 years
    Patient, 5 years, Female.

(6). Illnesses, including fits: Nil.
(7). Development: Probably normal.
(8). Temperament and peculiarities of disposition:
    ? - no information.
(9). Material home conditions: Poor.
(10). Attitude of parents to infant: Normal.
(11). Attitude of siblings and other associates to
    infant: Normal.
(12). Attitude of parents to each other and other
    members of the family: Happy atmosphere.
(13). Shocks, frights etc.: -

(B). CHILDHOOD.

(1). Illnesses: Nil.
(2). Development: ? - no information.
(3). Temperament and peculiarities of disposition:
    Shy and sensitive.
(4). Material home conditions: Poor.
(5). Attitude of parents to child: Normal. Mother
died when the patient was aged 8.
(6). Attitude of siblings to child: Normal.
(7). Family relations: Happy in spite of poverty
    and overcrowding.
    Standard, below the average.
    Did not mix much with other pupils, but was
    popular with teachers.
(9). Shocks or frights: Mother's death. (Patient
    aged 8.)

(C). ADOLESCENCE.

(1). Illnesses: Nil.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition:
    Shy, sensitive and solitary.
No. 780.

(Adolescence - Cont'd.)

(5). Attitude of Parents: Normal.
(6). Attitude of Siblings: Patient was popular with her brothers and sisters, and was probably overprotected and made a fuss of by her elder sisters.
(7). Family relationships: Happy.
(8). Work: Temporary factory work. Casually chosen. No strain until the last few months, when the work was fairly heavy. Attitude to others apparently normal.
(9). Shocks or frights: Nil.
(10). Social activities: No participation and few opportunities.
(11). Sex life:
   Attitude towards same sex: No information.
   Attitude towards opposite sex: Did not mix with opposite sex.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

Onset appeared to coincide with period of heavy work.

(F). HEREDITY:

Nil.

(G). CONCLUSIONS:

(1). Chief Factors:
   (b). Physical trauma: Physical strain at work just before onset of illness - probable precipitating factor.
   (c). Material conditions: Poor home conditions.

(2). Principal manifestations of mental disease:
Typical Schizophrenia. Patient was introverted, manneristic and her conversation disjointed and irrational. Gradually improved.

(3). Correlation of clinical manifestations and environmental factors:
No correlation.

(4). Insight regarding these environmental factors during remission or recovery:
No insight.

(5). Environment after discharge:
Discharged home (12.7.34). No further information obtained.
No: 302. MISS L.H.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: 16. Date of onset: 29.3.34.
Age on admission: 16. Date of admission: 12.4.34.

(A). PRENATAL - INFANCY.
1. Pregnancy: No reliable information.
2. Birth: No reliable information.
3. Feeding: No reliable information.
4. Age of parents at time of patient's birth:
   Father: 32.
   Mother: 30.
5. Spacing of pregnancies:
   Female, ? yrs, Male, ? yrs, Male, 3 yrs, Patient,
   2 yrs, Female, ? yrs, Female ? yrs, Female.
6. Illnesses, including fits: Nil.
8. Temperament and peculiarities of disposition:
   Normal disposition.
10. Attitude of parents to infant: Normal.
11. Attitude of siblings and other associates to
    infant: Normal.
12. Attitude of parents to each other and other
    members of the family: Apparently happy though
    poverty stricken.
13. Shocks, frights etc., -

(B). CHILDMOOD.
1. Illnesses: Accident aet 13, knocked down in street.
   Arm and leg injured. No head injuries.
   Diphtheria aet 14.
3. Temperament and peculiarities of disposition:
   Normal.
4. Material home conditions: Poor.
5. Attitude of parents to child and vice versa: Normal.
6. Attitude of siblings to child: Normal.
7. Family relations: Happy.
   Average standard. Normal relationships.
9. Shocks or frights: Accident, as above.

(C). ADOLESCENCE.
1. Illnesses: Nil.
3. Temperament and peculiarities of disposition:
   Normal.
5. Attitude of Parents: Normal.
6. Attitude of siblings: Normal.
7. Family relationships: Happy despite great squalor.
   Conditions fair. Atmosphere amongst employees
   not very happy.
9. Shocks or frights: -
(C). ADOLESCENCE (Cont'd).
(10). Social activities: Few opportunities but made the best of them.

(11). Sex life:
- Attitude towards same sex: Normal.
- Attitude towards opposite sex: Normal.
- Sexual knowledge etc normal for girl of 16.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.
Work. Onset of mental illness was sudden and she returned home from work one day in a confused and restless state.

(F). HEREDITY.
(a). Parents: -
(b). Siblings: Mental "instability" in two younger sisters.

(G). CONCLUSIONS:
(1). Chief Factors:
(a). Mental trauma: Unhappy atmosphere at work where other employees were said to be disloyal to employer.
(b). Physical trauma: -
(c). Material conditions: Home conditions always extremely poor.

(2). Principal manifestations of mental disease.
Onset sudden. Patient was restless and confused. Persecutory delusions that her employers were going to punish her and that she was going to be killed by "the Jews". Condition soon settled down and on discharge her mental state was quite normal.

(3). Correlation of clinical manifestations and environmental factors:
Obvious connection of her delusions with the financial worries at home and the unhappy distrustful atmosphere at work.

(4). Insight regarding these environmental factors during remission or recovery.
Gained good insight into her condition and realised that her fears were groundless.

(5). Environment after discharge.
Discharged 11.10.34. Returned home where conditions remain poor but her mental condition remains satisfactory and she is looking for work, which she hopes to find soon.
No. 824. MRS. L.S.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: 19  Date of onset: 1931.
Age on admission: 23  Date of admission: 27.7.34

(A). PRENATAL - INFANCY.

4. Age of parents at time of patient's birth:
   Father: about 26.
   Mother: about 26.
5. Spacing of pregnancies:
   Patient - 1 year - Female - 2 years - Male.
6. Illnesses, including fits: Nil.
7. Development:
   Walked at 18 months.
   Talked at 18 months.
   Teething normal.
8. Temperament and peculiarities of disposition: Normal.
10. Attitude of parents to infant: Normal.
11. Attitude of siblings and other associates to infant: Normal.
12. Attitude of parents to each other and other members of the family: Happy.
13. Shocks, frights etc.: Nil.

(B). CHILDHOOD.

1. Illnesses: Measles.
3. Temperament and peculiarities of disposition:
   ? normal.
5. Attitude of parents to child: Mother and grandmother spoilt the patient.
   Father was at war, where he was later killed.
   Stepfather from the age of 9. Normal attitude.
6. Attitude of siblings to child: The patient was jealous of siblings.
7. Family relations: Fairly happy.
   Standard, average. Normal attitude. She was said by her teachers to have ability, but did not apply herself to her work.
9. Shocks or frights: Nil.

(C). ADOLESCENCE.

1. Illnesses: Accidental loss of a finger at work when aged 19.
3. Temperament and peculiarities of disposition: Wilful, sulky, jealous and independent.
(Adolescence - Cont'd.)

(4). Material home conditions: Improved.
(5). Attitude of Parents: The mother's attitude now normal - no "spoiling".
   Stepfather normal.
(6). Attitude of Siblings: Not good, owing to the patient's jealous attitude.
(7). Family relationships: Fairly happy.
   Good record up to the age of 19.
(9). Shocks or frights: Accident to finger (age 19)
(10). Social activities: She went to dances, etc., with a boy friend. No other chance of social
      life in the poor district where she lived.
(11). Sex life:
      Attitude towards same sex: Normal.
      Attitude towards opposite sex: Normal. She kept to one particular boy friend.
      Sexual knowledge and instruction apparently inadequate.

(D). ADULT.

(1). Illnesses: Abscess in breast, following pregnancy in April 1934.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: 
   As in adolescence.
(5). Attitude of Parents: ? rejected owing to wilful behaviour and her marriage.
(6). Attitude of Siblings: She was not on good terms with siblings.
(7). Family relationships: Unhappy.
(8). Marriage: She was married at the age of 22.
   (a). Material home conditions compared with former home: Very poor - worse than her
       former home.
   (b). Attitude of and to husband: She had no interest in her husband after their marriage.
   (c). Attitude of and to children: She had no interest in her child.
   (d). Relationships between the two families: The marriage was not approved of. It took place 
       because the patient became pregnant.
(9). Work: Factory hand until she lost a finger.
(10). Shocks or frights: Illegitimate pregnancy (age 22).
(11). Social Activities: None.
(12). Sex life: She married the boy friend mentioned above.
No. 824.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

Onset of illness related chiefly to her married home life.

(F). HEREDITY:

Nil.

(G). CONCLUSIONS.

(1). Chief Factors:

(a). Mental trauma: Spoilt by her mother during childhood. Unhappy marriage - husband inefficient and unable to provide adequately. Illegitimate pregnancy - probably the precipitating factor. Accident to finger - ? precipitating factor.

(b). Physical trauma: Abscess in breast, following pregnancy.

(c). Material conditions: Poor conditions throughout her life, but especially after her marriage.

(2). Principal manifestations of mental disease. Before the onset of actual Schizophrenia, the patient presumably was abnormal - being more the "spoilt child" than actually schizoid. After her marriage she became dull and apathetic. Schizophrenia became fully developed after the birth of her child. She is impulsive, foolish and manneristic, and has little contact with reality.

(3). Correlation of clinical manifestations and environmental factors. Nil obvious.

(4). Insight regarding these environmental factors during remission or recovery. Nil.

(5). Environment after discharge: Still in hospital. This case is interesting in that it is one of an emotionally unstable adolescent, the result of maternal spoiling, being suddenly thrust into an unfavourable environment where she promptly developed Schizophrenia.
No. 830. MISS G.W.

DIAGNOSIS: Catatonic Schizophrenia.

MENTAL DEFICIENCY

Age at onset: 14 Date of onset: -.8.35.
Age on admission: 14 Date of admission: 17.8.35.

(A). PRENATAL - INFANCY.

(2). Birth: Normal.
(3). Feeding: Bottle fed.
(4). Age of parents at time of patient's birth:
   Father: ?
   Mother: 24.
(5). Spacing of pregnancies:
   Patient, 1 year, Female.
(6). Illnesses, including fits: Nil.
(7). Development: Backward in development.
(8). Temperament and peculiarities of disposition:
   Quiet and placid.
(9). Material home conditions: Poor.
(10). Attitude of parents to infant: Overprotected by mother.
(11). Attitude of siblings and other associates to infant: -
(12). Attitude of parents to each other and other members of the family:
   Unhappy because of father's mental instability.
(13). Shocks, frights etc.: Nil.

(B). CHILDHOOD.

(1). Illnesses: Boil - at onset of mental illness.
(2). Development: Backward.
(3). Temperament and peculiarities of disposition:
   Quiet and timid. She did not mix with other children.
(4). Material home conditions: Poor.
(5). Attitude of parents to child: Overprotected by mother.
(6). Attitude of siblings to child: Normal.
(7). Family relations: Happy, after father deserted mother when patient was aged 10.
(8). School: Patient was considered a definite Mental Defective, and was sent to a special school.
(9). Shocks or frights: Nil.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

Nil.

(F). HEREDITY:

(a). Father - ? mental defective.
   ? psychotic.
(b). -
(c). -
No. 830.

(G). CONCLUSIONS:

(1). Chief Factors:
   (a). Mental trauma: Overprotected by mother in the home.
       Unhappy home life owing to father's behaviour.
   (b). Physical trauma: Onset precipitated by boil.
   (c). Material conditions: Poor home conditions.

(2). Principal manifestations of mental disease.
    Sudden onset of Catatonic state.

(3). Correlation of clinical manifestations and environmental factors:
    Nil.

(4). Insight regarding these environmental factors during remission or recovery.
    Nil.

(5). Environment after discharge:
    The patient has gradually recovered from her Schizophrenic reaction, but the underlying mental deficiency is quite obvious. Still in hospital.
No. 832.  MISS N.W.

DIAGNOSIS:  Hebephrenic Schizophrenia.

Age at onset : 26  Date of onset : 1931.
Age on admission: 29  Date of admission: 21.8.34

(A).  PRENATAL - INFANCY.

(1) Pregnancy:  Normal.
(2) Birth:  Normal.
(3) Feeding:  Bottle fed 6 months.
(4) Age of parents at time of patient's birth:
   Father:  34.
   Mother:  about 30.
(5) Spacing of pregnancies:
   Female - 3 years  Male - 2 years  Patient.
(6) Illnesses, including fits:  The patient was a
   weakly infant, and suffered from rickets.
(7) Development:  Talked at 14 months.  Teething
   normal.  She did not walk properly until she
   was aged 4 1/2, because of rickets.
(8) Temperament and peculiarities of disposition:
   Quiet and shy.
(9) Material home conditions:  Good.
(10) Attitude of parents to infant:  Overprotected by
(11) Attitude of siblings and other associates to infant:
   ) family, because of her physical infirmities.
(12) Attitude of parents to each other and other
   members of the family:  Happy home atmosphere.
(13) Shocks, frights etc.:  Nil.

(B).  CHILDHOOD.

(1) Illnesses:  Nil serious.
(2) Development:  Normal.
(3) Temperament and peculiarities of disposition:
   Quiet and shy.
(4) Material home conditions:  Good.
(5) Attitude of parents to child:  Overprotected by
   parents.
(6) Attitude of siblings to child:  Overprotected by
   siblings.
(7) Family relations:  Happy.
(8) School:  Age of entry, 5.  Age of leaving, 19.
   Standard, average.
   She liked school, but made very few friends and
   never played games.
(9) Shocks or frights:  Nil.

(C).  ADOLESCENCE.

(1) Illnesses:  She suffered from "anaemia" age 15.
(2) Development:  Normal.
(3) Temperament and peculiarities of disposition:
   Shy, quiet and lacking in self-assurance.  She
   had very few friends.
Widened undrip of hot cylinders in neighborhood of plunger.

No. 832.

(Adolescence - Cont'd.)

(4). Material home conditions: Good.
(5). Attitude of Parents: Overprotected by parents.
(6). Attitude of Siblings: Overprotected by siblings.
(7). Family relationships: Happy, apart from financial worries brought about by the father's death.
(8). Work: She helped in the home until her father's death (patient aged 20) then did various clerical jobs for which she was untrained, and which she found a great strain.
(9). Shocks or frights: Father's death.
(10). Social activities: The patient had opportunities, but she always refused to participate in outside activities.
(11). Sex life:
Attitude towards same sex: She had very few friends.
Attitude towards opposite sex: She always shunned men.
No abnormal habits.
Menstruation started at 15, and has always been irregular.

(D). ADULT.

(1). Illnesses: Nil.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: As in adolescence.
(4). Material home conditions: Good.
(5). Attitude of Parents: Overprotective.
(6). Attitude of Siblings: Overprotective.
(7). Family relationships: Happy.
(8). Marriage: Not married.
(9). Work: Clerical.
(10). Shocks or frights: Nil.
(11). Social Activities: The patient did not participate in outside activities.
(12). Sex life: As in adolescence.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

Onset of illness definitely related to her work, which she found trying and uncongenial.

(F). HEREDITY:

Nil.
CONCLUSIONS:

(1). Chief Factors:
   (a). Mental trauma: Overprotected since infancy by parents and siblings. The strain of having to earn her own living, a thing which had never been anticipated until the father died.
   (b). Physical trauma: Feeble health during infancy - probably the direct cause of the overprotective attitude of the family.
   (c). Material conditions: -

(2). Principal manifestations of mental disease. Her illness commenced about November 1931 with a "neurasthenic" state. Thereafter she became apathetic, occasionally irritable and depressed, and her condition appears to be a slowly progressive Schizophrenic reaction.

(3). Correlation of clinical manifestations and environmental factors:
   Nil.

(4). Insight regarding these environmental factors during remission or recovery.
   Nil.

(5). Environment after discharge:
   Still in hospital.
No. 884. MISS K.U.

DIAGNOSIS: Hebephrenic Schizophrenia.

Age at onset: 14. Date of onset: 1931.
Age on admission: 18. Date of admission: 2.5.35.

(A). PRENATAL - INFANCY.

(1). Pregnancy: No details, but apparently normal. The patient is an illegitimate child.
(2). Birth: Normal.
(3). Feeding: No information.
(5). Spacing of pregnancies: Mother had one other illegitimate child, spacing not known.
(6). Illnesses, including fits: Nil.
(7). Development: Normal.
(8). Temperament and peculiarities of disposition: Normal.
(9). Material home conditions: Good.
(10). Attitude of parents to infant: Greatly over-protected and "spoilt" by foster parents who adopted the patient when she was 8 months old.
(11). Attitude of siblings and other associates to infant: None.
(12). Attitude of parents to each other and other members of the family: Happy with foster parents.
(13). Shocks, frights etc.: Query shock of being separated from own mother.

(B). CHILDHOOD.

(1). Illnesses: Tonsils and adenoids removed at the age of 5, and 10 days after the operation the patient developed "meningitis", but apparently made a good recovery.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Normal.
(4). Material home conditions: Good.
(5). Attitude of parents to child: Spoilt by foster parents.
(6). Attitude of siblings to child: None.
(7). Family relations: Happy.
(8). School: Normal.
(9). Shocks or frights: Nil.

(C). ADOLESCENCE.

(1). Illnesses: Nil.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Amiable extroverted type of personality.
No. 884.

(Adolescence - Cont'd.)

(4). Material home conditions: Good.
(5). Attitude of Parents: As before - "spoilt" by foster parents.
(6). Attitude of Siblings: One year before admission her foster parents adopted another girl (aged 10). She and patient seemed to get on well together.
(7). Family relationships: Happy.
(8). Work: Machinist. No trouble, etc.
(9). Shocks or frights:
   (a) In 1931 she stated that she had been interfered with by a man, but there is doubt as to the veracity of this statement. Genital region was inflamed, but this may have been self-inflicted, and the patient may have lied about the man to shield herself.
   (b) Knocked down by a car 22.1.35. Bruised but not unconscious.
(10). Social activities: Numerous outside interests, such as the "Rangers", church activities, etc.
(11). Sex life:
   Attitude towards same sex: Normal.
   Attitude towards opposite sex: Says she hates boys. Has probably masturbated a great deal.

(F). RELATIONSHIP OF ONSET TO ENVIRONMENT.

No direct relationship.

(G). CONCLUSIONS:

(1). Chief Factors:
   (a). Mental trauma: She has been idolised and greatly overindulged by her foster parents, and became a typical "spoilt child". ? attack by man 4 years ago. Motor accident 22.1.35 - precipitated present mental illness.
   (c). Material conditions:

(2). Principal manifestations of mental disease.
For some time following the episode of the "man" (1931) she was considered to be "queer". She was very short tempered and insisted in following her foster mother around wherever she went. This present attack was definitely precipitated by motor accident, and she is now in a definite schizophrenic (hebephrenic type) state.
(Conclusions - Cont'd.)

(3). Correlation of clinical manifestations and environmental factors:
At onset of present attack, she constantly cried out about "that car" which had knocked her down.

(4). Insight regarding these environmental factors during remission or recovery.
No insight.

(5). Environment after discharge:
Illustrates a Schizophrenic reaction occurring in a child who, though thoroughly "spoilt", maintained a fairly normal personality. Acute trauma precipitated the mental illness. The patient gradually recovered, and left the hospital on 18.3.36.
No. 898.  MISS L.A.H.

DIAGNOSIS: Schizophrenia (Dementia Paranoides).

Age on admission: 35  Date of admission: 11.7.35.

(A). PRENATAL - INFANCY.

(2). Birth:  Normal.
(3). Feeding: Breast fed 9 months. Easily weaned.
(4). Age of parents at time of patient's birth:
   Father: 22.
   Mother: 23.
(5). Spacing of pregnancies:
   Patient - 4½ years - Male - 2 years - Female -
   2 years - Female - 3 years - Male.
(6). Illnesses, including fits:  Nil.
(7). Development:  Normal.
(8). Temperament and peculiarities of disposition:
   ? rather quiet.
(9). Material home conditions:  Good.
(10). Attitude of parents to infant:  Normal.
(11). Attitude of siblings and other associates to
   infant:  Normal.
(12). Attitude of parents to each other and other
   members of the family:  Normal.
(13). Shocks, frights etc.:  Nil.

(B). CHILDHOOD.

(1). Illnesses:  Nil.
(2). Development:  Normal.
(3). Temperament and peculiarities of disposition:
   Rather quiet. Very tidy and particular about
   details.
(4). Material home conditions:  Good.
(5). Attitude of parents to child:  Normal.
(6). Attitude of siblings to child:  Normal.
(7). Family relations:  Normal.
   Happy at school. Reported by the headmistress
   as "energetic and active".

(C). ADOLESCENCE.

(1). Illnesses:  Nil.
(2). Development:  Normal.
(3). Temperament and peculiarities of disposition:
   Quiet and reserved.
(4). Material home conditions:  Good.
(5). Attitude of Parents:  Normal.
(6). Attitude of Siblings:  Normal.
(7). Family relationships:  Normal.
No. 898.

(Adolescence - Cont'd.)

(8). Work: Milliner's assistant for 6 months after leaving school, and then she helped in the family grocery business. She has always got on quite well at her work, but occasionally seemed to think that she was not progressing sufficiently by staying in the home business.

(9). Shocks or frights:

(10). Social activities: All her outside interests were centred around her fiancé, to whom she became engaged at the age of 22.

(11). Sex life:
   Attitude towards same sex: Normal.
   Attitude towards opposite sex: Normal.
   No abnormal habits.

(D). ADULT.

(1). Illnesses: Cyst in breast, which was removed by operation in January 1933.

(2). Development: Normal.

(3). Temperament and peculiarities of disposition: Quiet and reserved.

(4). Material home conditions: Good.

(5). Attitude of Parents: Normal.

(6). Attitude of Siblings: Normal.

(7). Family relationships: Normal.

(8). Marriage: Not married.

(9). Work: In family grocery business.

(10). Shocks or frights: The discovery of a lump in her breast was a great shock to her, and seemed to be quite definitely the precipitating factor in her mental illness.

(11). Social Activities: Nil, except going out with fiancé.


(E). RELATIONSHIP OF ONSET TO ENVIRONMENT.

No definite relationship.

(F). HEREDITY:

Nil.

(G). CONCLUSIONS:

(1). Chief Factors:
   (a). Mental trauma: Shock of finding the lump in her breast - apparently definitely the precipitating factor.
   Protracted engagement - Mother states that patient was ready for marriage at any time, but her fiancé always delayed the union because of financial difficulties. Fiancé decided not to visit her after the onset of her illness, and this apparently had an adverse effect on patient's condition.
(Conclusions - Cont'd.)

(1). Chief Factors:
   (b). Physical trauma: -
   (c). Material conditions: -

(2). Principal manifestations of mental disease. Incipient Schizophrenic reaction since January 1933 (when she discovered breast tumour). At present she is apathetic, and complains of vague fears, and there is a history of persecutory delusions.

(3). Correlation of clinical manifestations and environmental factors: Nil obvious.

(4). Insight regarding these environmental factors during remission or recovery. Nil.

(5). Environment after discharge: Still in hospital. As before.
No. 900. MISS M.P.

DIAGNOSIS: Schizophrenia, Mental Defective.

Age at onset: 16 Date of onset: June 1935.
Age on admission: 16 Date of admission: 22.7.35

(A). PRENATAL - INFANCY.

(2). Birth: Normal.
(3). Feeding: Breast fed 5 to 6 months. Easily weaned.
(4). Age of parents at time of patient's birth:
   Father: about 30.
   Mother: 24.
(5). Spacing of pregnancies:
   Male, 5 years, Patient, 4 years, Male, 2 years, Male.
(6). Illnesses, including fits: Rather a weakly infant. Measles when aged 3. Developed squint after this illness.
(7). Development: Normal.
(8). Temperament and peculiarities of disposition: Normal.
(9). Material home conditions: Poor - squalid district.
(10). Attitude of parents to infant: Certainly overprotected by mother.
(11). Attitude of siblings and other associates to infant: Normal.
(12). Attitude of parents to each other and other members of the family: Probably occasionally unhappy, owing to minor quarrels between the parents.
(13). Shocks, frights etc.: Nil.

(B). CHILDHOOD.

(1). Illnesses: Nil.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Possibly rather quiet, but mixed well with other children.
(4). Material home conditions: Poor.
(5). Attitude of parents to child: Overprotected by mother.
(6). Attitude of siblings to child: Normal.
(7). Family relations: Normal apart from minor quarrels.
(8). School: Age of entry, 5. Age of leaving, 14. Standard: Backward. She was protected by the staff from the other children, who were inclined to tease her.
(9). Shocks or frights: Nil.
(C) ADOLESCENCE.

(1). Illnesses: Nil.
(2). Development: Normal.
(3). Temperament and peculiarities of disposition: Rather quiet and appeared to be cowed by outsiders.
(4). Material home conditions: Poor.
(5). Attitude of Parents: Overprotected by mother.
(6). Attitude of Siblings: Normal.
(7). Family relationships: As in childhood.
(8). Work: Factory hand. She did not like the work, and was shy and afraid of the other girls. During the few months before onset of illness, she was helping her parents with their stall, an occupation which she seemed to enjoy.
(9). Shocks or frights: She had a great fright when she first menstruated (age 14). Even after this phenomenon had been explained, she continued to worry and was preoccupied over it, as she has an abnormally heavy loss.
(10). Social activities: Her only outside interest was the church choir.
(11). Sex life:
   Attitude towards same sex: Normal but few friends.
   Attitude towards opposite sex: Says she disliked boys, but the truth of the matter is that she desired their friendship, but was too abashed and selfconscious because of her squint to make any advances in the matter. Her mother considers that this was a great source of worry to the patient. Menstruation - menorrhagia for the first year or so. ? Masturbation.

(E). RELATIONSHIP OF ONSET TO ENVIRONMENT:
No definite relationship.

(F). HEREDITY:

(a). Both parents of rather low grade mentally, if not actually defective.
   Nil.
(b). Nil.
(c). Nil.

(G). CONCLUSIONS:

(1). Chief Factors:
   (a). Mental trauma: Overprotected by mother.
       Worried and teased by outsiders because of her backwardness and her squint.
       Worry over menstruation.
       Unsatisfied longing to have boy friends.
       Background of mental deficiency.
No. 900.

(Conclusions – Cont’d.)

(1). Chief Factors:
   (b). Physical trauma: -
   (c). Material conditions: Poor home conditions all her life.

(2). Principal manifestations of mental disease. Fairly sudden onset of hebephrenic type of Schizophrenia. She is noisy, deluded and hallucinated. Some of her earlier delusions included a belief that several famous male film stars were in love with her.

(3). Correlation of clinical manifestations and environmental factors: Obvious correlation between her delusions and her desire regarding the opposite sex.

(4). Insight regarding these environmental factors during remission or recovery.
   No insight.

(5). Environment after discharge:
   Still in hospital. This is a case which illustrates a Schizophrenic reaction occurring in a high grade defective. The patient seemed to realise her deficiency, and so the inability to "keep pace" with normal beings was a constant source of worry to her.