I.

NURSING THE MENTALLY ILL

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Without doubt the greatest sciences of today have been created toward furthering the intelligence of mankind. What greater task can medicine and its allied co-worker nursing take up than keeping that intelligence in good working order? This is perhaps an original and somewhat startling conception of that branch of medicine treating that group of people once contempuously called "crazy."

Probably one of the most fascinating phases of history can be traced in mankinds treatment of the mentally ill. Superstition, black and white magic have governed the original impressions of this group.

The first beliefs were those vested in prophets, demons, and witches. Some of the ideas of demoniacal possession are still in existence in their primitive manifestations in parts of Africa, East Indies and Australia. In civilized countries they exist in various concealed forms under religious auspices. As late as 1911, Charles Williams, a respectable London physician, vigorously defended demoniacal obsession and possession as cause of insanity.

From ancient Egypt evolved the priest physician who treated the ill with elaborate stylized invocations and

and ceremonies. Hyoscyamous, which is still used, was prescribed in various cases. They did not, however, distinguish insanity from other diseases.

That Greece attributed madness to demoniacal possession, is born out by their mythology. Madness was sometimes felt to be an honor in the necessary communications with the Gods; the oracle at Delphi was believed to be such an example.

Greece and Egypt were similar in establishing healing shrines. After having slept in the shrine overnight an attendant, dressed as a God wandered through, touched the patients indicating the seat of their disorder and whispering a remedy. If the patient did not respond they were cast out of the temple as unworthy of cure.

Greece in the 4th century B. C. was remarkable for:

(1) recognition of natural phenomen as causes of mental diseases

(2) crude attempts to classify mental diseases

(3) location of the brain as a center of intellectual activity

(4) formulation of specific remedies in healing of mental illness

Hyppocrates (460-370 B.C.) advised purging and blood letting as treatments. Asclepiades (B.C. 124) prescribed diet, massaging, bathing and exercise. Aretaus, the Cappadocian ((200 A.D.) pointed out differences between mania, melancholia, cerebral and spinal paralysis. He also accurately described symptoms of epilepsy, apoplexy and hysteria. Soranus of Ephesus saw the necessity of gentleness, tactfulness and

forbade the comings and goings of strangers in places of healing. Rather than employ mechanical restraint, he recommended theatres, music and leisurely voyages. Celsus on the other hand advocated chains, flogging, semi-starvation diets and application of terror and torture.

During the middle ages existed a period of stagnation and repression. Arabia, however, was notable for carrying out the best phases of treatment of ancient Greece during this period. The Heathen moslem also met with more gentle treatment than Europe gave to her insane. They also doubtlessly preceeded Europe in building asylums. The first asylum in Europe was built in Valencia, Spain in 1408 by Fray Gôpê Gilaberto. Ceremonial rights and chastisement of those possessed of the "evil one" prevailed.

In the 15-17th century "witches" were put to death by the thousands. Mathew Hopkins in England was appointed "witch finder general." Even the medical men agreed to this form of madness.

Paracelsus in this period was notable for repudiating galenism with his humoral pathology and ridiculing demoniacal possession. He believed in blood letting as a therapeutical agent while Feliz Plater of Basle (1536-1614) appealed for a more humane attitude toward the insane.

In 1369 Robert Deaton an English chaplain obtained a royal charter to found a hospital in honor of the Virgin Mary in All Hollows Barking. This hospital opened in 1403 with six patients and was named St. Mary's of Bethlehem, which quickly degenerated into Bedlam.

In America the colonial doctors were seldom prepared

for their work academically. These men, to a great extent, practiced blood letting and ascribed mental illness to an excess of bile, a carry over of Galen's humoral theory. Dr. Thomas Kitterridge, a colonial doctor, boarded his mental patients out, casting mechanical restraint out in favor of venesection.

The fever of demoniacal possession reached its height in Salem, Massachusetts under Cotton Mather. In May, 1693, Governor Phipps of Massachusetts colony, freed all persons (approximately 150) confined in prison on witchcraft charges ending this era.

Generally speaking, the colonial provision for mentally ill consisted of punishment, repression and indifference. The first laws passed, in regard to this class, were those regarding the estates of the insane. The responsibility for determining insanity was placed in the hands of civil officers. They were allowed to wander about, being treated like the brutes or wild beasts which popular opinion held them to be. The mild cases were regarded as paupers; whereas the violent received the punishments of criminals. Their destiny was, if apprehended, the jail, pillory, whipping post or the gallows.

In New York the first institution for the insane was a specially constructed building for the incarceration of Peter B. Paull, a "lunatic." Similar structures were employed elsewhere, but usually they were cast into the city jail or the almshouse depending on their particular phase of insanity. Another type of treatment of the mildly insane, paupers or

feebleminded (they were usually classed as one i. e. paupers) was bidding them off by the city fathers to the lowest bidder who agreed to keep them a year. During this time it was generally agreed he would get all the labor possible from the mad one; in some places he might be made to take out a bond as security.

The social revolution in America and France (1776-1789) brought about the period of Rational humanitarianism, "Man is free and everywhere he is in chains," as Rousseau put it, aptly fit the situation the mentally ill found themselves at this time.

The Pennsylvania Hospital was established by the Friend's Society and the first patient entered the institution in 1752. Occupational therapy was practiced to some extent by the Friend's Society.

Up to the end of the 18th century, patients were exhibited to sight-seers for a small fee. Extraordinary as it may seem, this was first inovated as a protection to the patient. More than 1100 admission fees were taken in Bedlam in one year.

In 1773, Williamburg, Florida built the first asylum used exclusively for the mentally ill. The personnel consisted of a keeper, matron, guards, nurses and visiting doctors. Determination of insanity was left to three magistrates. John De Sesqueya was the first visiting doctor; James Galt, first keeper; Dr. John M. Galt, first superintendent.

Benjamin Rush (1745), the father of American Psychiatry, became notable at this time for his methods of treatment. He

during the Civil War. She met with a great deal of conflict from the medical men who accused her of picking nurses not for their professional efficiency, but morals, and the general objection to a lay person.

In 1881, she retired to the haven of her "first born child" the New Jersey State Hospital in Trenton. Miss Dix is a symbol of an epoch aptly named "The Sentimental Years."

In 1884, "The original thirteen" formed the "Association of Medical Superintendents of the American Institutes for the Insane." This organization changed its home to the "American Medico-Psychological Association" in 1893 to 1921; it is now known as the "American Psychiatric Association." Following is a list of the "original thirteen" and some of their outstanding points of work:

1. Samuel B. Woodward, Worcester State Hosp...popularized Pinel and Esquirol methods in U. S. A.
2. Isaac Ray, Maine State Hosp. at Augusta....Legal aspects of disease in the "Treatise on Medical Jurisprudence of Insanity" and in 1863 "Mental Hygiene." He fought for statistics.
3. Luther V. Bell, McLean Asylum...."Bell's disease" also a prominent neurologist.
4. Charles E. Stedman, Boston Lunatic Asylum.
5. Nehemiah Cutler of Pepperell Private Asylum, Massachusetts.
6. John S. Butler of Hartford Retreat, New Hartford, Conn.
7. Amariah Brigham of New York State Lunatic Asylum at Utica. Founded the American "Journal of Insanity" (1841); also he was alive to the problem of removing the stigma

from mental disease. Later, his journal became the official organ of the society as the "Journal of Psychiatry."

8. Samuel White of Hudson (Private) Lunatic Asylum at Hudson, N.Y.

9. Pliny Earle of Bloomingdale Hosp, N.Y....Statistics.

10. Thomas S. Kirkbride, Penn Hosp. for Insane....trained nursing service, Kirkbride system of construction for mental hospitals was followed for years (a) Linear projection of wings, limit patients to 250; (b) Cottage system 1888....more privacy, elimination of monotony, facilitation of administrative control, two miles from city, not less than 50 acres, 8 distinct wards for each, all rooms with windows.

11. William Awl, Ohio Lunatic Asylum, Columbus.

12. Francis T. Stribling, Western Lunatic Asylum, Virginia at Stanton.

13. John M. Galt, Western Lunatic Asylum, Williamsburg, Va.

America was slow to accept the theory of no restraint. Mechanical restraint was defined by Albert Deutch, as "any appa apparatus that interferes with the free movement of the patient and which he is unable to remove easily." Although the medical superintendents opposed the theory of non-restraint, they were in practice reducing it to a minimum. Although they did not admit it, one of the reasons for opposition was economy. On Sunday and holidays restraints were freely employed because of the lack of attendants. They did not provide the safety-valves which with the

advance of Psychiatry treated the causes instead of merely the consequences. Another one of the reasons put forth for the impractibility of restraint, here, was that non-restraint might be all right for the English but not for Red-blooded Americans. Scotland and Germany had like arguments against non-restraint. Non-restraint laws have been passed in Massachusetts, and in 1911 in New York state a carefully defined law of restraint was passed by the Mental Hygiene Committee.

In 1833, the opening of Worcester State Hospital started an extensive movement for building state hospitals. There was a great need for this, as the pauper insane received no treatment and the indigent not enough. At that time there was in existence an unwritten law that acute cases went to the asylums, and if not recovered within a stipulated period (12 mo. in some cases), the patient was returned to the poorhouse.

To give the reader some idea of the insane portion of the population in ratio to the changing population of the country as a whole and the portion under treatment the following table is presented:

"Year	Total pop. of U.S.A.	Estimated no. of insane*	Insane in hospitals and asylums
1840	17,069,453	17,457	2,561
1850	23,191,876	15,610	4,730
1860	31,443,322	24,042	8,500
1870	38,555,983	37,432	17,735
1880	50,155,783	91,959	38,047
1890	62,947,714	106,485	74,028" *

(*insane and feebleminded inclusive)

Ordinarily the hospital dispensed curative treatment and the asylum custodial treatment. About this time there arose a general controversy to have or not to have the chronic in

* Page 232, Albert Deutsh, "The Mentally Ill in America", Garden City: Doubleday Doran & Co. 1937.

asylums and the acutely insane in the hospitals. In New York (1885) the convention of superintendents in Utica, N. Y., formulated a policy in regard to this situation which was probably the first of its kind in the country:

1. The State to make ample provision for insane not in condition to stay with private families.
2. They were not to be cared for in county poorhouses, almshouses or in a common receptacle for paupers.
3. Curable and incurables should not be provided for in separate establishments.

After a series of investigations a State Asylum for the chronically insane was established in New York in 1865 named for Dr. Williard. They removed all chronic insane from the county poorhouse to the Willard Asylum filling 1500 beds.

The principle of separate maintenance of the chronic and acute was already in operation in England, Germany and France. Among the opposition's reasons against it, was that both types were entitled to therapeutic care, doubtful diagnosis of curatibility and incuratibility in most cases; the mental anguish such a negative diagnosis might impose upon a patient, laxing of vigilant care when chronic inmates are regarded as hopeless.

In 1866, the Massachusetts State almshouse was converted into an asylum for harmless and incurable pauper insane, crippled epileptics, and the feebleminded.

As a result of this, the colony and cottage system, already existing in Europe, had an uncertain beginning. The

Friend's hospital at Frankford, Pennsylvania was probably the first. They used the classification system of the German Psychiatrics Spurzheim i.e. a central building for administration of curative treatments and special lodges for such convalescents and distributed patients as the harmless and chronic. At Worcester State Hospital and in Virginia a vigorous campaign was initiated for this system. The desirable features of such a plan included economy and efficiency.

The Civil War made people realize the necessity of centralized government. There were, at this time, many small charitable institutions who often overlapped in their functions. A central head was seen to be a necessity. Massachusetts was a pioneer in the movement to establish a permanent board of charities to supervise public charities. In 1863, Ohio, N.Y., Illinois, North Carolina, Pennsylvania, New Jersey, Wisconsin, Michigan, Kansas, and Conn. established correctional boards also. In some states these boards were handicapped by being authoritative only in an advisory capacity, and in unwinding the red tape to pass a measure, the cause was often lost. Samuel Gridly, Franklin B. Sanborn of Massachusetts; Frederick H. Wines of Illinois, Brinkerhoff of Ohio, and William P. Letchworth of N. Y. were keen articulate critics of the social order of the day. So scathing were they, that the boards were sometimes abolished by antagonized officialdom.

In 1871, an exemption was ordered to the Willard law for certain counties to provide for their own insane in local institutions; within a short period 19 counties were exempt.

Within the next few years much fierce controversy arose on the issue of proper state care for the insane. The medical superintendents and the State Charities Aid, Association (head of committee on insane-Louisa Lee Schuyler) dispersed opinions and propaganda in favor of state care. State care was adopted in many states after New York in 1890 until in 1937 twenty-four states were under this system. County care exists in Wisconsin, Pennsylvania, and New Jersey.

The barrenness of psychiatry in development was due to many causes within the profession as well as the outside. Medical superintendents might come into an institution fired with scientific enthusiasm, but due to administrative details, isolation, physically and culturally from a social and scientific life, settling done to a routine grind was the natural result. Psychiatric practice, in addition, lacked a sound base of scientific theory.

While Psychiatry deals with the study and treatment of personality disorders, a new medical speciality developed, dealing with the nervous system and its diseases which do not impair mental processes. Neurology was largely created by the Civil War due to gunshop wounds just as the World War gave an impetus to Psychiatry. The two factions; the psychiatrists and the neurologists were at odds with each other from the start. The neurologists, private practitioners or academic professors for the most part, severely, criticized the psychiatrists for their backwardness, institutionally and in treatment. A negative result of this was that the public became frightened, but it did make the

psychiatrists put their houses in order. Dr. Weir S. Mitchell (of the Mitchell Rest cure) was one of the leading neurologists of the day.

In 1882, Dr. Edward Cowles of McLean Asylum started a training school for nurses. Buffalo State Hospital opened their school one year later. Dr. Cowles was one of the first to introduce women nurses in male wards. Women physicians had been in practice in 1880 in Pennyslvania. Dr. Margaret A. Cleaves was given the medical direction of the wards in Harrisburg while Dr. Alice Bennet was with the Morriston State Hospital. Dr. William Hammond, Dr. Edward C. Seguin and Dr. Isaac Ray carried on the work of psychiatric instruction. Research was stagnant at this time, even autopsies were neglected. Dr. Van Greson, neuro-pathologist (1895), started the first steps toward scientific research by laboratory methods at Manhattan State Hospital. After extensive research by autopsy method, Dr. Adolf Meyer stepped into the picture and turned the major interest from the dead patient to the live individual by seeing the personality as a whole rather than the abstract mind alone. He also saw the necessity of social work in bringing about economic social adjustments. Dr. Meyer emphasized the necessity of complete case records, social, economic, hereditary,-makeup; physically, mentally and emotionally in regard to the community environment.

The after-care movement was introduced by Dr. Lindpainter, director of Eberbach Asylum in Nassau, Germany. France had their "Societê de Patronage" started by Dr. Fulret (1881); the "Guild of Friends for Infirm in Mind" (1871) was the organization

for this purpose in England. Richard Drew, Adolf Meyer, H. R. Stedman, Charles L. Dana, and F.X.Dercum were the prominent social workers as early as 1900. The Charities Aid Association of New York 1906 with their commission in Lunacy, in collaberation with several superintendents of hospitals adopted plans on this same idea. Miss Louisa Lee Schulyer and Dr. Richard C. Cabot were very important members.

True psychopathic hospitals, likewise, were slow in developing. The first ward was in Albany Hospital (1902), Pavillion F. under Dr. Montgomery Moshe. The University of Michigan opened a similar hospital with the view of training their medical students under Dr. Herdman in 1906. Dr. E. E. Southard was one of the foremost Psychiatric researchers of this period.

The adoption of the out-patient department in a mental hospital dates back to 1885 when the out-patient department of Pennsylvania hospital in Philadelphia became an integral part of the department. Among the recent better known clinics are The Henry Phipps Psychiatric clinic (1913) part of the John Hopkins Hospital at Baltimore, The Payne-Whitney Psychiatric clinic, New York Hospital association, The Cornell Medical college (1932) in-patient and out-patient with consulting service for the medical and surgical department of the general hospital, Michigan, Colorado and Iowa.

Clifford Whittingham Beers was the most important figure of the mental hygiene movement, being its founder. His older brother was a victim of epilepsy, while Clifford Beers was still an undergraduate at Yale University. The dread that he, Clifford

Beers, would become afflicted with the same disease became an obsession with him. In 1897 he entered business with considerable success. In June 1900 he became so broken down under the obsession that he attempted suicide. However, this resulted only in broken bones in his feet and a sprained ankle. The obsession disappeared, but alternating delusions of grandeur and persecution took its place for three years, during which time he spent in hospitals in Connecticut, except for a few months with a friendly attendant. The first hospital was privately operated on a profit basis. The second one was similar except it was a non-profit institution and was a state hospital. His treatment in these institutions was often that of the harsh and sometimes cruel procedure of ignorant attendants. He spent as many as twenty-one consecutive nights in a straight-jacket. During the first two years he suffered from vague unpardonable crime delusions. Swinging from elation to depression, in one of the moods of elation he formed his idea for a world wide movement to alleviate the evils of the psychiatic institutions. He deliberately provoked attendants after this period to put him into straight-jackets so he would know and experience the full vent of their treatment. The last months as a patient he wrote reams of experience with elaborate programs for reform on wrapping paper.

On September 1903 he was set free. The next two years (with the exception of a small amount of time spent in a large private hospital during a recurrence of mild elation) he resumed business and built up his program of mental hygiene.

The epic, "A Mind That Found Itself," went to press in 1908 after being commented upon favorably by a number of Psychiatrists, Psychologists, educators and other leaders in their fields. The book was quite different from previous work in the same subject due to the lack of unnecessary sensationalism. It had a definite mission:

(1) to form a program for amelioration and prevention of insanity.

(2) to form more humane and intelligent attitudes toward this group.

(3) to encourage and carry on research in causes, value and treatment of disorders.

(4) creation of services directed toward prevention.

On May 6, 1908, the Connecticut society for mental hygiene was created, with Mr. Beers as the principle.

On February 19, 1907, the National Commission for Mental Hygiene was created, Mr. Beers serving as the secretary. Among the prominent leaders in this field were (Lewellys F. Barker, Russell H. Chittenden, H. Flitch, August Hoch, Dr. William James, Julia Lathrop, Marcus M. Marks, Adolf Meyer, Frederick Peterson, Jacob Gould Sherman and the Reverend Auson Phelps Stokes). Among the many obstacles the society met with was that of skepticism in regard to prevention of mental disease; "once insane, always insane" was still the rampant theory.

When America first entered the world war in 1917, it was discovered that in ratio to the civilian population there was more mental disturbances in the army.

Hence a committee organized a Psychiatric and neurological staff of the army. Dr. Pearce Baily was the Chief. It functioned mainly to examine recruits, discharging unfit, and providing adequate care for the ill pending discharge and those discharged. The "war neurosis" aroused public interest on education, public health, general medicine, industry, criminology, and penology. Social work courses were started at the Boston Psychopathic hospital under Dr. E. E. Southard and Miss Mary C. Jarrett. The Smith College School soon developed more extensive courses in cooperation with the nursing staff, psychologists, psychiatrists and social workers.

In 1922 Pioneer Child Study Movements were established with the first Juvenile courts. Dr. William Healy was one of the foremost advocates of such activities working with the Juvenile Psychopathic institute (1909) in Chicago, and the Judge Baker Guidance Center in Boston (1922). In 1915, The National Committee for mental hygiene found facilities dealing with behavior problems in public schools non-existant. Largely through Dr. Salmon's work, who was connected to the Mental Hygiene Movement, a program of Child Guidance Clinics was established under the commonwealth fund. The first habit clinic was established in Boston in 1921 under the direction of Dr. Douglas A. Thom. In 1913 a survey found 159 adequately staffed child guidance clinics in the United States of America.

Work in the Prison went largely under Dr. Bernard Glueck in 1917 at Sing Sing Prison in New York. Among their achievements was that they were able to assist in solving problems of extra-mural adjustment, job placement in prisons and parole

cases. Last but not least, studies formulated a valuable field for research. In 1924 the "American Orthopsychiatric Association" was formed with the above purpose in view for professional interests.

Mental Hygiene in industry aided in personnel selection in considering the personal welfare and happiness of the individual.

From such vigorous beginnings National Societies for Mental Hygiene have spread in thirty countries. In May, 1936, fifty state and local societies were functioning, though mostly on a part time basis.

The history of the care of the mentally deficient ratio of humanity is filled with neglect and cruelty. The exception to the rule was the Moslem treatment who were instructed by the Koran to be kind and revere them.

In 1789 certain French sportsmen discovered the "savage of Aveyron." Doctors Itard, Edward Seguin, and Pinel trained him to a maximum efficiency through his senses, this method being utilized henceforth in private schools in Switzerland. (1842), in training of cretins by Dr. J. Guggenhühl, Berlin; Dr. C. M. Sargent, Dr. John Connelly, and Mr. Andrew at Bath, England, (1846).

With the ascension of Napoleon to the throne of France, Dr. Edward Seguin came to America and assisted Dr. Howe and others in methods of treatment in the United States. The feeble-minded were treated at the Perkins Institute for the Blind, under Dr. Howe's direction; and in the Massachusetts School for Idiotic and Feeble-minded Youth in 1851. The current trend

was to try to educate the feeble-minded to normality with little or no provision for custodial care. Numerous private schools were being opened in Ohio, Connecticut, Kentucky, Illinois, and New York. 1876 marked the beginning of the "Association of Medical officers of American Institution for Idiots and Feeble-minded persons" changing its name finally in 1933 to the "American Association on Mental Deficiency."

The hereditary factor of Feeble-mindedness goes back to Darwin's "Origin of Species" in 1859. Sir Francis Galton in 1865 made an extensive research into this field. In 1877, Richard L. Dugdale published the famed Jukes family history which under investigation found in the 709 individuals only one certified case of feeble-mindedness. Mrs. Josephine Lowell urged custodial care of females to check the multiplication of mental defectives at the source.

In 1905 Doctors Albert Binet and Thomas Simons of France devised the Simon-Binet test as a measuring scale of mental age. This was later revised by Lewis M. Terman of Stanford University, Fred Kuhlman and others. The Terman intelligence quotient which resulted was used first by Dr. William Stearns in treating social debtors.

Dr. Henry Goddard, Vineland, New Jersey, in 1910 formulated a classification of the feeble-minded:

(1) idiots--mental age up to two years.

(2) imbeciles--mental age of eight to twelve years.

(3) Morons (from "Greek Moros" stupid or foolish) comprised those with an I. Q. of less than 75.

The Eugenics movement was coined from the Greek, meaning

"well born" by Sir Francis Galton in 1883 as "The study of under social control that may improve or impair racial qualities of future generations either physically or mentally."

His propaganda was assidiously spread here from the year 1904 onward attributing 90% of the feeble-mindedness due to hereditary causes. A mania of social hysteria set in, hunting the feeble-minded, resembling the witch-finding mania of yore. Dr. Walter E. Fernald referred to this period as the "Myth of the feeble-minded." In 1912 Goddard published the "Family Tree of the Kallikak Family," 1913, "The Pineys," by Elizabeth S. Kite, "The Jukes" by Estabrook and the family of "Sam Sixty" by Koster, all supposedly illustrating hereditary factors in the transmission of feeble-mindedness, but in reality little based on fact.

Mental tests were criticized by the American Association On Mental Deficiency in 1934, as helpful and essential but not infallible; environmental, emotional, cultural patterns to be given important consideration in their gradings as 1/100 of the population is estimated as feeble-minded or 1,250,000 with 80,000 in institutions, segregation seems futile as a eugenic measure. Indeed many authorities now regard the feeble-minded group of high morons as a definite part of our civilization in that they fit in the unskilled trade with little or no dissatisfaction.

Human sterilization was first enacted as a state law in Indiana in 1907 of confirmed criminals, idiots, imbeciles and rapists. On July 1, 1936, twenty-five states had passed sterilization laws. Oregon, in 1917, permitted castration, a

law no longer in effect. A survey in 1926 disclosed that sterilization was in effect in four states, with moderate efficiency in eight states, and the remaining only spasmodically performed due to popular, religious, and scientific opposition.

The American Association for study of the feeble-minded endorsed selective sterilization in 1930 and the Mental Deficiency Commission of the White House conference on Child Health and protection approved it in principle. In Germany Nazi officials sanctioned it for "slightly feeble-minded," and racial non-aryan groups.

Insanity is not clearly defined by law. Broadly speaking it is that degree of mental disorder that exempts a person from responsibility for committing a crime, invalidates legal acts, and affords grounds for depriving that person of control of person or property. The old Roman law defined it similarly and in 1307 A. D. the lands and estate of the insane were expropriated by the crown of England. They were punished in the manner of criminals until the fourteenth century, when they were held not to be guilty in intent.

The "right and wrong" test is the sole criterian of criminal responsibility in 29 states and England at present, or if at time of the crime the person was laboring under such defect of reason that he did not know the nature and quality or the "wrongness" of the act. The status of Psychiatric expert testimony is in most instances only that of an advisory staff. In 1921, the "Brigg's Law" of Massachusetts formulated by Dr. L. Vernon Briggs was passed. This provided for an examination of certain clearly defined cases by impartial experts selected by

the "State Department of Mental Diseases" whose findings were to be submitted before trial, and in most instances accepted as final. Committment may be secured on the findings of a commission in lunacy, upon the advice of one or more medical examiners, or after trial by jury. The usual procedure is first a filing of the petition by the complainant. The notice is served, a certificate presented by the doctors, and a hearing by the court out of record. The committment order and guardians appointed and transportation to the place of committment is then carried out.

Voluntary temporary committment may be accepted in most states. Massachusetts passing the first voluntary admission law in 1881. The advantages of such a procedure is that it obviates legal procedure, delays and places emphasis on the patient as a patient.

A writ of habeas Corpus may secure the release of the patient being discharged as recivered, improved or unimproved, or transferred to another institution.

The United States Census Bureau in 1935 reported 49,000 patients on parole out of 397,781 patients on the books of the various state hospitals. The patients are required to report back at certain intervals, but in some states it is only a sham because of the lack of follow-up treatment.

The problem of child patient's treatment resulted in the separate childrens unit in mental hospitals. The children's institute of Allentown State Hospital, 1930 was the first specially constructed institution of this type. The child must be under sixteen years of age, and are

admitted on the written request of their parents, guardians or on the doctor's certificate. The cases range from conduct and behavior disorders to frank psychoses.

The State hospital is the keynote in State Mental Hygiene program, the psychiatric clinics in the community, supplemented with traveling clinics, have been established with the state hospital as the head.

To gain a keener insight into the nature of the disease one must consider the biological and functional processes of the body. The vital characteristics of all organisms are their modes of response to their environment. The more complex and developed the animal is, the more efficient is his defense mechanism and complex his behavior, reaching its highest attainment in man.

The general plan of the nervous system is that of an intricate communication center. The afferent or sensory nerves carry the impulses to the nerve centers and efferent or motor nerves carry the impulses from the nerve centers back to the muscle or organ originating the stimulus. The lowest level of the nerve centers is the reflex level centering on the spinal cord and stem of the brain, the impulse merely reaching that portion before returning by the efferent nerves to the stimulus. The second level or the "old brain" provides the mechanisms for more of our unconscious and semi-conscious mental activity, also dealing with the emotional responses. In the cortex is found the "new brain" on the third level. It is upon this level that our conscious activity depends and where the "association areas" are found.

The disordered nervous functions are manifested when the nerve centers are damaged or nervous pathways interrupted. The symptoms of the nervous disease appear as the loss of motility, sensibility, or disturbances of nutrition. The axones die with the death of the nerve-cells because they are only an expansion of the protoplasm of the cells.

When the cerebral hemispheres fail to develop, nerve pathway defects may appear as birth palsies with or without mental impairment. In the adult this structure may become diseased, as inflamation, new grwths, wasting, or arterial disease becomes present.

The spinal cord diseases that affects the grey matter is usually ploiomylitis. Locomotor ataxia and sensory disturbances affect the spinal ganglia and the white matter of the cord.

Endocrine glands and internal secretion have no small influence on the mental stability of man, but the exact status has not yet been scientifically determined.

Since the same modes of mental activity are utilized in health as well as in mental illness, we might as well stop here and reconsider that there is no kind of illness that does not along with its physical symptoms show attending mental symptoms that must be treated as well. The disfunction of mental activity may be one of quantity, or in less instances is one of quality.

In almost all cases the psychoses of the individual have their root in the childhood of that person. So comprehensive is this problem today that Karl Menninger was prompted to say "that the most shocking things a psychiatrist meets are not

degenerate sexual perversions, but neglect and abuse of children."

Hitherto, we have tried to fit the child into our ideas of convention so that they became preconceived "little men and women" without a definite personality of their own. Some of the maxims such as "the child is seen and not heard" may well describe the former general feeling toward children.

Our modern ideas of rearing the young differ radically in theory and practice. We treat the child as an individual in the process of development; not as a troublesome person until past adolescence.

In habit training, routine, discipline with reward and punishment are necessary, but must be intelligently executed with a full knowledge of the effect of such procedures.

Up to the age of three to four years the child should receive sensory training. This training involves a slight time effort on the part of parent; being accomplished by means of simple games and the child's natural ingenuity which should never be neglected. It is the concensus of opinion that the age of reason is reached at seven years and that the previous years are among those most important in developing the child's personality adjustments. The years before seven often are those in which fear-reactions begin. The fear-reaction in the infant is a generalized one, but becomes fixed upon some object as the child develops, frequently by conditioning. It is at this point re-conditioning is a necessary and oftimes successful maneuver. Re-conditioning can be accomplished by several methods, but one of the most successful is by substituting the painful stimulus or fear with an indifferent or pleasure

stimulus. One of the classical examples is that of a young child having been conditioned to fear rabbits (conditioning can occur by the simple introduction of a loud noise and sudden appearance of an object). By gradually introducing the rabbit at the pleasant interval of luncheon, he became indifferent to rabbits in general.

The environment of the child is perhaps the greatest factor in its development. Since congenial relationships of the home community and school are necessary, they must cooperate in their common task of making an integrated personality of the child. Where as the home prepares the individual, the school is important in developing the child into a social creature. The school is often tempted to consider the child a means to to the end, irrelevant of the fact that the school is a means to the end product of the child's personality.

We are all cognizant of the value of a harmonious atmosphere in the home. Marriage relationships of the parents, economic problems and social factors have a great effect on the happiness of the child; not to mention the others involved. Since we really want to give our youngsters an equal or every opportunity we can supply, we must realize that this environmental pattern is even more important than any hereditary skeletons we might suspect of lurking in the family tree.

Training from three to four years will be that of the senses and development of the child's language. All forms of letters are best obviated. Disorders of speech are likely to creep in at this point due to mental disability, failure of motivation, illness, or unhealthy emotional attitudes, mostly

originated by fear. The parent can do much by giving the child a motive for speech and watching carefully to prevent the fear from developing. It is at this point that phobias also often find their origin. A phobia is a condition that may result from any circumstance, that is impressed upon the child by fear and a strong and direct emotional experience, shame, guilt, and repression.

To prevent this the parent may encourage "talking out" of any "shameful" experience the child might have.

The innocence and purity of childhood so highly approved of by recent generations is usually a pernicious lack of information concerning sex. To have a healthy attitude toward these matters the child is entitled to:

(1) Complete and frank sex instruction (given unemotionally and sincerely as the occasion arises, the child will not comprehend immediately).

(2) Proper sleeping conditons--no child should sleep in same room as parents after age of one and one-half years and should not sleep with child of opposite sex, preferably sleeping alone.

(3) Development of a pride in a healthy and well developed body through organized sports.

(4) Organized social life so that both sexes may play with each other freely under proper supervision.

(5) Special interests, as boy scout and campfire girls organizations.

The stages of emotional development differ with the authority quoted, the psycho-analytical school citing stages

of narcissism, etc, with their oedipus, castration and other complexes involved. For our interests we may simply divide them into the following stages:

A self interest stage until first year, then rattles, dolls, beds, and other inanimate objects become his love. Shortly he is aware of parents as connected with pleasureable experiences and loves them. From six to twelve years, he loves people outside of the home, beginning the period of psychological weaning.

Of death, the child should know the facts and be helped to formulate a philosphy regarding death.

The Binet-Simon tests and others of similar nature help to present a more or less accurate picture of intelligence. In regard to these tests (for no one test is reliable) we must remember that they are not infallible, that it seldom if ever benefits the child to become familiar with his "I.Q.", and that though the degree of intelligence may be measured, the controlling factor, emotion, is not.

The genius or child of unusual intelligence should receive all the help to develop his faculties, care being taken that his physical needs are supplied and attempts made to adjust him so that he might live with his fellow men with the minimum amount of conflict.

I might elaborate upon the theme of security for the child, which is without doubt, most important, as is independence which springs from the same source. Suffice it to say, that Eve Curie in writing the autobiography of her mother, Madame Curie, expressed for posterity far better than the author can

hope to, in saying of all the heritages left by her mother the most important was "The instinct of independence which convinces us both that in any combination of circumstances we would know how to get along without help."

To go on with our subject of mental nursing is to consider the psychoses of the mentally ill and the procedures one finds most effective in treatment.

The qualifications for mental nursing require special training and experience. The personality of the nurse plays no small role in the recovery of the patient. She must have intelligence and insight which comes with the broadening concepts of mental hygiene, psychology, and other allied sciences. Her social and cultural development should be fairly complete. A full mastery of emotion on the nurses part is an invaluable asset. To accomplish this, some institutions require a psyvho-analysis of its personnel.

The approach of the nurse to the patient must be carefully evaluated beforehand in order that a satisfactory rapport may be established. The essential factors closely resemble those of interrelation between normal members of society. Politeness, tactfulness, friendliness, patience, truthfulness, even temper, a non-critical attitude, poise, confidence, and an ability to listen to people, "Confidence in one's self inspires confidence in others." Points to guard against are an attitude of superiority, over-rating of patient's speech, stimulation of ideas of reference, intimate friendships with patients, unfulfilled promises and hurried contacts. Stimulation of ideas of reference is often made by speaking within hearing of the

patient who seems not to understand. Remember that in many catatonic states the patient may go through agony because he feels unable to respond, although he understands you. Personal hygiene of the nurse is stressed because she often is the model of the patients.

Last but not least, mental nursing implies the physical care and re-education of the patient.

In observation of symptoms, it is well for the nurse to remember that the patient does not know or admit the illness. Furthermore, he thinks the treatment and control unnecessary and, at times, insulting. It is up to the nurse to look for physical symptoms. She must learn to discern symptoms of which the patient never complains, discriminating between the real and imaginary.

The simple symptom of temperature has many possibilities. Sadness and inactivity tends to lower the temperature, the high temperature not associated with infection and exhaustion may be produced by intestinal intoxication. Rectal temperatures, with the precautions meticulously observed, are routine.

In taking the pulse rate of the patient it is well to remember that emotional disturbances alter it, in depressed states it may be slow and that persistant worry increases the blood pressure.

Nausea, vomiting and headaches may occur simultaneously. Noting the time of vomiting and whether it is projectile in character, the time of headache and its character are important diagnostic symptoms in certain disturbances.

Dizziness, appetite, malaise, cough, and careful observation

of pain also count in the diagnosis.

Fatigue is physical or mental. The patient does not have to mention this state if the signs are present. Physically, they are depression of angles of the mouth, furrowed forehead, wandering eye, dark colorations beneath eyes, white lines about the mouth, bluish spots on cheeks and neck, either slow or rapid pulse, frequent headaches, and the general appearance of depression, Mentally, the patient lacks attentiveness, powers of perception and self-control, is irritable being quite miserable in the morning.

The speech disturbances are varied. It may be a paralysis of the tongue if the patient is unable to say L and T, of the lips if unable to say P and B. Scanning, slurring and stammering are also symptoms of Aphasia.

Pupillary changes vary with the disease and they may indicate convulsions, tremors, neurological disturbances, anaesthesias, hyperasthesia, or parasthesia.

When observing mental symptoms state exactly what happened, with-holding your interpretation, but finding out the cause if possible. Disorder of behavior are varied. Increased activity includes talking, shouting, scolding; decreased activity by the opposite--muteness in varying degrees. The patient's impulsive acts as wandering, kleptomania, pyromania may be caused by hallucinations. Suggestibility may be manifest by echolalia, echoproxia, catalepsy (cerraflexibilitas) and other forms of muscular anaesthesia. Negativism may be passive or active. Here also it may be caused by hallucinations or illusions. Stereotypy may be present in all phases. Bizzare mannerisms

are often caused by hallucinations. Aboulia is that hesitation, indecision, and loss of volition in any activity.

Daily behavior charts may be kept as an accurate record of these symptoms.

Disorders in the stream of thought are an important group of symptoms commonly encountered. Flight of ideas, a prominent symptom in the maniac type of psychoses, distractibility and blocking, often found in the dementia praecox, and retardation found in the depressed states are all frequent manifestations due to the disorders of thinking.

Emotional disorders vary in degree and are as numerous as the range of emotions. Indifference is a usual symptom of dementia praecox. Exaltation is often a sign of maniac psychoses. Depression and deterioration are other phases often encountered.

Abnormalities in mental content, group another form of familiar indications. Fixed ideas are those which cannot be banished without treatment. Obsessions, compulsions, and phobias or morbid fears, delusions, illusions, and hallucinations make up this group of symptoms. Delusions, expressive or expansive, are held by the psychiatrist to illustrate in a fluid form the unconscious desires of the patient. Delusion is a false belief not authenticated by the individuals past experiences and which cannot be changed by reason or persuasion.

Illusions are misinterpreted sense impressions or from Bleuler "real perceptions pathologically changed." Hallucinations are false sensory impressions. The mechanism is a dissociative process.

Disturbances of consciousness range from a cloudiness of

consciousness during which illusions may occur to delerium and stupor described as a "dissociation of consciousness."

Disturbances of the intellectual functions may be manifest in disorientation, memory impairment or loss, paramnesia, fabrication, aphasia, agnosia, motor aphasia, thinking, and intelligence. Paramnesia is when an illusion of memory occurs making one unable to distinguish between real and imaginary memory. Aphasia is a language disturbance, sensory when the patient can hear and see but not understand; Agnosia when there is an inability to recognize objects or their use; Motor Aphasia when there is present an inability to write or speak familiar words. Intelligence may be impaired, defective or deteriorated.

The impairment of a person's judgement is often a lack of insight. Insight often facilitates a faster recovery on the part of the patient.

These symptoms may be observed and reported by any nurse. Oftimes the public health, obstetrical or general duty nurse finds herself in an advantageous position in finding these symptoms to help prevent a developing psychoses.

Perhaps of all the special problems of nursing we encounter in patients of this type, personal hygiene is the most outstanding. As we said before, the nurse is often the model in carrying out good hygiene; mouth hygiene, false teeth, chapped lips, care of teeth and bad breath have to be accounted for. The extremeties may include manicures and pedicures. Modern methods of treatment have found beauty culture with all of its stress on good grooming effective in the recovery of the patient, especially the type classed as dementia praecox.

Catemenia records often aid the nurse to foresee periodic outbursts of activity, depression, or cessation of abnormal behavior so as to anticipate nursing procedures. Certainly involutional melancholia appears to be closely related to the menopause.

In trying to provide rest for the patient do not lay emphasis on rest but attempt to find the cause of unrest and remedy it if possible. Remember one of the tests of good nursing is to have your patient sleep well at night without the use of sedatives.

Indirectly, you may bolster your patient's self-respect by showing your interest in well-placed compliments and admiration of good hygiene carried out by other patients. Offer fluids whenever the opportunity arises, and such exercises as will stimulate circulation, increase his appetite and encourage normal sleep.

Then there arises the feeding problem. At times the patient may refuse food entirely. An explanation of the reaction by the psychiatrist will make the feeding problem easier to solve. Among the more general causes are delusions, voices, fear of poisoning, agitation, and indecision. Spoon feeding may have to be necessary. In carrying out the procedure of tube feeding the usual method is utilized giving approximately 2000 calories of food per twenty-four hours. At other times the voracious appetite may have to be guarded against by serving small portions, care being taken to remove any bones from the fish.

In seeking to manage excited patients be calm and do not

attempt to use force by yourself. If cooperation seems impossible and suggestion fails, have at least two other nurses help you.

Remember that any of the psychiatric patients are potential suicides and that the majority who do commit suicide are suffering from disorders from which they are likely to recover.

Though suicides occur frequently in depressive periods, active patients are to be watched as carefully.

Suicidal tendencies may spring from many reasons--hallucinations, lack of reasons to live, false belief of abnormality, hatred, and others. These tendencies seem to be exaggerated during convalescence and when entering the mental illness phase.

Homicide is contemplated when the person is suffering from delusions of persecution centered upon one person--frequent in the paranoid cases.

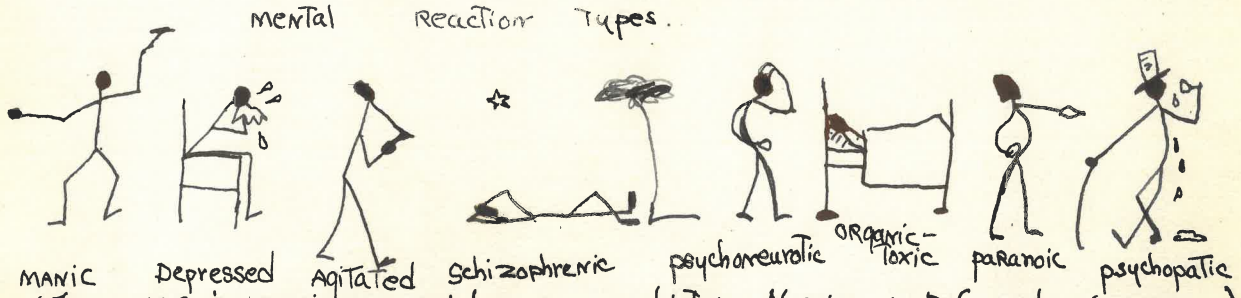
Observation of active suicidal cases, those who are planning to commit suicide or have attempted, requires knowledge of where the patient is and what he is doing every minute of the day and night.

Most effective in treating these cases is inspiring the patient to live. Thorough investigation of all the property of the patient should be routine to prevent any unsuspected suicide or mishap. Judgement of the nurse is often relied upon in removing articles, which may be dangerous. It is well to remember that successful suicides have been accomplished with such innocent articles as wads of hair (choking) bent safety-pins, paper clips, and invisible hairpins.

Extra precautions should be taken in passing medicines and locking up poisonous drugs, medicine closets and antiseptic solution. In treatment of accidents it may be advisable for the nurse to frequently review her emergency nursing technique, to be prepared. The nurse must not wait for choking, asphyxiation, strangulation, fire, burns, drowning, fractures, or poisoning to occur or the emergency will probably be met only with confusion instead of intelligent first aid.

The general suggestions for meeting accidents are to avoid crowds, maintain poise, avoid talking before injured person, and stay with the person.

"Psychoses" symbolizes prolonged abnormal behavior in people who previously demonstrated socially acceptable behavior--



(From M.E. Ingram.: Principles of psychiatric Nursing: W.B. Saunders Company.)

The Senile Psychoses is characterized by a gradual progressive mental weakness. The types are simple, presbyophrenic, delerious, confused, depressive, agitated and paranoid types. The physical symptoms are those generally seen in old age. Mentally the senses are dulled, perception faulty, memory defective, fabrication, poor attention, perseveration, illusions, hallucinations, delusions, nocturnal restlessness, hoarding, and resentment of young people's dictation.

In caring for this patient, treat the insomnia, give an easily digested diet, personal hygiene attention, and above all

try to make the patient comfortable avoiding all irritation.

The occupational therapy will consist of exercise, diversions, familiar forms of work, music, reading, games, light, and fresh air. They like to be left alone and not disturbed.

General paresis is a disease most often found in the older people. Syphillis of course is the cause, general paresis occuring in most cases eight to twenty years after infection. The physical symptoms are a slight headache, head pressure, fatigue, irregular sleep, speech defects, tremors of lips, tongue and hands, spastic gait, weakness, incontinence of feces, difficulty in swallowing, convulsions, knee jerk, loss or exaggeration, and irregular pupils. One can readily see why the disease has been called "the great imitator." The mental symptoms are insidious in onset, irritability, weakness of judgement, boastfulness, amnesia, fabrication, delusions of persecution, and emotional disorders. The continuous bath is a good nursing procedure. Suggestion, tact, soft foods, and special care of the skin are others. Due to the deteriorating effects of this ailment the diversions must be simple. Radio music and motor driving are reliable aids, juvenile paresis is a tragedy that sometimes occurs as early as eight years, the treatment is the same.

Cerebral syphillis is similar with less prominent symptoms. The individual's personality is better preserved. Wasserman tests and the spinal lumbar puncture are the diagnostic factors. The nurse's duties will be largely those of caring for the patient under treatment, special care given to the mouth if oral treatment is used and watching for chills when the lumbar puncture is

done.

The psychoses with cerebral arteriosclerosis is a chronic progressive mental disease due to the changes in the structure of the cerebral blood vessel. The physical symptoms have an insidious onset characterized by buzzing in the ears, vertigo, headache, fainting, pipe stem blood vessels and high blood pressure. Mentally the symptoms are also insidious, irritability, uncontrolled emotions, delusions of persecution, amnesia, aphasia and poor attention are manifest.

Procedures of nursing include rest, quiet, a light diet, good elimination, no excesses or hot baths. The nurse will have a keen appreciation of the disability and use tactfulness. She will give the patient occupational therapy, exercise and diversion, watching carefully for fatigue.

The symptoms of cerebral hemorrhage may be sudden, groups of muscles may be paralyzed, congested faces, respirations slow and subnormal temperature.

The nurse will loosen the clothing of the patient, avoid jarring, place the patient in a semi-recumbent position, elevating head, ice bag to head and dry heat to extremities. She will watch for cheyne-stokes respirations, drowsiness, delerium or vomiting.

Hemiplegia is painless unless the optic thalmus is affected producing burning sort of pain.

Cerebral thrombosis is a result of sclerotic changes producing an occlusion. The gradual symptoms of those already mentioned occur. The nursing procedures should be toward promotion of a collateral circulation with the patient in a prone position.

Cerebral embolism has a gradual onset. The warning signals are vertigo, tingling and involuntary twitching. The nurse will place the patient in a prone position and keep him quiet.

Paralysis Agitans is sometimes called Parkinson's Syndrome. It consists of a slow rhythmical "pill rolling" movement to more exaggerated movements. The symptoms are insomnia, disturbance of equilibrium, a bent-over-position, the countenance is mask-like. Mental irritableness, suicidal tendencies, and resignation are characteristic. Try to keep the patient out of doors, paying more attention to the general health of the individual.

It is presumed that we know the general picture of meningitic patients. Seldom is the disease free from the mental symptoms of irritability, drowsiness, stupor and deleria. Stimulation often causes agony and convulsions in the acute stage. The nursing is directed towards obtaining sedation, free elimination, and peace by a darkened room, with continuous baths, or the wet pack.

Multiple sclerosis has definite mental symptoms too. Young adults as well as the older element fall in this group. The onset is slow while the physical symptoms include muscular weakness, tremor, spasticity, speech defects, and jerky movements of the eyes. Mentally there is a mild depression, hallucination, difficulty in thinking, amnesia and moodiness.

Huntington's Chorea occurs in middle life, and is incurable today. The involuntary jerky movements of the voluntary muscles become generalized although during sleep they are rare. Speech defects are also found. The mental signs are irritability, moroseness, amnesia, dementia, suicidal trends, excitement, and motor unrest. The nurse will restrain the patient by offering diversions and occupations to suit the handicap.

Brain tumors almost always have subsequent mental impairment in the course of the disease. These symptoms, as one might suspect, differ with the portion of the brain affected. Physically the symptoms are severe excruciating headache, vertigo, projectile vomiting, a high tension slow pulse, cheyne-stokes respiration, convulsive movements of one side of the body, and unequal pupils. Dullness, confusion, hallucinations, aphasia, amnesia, irritability facetiousness, restlessness, and over-activity complete the mental symptoms. It is the nurse's duty to maintain peace and comfort of the patient. Careful notations of any convulsions that might occur should be kept.

As the patient gets well, books, rest, pictures, art, simple games, and handiwork serve as rehabilitating aids.

In discussion of the organic psychoses, one includes idiopathic (illness peculiar to self) epilepsy. As its name suggests, the cause is unknown, however, about one fourth of these patients are the offspring of parents, one or both of which presented a history of alcoholism when the child was conceived, this does not mean it was inherited. The marks of an "epileptic character" are selfishness, self-centeredness, a desire to have one's own way, irritableness, an overbearing and conceited personality, and a slow sing-song speech. The symptoms may be mild or severe. The attacks vary from grand mal (several minutes) to petite mal (fleeting), grand mal often being preceded by an aura, a wierd cry before the attack. Status epilepticus is a continuous series of attacks, temperature is elevated, as is the pulse and respiration, and is usually terminal.

Luminal is used as a sedative, in the clouded states, given rectally or intravenously. In carrying out nursing procedures

be patient, guarding the patient against self injury. The positive treatment stresses out-door life and a strict routine which accounts for every minute of the day.

The traumatic psychoses are due to head injuries or growths in the cranial cavities. The usual symptoms are shock, subnormal temperature, vomiting, headache, tendency to constipation or retension, paralysis of arms or legs and coma. The personality disorders are stupor, disorientation, amnesia, difficulty in thinking, apathy, irritability, lack of insight, delerium and dementia. The usual nursing acts are carried on as for a very sick patient, with particular regard to avoid jarring. Careful nursing notations must be kept. Light occupations, diversions, and exercise during convalescence help prevent deterioration.

The alcoholic psychoses are the first of the exogenous toxic psychoses we will describe. In regard to alcoholic psychosis it is another question of which came first--the egg or the hen, applied here--the alcoholic psychosis or the alcoholism? 10% to 12% of all psychosis are caused directly or indirectly from this group.

The acute forms include delerium tremens, acute alcoholic hallucinations, illusions, clouding of consciousness and confusion. If the case has a good prognosis there is recovery in seven to ten days, otherwise mental clouding precedes to the "typhoid state" and death results. Rest and good nursing care with medical treatment is indicated.

Acute alcoholic hallucinosis effects the chronic drinker in most instances; the onset is abrupt, tactile hallucinations

compounds, deals in, dispenses, sells, distributes or gives away opium or coca leaves or any compound manufacture, salt derivative or preparation thereof, shall register with the collector of internal revenue in his district."

Exogenous toxic psychoses include those diseases resulting in mental charges from acute infectious fevers, uremia, metabolic and glandular disorders. Strecker and Ebaugh gathered up the loose ends of the treatment in the following summary:

(1) Careful eliminative procedures.

(2) Careful search for and removal of actual foci of infection.

(3) Relief of constipation.

(4) Routine dietetic and tonic treatment, transfusion if hemoglobin is below 50%.

(5) Eliminative and sedative hydrotherapy.

(6) Serums and vaccines to secure immunity against infection.

(7) Surgery, X-ray, or radium in specified instances.

(8) Prevention of injury or suicide.

(9) Supportive care and follow-ups after the toxic symptoms are relieved.

*Strecker, E. A., and Ebaugh, F. G. "Textbook of Psychiatry," Blakiston's Son and Company, Philadelphia.

The functional psychoses are a particularly important phase of mental diseases. These include the maniac depressive psychoses, the schizaphrenic reactions and paranoid forms.

Maniac depressive psychoses are usually spoken of as recurrent, although it appears in more than one half of the cases, there is no recurrance of attacks severe enough to cause

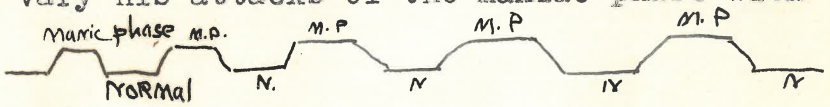
readmission to the hospital for mental disease. The average recurrance of attacks are about one year after recovery. The female sex seem more susceptible than the male, more cases found in the twenty- five to forty year age group.

Among the causes listed are environmental factors and profound emotional shock. The extroverted individual seems also more liable to this form of disease.

Physically the symptoms are motor restlessness, over-activity, absence of fatigue, flushed face, eyes more or less injected, temperature elevated, pulse rate increased. The patient is happy, elated, mischievous; has a distracted attention, rapid flow of thought, and speech acceleration.

Since the nursing care is directed toward securing quietness and calmness, it necessitates limiting their activity. Take care not to irritate the patient and see that he is groomed so that self injury is not likely to happen. Baths, wet packs, and sleep without drugs if possible are often prescribed.

The patient may vary his attacks of the maniac phase with normal states thus:



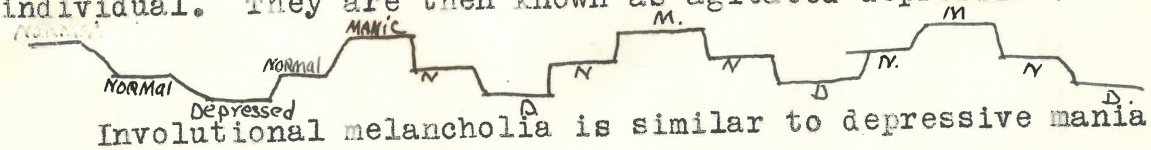
The physical symptoms of the depressive attacks are a cold moist skin, subnormal temperature, slow pulse and a morning headache. They are "downhearted," have delusions of persecution, hallucinations, suicidal tendencies and poor attention. They may become stuporous or catatonic.

The depressive attacks may vary with the normal state as:

The nursing procedures include vigilance, cheerfulness, tact, combating insomnia, massage, or salt glows. In trying to

arouse the patient's interest in social or motor activities, be sure he is not over fatigued.

The two states, the maniac and the depressive reactions often occur in more or less regular intervals in the same individual. They are then known as agitated depression:



Involutional melancholia is similar to depressive mania but is considered a separate entity. The menopause of woman or the analogous period of men is the time of its appearance. About 5% of state hospital admissions are supposedly due to this phase. The female sex hormones, theelin and others are in the experimental stage of development as a therapeutic agent.

The basis of nursing care is a combination of the treatments used in agitation and depressed states. Insomnia again must be overcome, other symptoms are feeling of distress and discomfort in the chest and heart regions. The patient is irritable, fearful, sad and often has delusions of persecution or self-accusation.

Perhaps the main objective is that one must help the patient to re-establish an aim in life. They feel old, helpless, and forsaken.

Dementia praecox or schizophrenia (derived from the word scissors) deals with patients with split personalities. Heredity is supposedly the determining factor although other authorities maintain environment is of more importance. It is true that the subject develops bad habits of thought from defective self-centered reasoning. Introversion, emotional, sensitivity, and active imagination, though not entirely predisposing the person,

to guard against sudden impulsive acts.

It is important to keep the patient occupied, sympathy, avoidance of friction, housekeeping, simple handwork, and calendars serve as useful tools. Re-education classes, and exercise help to develop perception, attention, and trains the memory. It is wise to encourage self-expression. This may take such forms as painting, dressmaking, and poetry.

The true paranoia psychoses affects adults. Physical symptoms are those incidental to fatigue. The mental symptoms are falsification, hallucinations, and suspicious delusions of persecution, (the delusions being rationalized), a changed personality with assaultive attacks on people whom their intense hatred is directed.

The nurse will do well to avoid any irritating factors and delusions. Occupy the patient's time with work which does not conflict with the delusion. Careful supervision and observation are necessary to prevent accidents.

The psychoneuroses are not classed as true psychoses but their incidence make them of importance. Henderson and Gillespie differentiate them as follows:

"A psychosis involves a change in the whole personality of the subject in whom it appears, while in the psychoneuroses it is only a part of the personality that is affected."

One should bear in mind that the average patient does not really want to be cured from his neurosis but only the symptoms. The early resistance one meets with may be due to a conscious struggle over the subconscious desires to remain ill.

The marks of neurosis as a class are:

(1) They are unable to adapt to life situations.

(2) They have no philosphy of life.

(3) The neuroses is used as an alibi.

(4) They will resort to hysterical expression of repressions.

(5) They establish compulsion rituals to partially relieve tensions.

(6) Suggestibility is increased in regard to: inferiority and emotional strain.

(7) Failure to recognize cure from a passing illness.

(8) Complaints of being misunderstood may be based on fact.

"Characteristics of Specific Types of Psychoneuroses"

Neurasthenia	Psychasthenia	Hysteria	Anxiety
Marked fatigue.	Phobias.	Dissociation shown in loss of function:	Irritability
Marked insomnia	Obsessions.	Motor (as Paralysis).	Hypochondriasis.
Many somatic complaints.	Compulsions.	Sensory (as anaesthesia, hyperesthesia).	Morbid anxiety.
A fear of " "going crazy."	Superstitions.	Intellectual (as amnesia).	Emotional instability of worrying type.
	Doubt and indecision.	Indifference about condition.	Often evidenced by simulation of epidemic illness.
	Panic.	Characteristic neurological signs.	Often precipitated after association with some one who has dreaded disease.
		Somnambulism.	
		Hypnotic states.	
		Atypical convulsive seizures.	
		Dermographia.	

Prognosis: Doubtful. Acute episodes usually clear up after accidental or planned suggestion. The psychoneurosis may lead to psychoses. Under intensive psychotherapy the individual responds well and usually effects a permanent remission."*

*Ingram, M. E. : Principles of Psychiatric Nursing, W. B. Saunder Company, Philadelphia.

One should bear in mind that the average patient does not really want to be cured of his neurosis but only the symptoms. The early resistance one meets with may be due to a conscious struggle over the subconscious desires to remain ill.

The nursing procedures should be developed along the lines of trying to teach the patient the nature and significance of his disorder, helping him to overcome and adjust to it. Dr. Weir S. Mitchell's "Rest Cure" is practicable at times. It is based on the theory of complete physical rest, gradually working back to the normal routine. Suggestion is one of the high points in treatment. Beware, however, of emphasizing the curative value of the treatment to the patient. The nurse is responsible for carrying out orders punctually to the letter, leaving no decisions to the patient.

They will be constantly on the alert to return to old reactions and it is up to the nurse to direct their attention from inner difficulties by providing attractive stimulating occupations. Easy tasks may be used at first to obtain the patients self-confidence and self reliance. As far as possible the products of the patient's skill should be artistically beautiful. Habit forming classes are especially essential.

The special nursing procedures and specific treatments of the psychiatrists are still in the developing stage.

Occupational therapy was practiced by the early Greeks, who used agriculture as a medium. Dr. Herman Simon presented, at the first International Congress on Mental Hygiene in Washington, D. C. (1930), a resume of the fundamental principles to be observed in giving occupational therapy.

Before such procedures are instituted the patient must be in good physical condition. The patient is kept in a "twilight state" rather than deep sleep to facilitate establishing a rapport between the doctor and the patient. Careful observation of the condition in regard to elimination and nourishment is the duty of the nurse as the patient is unable to care for these functions himself.

Frequently the convulsions occur several days after withdrawal (the medication is stopped in most cases over the fifth and eighth day) as a rule forty-eight hours after.

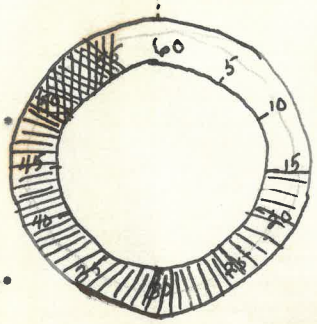
Dr. L. Von Meduna of Budapest (1934) introduced the convulsion therapy. Camphor was used at first, metrazol found more satisfactory later. As many as twenty-five grand mal seizures constitute the term of treatment. Certain cardiac, kidney, and acute febrile conditions, menstruation, severe anemia, previous history of several cranial injuries and throid conditions form the contra-indications. Temperature, pulse and respiration are to be especially noted by the nurse in the preliminary and treatment periods.

"Typical episode recorded in seconds."

Rapid injection

Rest phase: intense livid cyanosis, then stertorous breathing begins with return of normal color, patient completely relaxed.

Clonic phase: rhythmic jerking of head, hand, and feet, occasional incontinence of urine and semen.



Aura: cough--eyes blink head jerks--typical cry, skin flushed.

Precipitating phase: irregular jerking of arms and body.

Tonic spasm: tonic yawning, extremeties extended and rigid, pupils widely dilated, respirations cease.

Periof of arrested breathing
Livid cyanosis

Average: 40 seconds

Convulsive treatment of Dementia Praecox With metrazol Injection (Dr Stanley R. Dean).

The insulin shock treatment was introduced by Manfred Sakel of Vienna in 1933. The method had four phases: Preparatory, shock, rest, and polarization or terminal. Sweating, hunger, pulse varying from 40-120, if this limit is extended either way, terminate treatment. Disappearance of superficial reflexes, muscular stretchings, twitchings, tonic cramps, laryngeal spasms, respirations shallow or irregular, temperature may be extremely low, and excessive salivation or swallowing of tongue, are symptoms that will also be observed. The curative value of this treatment is that the patient's latent and repressed portions of his mind are reached by the doctor during the hypoglemic state.

Needless to say these treatments call for meticulous nursing observation and care.

We have not yet mentioned the value of the public health nurse in regard to psychiatric nursing. She, of all people is placed in a peculiar advantageous position in regard to mental hygiene. In her visits to the homes and community, she will be able to observe many people and children and adults who are potentially psychotic. The public health nurse will find herself confronted constantly with the mental side of illness. It is not necessary that she know the intricate phases of psychiatric nursing in order to carry out the principles of mental hygiene. They are simply to help the individual adapt himself to any precarious adjustments he may have to make and show him how to live with himself and others in harmony.

To summarize, nursing the psychiatric patient is a highly developed science to-day but the future holds the greatest

promise. We are still in the formative years and must realize this in any care we give the mentally ill.

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