

sexual indulgence. Excessive fatigue is marked and the patient is unable to concentrate for any length of time.

Freud regarded neurasthenia as largely a product of disturbance in the sexual sphere, and declared that the sexual impulses furnish the basis of psychoneuroses, repressed as they have so often to be in our civilization.

The thoughts retained in the unconscious state express themselves by means of somatic phenomena, which are the objective feature of hysteria and neurasthenia.

The cure for neurasthenia is rest; for the hysteric hydrotherapy is of value, bromides may be necessary. With patience and method much has been done and the work of Weir Mitchell, in which the patient is isolated from friends and given every attention by a capable nurse and a nourishing diet, has done much to cure many cases, but much depends upon the work of the nurse, and psychotherapy is necessary to achieve good results.

Obsessive states. These may be inhibitory, in which the patient has strange ideas that he must not do certain things or mix with people for fear of becoming infected with some disease.

There are other kinds of phobias of varying sorts, from kleptomania and crime to minor foolish acts which are performed by patients with impulsive obsessions. Usually these are imperative ideas which the patient cannot get rid of; they persist in the patient's mind and if he attempts to overcome them by not doing them he becomes worried and anxious.

The treatment of psychoneurosis or any of the functional nervous disorders is now usually directed to the discovery of the emotional disorder and the circumstances which accompany it. Advice is given if it has been decided that an anxiety neurosis is present; the patient is told the truth about the nature of his illness, that it is the consequence of psychological factors and is not physical in origin or nature, and when this has been brought into the patient's consciousness, recovery will usually take place.

It is only of recent years that the causes of neurosis are beginning to be understood and adequate treatment given and substituted for the neglect in previous years.

Hysteria, for instance, was previously thought to be a disease of the brain, and it had never occurred to anyone that it could have a psychological meaning. It required the genius of Freud and Breuer to discover this.

Doctor Breuer was a Viennese physician who, 50 years ago, discovered that the symptoms of hysteria disappeared if the patient was led to recall a long-forgotten memory that had been recovered while under the influence of hypnosis. This proved that the symptoms depended on something past and forgotten and recovery was assured by destroying this condition.

The commonest mental disorder met with in mental hospitals is what was once termed adolescent insanity or primary dementia. The terms are still used, but a more recent name is dementia praecox or schizophrenia, meaning the splitting of the mind or personality. This usually develops in the earlier years of life.

There are several types of dementia praecox, one being the simple dementia, occurring before the age of 20, and others being the catatonic dementia praecox and the hebephrenia, occurring between 20 and 30 years of age.

The disease may take the form of mania, melancholia, stupor, or pass and repass through these three stages. Delusions and hallucinations appear as in paranoia, but with the true paranoia there is a delusional state with no hallucinations and no dementia, the latter in dementia praecox supervenes with advancing years.

The treatment of dementia praecox has advanced greatly. Whereas the patients used to sit about unoccupied in corners for years, they are now found occupiable, and in some cases improve considerably under treatment, many being completely cured.

It was in 1937, following reports by Nyiro and Jablonsky, Straus and Steiner and Glaus on epilepsy and schizophrenia (during the years 1929-1932), that Dr. Ladislaus von Meduna of Budapest adopted in English mental hospitals treatment consisting of injections of cardiazol. This treatment consisting of producing an epileptic form of seizure, as there is a biological antagonism between epilepsy and schizophrenia. Camphor was given for this previously in 1935, but cardiazol was, for practical reasons, used instead.

Hypoglycaemic shock treatment with insulin, similar in reaction to cardiazol, was originally used for schizophrenia by Sakel of Vienna, but is now used for melancholia and drug addiction also. Many physicians are now using both drugs, insulin and cardiazol alternatively.

If the insulin treatment is given in cases of schizophrenia where the condition is not of too long standing, the earlier treatment is instituted the better the outlook for recovery, but where diseases such as nephritis, heart disease and florid tuberculosis are present, the treatment is contra-indicated, also any febrile condition.

It has been found that paranoid and catatonic cases respond best, and if treated within the first year 80 per cent. do well; if treated within two years, some 60 per cent. recover.

The hebephrenic type are treated with insulin first and when the response to this ceases cardiazol is given, returning to insulin later. Before treatment is commenced the relatives must give permission for the treatment. Then the patient is weighed, his temperature taken and pulse counted, a blood count, an estimation of the blood sedimentation rate and a blood pressure measurement taken, and an electrocardiograph should be taken before treatment is commenced. On the evening preceding a treatment no food is allowed after 7.0 p.m.; the following morning at 7.0 a.m. the dose is given deep into the muscle, usually about 30 units, increasing each day by about eight units per day, until the first symptoms appear, full shock requiring about 130 units. Then the dose is no longer increased, but remains the same each day (except Sundays) until the patient recovers. In some cases the dose of insulin required for a full shock has been known to be 300 units.

It has been found that as the patient in some cases becomes more sensitive the dose has to be reduced.

Treatment is usually for 10 weeks, and if the patient shows no recovery at the end of 12 weeks treatment is stopped.

The whole treatment is divided into four phases, the introductory phase, where increasing doses of insulin are given until a dose is reached that will produce shock or coma, this coma being called the second phase during which a varying number of shocks are given. The third phase is the rest phase which is represented by the regular and any additional rest days. Phase four is the polarisation and stabilisation phase, in which the patient is gradually weaned. Somnolence, salivation and sweating may take place for a few days, but sooner or later as the dose is increased the first shock appears, which consists of tremors, twitchings and muscular movements of a tic-like nature, the skin is cold and there is profuse sweating. This phase may last half an hour. The pulse rate sinks below 40 or sometimes rises above 140. The patient must be watched carefully as the breathing or the heart may stop.

In the early stages before coma is produced, treatment can be interrupted by the giving of 200 grams of sugar in tea, milk or water. If this is refused, tube feeding is given without delay through a nasal catheter; if this is not possible, an intravenous injection of 60 to 100 cc. of 33 per cent. sterile-glucose must be given.

Should there be delayed recovery and 30 minutes after consciousness is not fully restored, a further dose of glucose may be given intravenously and Betaxen injected intramuscularly; also bleeding up to 300 cc. may be tried.

The patient, when fully conscious, is then given food and

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