XXI.

PSYCHIATRIC NURSING

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P S Y C H I A T R I C N U R S I N G

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P S Y C H I A T R I C N U R S I N G

Psychiatric nursing requires that one have at least a good working knowledge of nervous physiology in order to understand how and why habit patterns are built up in the mind. One should see how mind content evolves, comes into being as it were. As food taken into the body nourishes and builds the billions of body cells so does the contributing environment provide food for the mind and makes its content and determines its nature. The nurse must understand how the mind of her patient has been built and of what it has been built. Also she must understand the effect of pathological conditions and their influence in changing mind and personality traits and the manner in which body pathology produces mental disorders. She must learn to recognize in every detail the causative factors which have brought about abnormal mind patterns.

The nurse will know that good behavior comes from a sound nervous system in a body free from disease. She will know that fatigue, alcohol, trauma, narcotics, syphilis, certain drugs, and many other factors are likely to impair normal functioning of the nervous system and upset the nerve impulses which would ordinarily lead to harmonious or good behavior. Often such factors cause impulses to travel over the wrong pathways and lead to nerve centers in the brain for which they were not intended and thus produce disordered behavior. For example, responses through the eyes may be transmitted to the ears and produce auditory

responses which are entirely false yet which seem to the patient to be true and real. Both physical and mental actions of an abnormal nature may be caused by this changing of the paths of nerve impulses.

Too, one must make allowance for greatly exaggerated impulses and very weakened impulses and note carefully both the mental and physical changes or symptoms because of the importance of such changes in correctly diagnosing the case. Such observations on the part of the nurse are valuable to the physician in charge of the case. Whether impulses are reflex, instinctive, or of an acquired or voluntary type of activity, they should be observed in order to better judge the nature of the case more fully.

Each person is, no doubt, born with certain inherited traits or tendencies and capacities. This represents the differences between the one individual and all other individuals. This fundamental nature or character should be understood as clearly as possible in order for the nurse to adapt herself to the patient. To this inherited temperament is added the mind and personality derived from experience in the various and complex environments of the patient. How the patient's mind has been developed and by what experiences, must be learned as completely as possible, because it becomes the task of the nurse to a great extent to remold, to recreate or rebuild the patient's mind as far as is possible. Because the patient's mind is no more or less than what has been poured into it from life's experiences, the nurse

can, to a large extent, in many types of mental disorders, shunt off or inhibit, or retard, the abnormal habit patterns and build more strongly and bring into action more strongly the better forms of personality patterns. It is in a way a job in mind building engineering, a process whereby the builders (the psychiatric physician and psychiatric nurse) remove the old and faulty mind structures and substitute new and improved as well as sounder mental material. The problems, it is true, are complex to an extreme degree but the knowledge of physician and nurse can and does recreate and regenerate many of those suffering from mental disorders.

Without question, the personality traits of the nurse are very important in determining her fitness for psychiatric work. After all, all of those who might be inclined to take up the profession of nursing would not necessarily be adapted to the special field of psychiatric nursing.

In the first place, considerable sheer mental capacity is required in this work in order to master the complexities which are presented in caring for the infinite variety of individuals afflicted with one or another of the mental disorders. No doubt, the success of the nurse in the long run will be measured by her ability to qualify herself in this new and great science. Psychiatric work indicates the need of a high type of intellect. The study needed for becoming more and more competent is practically endless. Again, this field is developing so rapidly that a nurse needs considerable mental power to keep up with the new findings

and add them to and coordinate these new findings with what her training and experience has already provided. It is a phase of medical science that is constantly broadening in scope and unless the nurse is prepared to keep abreast of the times, she can not hope to advance along with the science.

It would seem that the nurse faces the necessity of developing herself to the point of complete and systematic discipline of her faculties. She must be a person of perfectly controlled emotions, a blend of fine personality traits, deep sympathies, tolerant understanding along with the thorough intellectual grasp of medical science as it applies to mental disorders. Psychiatric nursing is not a cold and hard application of ordinary medical technique. On the contrary, it is something which requires the warmest sympathy, the most persistent patience and the greatest possible ingenuity as to methods of handling the various cases under circumstances which are often very trying. No two cases can ever be exactly alike; no two environments as important factors are ever alike, nor is it likely that the heriditary tendencies or even the present physical conditions of any two patients are exactly similar. Psychiatric nursing is, in deed, an ever varying, ever changing, complex work. The nurse must adapt herself to these changing and varied conditions which she meets.

Psychiatric nursing requires that one be able to probe as deeply as possible into the background of the patient, into their environment, into the personal associations which have affected the patient, into the work they have been doing. In fact, she

should be able to dig out, if possible, the beginnings of the trouble, and too, she must understand as perfectly as possible in certain types of cases, the pathological conditions which are producting symptoms. She must understand both the physical and mental phases of the case.

Nothing short of constant application, in reading the works of authorities on the subject and keeping up on new material constantly being written, will enable her to understand the different cases as they come under her hand. It is a recognized fact that the best and most experienced of physicians constantly read up on the new cases as they come to them. They do this in order to understand each case more clearly and more perfectly. The nurse should do no less than this in her psychiatric work with each new case. If the nurse will apply herself in this way, by study and by constantly learning all she can about each case from the physician in charge, and then constantly practice the art of nursing each case in all of its detail of physical care, re-education, etc., she will finally become highly competent.

In a majority of the cases that the nurse must handle, very pleasing qualities are required. It is true that the nurse must be strong and positive, but she must, at the same time, be kind, persuasive, gentle, and sweet. She should feel within herself what a wonderful opportunity it is for her to help in literally re-creating one of her fellow human beings, who has been so unfortunate as to become abnormal. She should feel and know within her very soul that hers is an opportunity to serve humanity in a fine and beautiful way. Her work can and should be one of the

finest services rendered in the field of humanitarian work. While it is required of her to be scientifically trained, very efficient, and practical, yet all of this is just a means to an end, that of accomplishing the regeneration and rehabilitation of a human being. Her work is then of the most important that can be performed in the interest of society and her [illegible].

The importance of her place in the scheme of things in organized society is well brought out in a speech made by Dr. Rock Sleyster, newly elected President of the American Medical Association and of the nation's foremost brain authorities, when he states, as reported in the "Oregonian" of May 17th, 1939, that "Evidence is available that at least 10,000,000 of the 130,000,000 persons in this country bear in their bodies a seed which may occasionally produce a feeble minded child. He said mental troubles are the nation's greatest unsolved medical problem and that an understanding of the human mind and the human way of thinking may aid in solution of problems of government. On any one day, he said, 1% of the population is in mental hospitals. About 13,000,000 adults, or 10% of the population, will at some time in their lives be more or less incapacitated by mental illness."

The opportunities then for the psychiatric nurse are boundless. If she is fortunate enough to be gifted with a good intellect, a genius for hard work, combined with an inspiring zeal for human service, plus, graciousness, sympathy, gentleness, and sweetness of nature, hers will indeed be a full, rich, and happy

life, and her citizenship one of fine contribution to the good of the people.

What Dr. Sleyster said in his speech as to the great need of psychiatric service is well illustrated by the fact that more than half of all hospital cases in the United States are those of patients suffering from mental disorders. Of the 9,000 beds in Oregon provided for sick people, some 5,000 are constantly needed for mental cases. The rather brief paper submitted regarding the new psychiatric hospital to be operated in connection with the Oregon School of Medicine presents quite clearly the vast amount of work that must be performed in Oregon, if we are to cope successfully with the problem of efficient treatment in mental cases.

BIBLIOGRAPHY, CHAPTER I.

Nursing Mental Diseases- - - - - - -Bailey

The Psychology of Mental Diseases- -Myerson

Psychology for Nurses- - - - - - - -

Introduction to Mental Hygiene - - -Groves and Blanchard

M E N T A L H Y G I E N E

Often psychiatric nursing may lead one into mental hygiene service as provided by the city, county, state, or federal government. There are many phases to this work, each requiring special study and research. Much more of this work is needed in most parts of the country than is being provided at the present time. Properly carried out, work of this kind leads one strongly into the field of psychotherapy, psychoanalysis. This work in some of its phases, at least, demands a rather broad knowledge of psychology, psychiatrics, psychotherapy, psychoanalysis. Often one becomes a school nurse and must be competent in judging capacities of the children and understanding them as problem individuals. Few school teachers are qualified to understand their pupils. The well-trained psychiatric nurse can render an able and valuable service in this field. It is an interesting work and one greatly needed in making the educational system a more complete and efficient one.

Psychiatric nurses in their work in mental hygiene are often sent to the home where they must make a thorough analysis of the various members of the family, where they must do some real research work into the background of all of the individuals who are associated together in the family. Such personal work requires great skill and incite. The nurse who expects to be successful in such work must study her work thoroughly and constantly improve her methods in handling the pupil and in learning how to dig out all of the facts in the case. Often she performs important

services in the case in dealing with domestic relations. Courts of domestic relations are in need of the service of competent and well qualified psychiatric nurses. Fine opportunities are constantly opening up along these lines, and one who can find an ample opportunity for a life work of both service and personal development.

Perhaps, in the not distant future, as psychiatric nursing is going to be more fully recognized and better appreciated, there will be a sufficient number of full-time psychiatric nurses to care for the entire populace who are in need of help and adjustment. Often follow-up work is required in the home after a patient is discharged from the institution for the treatment of mental disorders. Delinquency in children requires a great deal of psychiatric attention. In fact, the field is almost endless.

The present social order does not provide efficient and good environments on the whole for people to live in and develop in, therefore, a great number of the people partaking, or being subject to faulty environments, become faulty themselves, and do not succeed in building up good mental patterns, and consequently, do not exhibit good behavior. An entirely new order of society in this respect will probably be built up or attempted, at least, as medical science broadens its influence in controlling and guiding the social order.

Citizens are, to a large extent, what their environment makes them. It would appear then that a more scientific and wholesome environment with good guidance provided by properly trained medical physicians and nurses would add greatly to the progress and advancement of the nation.

BIBLIOGRAPHY, CHAPTER II.

Introduction to Mental Hygiene - - - - Groves and Blanchard

M E N T A L D I S E A S E S Y M P T O M S

The nurse must observe all symptoms and learn to differentiate as to the meaning of these symptoms, as to whether they are of physical origin in their meaning, or as to whether they are purely mental symptoms, and if they are mental symptoms, to judge, if possible, the type of mental disorders indicated. Often physical disorders react and aggravate the mental condition. Careful observation on the part of the nurse will enable the physician to correct the underlying physical causes. In mental cases it is not always easy to find out what the true symptoms are. In many instances, the symptoms are masked; in other instances, symptoms are exaggerated. The patient may not complain sufficiently to let the physician know that disease is present; therefore, the nurse should be very thorough in her observation and study of the case. If, for example, there is a persistent elevation of temperature even to a slight degree, the nurse should report this to the physician, so that he may look for such diseases as tuberculosis, diptheria, or some of the various infectious diseases. In mental cases, it is always best to take the temperature per rectum and not permit the patient to hold the thermometer.

In taking the pulse, it becomes necessary at times to make the count frequently in order to be certain of the findings. Changed mental states often produce extremes of heart action. Fear, anger, worry and many forms of emotional upsets greatly influence the pulse. Blood pressure may be altered too due to

change of mental state. Respirations must be watched closely. In different types of mental disorders, certain forms of respiration appear. Those suffering from worry and anxiety usually breathe slower. Cheyene-Stokes respirations are often found in disorders of the central nervous system; they should be observed and reported to the physician. Nausea and vomiting should be observed and studied, and as to what type, and as to when the vomiting takes place, and if there are headaches associated with it. Dizziness should be reported and carefully studied as it may be related to either physical or mental conditions. Likewise, the appetite should be carefully watched, because if there is a persistent loss of appetite, physical and mental changes will soon follow. Weight should be carefully checked and noted in relation to other disturbances of the physical or mental states. Fatigue is something that occurs in many different conditions and may be due either to mental or physical changes. Excessive worry and the many forms of fear will produce fatigue. Any skilful and experienced nurse should be able to determine fatigue in the patient. Fatigue is certain to react and produce increasingly unfavorable mental and nervous symptoms. Always disturbances of speech are recorded because they are important symptoms. Any changed or abnormal form of speech should be observed and reported. Because the pupils of their eyes change so often in many forms of diseases, they should be observed carefully. They represent at times in their changes toxic and organic disturbances in the brain. Such symptoms as convulsions, tremors, anaesthesia, hyperaesthesia, paraesthesia should be recorded. The nurse should take notice of the skin color, coughing,

if any, all forms of injury of the body, of possible fractures and dislocations, hemorrhage, palor, cyanosis, twitchings, convulsions, state of perspiration, whether there is involuntary urin or feces.

Great efficiency is needed in observing and carefully noting all mental symptoms. Mental symptoms are infinite in variety, are more subtle and hidden than physical symptoms. Often the nurse will find the mental symptoms when the physician is unable to, due to the fact that the patient is trying to hide things from the physician and also because she is with the patient more of the time. It is necessary that the nurse report the symptoms exactly as they are and all conditions as they are and let the physician judge their meaning and value. Attitudes, states of the body, and actions, speech of the patient, every noise he makes, every move he makes, and all the peculiar things he does will have a meaning for the physician. Careful questioning of the patient on the part of the nurse and the various services which she performs for the patient will often enable her to discover what is troubling the patient, what the real background of the patient is, and this she can report to the physician to his great advantage. The nurse, if she can, should find out what the patient was like formerly when in a normal condition and thus will better be able to judge by the tone of voice, the type of expression, and various actions how much change has taken place. Often

loudness of the voice, vulgarity of speech, physical restlessness, or any form of violent physical movement will indicate the extent of the mental disorder.

Many of the mental cases show a high degree of suggestibility. If the patient has a tendency to repeat exactly the words of another, it is called echolalia; if the tendency is to repeat or imitate the movement or actions of another, it is called echopraxia; the tendency to hold rigid positions of the body or members of the body is called catalepsy. In negativism the response to a stimulus is the reverse to the usual reaction. In the passive type it is a refusal to do what is asked, while in the active type, the opposite action to the request follows. When actions are repeated the same way again and again it is called stereotype. This may take place either in postures or speech or thoughts. The different mannerisms, and odd forms of conduct should also be observed.

It should be observed whether there is an ability to conclude sentences or to follow up a line of thought or whether the patient is easily distracted by things happening around him, or as to the speed of thought when speaking, whether he is slow or not. Apathy on the part of the patient in relation to happenings around him, the response to fear or joy should be noted. Whether he is depressed or happy or has no interests at all or change in moods, all of these things should be observed. The general trend of his thoughts and ideas or whether he suffers

from obsessions or compulsions in any form should be noted. Every type of phobia, delusion, and hallucination should be carefully observed. A delusion is a foggy, sense perception, not amendable to reason; a patient, for example, who declares a fence post across the road is a man and when taken to carefully examine the fence post still declares that it is a man. An hallucination is purely psychic. An illusion is a faulty sense perception which is amendable to reason, for example, a patient may declare that a fence post is a man, but when this patient has a chance to carefully examine the fence post, he will admit that it is a fence post. An illusion is a sense impression or perception falsely interpreted. In delirium there is at least temporarily a general disorder or disturbance of conciousness so that the intellectual and perceptive faculties are perverted and confused for the time being by delusions and hallucinations. This results, of course, in senseless, muttering speech and disordered actions in general. In general it may be said that every conceivable variation from normal, mental, emotional and physical functions should be observed and charted in order that a complete sizing up of the case be made.

The nurse in psychiatry must understand all of the regular medical procedures, and, in addition, learn all of the techniques required in handling mental cases. She must understand what to feed the patient and how to feed him under all sorts of conditions. It may be difficult to feed the patient because of the resistance or appetite or because the patient may

think the food is poison. She must overcome all obstacles and provide the patient with nourishment. She may have to resort to nasal feeding or rectal feeding, and she must understand feeding in relation to all varieties of cases and conditions of the patient. She must be particularly careful to not let the patient injure himself with the implements of feeding or scald himself with hot food. Carelessness in feeding can not be permitted in psychiatric nursing. She must understand the use of hypnotics and guard them carefully against misuse on the part of the patient and give them strictly in accordance with the physician's directions. In many of the cases, she must guard against bed sores and be familiar with the best form of care and treatment of this condition. She must watch for undue distention of the colon and bladder and procede accordingly to relieve these conditions according to the best practice. The management of convulsions must be understood and convulsions must receive immediate attention, else the patient may injure himself. During convulsions the nurse should make careful observations and report them to the physician.

Extraordinary conditions are met with on the part of the nurse in psychiatric cases. Excitable, boisterous, noisy, and oft times violent conditions have to be dealt with. Sometimes the nurse is in danger and should secure help immediately in case force is required to control the patient. In handling excitable and violent cases, the nurse must, if possible, anticipate the attack, judge accurately the condition and act

quickly. It is said that the ingenuity and cunning and the stubbornness or determination of some patients is boundless, and it requires a shrewd, quick and experienced nurse to handle these cases. Many times, the patients will injure themselves with poisonous drugs, by swallowing objects, by strangulation with sheets, towels, or curtains, by burning themselves with corosive chemicals or hot fluids, or they may jump out of a window, or injure themselves in some manner. The nurse must be prepared to handle any of these emergencies with appropriate medical service. Whether it be fire, hemorrhage, strangulation, poisoning, drowning, fractured bones, or dislocation, the nurse must act at once and save the situation.

In senile psychoses, sensation is usually dulled, and the perception is sluggish and faulty. There is a lack of clearness in identifying persons and things and a disorientation as to time and place. Usually facts of early life are recalled accurately, but those of later life have faded out. There is a tendency to reminisce. Lieing is common and ideas are limited. Delusions, and illusions are common and hallucinations too are quite common. Most of these cases are dissatisfied and irritable, anxious, and depressed. They have a tendency to wander around and be restless, particularly at night. Probably, little can be be accomplished except careful attention in regard to their diet, bathing, attention to the bowls and bladder, stimulating baths and rubbing. Whatever form of occupation and exercise can be given along with suitable entertainment.

In psychosis with cerebral arteriosclerosis the patient has a buzzing in the ears, often fainting attacks, headaches, and dizziness. The blood pressure is usually high and the pulse is hard. Early in the case there is observed a change in disposition and an increased irritability. Later, emotional control is lost and extremes of emotional expression are observed either of depression or boisterousness. Great suspicion and delusions of persecution are observed. Defects of memory are common. A calm, quiet life must be provided for them to avoid any strain which would force up the blood pressure; excesses of all kinds must be avoided. Diet must be carefully regulated; very light work and forms of occupation which would be pleasing should be provided. There is a likelihood of cerebral hemo- hemorrhage in which case the nurse must remove any constrictive clothing about the neck or other parts of the body, apply cold compresses to the head and dry heat to the extremities. The patient must be kept quiet and moved as little as possible. The nurse should be very careful to see that strangulation from any source is prevented. Directions given by the physician must be carried out very strictly.

In general paralysis or what is known as paresis, the cause is syphilis and the symptoms at first are slight, perhaps just a slight headache or head pressure or fatigue or a tendency to irregular sleep. One of the most frequent symptoms is a speech defect, which is demonstrated in the pronunciation of such words as "electricity," or "truly rural," or Methodist Episcopal." The defect of speech is due to muscular incoordination of the

finer speech movements. Such symptoms as tremors of the muscles of the leg, of the tongue, and hands, variable, tottering gait indicate paresis. Later symptoms are so pronounced as to produce complete paralysis or complete helplessness with incontinence of feces; convulsions will likely appear and grave changing in the reflexes will be observed. Mentally, there are observed marked changes in the personal habits, boasting of power and influence and a too free communication of their own private business to strangers. The moral tone is lost and evil and corrupt associates are formed. Character and judgment are both degraded. Reasoning is impaired and extreme delusions are suffered. Excitement and violent outbursts occur without any apparent provocation.

These patients are often difficult for the nurses to manage because of their irritability and tendency toward violence. Sometimes they can be quieted down by proper suggestion and tactful management. Often a prolonged bath has a soothing and controlling effect upon them. Naturally, the usual medical procedures will be used and a Wassermann test made to prove the case. The physician will prescribe accordingly, and the nurse will carry out the orders strictly. The drug treatment must be specific and exactly administered. Care in regard to the prescribed diet, the use of hydrotherapy, and other measures indicated according to the case will be attended to.

In nursing, Huntington's chorea, which is an inherited and incurable condition, it is a question principally of careful

hygienic measures. The bed, for example, must be enclosed to prevent the patient from falling out. It is difficult to find anything that these patients will do. Their movements are extensive, irregular, and jerky. In the later stages, there is a series of muscular contortions. These disappear almost altogether during sleep. In time all control of the voluntary muscles is lost and the patient is confined to chair or bed. Speech is strongly affected.

In brain tumor there is severe and extreme headaches, dizziness, nausea, and vomiting, cheyne-stokes respiration, muscular spasms in the face or hands, or perhaps convulsive movements of one side of the body, unequal pupils and later on dilation and blindness. These changes are produced by the various degrees of intracranial pressure. Often the mental symptoms are dulled and the patient is drousy; confusion is present and mental activity is clouded or even lost; memory is greatly impaired, and there may be delusions of persecution; in some cases, there is a great deal of restlessness and over activity until sufficient intracranial pressure reduces the activity. Many of these cases require treatment in bed. Feeding is sometimes difficult, ice bags are needed to relieve the headache, and a quiet, dark room free from disturbance should be provided. Careful observation should be made of any and all sumptoms, and the usual careful attention given in cases of this type.

In paralysis agitans or Parkinson's syndrome or as it is ordinarily called "shaking paulsy", the mental symptoms are

not very marked, except perhaps some irritability, complaining disposition, and periods of anxiety. These patients need as much out of door's activity as it is possible to provide. Careful dieting, physiotherapy, and pleasant, constructive occupation along with whatever indications there are for strictly medical service constitutes the usual procedure. Paralysis agitans is a progressive type of paralysis beginning with a typical type of tremor and progressing to the point of severe paralysis. It has its characteristic gait, muscular rigidity of the face with its masked-like appearance. It is easy to recognize.

In meningitis, multiple sclerosis, tabes dorsalis, acute chorea, encephalitis lethargica, variations in the nursing technique and special requirements of each case and disease must be allowed for and become a part of the nurse's work.

Alcoholic psychoses presents a picture of irritability, restlessness, preliminary dreams of a terrifying nature, mild hallucinations of sight as early symptoms. Later symptoms are those in which the patient sees all sorts of horrible shapes and forms such as snakes, rats, insects, and worms--all of which may appear to be taking possession of his body. Illusions are common and the patient may injure himself by trying to escape his tormentor. The illusions may take on many different forms.

The attack may last for a few days or a week and as the patient is very sick, he must be kept in bed and quiet must prevail. Sense stimuli must be reduced to a minimum. Hypnotics are of little value until the acute stage is over, after which

time they are probably not needed. Paraldehyde is a drug most frequently used. Heart action must be watched, water given frequently, and a generous diet provided, preferably of hot milk and such solid food or liquids as are indicated. Bowels and bladder must be taken care of.

In nursing drug psychoses one of the principal necessities is to prevent the patient from obtaining any of the drugs other than that prescribed by the physician. The most extreme watchfulness is necessary to prevent the patient by one device or another from securing a supply of the drug. The ability of these patients for securing the drug is positively uncanny. Directions of the physician in these cases must be very thoroughly carried out. The patient is to be kept as quiet as possible. Usually some form of hydrotherapy is used. Occupational therapy, suggestion, tactful, care and management, suitable entertainment, and good hygiene in general indicate the road to recovery.

The physical diseases such as the fevers from infection produce mental symptoms and conditions requiring careful nursing. It is taken for granted, of course, that the nurse will carry out the standard procedures for the care of each type of disease. Fever, in particular, requires careful attention to the mouth, very careful attention to the diet, watchfulness of the bowel and bladder to be sure of thorough elimination, attention to every detail of bathing to assure health of the skin and assistance in the regulation of temperature. Recognition of the mental symptoms, as being a result of fever, must be known by the nurse and not confused with mental symptoms from other type of mental disorder.

There are types of psychoses coming from exhaustion as in hemorrhage, over exertion, starvation, prolonged insomnia, or disability from wasting disease, etc. These symptoms are often similar to those of delirium, gradually increasing in length and then diminishing as the patient slowly recovers; or in some cases, the symptoms become very sever with a collapse, followed by a coma. There is a similarity between these symptoms and those of fever, except that in the delirium of exhaustion, there is no fever.

Mental symptoms are observed in advanced cases of cardio-renal disease. These should be observed as especially relating to cardio-renal disorders and the nurse's work governed accordingly.

In nursing diseases of the endocrine glands, the nurse will probably be instructed by the physician in charge as to the gland or glands involved and the peculiarities of the case. Unless the nurse happens to be a student of endocrinology, she must inquire very carefully with the physician after the nature of the case and the procedure to follow. She must gather her facts very carefully and make the most accurate observations so that the physician can procede toward effective treatment.

It is taken for granted that all well-trained nurses will understand diabetes mellitus and the symptoms and conditions associated with this disorder. She will be expected to understand the use of insulin and the proper balancing of the diet.

Manic-depressive psychoses shows condition of general over-activity of the motor system with an absence of fatigue. The

face is flushed, mouth and lips dry, or frothy from excessive talking; hot, dry skin with a slight increased pulse rate and temperature. Excessive elation and happiness or antagonism and combat will be shown. Attention is easily distracted and the thoughts are constantly changing. Memory is good and delusions and hallucinations are few. There is an excessive amount of speech inclining to boisterousness or perhaps violence. Nursing requires the activity of the patient be reduced by keeping him in bed, isolated, if possible, where it is quiet. Hydrotherapy should be applied, prevention of injury taken care of, and careful nursing in regard to feeding attended to. The nurse must be very adept in talking to the patient and in giving him suggestions. They are easily stimulated and their reactions may be very unfavorable unless the nurse knows how to take care of them mentally. Hydrotherapy has been particularly valuable in treating of these cases. No more physical restraint than is absolutely necessary should be used. Extremely careful nursing is certainly a very important part for the care of these patients. Occupations and constructive amusements suitable to the case should be provided.

Involution melancholia shows a picture of irritability, anxiousness, fear, and sadness, with delusions of persecution and self-accusation. There may be hallucinations of sight and hearing; the patient is restless, uneasy, agitated, and inclined to pick and rub the face or ring the hands, chew the nails, etc. Tactfulness should be used in managing patients, in persuading them to follow their diet and other measures necessary for their recovery. They must be watched carefully to prevent them from injuring themselves.

Dementia praecox describes a group of mental disorders of youth and early adult life. This condition includes a wide range of symptoms which lead to mental deterioration manifested by change in the patient's conduct and emotional reaction. Schizophrenia is another term used by the later writers to describe dementia praecox. It indicates a split or divided personality. Various physical disturbances with a lowering of vitality and a gradual break down of the physical system occur. Early in the case, hallucinations are common, even though, memory shows no impairement and the general mental content is well retained. Hallucinations gradually occupy the mind so much that thought and ideas become narrowed or scattered with a gradual increase of delusions and loss of judgment. There is despondency, at first, followed by indifference and apathy. This finally lessens the emotional reactions to either pleasurable or painful experiences. Naturally, the conduct is disordered as observed by impulsiveness or negative states, various mannerisms, etc. There are four forms of dementia praecox, namely: (1) simple, (2) hebephrenic, (3) catatonic, (4) paranoid. The different forms are somewhat degrees of the same condition. The simple form, hallucinations and delusions do not occur; while in the hebephrenic form, there is a good deal of silly laughter and foolish actions with some hallucinations, with bad habits and untidiness, and more of disordered emotions. In the catatonic form, greater disorder of conduct, muscular rigidity and more extreme symptoms are observed. In the paranoid form the most improbable and absurd delusions of persecution occur. Violence may be associated with this. Good nursing is essential

in regard to the physical care, mental suggestion, every form of tactful persuasion that it is possible to use. A great deal of physical care is necessary in regard to baths, dieting, attention to the excretory organs. A great deal of attention must be paid to reconstructive work in guiding and teaching the patient. Some form of work must be devised for them suitable to the age and mental condition.

In paranoi there is good memory, consciousness is clear; and orientation is not disturbed. There may be retrospective falsifications. Most marked are the symptoms of suspions and delusions of persecution, which are unchangeable, thoroughly organized and persistently defended. These patients very skilfully arrange a defense for their delusions. The patient often thinks himself to be very important, as though a god were directing him. Intense hatred develops and often the patient becomes very dangerous. Because these patients are suspicious and quarrelsome, great tact is necessary in managing them. Diversion and occupations by useful and pleasurable work is needed.

Epilepsy is commonly understood by most nurses and its treatment and management pretty well worked out. Epileptics are difficult to manage. The nurse must be very careful in feeding them to prevent strangling. The bowels require careful attention. The drugs prescribed by the physician must be administered carefully. A healthful outdoor life and good general hygienic care is indicated.

In nursing the psychoneuroses, the nurse meets with hysterical types, psychasthenic, and neurasthenic types, etc.; here is where a real knowledge of psychoanalysis and psychiatrics is needed. A nurse has a great deal to do with the success in correcting the conditions of these patients. It is up to her to make extensive observation of the mental symptoms and all symptoms which have a bearing on each case and to do this, she must have a thorough knowledge of psychiatrics. She must learn how to dig deeply into the background of each case and find out how and why the patient got that way. She must replace the mental states which are disordered, by mental states which are orderly and harmonious. She must do a good job of displacing the disordered material and build in new mind stuff. It will require every ingenuity she possesses to do a good job. It is taken for granted, of course, that proper hygienic conditions will surround the patient whenever possible, and the best hygienic measures used in building health for the patient. Psychotherapy for increasing confidence in the patient should be used. This, too, for bringing good coordination and harmony to the mind. The work that the nurse does in psychotherapy will, of course, be merely an addition to what the physician in charge is doing, but she can be a great help to the physician if she understands what the physician is trying to accomplish which is psychoanalysis and psychotherapy.

BIBLIOGRAPHY, CHAPTER III.

Nursing Mental Diseases- - -Bailey, Page 71- 93
201-203

Institutional Care of the Insane- - - - - -Hurd.

S P E C I F I C T R E A T M E N T

In psychiatry "shock treatment" has become a frequently used measure for the treatment of schizophrenia as well as for certain other psychoses. The term "shock" is applied to pharmacologically produced coma or convulsions, using insulin in large doses or metrazol, the cardiac stimulant. The advantages of psychiatric training for the nurse assisting with shock therapy cannot be over emphasized. Aside from her function in assisting the physician with the treatment, probably the nurse's most important function is to reassure the patient, first by her presence, and then by her interest, friendliness, and kind understanding. Anyone who has seen this treatment cannot help but notice the anxiety and apprehension these individuals evidence at the thought of the treatment.

Nurses entrusted with the nursing care of patients during shock therapy should, if possible, have an opportunity to study or at least to observe such patients under treatment. In many hospitals the nurses are given an opportunity to see some moving pictures of metrazol treatment before it is given to their patients. Such opportunity is quite desirable because it enables the nurses to be more capable in the nursing care, more reassuring to the patient, and to assist more ably the physician. It is more efficient for all concerned to have the same person or persons assist the physician throughout the course of treatment for any particular patient for two reasons: First, the patient gains reassurance and responds to someone in whom he has developed confidence, and Second, the nurse becomes acquainted with the doctor's routine and may anticipate his needs for the treatment.

Insulin Shock

As with many other scientific discoveries, the use of insulin for schizophrenia came about partly through accident. It had been in use in an experimental way in connection with the treatment of drug addicts, to help them through the withdrawal period.

The injection of insulin results in a rapid drop in the blood sugar, and if this is carried beyond a certain point, unconsciousness follows. During the work with drug addicts, on several occasions small overdoses of insulin resulted in coma. Following the coma, striking personality changes were found in the person.

Using this as a starting point, about three years ago, experimentation was begun in the use of induced insulin shock as a method of reversing the disease process in schizophrenia.

The treatment itself consists of a series of severe shocks caused by the injection of insulin intramuscularly. The amount of insulin used varies within wide limits, for various individuals. The coma which follows and which is regarded as the most important therapeutic phase is allowed to last one to two hours. During this time the patient must be under careful observation. Conceding its value as a therapy still, this hypoglycemic (low blood sugar) state is dangerous, and menacing symptoms frequently appear, calling for instant action by the physician. Fortunately, the administration of glucose alone or with adrenalin will usually take the patient out of danger.

From the moment the insulin is injected into the muscle of the patient, he is under the most careful scrutiny. A special

nurse is assigned to him. Pulse and respiration are taken every few minutes, and a physician is constantly nearby.

The effect is quick. In five minutes the patient is sitting up in bed, smiling, and fortunately, remembering nothing of what has taken place. The temperature may drop as low as 92°, another omnious sign, and again the adrenalin and sugar are used. There is always danger of sudden vasomoter collapse.

Observing the severe physical manifestation during the shock period, one cannot help wondering what is going on in the body of the patient.

Manifestations during this period of shock are sometimes quite interesting. Sakel described the personalities as being almost reversal--as though the individual had two personalities and the one dominant during conscious moments were temporarily paralyzed during the coma, while the other emerged. It is not unusual for patients who have been mute for months to become suddenly talkative.

Sometimes, during the later period of treatment when the patient is practically recovered, there will be an interesting return of the original symptoms during the period of shock--though not at any other time. This is interesting in trying to understand the process by which insulin brings about a change in the functioning of the brain. One theory is that the insulin helps to subdue certain brain pathways of circuits which are of an inferior type, at the same time, allowing the superior cells to function again. In other words, a primitive type of thinking, characterizes the schizophrenic. He has regressed to a lower

intellectual level and thinks in terms of another and lower culture. The insulin, so it is reasoned, reactivates the higher centers of thought; and thinking once more takes place on this level.

Metrazol

The drug metrazol, as an addition to the therapeutic treatments of schizophrenia, has been used in this country less than two years. In fact, the first paper by its originator, Meduna, appeared only in 1935. It has, however, gained a very widespread use, and although the literature on the subject is still meager, it is increasing rapidly. Despite the fact that the therapeutic mechanism of metrazol is entirely unclear and its threat of possible organic brain damage is still undetermined, its occasional spectacular results have gained favor for its use in probably the majority of progressive institutions. Regardless of spectacular results, however, one must keep in mind that in no place has it been used for a sufficient length of time to evaluate adequately other than the immediate result.

Metrazol belongs to the class of substances known as analeptics or restoratives rather than to the broader classification of "stimulants" as generally understood. It may be classed with the latter group by virtue of its action on the medullary centers controlling circulatory and respiratory activity, but its action differs from that of epinephrine and ephedrine in that the stimulation which metrazol produces is not an over stimulation, and from that produced by caffeine in that its action is directly on the centers controlling circulatory and respiratory activity.

Metrazol when used in treatment of dementia praecox is given intravenously. The initial dose is from o.4 gram to 0.5 gram of 10% solution. This dosage is maintained as long as it produces a convulsion, but if the convulsion reaction is not obtained, increases of o.1 gram are made until the desired effect is reached. Rapid injection of the drug so that it reaches the central nervous system at once is essential. If for any reason, the injection is interrupted, a convulsion is unlikely, and it is desirable to wait for a half hour and repeat the whole dose.

Injections of metrazol are given three times a week. The largest single dose should not exceed 1.6 grams. Twenty-five to thirty convulsions may be considered average. This number may be increased if there exists a possibility of further improvement or in patients with psychoses of long standing.

Sometimes, a few convulsions are sufficient to effect a drastic improvement of even remission. It is always important, however, where remissive changes appear as a result of the treatment, to administer several more convulsions to consolidate the gains made. In refractory cases and in patients whose original improvement has been followed by relapse, a course of metrazol is repeated.

Important contraindications for this treatment are the following: cardio vascular and pulmonary diseases, excretory disorders, thyroid affections or fibrile illnesses of any kind. Treatment should be discontinued during menstruation because of danger of hemorrhage.

The two men who did the first work with metrazol and insulin in the treatment of schizophrenia do not offer much information about the theory and psychology of this new therapeutic measure. "Sakel is of the opinion that insulin treatment may be compared to the knife of a surgeon, but it is not the knife, but the surgeon who uses the instrument skillfully that makes the treatment a success. Von Meduna does not take the psychological effect of metrazol treatment in consideration at all."

Hydrotherapy

This department is recognized as having exceptional value in the treatment of mental patients at all psychiatric hospitals. The treatments have a marked effect on the patient's recovery, and tend to shorten the time of hospitalization. It is a common tendency of a patient at work against the suggestions of a nurse, rather than with her, thus thwarting any benefit to be derived from the treatment. To insure cooperation, it is very necessary that the confidence of the patient be gained, therefore much depends upon the personality, low, evenly modulated voice, kindness, tact, firmness and training of the nurse in charge.

Facilities for mild sedation, for elimination through the skin, and for stimulating and tonic effects are provided in the hydriatic room. The major sedatives in general use are the continuous, or prolonged neutral bath, and the wet sheet pack. Of these, they have found the prolonged neutral bath most efficient.

There are two continuous tubs, always in use; treatments varying from three to eight hours daily, for different periods of time. The temperature is kept between 92° and 94° in a room 78° or higher. Effects are to induce rest and sleep, aid in elimination, relieve toxic conditions and quiet an excited patient. Three to six hours daily are given to an excited patient. The nerve contents are at rest, consequently agitation, excitement and motor activity are relieved and sleep induced.

Tonic baths are given to patients who need improved nutrition, careful stimulation, or mild sedation. These baths consist of a preparatory treatment, supplemented by a warm needle spray and immediately followed by fan douche at a lower temperature. The needle spray is always given warm, the fan douche at about 96°, and gradually reducing temperature a few degrees daily. The jet and Scotch douches are used to complete the bath when patient is able to take these vigorous treatments. The steam cabinet bath, sitz bath, body shampoo, and salt glows are prescribed as preparatory treatments. Cabinet baths are prescribed for slight or free perspiration. Ice collars and Cephalic compresses are applied during the bath, and cold water to drink as desired. A rest in bed of at least one half hour follows these treatments.

Recreational Therapy

The individual who is mentally ill has a morbid tendency to spend his time for leisure in preoccupation with his fears, anxieties, hates, loves, ambitions and desires. Such concentration

alone tends to create emotional tension regardless of the content of thought.

From an unpretentious beginning of occasional games of cards, checkers, and dominoes, the recreational program in most hospitals has grown to include a variety of activities such as ping pong, bingo, singing, dancing, marching, solving jig-saw puzzles, various ball games, spelling contests, memory tests, telling stories and jokes, reading, drawing, and making scrap books. In this way a large share of the patients' spare time is occupied. In order to stimulate interest in music and to reawaken the desire for musical expression, organs, pianoes, and radios are placed in the wards of many hospitals. Radio music is used frequently for dancing. Dancing for a half hour after the evening meals makes for quieter more restful nights.

Time which was formerly spent brooding over difficulties is now spent in interesting, stimulating diversions. Conversation when indulged in formerly dealt only with personal problems, but now much time is spent discussing the movies, their games, the acting, the costumes or the music, articles from newspapers, magazines, books, practicing steps for the next dance, and speculating about new games and exercises. Many patients have come to the realization that treatment in a mental hospital does not mean solitary confinement but supervised and directed freedom.

Cosmetic Therapy

During recent years many mental hospitals have recognized the importance of paying more attention to the personal appearance

and personal hygiene of mental patients and have established special departments for cosmetic and similar purposes.

They first concentrated mainly on the hair and scalp. The results not only showed an improvement in the hygienic conditions of the scalp but also general cleanliness and created a new morale among all patients.

Awakened interest in personal appearance spreads in a group like a contagion. Self respect is increased and there is a new uplift and greater satisfaction in surroundings where these factors help create a wholesome atmosphere. Marked improvement in mental reactions is noted. Neatness and tidiness of patients not only has hygienic but decided therapeutic effects, and this has led to a cosmetic therapy department in the modern psychiatric hospitals.

From the original aim which was to teach and administer hygiene in the care of scalp, hair, skin, and nails, they have grown to include objectives in the assignment of specials as the arousing of interest in personal appearance, the building up of self esteem, the preservation of individuality, the re-socialization of the patients, and the creation of opportunities for mental relaxation as well as stimulation.

BIBLIOGRAPHY, CHAPTER V.

Introduction to Mental Hygiene- - - Groves and Blanchard

Nursing Mental Diseases- - - - - - -Bailey

Name - - - - - - - - - - Miss N.	Service- - - - - - -Medical
Age- - - - - - - - - - -.25	Diagnosis- - - - - -Schizophrenia
Date of admission- - - Sept. 4, 1938	Occupation - - - - -Secretarial work
Date of discharge- - - Oct. 31, 1938	Chart No. - - - - - - W2858

I N T R O D U C T I O N

Miss N, a very attractive American girl, age 25, was brought to the Good Samaritan Hospital after four years of displaying increasingly peculiar and odd attitudes toward her family and associates. She was admitted for insulin shock therapy on September 4, 1938 in hopes of curing what was diagnosed as an acute psychotic case of schizophernia.

S O C I A L H I S T O R Y

Miss N. was born in Eugene, Oregon and there spent the early years of her life. She went two years to a country school and the remainder of her grade school years in Candon Grammar School in Eugene. She came to Portland, Oregon in 1929 and went to Washington High School and there took many of the business courses.

One year at Oregon State College gave her further education in business administration, many new acquaintances, and a desire to have a broader and more rounded out life. She quit college after the first year to work and help send a boy friend through college, but never did she give up the desire to further her education and thus continued with extension courses.

Work was not difficult for one to find who appeared so efficient and was as attractive as Miss N. She worked for a private school for awhile, doing

secretarial work and later obtained work at Meier and Franks as a salesgirl. She later was employed at the Old Peoples Home in Euguene and worked there for several months. Up until about six months before coming to the hospital, she was employed at Alis Chalmers and Co. in Portland.

Miss N. is from a moderately financially fixed family, her father being a prominent lawyer of this city. Both father and mother are very intelligent and thrifty people and have raised a family of five girls and two boys. One brother and one sister are married; two sisters are school teachers; another works at the Eastman Kodak Co. in Portland, and a younger brother is still in high school.

Skating, tennis, and the active sports have been a favorite past time. She is very well read and likes especially the more difficult and worthwhile books. Her friends and associates seem to have been many up until about four years ago when she began to avoid them as much as possible and assume an incongruous attitude toward them.

The last few months have been a gruesome, miserable experience and fortunately with the impetus offered by her family, she has been able to obtain medical treatment.

S U B J E C T R E V I E W

The Dementea praecox, or more modernally called schizophrenia, group of psychoses results from the attempt of the personality to make an emergency adjustment to the unbearable burden of life. Of all the reversion types of behavior, schizophrenia is one real mystery of psychiatry, the least understood and most complex form of personality retreat, whose pathology is unknown, and

whose clinical aspects are not entirely settled. In 1896 Kraepelin, a noted psychiatrist made the important differentiation between the manic depressive psychoses and dementes praecox. In 1911, Bleuler introduced the term schizophrenia to designate all cases of functional, mental disturbances with the exception of the typical manic-depressive psychoses. He suggested that all other psychoses could be classed as a splitting of the personality. "Schizo" means to split and "phrenia" refers to mind.

Kraepelin described three distinct types of dementia praecox which he termed hebephrenic, catatonic and paranoid. He later added a fourth type which he called simplex, simple, or apathetic type. We are chiefly concerned with the simple or apathetic phase of the schizophrenia psychoses as this most nearly presents the symptoms and reactions of the patient to be studied. Dementia praecox of this type usually attacks the young person who seems to be doing so well, and is enjoying satisfactory social relations with the young people in the community. These individuals may be unusually brilliant. A first danger signal is generally somewhat lack of interest, particularly in work, followed by gradual dropping of associates of own age. The earmarks of this stage of the disorder are secretiveness, seclusiveness, indifference to reality, marked mistrust and suspicion.

The tendency to withdraw from the family and friends, to retreat to a dream world of the inner life steadily develops. Extreme moodiness and irritability are manifested very early by such people and they often have short periods of emotional excitement with marked resentment of something in their environment. They develop a growing desire to be alone, take on queer mannerisms, and often become slightly negativistic. Before being incapacitated for work, they change

jobs frequently and slowly drop into subordinate positions as they become too inefficient to hold better ones. When these people do not receive help early in their afflictions, the disorder finally progresses to the point where they can no longer function in society.

MEDICAL HISTORY AND NURSING CARE

Miss N., up until the last four years, has been described as an active, enthusiastic, athletic type of girl who enjoyed all social activities. Her illnesses have been few and none are known to be directly pertinent to her present condition. She came into the hospital on the evening of September 4, 1938, very apprehensive and nervous. She was seen and when talked to, never said more than just to very curtly answer questions asked and never to look directly at one to speak. At that time she was found to be apparently a "shut-in" personality type who had been introspecting and brooding over her inability to carry on her stenographic work. She had a feeling of mental incompetency, and the inability to concentrate on her work had preyed on her mind so consistently that at that time, she was in a constant state of apprehension and worry. Several times while at work, she had had fainting spells and had to be sent home for the day but only to return the next day with the same noticeable uneasiness. Delusions of persecution to the effect that she imagined everyone thought she was "horrible" and that she was being followed, now plagued her thoughts. At home she had often hid in the basement of the family home to escape people and things to avoid going out as much as possible.

In the background there seemed to be several things relevant to her condition at this time--possibly just a failure to make proper adjustments. There

is a boy friend who she had been going with for several years that seems to be continually on her mind. After spending one year at college she felt it more necessary for him to continue his schooling so she helped him financially through the university by working herself. It seems that he being a very intelligent fellow won a scholarship, and she began feeling inferior and unable to keep up with him socially. The first thing her friends noticed was that she lacked her usual enthusiasm about going out and often found her unable to make up her mind about various situations. Where previously she had been ready to make decisions of her own, she now seemed to be the master of no situation. She ran away from her work about six months before coming to the hospital and then being afraid of the criticism and fear of what her friends would think, she dared not go back to work. She became afraid even to go out of doors for fear someone was watching or making fun of her. Her parents, perhaps being too demonstrative and too willing to help, made her feel she was not deserving of such consideration and thus made the vicious cycle only point to a more fatal end. At home she seemed to efficiently accomplish the general household duties as sweeping floors, dusting, and cleaning. Where she had been sleeping in her own room, it became necessary for her to move into the same bedroom with her sister. On a few occasions she would climb in bed with her sister trembling with fear and cold and moist with prespiration. She would tell her sister that she knew people hated her and were trying to follow her. This sister seemed to be the only person to whom she would reveal any of her thoughts. It was decided by her sister and boy friend that he would stay away from her for awhile, but her condition and apprehension only seemed to grow worse. A psychiatrist was willingly seen but the unfamiliar terms and haziness of the whole thing only confused her to a greater extent. A second psychiatrist was approached, but finding that her case was beyond trying to make her realize what was taking place, she was sent to the hospital for insulin shock therapy.

At that time she was very emotionally upset, crying on the slightest provocation and continually clenching and unclenching her hands. Her diagnosis was an anxiety tension state of psychoneurosis bordering on an acute psychotic state of schizophrenia.

An examination on the evening of admittance disclosed a normal, healthy individual physically. Her blood pressure was 115/80, her temperature 98, and pulse 92, strong and regular, and respirations 22. Her weight was 125½ pounds, which was about five pounds below her average weight. She did have acniferus lesions around her face and shoulders. This is an infection of the skin due to inflammatory changes in the sebaccous glands and characterized by small pustules. As the efficiency of the heart is of vital importance in undergoing such a treatment, it was carefully checked and found to border within normal limits. The heart tones were of good quality with no valvular murmurs. There was normal pulmonary resonance throughout the diaphragm and good vesicular breathing with no rales or other adventitious sounds. There was no sensory disturbances found and the only motor malfunction noted was an inability to talk plainly and often stammered or slurred her words.

A urinalysis was done and found to be normal. The hematology report revealed an erythrocyte count of 5,010,000 per cubic millimeter and hemoglobin 95%. The leukocyte count was 6000 per cubic millimeter with the polymorphnuclear leukocytes comprising 63% which is normal.

Her whole general physical condition seemed good, which is very necessary in undergoing satisfactorily insulin shock therapy.

Miss N did sleep part of the first night but let us observe her general appearance the following day. She was very nervous and self conscious, especially when the nurse first entered her room. She sat for an hour at a time with her

head resting on her knees and clutching or picking at the bedclothes. She talked very little and seemed to have great difficulty in enunciating clearly or saying the thing she wished. She never met your gaze when speaking. When touching her hands or feet you find them cold and damp. In the evenings she seemed more composed.

After three days of becoming accustomed to the hospital, nurses, and her new environment the insulin shock therapy was started. Insulin or Illetin is a watery solution containing the active substance of the Island of Langerhans of the pancreas of animals. It is also made from the pancreas of fishes, from vegetable substances (such as onions) and from certain kinds of yeast.

Peering into the theory of insulin shock therapy, there is no satisfactory explanation of the effect of insulin shock on the schizophrenia subjects. Dr. Manfred Sakel of Vienna made the first observations of this treatment in schizophrenia cases, and he has the following picture or tentative working theory: (1) Insulin shock stimulates metabolism in general and the liver functioning in particular so that toxins are eliminated. (2) Insulin shock, like any other shock, receives strong primitive responses and eliminates recent abnormal ones. (3) Insulin has a specific vagatropic action. Sakel pictures schizophrenia as a state in which nerve impulses travel fast and free and fly, so to speak, of the handle. Insulin inhibits or blockades the nerve cell so that the nerve pathway pattern finally may come back into order. The seat of action, he believes, is in the vegetative centers. Insulin lowers the blood sugar and apparently deprives the nervous tissues of their nutrition for a time. Through this period of hypoglycemia or shock period the patient must be very closely watched and the treatment requires a good deal of skillful

variation in individual cases. Some patients need a period of deep coma while another patient will show much improvement if not allowed to go into comas, but simply treated until sleepy and no longer. It is very important that the patient at all times, be handled with special tact, especially when beginning to improve and gain a little insight. A tactless word or gesture could worry or excite the patient into a relapse.

Miss N. was placed in a room by herself as it is necessary to have a room very well ventilated, darkened during treatments and no disturbing outside influences. It is vital that she have confidence in her nurses and not have a feeling that anyone around is an enemy. The same nurse was with her every day during treatment, because an important function is to reassure the patient during a treatment first by the nurse's presence, then by her interest, friendliness, and understanding. The first intramuscular insulin injection was given on a fasting stomach at seven o'clock in the morning. Fifty units of insulin was administered which is more than the usual first dose. Eight to thirty units is the most common initial dose, and then the amount is increased five to ten units until shock is reached. This preliminary phase is called phase one. The patient begins to respond, as a rule, even in this first stage, by growing calmer and more accessible, especially during the hypoglycemic period. When the insulin doses are high enough, the patient responds with coma. Miss N. received enough insulin in the first injection to go into a slight reaction but not reaching the comatose stage. At an hour and one half after the injection she became very excited, talking and crying at intervals. She repeated sentences or phrases three or four times in succession which went like these: "I don't want to go to that place. They want me to go all the time. I don't want to keep living. I

can't stand this person. I hate this person. I am horrible." At about 8:45 A.M. she became quieter and laid with her eyes closed for several minutes at a time. Her pupils were dilated and skin warm and moist. By 9:30 A.M. she was sleeping for short intervals at a time and several involuntary muscle twitchings of left arm were noted over a period of ten minutes. At ten o'clock she was perspiring profusely. By 10:45 A.M. Miss N. was awake and said something about not having to see them for awhile. She complained of being weak and hungry. Arcund 11:30 she talked but little but it was noticed that she seemed less nervous and apprehensive and her eyes less "glarey" appearing than before the treatment. At noon she was given 180cc. of orange juice and followed shortly with 100cc. more. Soon her skin became dry and she began to feel stronger and seemed more cheerful than at any previous time in the hospital. She smiled and talked directly to you, meeting your gaze. That evening she returned somewhat to her former state. Although she appeared very nervous and again played with the bed clothes, she was very quiet.

The first treatment over, there are many things of vital importance to be noted and carried out in detail. It is necessary to omit the breakfast on the treatment day to make the insulin more effective. When giving the insulin injection, great care was taken to give it under the subcutaneous tissues and not into a vein to prevent hemorrage and unnecessary injury to the tissues. Questions and manipulations were avoided as much as possible to avoid keeping Miss N awake and maintaining a quiet and restful atmosphere. Her weight was routinely taken to be sure that she was maintaining her good physical condition and her blood pressure and pulse checked before and during the treatment because this record is of concern and acts as an indication for

increasing and decreasing the insulin dosage. Blood pressure and pulse give some hint as when to expect motor excitement or may indicate an approaching epilleptic seizure. A steadily increasing pulse rate and rise in blood pressure sometimes indicate that the insulin dosage is being neutralized so that the patient remains awake and active. If the pulse and blood pressure curve stay flat or rise only for short transitory periods and drop again to their formal level, we can expect that the insulin effect will finally even out.

An equipment tray was set up and kept close at hand in case of an emergency. This tray included the following:

Sterile

50 cc. syringe
10 cc. syringe
insulin syringe
2 cc. syringe
assortment of I. V. needles
2 or 3 small hypodermic needles

Unsterile

2 ampules of 50 cc. of 50% glucose
2 ampules of coramine
2 ampules of caffeine sodium benzoate
ampules of adrenalin chloride
ampules of atropine sulphate 1:1000
files for opening ampules
insulin
stethoscope and sphygmomanometer
stomach gavage set with nasal tube
glycerin
alcohol and cotton pledgets
tourniquet
mouth gag
emesis basin
orange juice

Ankle restraints were used, made by using a large sheet and tying them to the foot of the bed. Leather arm and wrist restraints were kept ready in case of necessity. Since subnormal temperature develops during hypoglycemia, and she perspired profusely, extra blankets and hot water bottles were used generously.

After recovering from the hypoglycemic state she received a full sponge bath, massaged with alcohol and given fresh lines. Water was administered freely all during the treatment to make up for fluids lost in perspiration.

As insulin lowers the blood sugar and apparently deprives the nervous tissues of their nutrition for a time, most of the symptoms of hypoglycemia can therefore be relieved by giving the patient sugar again, either by mouth or by vein. As long as Miss N. was able to take orange juice by mouth, this was the method used. A third indirect way of increasing the blood sugar in emergencies is to give the patient an injection of 1 cc. of a standard 1:1000 solution of adrenalin chloride. This serves to discharge the carbohydrate stores (glycogen of the liver) into the blood stream so that the patient is aroused again. Adrenalin, however, only works when there are glycogen stores left in the liver, and its action is otherwise so quick and strong that it is generally preferable, in emergencies, to use the physiologically simpler procedure of injecting intravenous sugar.

There are certain indications for termination of shock that the attending nurse must be very familiar with and alert to note the first symptoms of the onset. Indications for termination are namely:

1. Collapse, irregular pulse or bradycardia under 35 to 40 beats per minute.
2. Sudden marked fluctuation in pulse rate up to 180 and down to 90.
3. Larngospasms
4. Tonic cramps or contractions
5. Epileptic seizures
6. Respiration disturbances such as Cheyne-stokes, stertorous or broncho-spastic breathing.

Psychomotor excitement, cyanosis of the extremities or myoclonic twitchings are not indications of termination. A wild or panicky demand for food is a danger sign , and the patient should be fed. This, however, should not be confused

with the more or less mild complaints of hunger which a patient may make and which are often a good omen.

The first treatment having proved so satisfactory, the insulin dosage was increased to 70 units on September 8. This was given at 6:30 A.M. Checking her weight, we find that she had gained a pound and her blood pressure and pulse were of good quality. She had resumed her former state of apprehension and muscular rigidity. In an hour she was complaining of dizziness, her skin was dry and warm, and she would lie for several minutes with her eyes fixed in one direction. By 8:45 she was sleeping and perspiring profusely. Again she was mumbling to herself and talking in a low voice, saying repeatedly that "she didn't want to keep living" or "she didn't want to see people." There were a few muscle twinges noted just before giving 300 cc. of orange juice. After being bathed, given an alcohol rub and having finished her dinner, we find her smiling and acting quite normal. She seemed cheerful and emotionally stable. She said that she had felt very strange before taking her orange juice.

On the third day of treatment, the insulin dosage was again increased to 80 units. This morning she was smiling and would meet ones gaze fairly well, even though she did appear nervous and apprehensive. The treatment went along very well until about 10:15 when she developed a decided tremor of her hands, twitchings of muscles of forehead and eyelids and flushing of face. She was complaining of hunger and a feeling of suffocation. By giving orange juice, these symptoms were relieve; it was not believed that these were danger signals.

Having progressed to the stage when the insulin dosage was high enough so that Miss N responded with coma, we find we have introduced Phase two of the treatment. Coma comes on, typically, about two to four hours after a large insulin injection and is characterized by the more or less profound unconsciousness, flushing of the

face, and profuse perspiration as described. Much of the time she looked relaxed and comfortable though she could not be aroused. It is very important to learn to distinguish coma from mere drowsiness or sleep, and judge the depth of coma. In general, some mild stimulant such as blowing on the eyelids or wiping the face with a cool, damp cloth is sufficient to find out if the patient is in coma. In deep coma most of the superficial reflexes disappear.

Another treatment was given Saturday increasing the insulin dosage to 90 units. She still talked and mumbled to herself during the treatment, expressing fears and maladjustments with her former associates. After being aroused from the shock she had to be reassured many times that she had not been away from her room. She was perplexed and confused about what had taken place.

Sunday was declared the rest day or that day in which no treatment is given. Hypoglycemic treatment is always given daily with at least one rest day a week until the patient becomes symptom free, or until the judgment of the physician reaches a point where further treatment is not indicated. This rest period constitutes Phase 3 in insulin shock therapy.

During the rest of the day Miss N remained quite cheerful and looked directly at you when engaged in conversation.

Treatment continued very satisfactorily for the next two weeks. Mention should be made about some of the other items to be noted during the second phase of the treatment. We find the insulin dosage fluctuation from 70 to 120 units a day depending upon her response the previous day. On two occasions she became unusually restless and screamed out several times and rolled her head from one side to another. Fifty grams of 50% glucose was given intravenously on these occasions to bring her out of the reactions more readily. As she was now sinking into the deep comatose stages, she was unable to be

commanded to drink orange juice; thus a levine tube was passed each morning after going into coma and was removed before she knew what had happened or until she was able to drink the orange juice.

Frequently a lot of mucous accumulated in her throat. One must be careful that this is not aspirated into the lungs when the muscles are so relaxed and the reflexes non-trustworthy. She was propped on her side to facilitate the flow of saliva. Atropine sulphate grs. 1/150 was given hypodermically when the mucous became exceedingly excessive. Atropine is an alkaloid obtained from the leaves and roots of the atropa belladonna or deadly nightshade. It is a perennial plant about three feet high, naturally growing in England and other parts of Europe. It has a bitter, burning taste and checks the secretions of saliva, mucous, and all other secretion except pancreatic juice. It usually comes in tablets grs. 1/150 to be given by mouth or hypodermically.

Charting during treatment was given much thought and special care. Every day all the objective findings, weight, blood pressure, pulse, her behavior before the insulin was given, during the hypoglycemia, immediately after termination, and her condition the rest of the day was considered separately. It is very essential that an accurate record be kept of the exact time of appearance of perspiration or tremor, of changes in pulse rate, of the onset of somnolence, deep somnolence, superficial coma and deep coma. The time and method of termination, the quantity of sugar administered, and the method used was recorded. In cases of this type the physician scrupously scans the nurses records to obtain that information which guides him in his treatment.

Occupational therapy was a problem of concern. Simple tasks that were not too tiring, as weaving, was given her to occupy her mind. Reading materials that might be too suggestive and cause her to worry was not allowed. She was allotted two or three cigarettes a day, but only when there was someone in the room with her. In the evenings she was taken for short walks, sometimes

around the hospital and on a few occasions out-of-doors in the nearby vicinity. This did not only give her exercise but gave the nurse an opportunity to gain her confidence.

In cases such as this one usually finds a balance established between the "constipating action" of insulin and the "laxative action" of the sugar given to keep the bowels in good condition. Miss N did however develop a rather severe diarrhea after a period of three weeks. Tincture of opii, minims fifteen, was given t.i.d. and the insulin treatment discontinued for three days. Tincture of opii is a compound prepared from opium which is the hardened dried juice of the unripe capsule of the white poppy. The action in this case is valuable because it lessens the contractions of the involuntary muscles. Intestinal peristalsis is thus lessened, which, in addition to the diminished secretion of the intestines are factors which cause constipation. The usual dose is minims fifteen. Hot packs were also ordered to help relieve the spastic condition and discomfort.

Up to this time we find that Miss N8s reactions to treatment have been very typical and favorable. After our three days of rest we have presented quite a different picture--one in which we find it necessary to terminate shock rapidly. There was only 80 units of insulin given on a fasting stomach at the regular time, so it proves that the amount of insulin given does not indicate the type of reaction. The first unusual symptom noted was the queer pleading facial expressions and generalized muscle twitchings. She started with the mild convulsive reactions which developed into those more sever and of the epileptic type. She was frothing at the mouth with an exceedingly large amount of saliva present. Suddenly she stopped breathing and became cyanotic; her pulse was weak and irregular. Adrenalin ampules one was given hypodermically and 600 cc. of orange juice was given through the levine tube. The condition was relieved immediately. Adrenalin chloride or epinephrine is a 1:1000 solution made from the suprarenal glands, or synthetically in normal saline solution. The usual dosage is from

minims ten to fifteen. By ten thirty she was complaining of severe headache and was given codeine grs. I with aspirin grs. ten to relieve this discomfort. Codeine is an active alkaloid of opium used as a hypnotic, sedative and especially as an analgesic. It comes in small white tablets grs. ½ and may be given by mouth or hypodermically. Aspirin or acetlsalicylic acid is a coal tar derivative. It is a white powder, slightly soluble, made up into tablets each containing grs. five. It is an analgesic and antipyretic used especially for headaches.

Miss N was unable to eat her lunch and vomited the greater part of her orange juice. Not having taken the necessary sugar to utilize the insulin it was not surprising to find that in the early afternoon she appeared dull and apathetic. Later she was found sitting up in bed, head fallen back, eyes widely dilated, and was unresponsive to any outside stimuli. This was immediately diagnosed as late shock and 25 cc. of 50% glucose was given intervenously. The coma was relieved immediately. Patients may slip back into coma at any time from a few minutes to twelve hours after termination. Probably the most frequent reasons for this late shock is due to the fact that insulin is still being absorbed long after sugar is given, or else too little sugar was given or absorbed at the time of termination. The latter was the reason in this case.

That evening Miss N seemed much at ease and natural as she had been for the last several days. Infrequently did she show any undue anxiety or nervous tension. She began to be interested in what her friends around the hospital were doing and things of interest outside of her room. Twice her sister was allowed to see her for a few minutes at a time. She seemed pleased to see her sister and did not become nervous and excited. Her condition in every way seemed much improved. Her weight was up to 130 pounds.

After having the severe reaction the attending physician discontinued the treatments temporarily. Unfortunately, she was moved into a four bed ward thinking that the company and outside interests would be valuable to her. She developed

a severe cold and was given ephedrine nose drops, continuous tincture of benzoin inhalations and had her sinuses irrigated by a doctor. She was not allowed to get up out of bed and fluids were forced to 3000 cc. daily. After about five days this infectious condition was remedied. Ephedrine nose drops were used because when applied locally it contracts mucous membranes, especially of the nose and throat, and thus relieves congestion. Ephedrine is a vegetative alkaloid obtained from Ma Huang or Ephedra Equisetina, a very common Chinese plant. It comes in tablets for oral use, ampules for hypodermic use and dissolved in vegetable oil for local use. Tincture of benzoin is derived from the thickened sap obtained from the styrax benzoin, a Peruvian tree. It is used principally to increase the secretions in the lungs, and in inflammations of the nose and throat. A croup kettle is used making the solution with drams one of the tincture of benzoin to a quart of water.

Theelin or amniotin was given intramuscularly several times. This is a crystalline substance obtained from urine of pregnant women and is one of the active hormones of the ovary. It was used to relieve premenstrual tension, nervousness, and irritability, exhaustion, and dysmenorrhea. It may be given orally, hypodermically, or intramuscularly. It comes in ampules containing one cc. of a 2000, 10,000 and 50,000 international units.

She had a rather severe case of athlete's foot which was also being treated at this time. This is a trichophyton infection of the feet, difficult to get rid of, and unpleasant to have. She was given potassium permanganate foot baths twice a day followed with the application of wakefields ointment. The potassium permanganate is a salt of manganese; its efficiency depends upon its antiseptic and disinfectant value. It comes in one half grain tablets and the solution made from these. Her feet became much better, but it is only over a period of many months of treatment that one can be sure of a cure.

Even with these discomforts it was not for several days that Miss N became upset, excited, and began crying with the slightest incitement. She was again disoriented and seemed to have resumed many of the symptoms of her former state. In

In accounting for such a relapse probably much of it was due to the environment and stirring atmosphere caused by other patients in the ward. It so happened that one woman became critically ill and had to be removed from the room. Another patient having had an amputated leg, being heavy set, and boisterous individual told many weird and gruesome experiences. These ideas tantalized her until she was unable to forget them even when taken for walks. She began to think her idle life was of no benefit but only a burden to people. She felt disturbed about her hospital bill and fretted over the obligations her family had so willingly accepted.

Miss N was moved back into her former, single room and on October 21 again given four insulin treatments starting with 25 units. She was much afraid and discouraged. Even though she went into a mild reaction, she was mixed up and confused. She kept saying, "It is terrible to be alone", and She wished she could get things straightened out." Her whole attitude and channel of thoughts were undoubtedly more favorable in spite of the confusion. In the following three days of therapy she became more cheerful and even suggested that she return to her home and family. She was allowed to go into coma, but she remained cooperative and optimistic. She was allowed to do some light reading. When the patient becomes symptom free during hypoglycemia, as well as the rest of the time, and the treatment has been concluded with a few days of further treatment with small doses of insulin, this constitutes the final Phase 4 of the insulin shock therapy. Phase 4 usually lasts one to two weeks but in this case only four days.

Miss N returned to her home for one day, but as she did not seem ready to make that adjustment it was arranged for her to do odd jobs around the hospital, return to the friends she had made at the hospital and gradually become accustomed to accepting people and situations.

PRESENT CONDITION AND PROGNOSIS

It is the picture of an entirely different personality that we see working in the hospital supply room, cataloging library books and enjoying the contact of people in her duties than the one that come into the hospital three months ago. Miss N plans her time off work to go shopping down town, skating, going to shows, and again being that jovial type of person she was once described as being. That peculiar look in her eye has disappeared; those quick fidgity movements of her hands has been lost. She now reveals many of her secrets to her friends as telling of her schemes of how she had planned to commit suicide. Now she seems to realize that she is too young; there is too much to like to so weaken. At the present time her prognosis appears to be good.

From a summary of results of insulin treatment for dementia praecox in a Western State Hospital from November, 1936 to August 15, 1938 we find that of the 114 cases, 36 or 27.2% have recovered. Fifteen, or 13% are much improved; 30, or 26.1% are improved, leaving a total of unimproved 31.1%, making approximately 70% improved or recovered.

The cases have been carefully checked over as to their mental condition and not called much improved, or improved, unless they are at approximately normal mentality for them. It has been shown that there is an average parole of 37% and of the parolees, 46 in number, 14 have returned for further treatment. This leaves a net percentage of 28.2 who are still on the outside, and according to the reports of the Social Service Department have adjusted themselves sufficiently to maintain themselves in the business world.

WHAT PATIENT TAUGHT

Perhaps some of the most important things taught this patient will never be realized. It has been that gradual exposure to a fixed balanced mental attitude

that is the test of what has really been accomplished. Teaching her that people had not ceased to be her friends and were not condemning her by interests shown, was of vital importance. That continuous steering of her mind in a more salubrious direction has made her again enjoy just living. By encouraging her to express herself freely about her fears and maladjustments, it has been possible to answer questions which to her have been crucial.

WHAT I LEARNED FROM THIS CASE STUDY

In writing this case study I feel as though I have become acquainted with a disease and its treatment that in the future is going to become of increasing concern. Satisfaction of seeing a person and personality being so miserable as to desire to commit suicide, change to getting actual enjoyment and happiness out of living is very inspiring. I realize now that a tactful, intelligent, efficient nurse is extremely important in obtaining the desired results. The equipment needed for insulin therapy, the danger signals of the treatment, and upon what theory the physician believes to be the prime factor in cure has been greatly clarified.

HISTORY OF MENTAL DISORDERS AND TREATMENT

It would seem that in the more enlightened ages before the dark middle ages that some of the thinkers and physicians understood at least a little about mental disorders and put forth some effort to relieve this type of ailing patient. It is said that as early as 860 B.C. in Egypt the mentally disordered patients were taken to the temples of Saturn and in Greece to the temples of Aesculapius where the priests studied these cases and applied treatment for alleviation. Considering that these temples were nearly always situated in the mountains or other known healthful places unquestionably a good many of the sick must have found at least a measure of relief. Here at these ancient health resorts, baths, massage, suggestion, recreation, music, rest, singing, and other contructive methods served to benefit the patients disordered mind and body.

Hippocrates, "The Father of Medicine", a noble and scholarly Greek who lived in 460 B.C. studied mental disorders and believed them to be caused by disturbance of brain function.

Later handling of mental cases, particularly in the middle ages, was one of the blackest and cruelists in all history. Such patients were often beaten to death, starved, chained in dark dungeons without sufficient food and water and with no medical attention whatsoever, and subjected to every form of torture that could be devised by superstitious, ignorant and inhuman brutes. Evil spirits were believed to inhabit the insane, or else the disease was considered to he due to some terrible sin committed by the person afflicted. Abuse and torture became then the logical and proper treatment for these poor unfortunates.

After insanity became recognized as a disease, a hospital was provided for such cases in Jerusalem in 491 A.D. Then in the twelfth century the Arabians who were more advanced and humane provided a "House of Grace" as a refuge for the mentally afflicted.

Following is a general outline of the order of development of facilities for treatment of the mentally disordered:

1547 First European insane asylum, a monastery converted into an asylum. This was called Bethlehem Asylum later called Bedlam. It housed fifty patients to begin with. These patients were allowed to act as beggars on the streets of London.

1784 Opening of the Viennese Narrenthurm "Lunatics Tower" where the public visited as they would at a wild animal exhibit.

1792 In France there was appointed in charge of the great hospital for males, a physician who viewed insane patients in a more scientific and humane light. This was Philippe Pinel. This great man brought about some wonderful improvements in the care and treatment of the insane.

1796 In the City of York, England, William Tuke, through the Friends Society, Quakers, organized a retreat for the mentally ill where kindly measures were exclusively used in caring for the insane. This method proved to be far superior to cruel methods formerly employed.

1800 or about this time, Jean Gaspart Itard, a French physician instituted methods of teaching for idiots and the insane. Later some of Itard's students carried the teaching method much farther in handling the mentally defective.

America had done little during the eighteenth century to develop good methods for caring for and treating the insane, though the Quakers, as early as 1709, made some effort in Philadelphia along

this line. Dr. Thomas Bond a physician of true understanding and nobility finally interested Benjamin Franklin in the problem of the insane and so a petition to the civil authorities was presented January 23, 1751, asking for provisions for a hospital for the mentally disordered. Thus was the beginning of the Pennsylvania Hospital. First patient was received in the temporary hospital, a converted mansion, belonging to Judge Kinsey, on February 11, 1752. Of particular note was the work of Dr. Benjamin Rush who for thirty years during this period faithfully and skillfully ministered to the insane and who at that early period advocated manual and industrial work as a therapeutic agent.

1773 witnessed the opening at Williamsburg, the first hospital restricted exclusively to the care of the insane. This institution is now called the Eastern State Hospital.

1771 New York Hospital at New York City chartered, but not opened for patients until 1791. 1808, a separate building was added as a Lunatic Asylum, which was the beginning of what is now the Bloomingdale Hospital.

1798 Began the construction of a hospital for the sick and insane on the present site of Johns Hopkins Hospital in Baltimore, Maryland.

From this time on, various State Legislative Bodies, and other agencies continued slowly the development of facilities for the care of mental disorders. Most noteworty was the beginning of the work in 1841 of a school teacher in Massachusetts by the name of Miss Dorothea Lynde Dix, who on observing the pitiable

and terrible conditions in which mental cases were being handled in jails and other poorly arranged places, placed a memorial before the Legislature which, because of its drastic treatment of the subject, and which was proven to be absolutely true, aroused not only the populace but the authorities as well to begin the preparation for at least some decent measures of care and treatment of the mentally ailing. This lady continued her investigations in American and submitted her evidence to various official bodies, both civil and medical, and accomplished many needed reforms. She also extended her work to England, Scotland, the continent of Europe with excellent results. She was not only a great philanthropist, but a capable humanitarian in her chosen work of developing improved methods for caring for the mentally disordered.

Recognition of the scope of psychiatry is spreading rapidly in medical circles and more slowly among the laity. However, more rapid progress is being made at the present time than in past years. The success achieved here in Oregon in securing funds by appropriation from the last meeting of the Oregon Legislature for a new Psychiatric hospital is evidence that modern medical science is at last on the road to as much of a solution of the problems of mental diseases as can be expected considering our present knowledge of psychiatry. It is to be hoped that psychiatry will be extended and expanded widely in the immediate future for the need of it is very great in this present social order. Modern medicine in the progress of psychiatry should within the coming generation write one of its most brilliant chapters of accomplishment in the field of human service.

BIBLIOGRAPHY, CHAPTER IV.

Principles and Practices of Hydrotherapy- - - - Baruch

Nursing Mental Diseases - - - - - - - - - - - - - - Bailey

Pharmacological Treatment of Schizophrenia- - - Blumgarten, 7th Edition

Psychiatric Nursing - - - - - - - - - - - - - - - - Sadler

Textbook of Materia Medica and Pharmacology - - Blumgarten, 7th Edition

Journals

American Journal of Nursing, "Insulin Shock in Psychoses"
Joseph Worlis, M.D. & Jeff Roberts, R.M.

Forum- - - - - - - - - - - - - "Insanity and Insulin"
Burbargame, February, 1938, Pgs. 98-102

Harpers- - - - - - - - - - - - "Age of Schizophrenia" Barber
December, 1937, Pages 70-78

Hygiea - - - - - - - - - - - - "Heredity in Relation to Damentia Praecox"
February, 1933, Page 176

Pamphlets

"The Washington Bulletin"- - - Vol. 2, No. 9, September, 1938
" " " Vol. 2, No. 8, April, 1938

"The Menninger Clinic"- - - - September, 1938; Vol. 2, No. 5.

The following brief was prepared by the Oregon Mental Hygiene Society as a guide to the Committee on Medicine, Dentistry and Pharmacy in the State Senate to enable these members better to understand some of the problems in Oregon which relate to Mental Diseases. As will be noted, the need of additional facilities is pointed out, and the picture well presented as to actual conditions, not only in Oregon, but in the nation as well. I believe that information of this nature when made known to our legislative body will accomplish a great deal in the way of official and public cooperation in dealing with the many increasingly serious problems of psychiatry. Success in achieving the goal hoped for was granted by the legislative body.

WHAT IS A PSYCHIATRIC HOSPITAL?

A Psychiatric Hospital, in the modern sense of the term, is a hospital designed to give to those suffering from nervous and mental diseases, expert diagnostic service, along with adequate treatment and nursing care. It does for this group of patients what a first-class general hospital is able to do for patients suffering from such diseases as pneumonia, diabetes, and heart disease.

Like every first-class hospital, it serves three objectives:

1. STUDY AND OBSERVATION for patients mentally ill.

2. INVESTIGATION AND RESEARCH into the problems of cause, prevention and care of mental illness.

3. EDUCATION of physicians and students to enable them better to meet the problems which they face in practice.

   EDUCATION of nurses in the methods of handling cases of this type.

   EDUCATION of those interested in the social services, in this special division of their field.

SCOPE OF SERVICE OF THE PSYCHIATRIC HOSPITAL

1. Under the present system, where a patient becomes sufficiently ill, mentally, to present a serious problem in his family or to the community, there is usually no alternative but commitment. A Psychiatric Hospital will provide temporary hospitalization for patients of this type, where an adequate study can be made. Many times, it will be possible to solve the problem of diagnosis and treatment, and the patient can be returned home in 30, 60, or 90 days, without the necessity of commitment.

2. The advantage of this is obvious. It removes from the family the embarrassment of commitment; it removes from the state the financial burden of commitment.

3. One of its important functions is to cooperate with the state hospitals. This will be done through:
   (a) Pre-commitment service.
   (b) Supervision of paroled patients.
   (c) Medical follow-up.

4. It will aid the commitment courts by providing facilities for observation and diagnostic study in doubtful cases.
   It will act in correlation with other clinics and departments of the University of Oregon Medical School Hospitals and Clinics.

It will be a center of clinical and laboratory investigation, so that this costly type of illness may be better understood, and its incidence lessened.

It will be a center where the problem of juvenile maladjustments may be studied in a coordinate way, from the medical, social and legal standpoints.

5. It will help in the development of a general picture of the problem of mental disease, including preventive, remedial, and custodial phases.

6. It will serve as a center for undergraduate and graduate teaching of mental disease.

PLAN OF OPERATION

The proposed hospital would be a unit of the University of Oregon Medical School Hospitals and Clinics operated in cooperation with other state hospitals from funds provided by the legislative budget for this purpose.

The hospital would be an 80-bed unit with facilities for ambulatory care and follow-up.

FACTS ABOUT MENTAL ILLNESS AND A PSYCHIATRIC HOSPITAL

The campaign to reduce insanity is not charity - it is a national defense measure.

Insanity is a disease - a most expensive one - $200,000,000.00 annually is the national cost. Oregon spends over $1,000,000.00 annually for the care of more than 6000 persons. When we add to this the loss of earnings, we increase the dollar cost of mental disease in the United States to about $700,000,000.00.

Mental illness can often be prevented by early treatment. This is especially true in children. Stealing, truancy, and many similar acts are symptoms of poor mental health. If allowed to go untreated, they may get worse, and result in permanent maladjustment. Some of these become commitment cases later. The whole focus of modern medicine is on prevention and early treatment. This is especially true and especially important in mental disease.

In 1937, the Oregon State Hospital received 867 new commitments plus 170 who had been commited here once before or had been committed to some state hospital elsewhere, making a total of 1037 commitments during that year.

Statistics for 1938 are not yet compiled, but they will run still higher; therefore, it would be safe to say that three persons each day are admitted to one of Oregon's state hospitals.

We are not yet winning the fight against this vicious "morale breaker". During the past two decades patients in the Oregon State Hospitals for mental disease increased 49.4% while the general population increased only 16.4%. This Psychiatric Hospital would serve all sections in Oregon.

There are evidences of progress which give us all hope: Oregon has twelve Child Guidance Clinics in the larger cities operated as an extension of the University of Oregon Medical School program; Portland has a full-time Child Guidance Clinic. Last year some 700 children were given preventive treatment under the entire program. The superintendents of Oregon schools have requested continuance and extension of the program of the Child Guidance Clinics for the biennial period 1939-1940 which requires a legislative appropriation of $24,000.

WHAT TYPES OF PATIENTS WOULD BE SERVED?

The following types of diagnoses of nervous and mental disorders were treated in the Oregon State Hospitals during the past two years.

Patients whose mental disorders were diagnosed as:

		Number
1.	General paresis (syphilis)	107
2.	Psychoses with infectious diseases	2
3.	Alcoholics with derangement	148
4.	Psychoses due to drugs, and other poisons	30
5.	Involutional psychoses	83
6.	Psychoses due to brain tumors	4
7.	Psychoneuroses	133
8.	Dementia Praecox	267
9.	Paranoid conditions	174
10.	Psychoses with mental deficiency	34
11.	Psychopathic personalities	48
12.	Without psychoses	16
	Total - - - - - - - - - - -	1,046

Patients diagnosed as indicated above appeared at the state hospitals for the first time during the past two years; over 500 each year.

WHAT PROGRESS HAS BEEN MADE?

1850 First U. S. census reports of Insane in Oregon.

1860 Newspapers complained because the insane roamed the state terrorizing women and children.

1865 Insane "farmed out" to families, the state paying for their care.

1868 Governor Woods by direction of legislature contracted East Portland Asylum for care of patients.
Governor Woods said "good taste and humanity rebel against hawking these unfortunates to the lowest bidder".

1883 State Asylum at Salem constructed.

1913 Eastern Oregon Hospital erected.

1921 Multnomah County survey by Dr. H. R. Viets of National Committee for Mental Hygiene showed - over a ten year period:

55.7% increase in population of insane hospitals
and only 16.4% increase in population.

1937 Resolution authorizing appointment of Interim Committee.

1937 Interim Committee Report in favor of Psychiatric Hospital at the University of Oregon Medical School.

OREGON INSTITUTIONAL GROWTH - 1914 - 1938

	1914	1916	1918	1920	1922	1924	1926	1928	1930	1932	1934	1936	1938
OREGON STATE HOSPITAL	1576	1572	1631	1743	1845	1864	1873	1872	2026	2110	2204	2427	2582
EASTERN OREGON STATE HOSPITAL	346	494	515	488	558	736	810	1017	1016	1171	1314	1329	1308
	1922	2066	2146	2231	2403	2600	2683	2889	3042	3281	3523	2756	3890

49.4% INCREASE SINCE 1914

SOURCE OF INFORMATION: PAGE 20 OF THE THIRTEENTH BIANNUAL REPORT OF THE OREGON STATE BOARD OF CONTROL

RESULTS OF AN INADEQUATE PROGRAM

Figures show national costs and Oregon comparison

NATIONAL

a.	550,000	number of mentally ill
b.	1,000,000	number of hospital beds. (all illnesses)
c.	$200,000,000.00	dollars spent annually
d.	$700,000,000.00	if job loss earnings included
e.	$1,000,000,000.00	represents capital investment
f.	122,775,046	population

OREGON

a.	4886*	mentally ill in hospitals
b.	9929	number of hospital beds. (all illnesses)
c.	$967,588.00	dollars spent annually
d.	$5,000,000.00	pro-rated job loss earnings
e.	$10,000,000.00	represents capital outlay
f.	953,786	population

* Includes Fairview Home

REPORT OF GOVERNOR'S SPECIAL COMMITTEE

(Excerpt)

Regardless of the cause of the increase, which has necessitated frequent enlargement of facilities for custodial care, your committee feels that great effort should be directed toward the preventive aspect of insanity and the treatment of incipient cases, with the view of arresting some forms of insanity at the source - as well as providing permanent care for those who have advanced so far that the effectiveness of treatment is greatly reduced and oftentimes rendered useless.

Whatever can be done in prevention, in treatment that deals not only with the effects but with the causes, and in humanely efficient custodial care, represents in corresponding degree an increase of human happiness, the allaying of distress, and the lightening of the tax burden through reduction in the institutional load. Only the briefest reference need be made to the enhance economic and social values to be derived from effort and administrative policy looking toward the maximum number of normal and productive citizens.

Solicitude for the mentally sick, and for the manner in which Oregon is meeting its duty to them, prompted the appointment by Governor Charles H. Martin of the undersigned committee.

THE COMMITTEE RECOMMENDS A MEASURE OR MEASURES TO EFFECTUATE THE FOLLOWING PURPOSES:

(1) The expansion and extension of Child Guidance Clinics.

(2) The establishment of a psychiatric hospital in connection with the University of Oregon Medical School.

a. To provide treatment of improvable and curable cases.

b. To provide an outpatient station for treatment of patients who are ambulatory and need not be hospitalized.

c. To provide a teaching center for the medical and nursing professions in the principles and objective of mental hygiene.

d. To provide facilities to promote and stimulate investigation and research into the whole problem of the cause, treatment, and prevention of mental disorders and feeblemindedness.

Signed:

Mr. Wallace S. Wharton - Executive Secretary to the Governor
Dr. J. C. Evans - Superintendent, Oregon State Hospital
Mr. Marshall Dana - Associate Editor, Oregon Journal
Dr. R. B. Dillehunt - Chairman, Dean of the University of Oregon Medical School.

SENATE CONCURRENT RESOLUTION NO. 7 (THIRTY-NINTH LEGISLATIVE ASSE

Introduced by COMMITTEE ON EDUCATION and read March 2, 1937

Whereas there is a steady increase in the ratio of commitments of insane and feeble-minded to the various institutions of the State of Oregon; and

Whereas vast sums of money now are required in custodial care of mental incompetents in state, county and municipal institutions that might be obviated by early observation and scientific determination prior to judicial commitment; and

Whereas it is highly desirable that efforts and measures be directed and adopted toward the preventive aspect of insanity and the treatment of incipient cases, with a view of arresting some forms of insanity at their source; and

Whereas the State of Oregon, through its state board of higher education and the University of Oregon Medical School has ample facilities, which may be utilized in scientific research, leadership and cooperation with all state, county and municipal agencies and institutions to assist in lightening the tax burden by preventing unnecessary custodial care; and

Whereas the special committee appointed by the governor to study certain phases of the Oregon state psychiatric program has rendered a comprehensive report on this subject and has recommended the establishment of a psychiatric hospital on the campus of the University of Oregon Medical School.

BE IT RESOLVED BY THE SENATE OF THE STATE OF OREGON, THE HOUSE OF REPRESENTATIVES CONCURRING THEREIN:

That a special interim committee be appointed to study ways and means to finance the building of a psychiatric hospital on the campus of the University of Oregon Medical School at Portland, Oregon.

COMMITTEE RECOMMENDATION

At a meeting of the Special Committee, provided in the legislative enactment (1937) held in November, 1937, the following action concluded the study and discussion:

"The Committee unanimously voted to approve and recommend to the Fortieth Legislative Assembly the constructing, equipping, and maintaining of a Psychopathic Hospital Unit on the campus of the University of Oregon Medical School."

Signed:

Senator H. C. Wheeler
Dr. J. F. Hosch - Representative
Marshall Dana - Associate Editor, Oregon Journal
Senator W. E. Pearson
Dr. A. O. Waller - Representative
Dr. R. B. Dillehunt - Chairman, Dean of Medical School

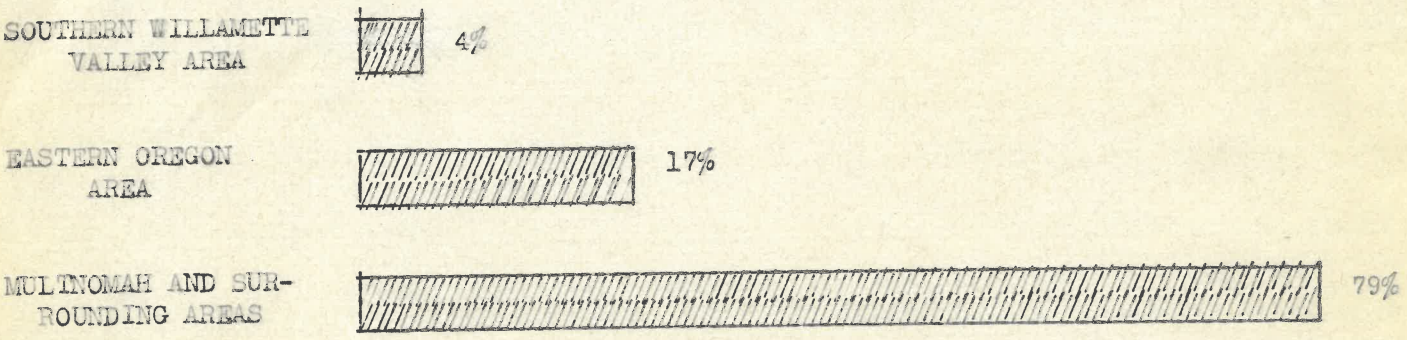
INSTITUTIONAL POPULATION

County Source	OSH	EOSH	TOTAL	GENERAL POPULATION	NO. Com. Per 1000	No. Com. Per Month
Baker	1	68	69	16,754	4.3	3
Benton	38	5	43	16,555	2.6	2
Clackamas	89	28	117	46,205	2.3	5
Clatsop	55	31	86	21,124	5.5	3
Columbia	38	5	43	20,047	4.2	2
Coos	62	13	75	28,373	2.8	3
Curry	10	1	11	3,257	3.3	1
Crook		7	7	3,336	2.7	1
Deschutes	3	26	29	14,749	1.9	1
Douglas	78	11	89	21,965	4.5	3
Gilliam		12	12	3,467	3.4	1
Grant		22	22	5,940	3.7	1
Harney		28	28	5,920	4.7	1
Hood River	2	23	25	8,938	2.8	1
Jackson	52	16	68	32,918	2.6	3
Jefferson		2	2	2,291	1.0	-
Josephine	45	8	53	11,498	4.6	2
Klamath	57	12	69	32,497	2.1	3
Lake	4	3	7	4,833	1.4	-
Lane	109	23	132	54,493	2.4	5
Lincoln	29	5	34	9,903	3.4	1
Linn	81	18	99	24,700	4.0	4
Malheur	1	39	40	11,269	3.5	2
Marion	245	35	280	60,541	4.6	12
Morrow	2	16	18	4,941	3.7	1
Multnomah	805	539	1344	338,241	4.0	54
Polk	36	3	39	16,898	2.3	2
Sherman	1	6	7	2,978	3.0	-
Tillamook	23	3	26	11,849	2.2	1
Umatilla	3	127	130	24,399	5.3	5
Union	2	62	64	17,492	3.6	3
Wallowa		22	22	7,814	2.8	1
Wasco	3	56	59	12,646	4.7	3
Washington	71	14	85	30,725	2.7	4
Yamhill	53	10	63	22,036	2.8	3
Wheeler		9	9	2,799	3.3	1
Total:	2006	1308	3314	953,786	3.4	138

Oregon State Hospital - Eastern Oregon State Hospital

Source of Information: Page 36 and 61 of the Thirteenth Biennial Report of the Oregon State Board of Control.

GEOGRAPHIC SOURCE OF COMMITMENTS 1937-1938



HIGH COUNTY COMMITMENT RATES
(Per 1000 Population)