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Textbook of

PSYCHIATRIC NURSING

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Textbook of

PSYCHIATRIC NURSING

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FOURTH EDITION

previous editions known as
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PREFACE TO THE FOURTH EDITION

In the present edition of this book it has been the aim of the authors to discuss more fully than previously the various nursing techniques involved in specific treatments of the mental patient. It is believed that in view of this increased emphasis on nursing procedures the fundamental purpose of the book would be more accurately suggested by the title, *Textbook of Psychiatric Nursing,* which has been substituted for *Textbook of Psychiatry,* that borne by previous editions.

Although there has been an increased emphasis on the techniques of psychiatric nursing, the technique of understanding remains the indispensable skill. This, it is hoped, the student will in no small degree acquire during an affiliate training in a psychiatric hospital. Here she should learn that her patient is first of all a person and that her task is to nurse not only his physical needs, but also his fears, opinions, strivings, hates, aggressions, and his feelings of guilt and frustration. The insights acquired through her knowledge of psychiatry should help her in establishing order, peace, and security in her patient's personal life.

It is a pleasure to acknowledge the many helpful suggestions made by Mrs. Hilda O. Schmalbach, R.N., superintendent of nurses, Norristown State Hospital, and by Mrs. Bonnie W. Corey, R.N., instructor in psychiatric nursing, St. Elizabeths Hospital.

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Textbook of

PSYCHIATRIC NURSING

CHAPTER I

PSYCHIATRY AND PSYCHIATRIC NURSING

Health Not Merely a Matter of State of Body. Physicians formerly thought of health largely as a matter of soundness or disease of the organs or the systems of organs. They did not realize that health concerns the whole individual and includes the feeling, thinking, and doing aspects of his life. It seems as if they often thought of the patient as a sort of receptacle containing organs, and that these organs and their container, the thinking, feeling individual, operate more or less independently of each other. We now think of a person as a biological organism that reacts or responds as a unit. He is, however, a human organism and both his behavior and his bodily processes may be influenced by thoughts and feelings as well as by impersonal agents such as infections or poisons. The reactions and behavior of this human organism, the individual, have gradually become more clearly and fully understood. As a result, physicians, in seeking to diagnose and treat the ills of their patients, are increasingly taking into consideration all the life experiences and situations of the individual as well as the more impersonal physical states of his body. Similarly the nurse can be of much greater assistance to her patient if she has an understanding of his thinking and feeling life, and if she understands how his previous experiences, and what they have meant to him, have influenced, or perhaps produced, his present condition. Armed with such an understanding of her patient the nurse can do much more than record his functions and alleviate his physical discomfort.

Mind and Body Not Separable. Formerly psychiatry was considered a subject that is concerned with "insanity," a mysterious "disease" of the "mind." Mind was regarded as something added to or apart from the body yet somehow related to the brain, the processes of which stood in a sort of parallel relation to mental events. It was the custom to speak of body and mind as if they were two unrelated or contrasting parts of a person. Now, however,

mind and body are no longer viewed as separate and distinct elements but merely as different aspects of a living organism. Growing out of our knowledge of the development of lower organisms and their biologically adaptive processes, we have now come to think of man as also a biological organism, although one that is highly socialized. We have come also to look upon his mind as the thinking, feeling, doing, and adjustive aspect of this socialized, biological organism. By "mind," therefore, we do not mean any actual entity or even any mysterious mechanism associated with the body by some inexplicable means. Mind is merely a collective term applied to the sum of the activities, functions, and responses representing the interaction between an organism and its environment. Viewed in this way, the body would be the structural, physical aspect of the organism.

Psychobiology. Since it deals with disorders of behavior and with the unwholesome ways of thinking, feeling, and doing which the human organism may adopt in its efforts to adjust to the problems and experiences it meets, psychiatry may be looked upon as a branch of biology—a branch often spoken of as psychobiology. Viewed in this way, it will be seen that psychiatry as a psychobiology of the individual is concerned with a much larger problem than the medical diagnosis and treatment of persons suffering from those gross disorders of mind or of personality that so disturb the sufferer's social relations that he must be placed in an institution for mental diseases. Psychiatry, therefore, is that branch of medicine that deals with personality problems and disorders. In addition to major, obvious mental disorders, psychiatry deals with many minor disorders of personality which render individuals socially and economically inefficient or result in disturbing personal and family maladjustments.

Another large group of disorders which can be understood and successfully treated by psychiatric methods only is that characterized by many and varied physical complaints for which no organic basis can be found. The symptoms, which represent the translation of mental and emotional conflicts and tensions into physical complaints, may simulate almost every known type of physical disease. It is estimated that approximately 40 per cent of patients seeking relief from physical complaints are ill not because of real physical disease but because of emotional and mental conflicts and maladjustments within their personalities. The patient is usually un-

aware of the relation of his mental conflicts, tensions, and fears to the symptoms for which he asks relief. If his medical adviser is not familiar with the marked influence of mind and mental habits in the causation and course of physical complaints, the psychic or mental source of the ailment may remain unsuspected and the patient may suffer from years of invalidism. Both medicine and nursing need a greater appreciation of the role which emotional and other mental factors play in the health and well-being of the individual.

Extent and Variety of Mental Ill Health. Only comparatively few nurses are engaged in the care of patients suffering from gross mental disorders. Psychiatric nursing should not, however, be concerned solely or even largely with outspoken mental disorder. Most unhealthy mental processes do not lead to the serious mental disorders encountered in psychiatric hospitals. Like physical illnesses, mental disorders may be mild. In these less serious types of illnesses persons unacquainted with psychiatric principles often fail to recognize that the less disturbing forms of personality disorders are the result of the same personality difficulties and of the same mental processes as are the serious illnesses. In fact frequently it is not recognized that the mild forms are mental disorders at all. Many headaches, much chronic fatigue, and various other physical ailments, marked character traits, pronounced social and emotional attitudes, and many behavior disorders may be the result of the same factors and serve the same psychological purpose in the lives of some persons as do the major mental disorders in the lives of others.

Psychiatric Educational Facilities. Of course, the nurse who desires to follow either institutional or private duty nursing of mental patients must have an extensive knowledge of the natural history of the commoner forms of mental disease and of the problems that may arise in the care of the patient suffering from them. For this reason considerable training in a hospital for mental disorders is essential for the nurse planning to specialize in this branch of her profession. The student who expects to follow either general nursing or some specialty not definitely psychiatric does not, of course, need a long period of training in a mental hospital where for the most part she observes the end results of unwholesome mental processes. She will, however, find that the training afforded by a residence of a few months in a psychiatric hospital is invaluable. In an ideal course of instruction such a training should be sup-

plemented by experience in an outpatient or mental hygiene clinic where mild personality disorders are observed. The frank psychoses and the well developed psychoneuroses afford clearer pictures of personality disorder than do the mild disturbances of personality which we observe daily as they interfere with smooth and successful personal adjustments. The principal stress should be upon the less obvious disorders, both because of their greater frequency and the fact that they constantly complicate general medical and nursing practice. The custom increasingly adopted in general hospitals, whereby a psychiatrist routinely examines the patients in the medical and the surgical wards, offers the nurse excellent opportunities for supplementary training in psychiatry provided she is instructed as to the personality problems and psychiatric complications presented by these patients. Discerning observation and judicious psychiatric teaching on such wards may be of great value in assisting the nurse to realize that there is a reciprocal relation between personality reactions and physical health; that on the one hand fears and conflicts may be translated into physical complaints referred to various parts of the body, and that on the other hand weaknesses of personality that have been masked during health are prone to come to the surface during physical illness.

Psychopathology, and Value of Knowledge of It. A training in psychopathology, or the branch of medicine which deals with the influences and processes that lead to personality disorders, will be of great assistance to the nurse. If she realizes the subtle but far reaching effects that may be produced by mental and emotional factors, she will be able to render much greater assistance to the physician in his effort to formulate a diagnosis and outline a treatment. Her intimate and rather continuous contact with the patient makes it possible for the nurse to observe details of behavior and personality expression that may be indicative of mental and emotional problems having an important relation to the patient's illness. If her services are rendered in the patient's home the nurse may discover such unwholesome emotional relationships as jealousies, resentments, dominations, feelings of guilt, undue dependence, and other reactions and attitudes that may predispose to the development of mental disorder, or, in the case of the person physically ill, may influence the course of his disease or its convalescence.

Mental and Emotional Problems Found in Every Branch of Nursing. Only through a knowledge of the subtle ways in which

the mind operates will the nurse recognize these problems, and the ways by which the patient has attempted to solve them—ways, however, which have not been successful but have complicated, if not created, the ailment for the relief of which the nurse is called upon to administer. The light shed on human behavior by a study of psychiatry should assist the nurse in acquiring a rational and practical understanding both of her patients and herself. The point of view promoted by psychiatry more than by any other branch of nursing tends to make the nurse realize that her professional task is to nurse human beings, not diseases. She will learn also that fully effective medical and nursing care cannot be given a patient unless any mental and emotional problems that exist are understood.

In subsequent chapters some of the difficulties and problems that are frequently found perturbing will be pointed out, the various mental methods or mechanisms by which the patient attempts to deal with them will be explained, and the disturbances of personality that may follow from them will be described.

Scope of Psychiatry. From what has been said it will be seen that psychiatry is not concerned merely with the investigation, diagnosis, and treatment of major mental disorders but with the various manifestations of disturbed personality functions wherever found. Psychiatry does not deal with mind in the abstract but with human beings as they think, feel, and behave in face of the stresses and problems that life has brought them.

Summary

1. Health is a matter of thinking, feeling, and doing, as well as a matter of the general well-being of body.
2. The human organism is influenced by thoughts and feelings as well as by the usual disease-producing agencies.
3. Mind and body are different aspects of a living organism.
4. Psychiatry deals with unwholesome ways of thinking, feeling, and doing in the face of stress and problems.
5. Most mental ill health is not in the form of serious mental disease.
6. Psychiatric experience is of great value to the nurse.
7. Knowledge of influences producing personality disorders is of great value to the nurse.

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CHAPTER II

CONSCIOUS AND UNCONSCIOUS MENTAL PROCESSES

Mind More than Consciousness. During our ordinary waking state we are cognizant of our existence, of our acts and experiences, aware both of that which is felt as within ourselves and that which is perceived as without. On first thought it may seem that this sense of awareness or consciousness constitutes the entire mind since it is the only part of which one is sensible. While most mental functions take place under conditions of clear awareness, careful observation of the operations of the mind, particularly of persons suffering from mental disorder, shows that mental activities take place under widely varying degrees of consciousness and even without any awareness whatsoever. Our mind, therefore, includes much more than that of which we are conscious. While normal behavior is determined more by consciousness than is that of persons suffering from mental disorder, yet we all may observe that in making important decisions our acquaintances are at times led to their conclusions by influences of which they are not aware. Our slips of tongue and pen are often due to mental content of which we are not conscious. We like to believe that our behavior is the result of rationally considered decisions of our conscious mind, but in fact it is often greatly influenced or even determined by mental content or processes of which we are dimly or not at all aware. Our preferences and antipathies are often determined in this way.

The lack of awareness of many processes in our mind or even of the motivations of our behavior is not unlike what may be observed in a person subjected to hypnosis. While in the hypnotic state it may be suggested to the subject of the experiment that after he has awakened he is to perform a certain act (e.g., to open a certain book on the hypnotist's table). After the termination of the hypnosis the subject obeys the suggestion made during the hypnotic state and opens the book indicated although he does not consciously attribute his behavior to the hypnotic suggestion.

The Unconscious. That part of our minds of which we possess no conscious awareness we designate as "the unconscious." Until considered thoughtfully and until various manifestations both of the normal and of the diseased mind are studied, the supposition that we are not aware of everything that constitutes our mind may seem beyond the bounds of reason. We find, however, that the theory of an unconscious is an invaluable aid to the understanding of many mental reactions. Many facts of consciousness and many manifestations both of normal and of diseased mental states can be explained only by the assumption of unconscious content and processes in our minds. To be sure, we cannot explore the unconscious with any of our five senses yet the absence of any such ability does not prove the falsity of our assumption. We cannot see or touch the force of gravity, yet such a familiar, observable fact as the falling of an apple from its branch can be explained in no other way than by the assumption of a force that causes bodies to fall to the earth. The unconscious, therefore, must not be regarded as a passive mental state but as a dynamic, or motivating and directing, component of the mind, exercising a positive influence on the mental life, modifying thought content and determining many behavior reactions.

Various analogies are at times employed to indicate the active and relatively important part of the unconscious in the mental life of the individual. In one of these the mind is compared to a body of water only a small part of which, the surface, is visible to the observer, while beneath the fractional part obvious to our eye is a great invisible mass with its directing currents charged with energy. In this analogy the surface, the small part apparent to our sight, may be compared to consciousness which we now believe constitutes but a small part of the entire mind, while the unconscious would be represented by the great quantity of water beneath. We know that there is a constant interchange of water between the surface and the depths as some molecules rise to the surface and others sink to lower strata. Similarly, elements in the mind constantly pass from awareness down into the unconscious, the currents or motivating forces of which play an important part in directing our thoughts, feelings, and actions.

Two Sources Contribute to the Unconscious. That part of the mind of which we are not aware seems to contain material from two sources. One source lies nearer to conscious awareness, while

the other is more deeply situated, more remote from consciousness. The former is known as the individual or *personal unconscious* and is made up of the lost memories of all those feelings and events which one has experienced since birth. Some of these lost memories are those of painful and incompatible or conflicting thoughts and feelings the continued awareness of which would be unpleasant and they have therefore been repressed or excluded from awareness. Since the life experiences and influences of people always differ one from the other the personal unconscious is likewise unique to the individual.

More deeply placed, more remote from conscious awareness, is the second part of the unconscious which may be described as the *racial unconscious.* This consists of those ways of thinking and feeling that constitute the deposit or product of the experience of the race and have nothing to do with the experience of the individual. It is our legacy of ways or patterns of thinking and feeling, our inherited tendencies.

Figure 1 illustrates the theoretical structure of the mind, which may be represented by a triangle. In the upper angle is a relatively

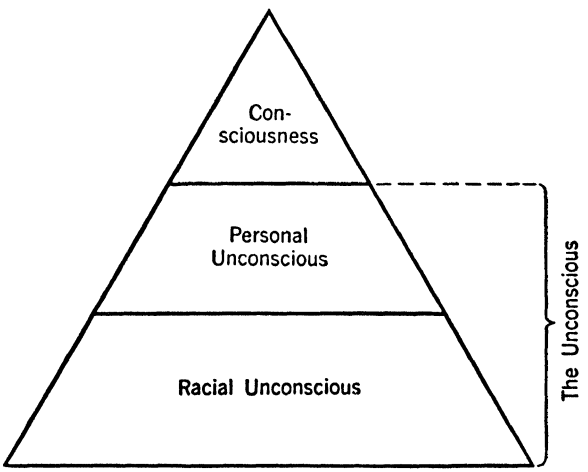


FIG. 1: SCHEMATIC REPRESENTATION OF THE STRUCTURE OF THE MIND.

small part of the mind made up of the conscious part of the individual's mind containing all of which he is aware or which he can readily recall. Below this and constituting a somewhat larger

part of the mind is the personal unconscious containing the individual's forgotten and repressed thoughts, feelings, and mental experiences. Beneath the personal unconscious and forming a large part of the mind is the racial unconscious containing all those elements of human nature potentially present as an inheritance from our ancestors.

It must not be concluded that the conscious and the unconscious are really the sharply separated regions or systems that might be inferred from what has been said. On the contrary the conscious and the unconscious act together, and in most cases both conscious and unconscious processes have contributed to the mental product. The extent to which unconscious processes determine thought, feeling, and action varies greatly but they exert much more influence in mental disease than in mental health. In fact there seems reason to believe that much mental disease is produced by the extreme and unwholesome part sometimes played by unconscious processes. If unconscious elements and processes control the personality, mental disease may result. We do not know just what mental processes may take place in the unconscious although latent memories, unrecognized strivings and urges, deeply seated emotional feelings, and other internal drives and motives apparently participate. The unconscious, then, might be defined as a collective name for a number of mental processes lacking the quality of consciousness. Many of these processes exert great influence on the personality, the character of its problems, and its methods of dealing with these problems. An important part is assigned to the unconscious because of the marked influence that it may exercise upon the personality and its attitudes and tendencies and on the conscious thoughts, feelings, and activities of the individual. The unconscious is not a passive state but is dynamic, that is, the unconscious modifies a person's thought-life, influences his personality and its problems, and determines many of his behavior reactions. The theory of the unconscious is of course a hypothetical explanation. It cannot be scientifically demonstrated as can digestion, circulation of the blood, or other chemical or physical process. It is a theory, however, which up to the present time best accounts for many phenomena of human behavior.

The Personality. In the preceding paragraph, reference was made to the personality and to the fact that forces of which we are not aware are important in shaping the patterns or nature of the per-

sonality. We should therefore define what we mean by the personality since it is a term which we shall constantly employ. In his use of the term "personality" the psychiatrist does not, of course, mean a supposed personal charm and distinction which some people believe may be acquired by some vague type of cultural regimen. When the psychiatrist speaks of personality he means the system or design of organic, hereditary, emotional, thinking, and striving capacities and tendencies which characterize the individual and largely determine his habitual manner or pattern of behavior. The nature or design of the personality is determined by two contributing elements. One is the organic, determined by inheritance and the other prenatal factors and manifested by racial and family characteristics. The other element is individually determined by postnatal influences and experiences, particularly those that result from the individual's attempt to adjust himself to the life he has to live. Personality, therefore, is the sum of characteristic traits which are consistently peculiar to a given individual.

Summary

1. Many mental phenomena can be explained only on the assumption that unconscious as well as conscious processes take place in our minds.
2. The unconscious exercises much influence on the mental life, modifying thoughts and beliefs and determining many behavior reactions.
3. Part of the unconscious, the racial unconscious, is derived from the experiences of man as a biological species. Another part, the personal unconscious, is derived from the experience of the individual; while many incidents and emotional experiences have been pushed out of his memory they continue to exercise great influence upon his thinking and doing.
4. The personality is the general pattern of one's makeup and of the characteristic manner in which he reacts as determined by hereditary influences and the particular ways of thinking, feeling, and doing which he has habitually established in dealing with the experiences and problems of life.
5. In psychiatry we are especially concerned with the organic and psychological factors and influences that have made the individual the person as we know him, with the manner in which

his happiness and social adjustment are disturbed by being the type of person he is, and with the ways by which unwholesome tendencies of his personality may be so modified as to promote his happiness and efficiency and facilitate his adjustment with other persons.

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CHAPTER III

MENTAL MECHANISMS AND MOTIVES

Dynamic Psychiatry. During relatively recent years psychiatry has advanced from a description of symptoms of mental disorder to an attempt to explain the cause, meaning, and purpose of symptoms and of other disturbed personality manifestations. This advance has been made possible by the development of what is often spoken of as a dynamic psychiatry, i.e., a psychiatry based on the assumption of cause and effect in the origins and manifestations of behavior. Progress has been largely due to the increasing recognition that one's behavior, whether of a highly socialized and useful nature or so fantastic and disregardful of reality that we call it psychotic, is largely a purposive effort to satisfy inner drives and emotional needs. In the present chapter we will consider some of the methods by which symptoms and other personality manifestations are produced.

Adaptation a Universal Phenomenon. The various forms of animal life have developed special structures and functions which assist them in adjusting to the particular conditions which they must meet. Many butterflies, for example, develop a protective coloring whereby they so simulate the appearance of the surface on which it is their habit to rest that their enemies are unable to distinguish them. The camel has developed various anatomical modifications or adjustments that aid in accommodating to the physical conditions encountered. Its nostrils are in the form of oblique slits which can be opened or shut at will and thus protect its highly acute organ of smell from the clouds of desert dust; its toes are joined by means of a broad elastic pad which supports the foot and serves to buoy up the camel as it travels over soft and shifting sand; its hump is a mass of fat which constitutes a reserve of nourishment to be used when other supplies fail.

Mental Aids in Adjustment. Since adaptation is one of the most fundamental characteristics of life it is not strange that man, both

physically and mentally, is the most highly evolved species. He has not only developed anatomical arrangements that facilitate his accommodation to physical circumstances but has also evolved mental devices that assist him in dealing with the needs and problems of his inner life. These mechanisms, for example, may afford the individual a sense of security, protect his self esteem, or solve his emotional dilemmas. By acting without conscious recognition on one's part, these mental devices effect an adjustment to inner situations and experiences that would otherwise be sorely, even intolerably, troublesome. The self-conscious personality with its intense need for a sense of security and self-esteem evokes mental mechanisms of a protective nature as instinctively as self-preservation prompts protection against physical harm. The mind, by various methods, seeks to avoid, forget, or nullify whatever is troublesome. It is its task to operate in the interest of the emotional and other psychological needs of the organism just as it is the business of the body to minister to its physiological wants.

We all employ some of these mechanisms to a greater or lesser degree to supply comfort, support, or defense. A knowledge of the mechanisms which the mind may adopt will deepen one's understanding of human behavior and should lead to a clearer understanding of the forces operative in one's own life. In mental disease the operation of these mechanisms is often revealed with evident clearness. In physical illness the patient is prone to employ these various mental devices to more than the usual degree, with the result that his habitual personality traits are exaggerated or previously unrevealed tendencies are disclosed. In physical illness, too, the patient may adopt various methods designed to meet the mental and emotional problems arising directly or indirectly from his sickness. The nurse, therefore, has unusual opportunities to observe the methods by which people seek to deal with the psychological problems with which they are confronted. With the understanding of mental operations which she should thus acquire she should be able to discover how certain mechanisms have arisen, the purpose they serve in the life of the patient, and how the mechanisms involved have produced the symptoms presented. She should in some measure, too, be able to promote those methods which are favorable to mental health.

Mechanisms Influence Personality. Among the most important emotional essentials necessary for the development of a wholesome,

balanced, and adjusted personality are affection, security, social recognition, and a feeling of achievement. Some mental mechanisms if employed within certain limits may help to promote a sound personality and may aid social and cultural adaptation but if used imprudently may lead to its distortion. Other mechanisms progressively disorganize the personality. In their effort to protect or support the personality, certain mechanisms may lead one to ignore the hard facts of reality and to formulate conclusions that are delusional and therefore unsafe guides for behavior. To a large extent, therefore, our mental health is determined by the mental mechanisms we employ. We rarely recognize the mechanisms resorted to, particularly those that are unwholesome, and if their use is called to our attention we indignantly deny their employment.

Conflict. Almost universally in Nature we observe the association of mutually opposing forces or tendencies. In our bodies there are flexor muscles to bend a limb and extensor muscles to straighten it; there are a sympathetic division of the nervous system to stimulate the activities of important organs and an autonomic division to inhibit them. The successful maintenance of health depends upon the constant functioning of the two antagonists. Paralysis of either flexor or extensor muscle destroys the usefulness of the extremity; disease or injury of either sympathetic or autonomic division of the vegetative nervous system causes serious impairment of vital functions. Similarly we find competing impulses or tendencies in the mental life of the individual. We meet constantly with this duality of human nature, a conflict between a conscious, acceptable, idealistic force and unconscious, primitive inclinations. The desires of the individual, the recognition he craves, and the gratification of his instinctive drives and impulses are frequently not compatible with the attitudes, habits, and values he has absorbed from the family, school, church, and various other carriers of ethical and moral standards and traditions. There is a struggle between two antagonistic impulses—between those derived from the ethical and moral ideals of the personality on the one hand, and the selfish, instinctive, and often unconscious forces of the individual seeking for gratification of his pleasures and needs on the other hand. This dilemma in which the individual is impelled by antagonistic mental forces and irreconcilable, competing demands is known as a psychic conflict. It may be thought of as a clashing between contradictory strivings of the personality.

There are rivalries between the motivations of behavior. A part of one's self desires what is repugnant to another part; one desires something and does not desire it at one and the same time. The individual is torn between his wishes and his aversions, between his fears and his longings. If one of the rival motivating factors lies below the level of awareness and becomes unduly strong, the patient cannot by conscious effort restore the balance of motivating forces since he is ignorant of the unconscious force that has disturbed the balance. The result is that the conflict tends to destroy a harmoniously working unity of the personality; the mind becomes divided against itself and a sense of tension exists.

Repression. One of the mechanisms most frequently adopted for the purpose of dealing with a conflict and of resolving a dilemma is that of repression. Through repression aspects of the personality which should have been outgrown, and wishes, impulses, and thoughts which are incompatible with or painful to one's conscious self-requirements and self-regard, are excluded from the field of awareness and are pushed down, as it were, into the unconscious where they are held confined. Repression arises from the aversion which everyone has to recognizing in himself emotions, wishes, and tendencies which are unacceptable and in conflict with prevailing standards. Just as a child's rubber ball may be held beneath the surface in a pool of water, so repression serves to hold instinctual and egoistic tendencies and painful ideas from rising into consciousness. To continue our comparison: we find that just as the buoyancy of the ball will cause it to rise to the surface if the restraining hand is removed, so repressed desires and instinctual drives may break through in manifest or disguised expression if the repressing force is relaxed. As we shall observe later this is the process that is active in the production of some instances of mental disorder. Complete repression is no longer possible so impulses push up and secure disguised expression.

Repression is not produced by a deliberate and conscious effort of rejection on the part of the one in whom it operates. On the contrary it is an involuntary repudiation or denial, an unconscious process that automatically exercises a resisting, rejecting influence and blinds one to what is going on inside. By it we are enabled to ignore what would otherwise greatly disturb us.

Suppression. Repression must not be confused with suppression, in which there is an effort to dismiss from consciousness the memory

of unpleasant or rejected thoughts, desires, or experiences. In suppression, attention is deliberately directed elsewhere when the undesired appears in consciousness.

Origin of Prejudices. Inasmuch as repression frequently decides the conflict in favor of the ethical and moral inclinations of the individual it often assists him in adjusting to the social and cultural standards prevailing among his associates. To this extent the mechanism is a desirable one and leads to cultural progress. Unfortunately repression is not without disadvantages. The energy of inherent drives and urges is not destroyed by repression but, on the contrary, although automatically restrained, remains unchanged in quality and intensity. It is, in fact, unmodified in any respect save that the individual is unaware of the disowned strivings. Though frustrated, this energy constantly seeks discharge. To make sure, however, that the undesired awareness and expression do not occur, the mind automatically and without conscious deliberation seeks to crush the strivings, wishes, and thoughts by the cultivation and promotion of purposes and mental content sharply opposed in nature. These contrasting characteristics, designed to reinforce repression, lead to exaggerated personality traits and the formation of prejudices. Many apparently inexplicable prejudices and aversions represent the overdevelopment of reactions and traits that were originally evoked through repression. The man with a prejudice against vivisection, for example, will usually be found to be by tendency a cruel person who has repressed his disposition to be cruel. In order to guard against the arousal of this repressed tendency he professes unusual solicitude for animals and blindly refuses to see that any good can come from the investigation of disease by the practice. At the same time such a person attributes to the investigator the cruelty really belonging to his own repressed tendency. The more repressions a person has, the more prejudices and biases it will be found he develops in order to prevent the arousal of his repressed desires.

Repression and Mental Disorder. The numerous and bitter prejudices held by a certain man were frequent subjects of comment by his acquaintances. At 55 ill health made it increasingly difficult for him to maintain the repression of certain disowned desires, any awareness or expression of which his extreme prejudices were designed to prevent. Now we know that if the repression of a repudiated, unworthy desire weakens with the result that the

rejected wish threatens to become conscious, the desirer may develop feelings of guilt and depressive ideas so extreme and so without apparent reason that he is considered mentally ill. As a result of a relative weakening of this man's repressions he developed active mental disease characterized by depression and ideas of unworthiness and of self-accusation. The effort to meet the conflicts through repression, even though this mechanism was aided by the formation of prejudices, ended in failure.

Some Manifestations of Failing Repression. From one point of view prejudices, mild mental disorders, such as psychoneuroses, and also many psychoses or serious forms of mental disorder are, in but different degrees, the results of unsuccessful repression. Prejudices represent efforts to strengthen repression while psychoneuroses and psychoses result from the failure of repression. In the psychoses the repressions may be expressed in forms that quite disregard reality. An hallucination, for example, may, in the form of an imaginary accusing voice, represent the weakening repression of wishes so unacceptable to consciousness that if entertained there they would create a feeling of guilt. Remarks of normal persons made hastily, "without thinking," often betray fundamental wishes which have not been effectively repressed. In intoxication, delirium, and other disturbed mental states, repressing forces may be suspended and tendencies quite foreign to the patient's usual behavior be shamelessly expressed.

Not only may unacceptable wishes and instinctual tendencies be repressed but also memories that would wound self-esteem. In such a case repression may serve as a sort of anesthetic for mental distress. A woman, for example, suffered from a period of confusion following the murder of her own baby. She soon recovered from her confusion but continued to have no recollection of having killed the child.

Results of Repression often Beneficial. It must not be concluded from what has been said that repression is always pathological and its results are undesirable. It is a mechanism which if it operates smoothly and without undue effort may result in a well adjusted life. Should its operation require supplementary reinforcing devices such as prejudices and scruples, it may easily break down and a disguised expression of the repressed tendency appear in the form of a psychosis or as obscure and chronic invalidism apparently physical in nature. One's repressions and the manner in which he

deals with them may greatly influence his personality pattern, character traits, and general life reaction. In some instances repression and other mental mechanisms designed to deal with conflicts may result in the formation of qualities of character that are in many ways estimable. Since, however, they were formed in an effort to reinforce repression and serve as defenses against repudiated wishes and tendencies, they must be looked upon as psychopathological products, that is, they are the products of the same mentally unwholesome mechanisms that frequently lead to mental disease. Qualities of character arising in this way as defenses against repressed and repudiated tendencies are apt to be overdeveloped and be of uncompromising austerity.

The Complex. Attention has already been called to the fact that not only may tendencies and desires be repressed but also subjects of thought which would be painful if admitted to consciousness. Repression is therefore the active mechanism in the formation of the mental product known as a complex. This consists of a group of associated ideas which, because they are invested with highly troublesome emotional feelings, have been repressed. Although such a group of associated ideas and their attached emotions is repressed it does not cease to exist, with the result that the latent tension in the emotionally toned memories, strivings, and tendencies of the complex may be touched off by some apparently insignificant remark or experience and manifest itself in various forms. In persons not psychotic a not uncommon manifestation of the complex is in the form of an exaggerated reaction or sudden outburst of emotion touched off by a slight stimulus. Such emotional storms and disproportionate reactions to trivial occurrences will usually be found to be linked up with something very personal and significant in the previous life of the individual. The following instance will illustrate how complexes may be formed and the psychic energy with which they are charged be touched off:

One day a boy of 10 asked his father for a bicycle. To the surprise of all the family, including the father himself, the parent's face became flushed, he was obviously tense, and with much exhibition of emotion he angrily informed his son that boys should not have bicycles and that no son of his might have one. It later transpired that this apparently causeless outburst of emotion had its origin in an experience occurring in the father's own boyhood. Years before, when on a bicycle excursion with a group of boys, he had committed some misbehavior as a result of which he had been

severely punished. The incident left strong feelings both of vexation and mortification; his brothers taunted him and he considered the punishment unjust. With knowledge of the boyhood experience of the father it became plain how the request for a bicycle constituted a stimulus that easily released the latent tension buried in the complex.

Not only may a complex manifest itself in such unexpected and disproportionate emotional displays but also in various character traits, mannerisms, slips of speech, or in forgetting to carry out some intended action. When one exhibiting such complex-determined behavior attempts to account for it, he will fail to recognize what has really prompted it and will explain the apparently causeless acts as matters of accident or chance. We know, however, that mental manifestations, like physical manifestations, arise only from definite causes and follow a logical sequence of events, although we may not always succeed in discovering these.

Sometimes, unfortunately, complex-determined behavior may lead to results more serious than those just indicated, as in the following instance:

Years previously Miss X, while still a schoolgirl, indulged in certain behavior any conscious acknowledgment of which was painful to her scrupulous ethical and moral sense. Later this complex was the active agent in producing a neurosis manifested by an overwhelming fear of dirt and a compulsion to wash her hands whenever she touched an object. Each Saturday she would visit the church she was accustomed to attend in order that she might wash the seat she expected to occupy the following day. Miss X was not at all aware of the fact that the distressingly toned experience of her childhood, which she had doubtless long ago repressed from consciousness, had determined her compulsive washing, that the fear of dirt was a disguised fear of moral uncleanness, and that the washing was a symbolic purification from a sense of guilt.

In many ways complexes, or repressed experiences having a strongly unpleasant feeling-tone associated with them, may by a sort of subterranean process unconsciously exert a far reaching effect on the course of psychic events and mental health.

Sublimation. We have seen that repression is a mechanism for dealing with conflicts and instinctual forces which if successful will lead to a well-ordered and socially acceptable life. As repression is in effect the overcoming and imprisonment of one force by another the energy in the repressed force is not available for constructive, directed activity. It would be highly desirable, therefore, if the

energy inherent in instinctual drives, urges, and impulses could somehow be transformed and flow with relative freedom into the conscious mind and there direct our interests and activities. The mechanism by which this is made possible and by which the primitive biological energy inherent in the instinctive drives and tendencies is modified and utilized not merely for the preservation of the individual or the race but for psychosocial adjustment and achievement, is known as sublimation. An instinctive tendency is diverted from its original aim into activities which are socially acceptable and at the same time are more or less adequate substitutions for the instinctive impulses. Instead of utilizing instinctual energy for the primitive and selfish purposes for which its evolutionary origin would naturally employ it, sublimation transforms it and directs it into such channels as art, literature, religion, science, sports, or other activities that promote progress and culture and the development of a more abundant life, both for the individual and the social group. The energy transformation by sublimation may be compared to the transformation of the hydrodynamic energy in such falls as those at Niagara where the electric generator transforms this hydrodynamic energy into electric energy that may be utilized in a thousand ways. The primitive energy of the waterfall is no longer expended in erosion or other crude forms but, refined and disguised, serves the material and cultural needs of man.

Described in somewhat different terms, sublimation may be regarded as a substitution of socially desirable interests and activities for selfish, instinctual impulses. The substitute is pleasurable yet no longer of a quality to suggest its derivation in primitive strivings. Rarely does the individual recognize that his activity, which serves the material, mental, and cultural welfare of himself and his fellows, derives its energy from forces originally developed for biological and selfish ends. The scientist engaged in research on problems of importance to the health or welfare of the entire race does not consciously recognize that his researches are but the disguised and refined expression of a pronounced, innate drive of curiosity.

Conscious Control. Upon thought it will be recognized that the mechanisms of repression and sublimation are ones that operate without awareness and that therefore their products are not the result of conscious and critical examination on the part of the individual. To make the most successful adjustment to the situations that meet us there should be no tendencies or feelings of which we

are not aware and are therefore beyond our control. The more one can learn to recognize the obscure motivations of his behavior and understand the various mechanisms of defense or escape which he is prone to adopt when confronted by difficult situations, the more he can rationally direct his behavior. So far, therefore, as one can direct his behavior by the mechanism of conscious control the more he can free himself from the blind direction of instinctual forces. The more one can consciously organize the energies within his nature, the more effective the personality functioning. Insight as to the motivations of behavior and as to the particular liabilities and limitations of one's personality tends to promote mental health. Self-guidance and self-control in accordance with the most desirable principles of mental hygiene require a discriminating understanding of the mental forces operative in one's self.

Rationalization. Although we should all prefer to believe that our behavior is the result of conscious deliberation, unbiased judgment, and a full awareness of all the motives prompting it, yet this is true to a much less extent than we realize. All too frequently we act in response to motives of which we are unaware and after the action offer various ostensible "reasons" for the action. This mechanism by which we formulate justifications to account for something that has arisen from quite different and largely unrecognized motivations is known as rationalization. Self-esteem renders one blind to motivating influences which do not measure up to the conscious estimate of what he believes his motivations should be. After one has acted in response to the wishes and motives that fail to measure up to consciously imposed standards, various ostensible reasons for the action are offered in an effort to make it appear respectable. Rationalization, then, is a device designed to maintain self-respect, yet does so through self-deception. Often our rationalizations contain a certain element of truth which, however, renders us blind to the consciously unacceptable motives that really determined the behavior. Those motives which are acceptable are selected and considered to be the only ones that have prompted us. Rationalizations are usually defended with great emotional intensity since they are created to afford psychic self-protection. If someone makes me angry I am apt to try to find a reason to prove that he is wrong and that I am right, regardless of the facts of the situation. Almost without an exception, it may be added, I will find, what is to me, absolutely convincing proof that I am right.

Multiple Factors Determine Behavior and Beliefs. Perhaps at this time, while discussing the actual reasons for our behavior in contrast to what we believe are the reasons, attention should be called to the fact that to a comparatively small extent only is either our thinking or our behavior determined solely by the contents of our awareness. The teachings of our childhood, our repressions, our desires, both those of which we are aware and those in our subconscious, as well as the thousands of previous experiences which may seem to have little or no relation to the present situation—all these have an important influence in determining our beliefs, the choice of our friends, our forms of amusement, our vocations, and other expressions of the personality.

Compensation. It is a well-known medical fact that if a valve of the heart leaks, the heart muscle increases in thickness and strength in order that additional force may be available to pump the blood and prevent the impairment of circulation that would otherwise follow. In other words the heart compensates for its defect. If from disease or faulty habits of posture a curve develops in the spine another curve above or below the first develops in the opposite direction in order to compensate for the primary one and thereby prevent a displacement of the center of gravity. In many other ways Nature compensates for disease or defect in our bodies. Similarly our minds constantly make use of the mechanism of compensation as a means of adaptation to life-conditions. We have all met persons of small stature but loud of speech and of a blustering, imperious manner which betrayed the fact that they were struggling for a recognition and sense of security which had not been normally attained because of their physical handicap. Methods of enhancing self-feeling may vary from the simple "showing off" seen daily on the school playground or in the pretentious display of Peacock Alley, to the formation of delusions of grandeur. Discordances between a person's strivings and his ability for accomplishment may lead to compensations.

The nurse will not rarely observe that disease or deformity which thwarts the patient's normal ambitions leads him to wishful thinking, namely, to thinking in which representations or conclusions are determined more by desires than by the facts of logic and of reality. Frequently such wishful thinking sufficiently satisfies a patient's emotional needs, yet in extreme cases the underlying needs lead him so to disregard reality that delusions are formed.

A boy who was so tall, angular, and ungainly that he had always been extremely self-conscious enlisted in the Army. (Probably without consciously realizing it his enlistment was prompted by the fact that the military uniform and a certain amount of glamour connected with military life seemed to offer hope of relief from the sense of inferiority produced by his figure which stood out so unpleasantly in contrast to that of others.) Because of his clumsiness on attempting to execute the various drills he became an object of raillery by his more apt associates. After having struggled in vain for adeptness the boy was placed in the "awkward squad" where he naturally felt even more self-conscious and more painfully aware of his deficiencies. The indignity suffered by his self-esteem was too great; the needs of his personality for recognition and for a sense of security exceeded its limited resources and he therefore constructed a fictitious substitute by developing the belief that he was a major general. He was no longer the awkward soldier unable to compete with his associates but was their commander and directed affairs of great military importance. The compensatory delusion satisfied the recruit's emotional needs but destroyed his usefulness for the realities of military life and necessitated his hospitalization.

A feeling of being unwanted, unloved, or disregarded may lead to feelings of insecurity which may be covered by a marked desire for independence, a driving ambition, or by self-assertive and self-righteous attitudes.

Reaction-formations. The mechanism of compensation often participates in that mental process by which a person becomes blind to undesirable natural leanings of his own personality and develops qualities of a contrasting nature. A character trait, the reverse of that which would ordinarily have followed from such unfettered tendencies, one developed to restrain and conceal these repressed inclinations, is known as a reaction-formation. Overstrict character traits are often reaction-formations developed as defenses against disowned tendencies, desires, or drives. Closely allied are special attitudes which one may entertain toward certain persons. Feelings of rejection or of hostility, for example, may be disguised by scrupulous politeness or effusive expressions of gratitude. Intense jealousy of a more talented sister may lead a girl to bury her hatred beneath a reaction feeling of extremely solicitous sisterly love. Such an overcompensation often serves to appease a sense of guilt.

Symbolization. Symbolization is a mechanism that we use almost constantly although usually we do not think of it under that name. By this mechanism an idea, quality, or object is represented by a meaning-bearing sign. As citizens we pay particular respect to the

flag of our country. The flag is intrinsically nothing but a piece of cloth with certain colors and marks on it. Of itself it is very little but as a symbol it stands for something else which is very different: it represents our country and arouses sentiments of loyalty. The nurse's cap serves no useful purpose as an article of apparel. As a symbol, however, it signifies the profession of the wearer, a technical skill devoted in a spirit of kindliness and sympathy to the relief of suffering along with other qualities and aims that have come to be associated with the ideals and traditions of her vocation. To a large degree art consists of the symbolic portrayal of the emotions, wishes, and struggles common to all mankind. In his creation the artist symbolically represents not only his conscious ideas and feelings but frequently, without being aware of the fact, he expresses the problems, desires, and tendencies of his inner life. In normal persons, and particularly in persons suffering from mental disorder, ideas and strivings that have been repressed reappear in consciousness in the guise of substitutes, namely, in symbols. These symbols, appearing in the content of dreams, hallucinations, and apparently meaningless ideas, give expression particularly to those contents of the patient's inner life with which much feeling is connected. As the medium of expression they reveal in disguised form the conflicts and complexes that are playing an important part in the deeper mental life of the individual. Symbolization may be thought of as the language of the unconscious.

Projection. It is not uncommon to observe persons who severely criticize in others the very same faults which are the weak points of their own character, utterly failing to recognize that they themselves exhibit the rejected qualities. This mechanism, by which deficiencies, wishes, and motives which one possesses but may not consciously acknowledge as belonging to himself, are disowned and attached to others, is known as projection. What one sees in others is often but a mirror image of one's self. If a person has desires that he may not acknowledge even to himself, projection may be employed to exclude the rejected wishes from conscious awareness and thus make him more comfortable. He attaches to others the qualities he cannot or will not accept as a part of himself. The attitudes he imagines he sees in others are really his own. By attaching our own rejected qualities and tendencies to others we escape self-reproach and feel free to criticize and condemn such weaknesses.

A feeling of guilt may be effectually pushed aside by developing the mechanism of projection. By this mechanism another person, often an alleged persecutor, becomes the one who entertains the repudiated wishes or is guilty of scandalous misbehavior. The one who is in this way relieved of a sense of guilt often betrays, by an air of self-satisfaction, his conviction that he is not as other men.

Since through the mechanism of projection others come to represent and personify the desires, qualities, and tendencies which he consciously hates and repudiates, the individual sees hostility and injustice in the attitude of others toward him. As a result of this process he develops socially embittered attitudes and is apt to feel that he is hated by those around him. Other results of the mechanism may be excessive criticism, irascibility, pessimism, sarcasm, cynicism, prejudice, intolerance, hatred, brooding, unreasonable jealousy, and unjustified suspicions and accusations—characteristics which naturally often produce estrangement of family and friends.

When the need for self-protection against disowned impulses and motives becomes very great they may be projected either in the form of delusions, particularly delusions of persecution, or in the form of imaginary perceptions, viz., hallucinations. The hallucinations are frequently those of voices which accuse or threaten the patient. Projection is a defensive process which, by shifting responsibility and promoting self-respect, tends to make the individual more comfortable, but at the cost of warped attitudes and unhappiness on the part of the projector, and of injustice suffered by others.

Identification. In the mechanism known as identification we deal with a method which in certain respects is the reverse of projection. In this mechanism we do not make ourselves more comfortable by attaching our rejected characteristics to others, but by first establishing an emotional tie with another we so blend our personality with certain characteristics of his that we feel ourselves in his place, as it were. The qualities and purposes of the second personality are felt to be our own. In the successful play the members of the audience identify themselves with the character whom the actor impersonates. The servant of a distinguished personage may identify himself with his admired master and thereby acquire a gratifying sense of superiority. The exaggerated sympathy sometimes shown by one person for another (even at times when the second person is charged with some re-

pugnant offense) results from identification—a certain unconscious sensing of a common quality shared with the second individual. Through this identification one may vicariously satisfy some desire, any fulfilment or even conscious recognition of which would not be knowingly permitted.

In a somewhat different type of identification the image held of one person and the emotional attitudes directed toward him are transferred to another who comes unconsciously to represent the first. In this way are to be explained some of our apparently causeless likes and dislikes of persons whom we have unwittingly identified with someone who had once aroused similar emotions. We may have an irrational dislike for a certain person because he looks like someone who hurt our feelings in childhood.

Stages of Personality Development. During the early part of a child's life his interests are centered on the satisfaction of his own needs and pleasures. He is concerned with himself and his own person. Then follows a period marked by self-consciousness and phantasy and perhaps by conceit. The child next passes from a stage characterized by limitation of interest in itself to one which includes others of the same sex. At this time the child begins to appreciate sex differences and finds little of common interest with the other sex, and is often inclined to avoid its members, toward whom he feels a certain superiority. If it imitates those of the opposite sex it is called a "sissy" or a "tomboy" by other children. This stage is typically exemplified in the "crushes" between girls in the early adolescent period. Unless unduly prolonged or accompanied by the development of a tendency toward the psychological characteristics and traits of the opposite sex, it is a period of normal, healthy growth. From this period the individual passes on to normal, adult interests when he selects persons of the opposite sex as the natural objects of interest and love.

Fixation. Concurrently with this development of that aspect of the personality concerned with the character of love objects there should be a development of the individual's interests and desires, of the methods of thinking, of meeting difficult situations and the frustration of wishes, and of the control and expression both of emotions and instincts. As the personality and its interests evolve through these various stages, those aspects and stages which no longer operate for its growth should be left behind just as a child discards toys which he has outgrown. Unfortunately, the develop-

ment of some aspect of the personality may be halted at an incomplete stage of its evolution with a resulting persistence of certain incompletely matured components. Just as the child may continue his baby talk and remain dependent on his mother beyond the period when these characteristics should have been outgrown, so phases of his personality development may be arrested at various stages. The individual may be so well satisfied with the arrested stage of some aspect of his personality; it may give him so much pleasure, that its normal development ceases or lags behind other aspects. Emotional organization remains at an immature level, and the individual is handicapped by attitudes which have not been outlived and do not properly correspond with adult needs. This arrest of interests or of personality evolution at an incomplete stage of development is known as fixation.

One of the most important problems of personality maturing is concerned with the emancipation of the child from the binding influence of the parent. This persistence of child-parent ties and of a parasitic clinging through fixation is usually due to the selfishness of a parent, most frequently the mother, who strives to keep the child a part of her personality with the result that the child as he approaches adulthood fails to transfer interest to one of the opposite sex. This arrest of psychosexual (i.e., the emotional, dispositional aspect of sex) development of the personality at a stage—the so-called homosexual one—when deep-seated but often unrecognized inclinations toward those of the same sex continue to exist, may lead to serious psychological difficulties and jeopardize mental health.

Regression. We have just considered how the progress of development of certain aspects of the personality may be held back by fixation with the result that its complete and harmonious development never occurs. By another mechanism known as regression the personality may suffer a return from a higher to a lower level of adjustment and of expression. Regression is not a wholesome mechanism of adjustment and does not promote a desirable adaptation. A simple illustration from everyday life will, however, indicate its general method and direction. We have all met people who when well are adaptable, self-reliant, and amiable. When physically ill they are, on the contrary, irritable, dependent, tend to indulge in fancy, require humoring, and are described as childish. Such persons adjust easily to reality and deal effectively with

it as long as they are well, but the added burden of ill health disturbs this ability and they tend to return to the behavior patterns of childhood. Temporarily they have, to a slight extent, returned to the interests and behavior that characterized an earlier stage of personality development. Aspects of the personality which had been outgrown reassert themselves and render the individual less well adapted than formerly for meeting the realities of life.

Extreme forms and degrees of regression result in a serious disorganization of personality and lead to a type of behavior that is so far from the general average or normal that the mechanism constitutes an important part of one of the most serious mental disorders—schizophrenia. Regression may be considered as resulting from an inability on the part of the individual to deal adequately and openly with the various problems of his mental life, including those arising from outside himself and particularly those arising from his inner mental life—his conflicts, instinctual drives, and emotional needs. Unable to deal with the problems and difficulties which beset him, the individual retreats to an earlier phase of his personality development. Mature methods of adjustment are dropped in favor of outgrown and easier ones.

The following case illustrates an unusually simple instance of regression:

> Although rather sensitive and shut-in by temperament, the patient prior to young womanhood had apparently not been strikingly unusual. Perturbed at that time by a sense of guilt and by an increasing intensity of certain conflicts, there was a withdrawal from social contacts and a marked tendency to preoccupation and moodiness. After a period of inner struggle there was an indifferent sinking of her interests, activities, and personality functions to a level comparable to that of childhood. Now a middle-aged woman she has for many years lived in a psychiatric hospital where her interests are limited to her doll which she cares for with great solicitude, talking to it in a high-pitched childish voice. Her manner, her behavior, and her language are all childish. Her mental energy is no longer expended in dealing constructively with reality but is directed toward simple, stereotyped interests, similar to but less varied than those of childhood.

The untidy excretory habits, the postures, and the symbolic behavior of many schizophrenic patients indicate a profound regression. In regression there is never an identical re-establishment of the earlier personality although much that is comparable or related is observed. Such a sinking back to the level of childish or infantile activities may be because the earlier period was the

only satisfying one in the life history of the patient. Again the regressive behavior may be because he is suddenly overwhelmed by the pressures and torments of more adult responsibilities and demands.

Phantasy. In mental health the freely wandering thought of imagination promptly corrected by reality plays a useful part in constructive thinking. If, however, undirected thinking is not restrained by the demands of reality, but provides a pleasurable escape from these demands such musing is known as phantasy. Through phantasy there is provided the illusion of fulfilment of wishes that cannot be satisfied either because of the obstacles of reality or because self-imposed standards of behavior forbid actual gratification of strivings and wishes. Often these strivings and wishes are of a character such that directed reflection on them would scarcely be permitted. Circumstances too painful or too burdensome to be faced with reality are remedied or obliterated by such thinking. Phantasy, then, is an escape or defensive mechanism offering either an illusionary release from unsatisfying reality, or an imaginary satisfaction of wishes of which any actual gratification has been forbidden by repression. Because so seductive and so satisfying in itself phantasy tends to deter or to serve as a substitute for directed effort at adjustment to the actual realities of life. Phantasy is often an index of the conflicts and unsatisfied desires of the individual. Not infrequently one will observe children sharing their activities with imaginary companions created by phantasy. Much feeling is often attached to these activities which tend to be patterned by the emotional needs and problems of the child. Play based on phantasy may reflect parental attitudes, particularly disciplinary attitudes and the child's reaction to them.

In this chapter we have discussed various methods by which the human personality attempts to repair its defects, meet the demands of life without and instinctual drives within, attain a sense of security, preserve its self-esteem, and satisfy its various emotional needs. Striking or erratic attitudes, beliefs, and behavior as well as the reactions of the psychotic may be explained and formulated in terms of these mechanisms. In the exaggeration, deficiency, or distortion of these mechanisms is to be found the explanation of many mental disorders. They tend to operate beneath the conscious, purposeful life, yet with some thought as to the individual's personality problems and limitations. They

may often be recognized and therefore guided and corrected in ways that promote mental health and wholesome personality growth. More often perceived in others than acknowledged in ourselves, an acquaintance with these mechanisms should promote a more understanding and tolerant attitude toward the efforts—sometimes irritating and unpleasant—of persons struggling, perhaps ineffectually, with the problems of their inner lives.

Summary

1. Adaptation or adjustment is one of the most fundamental characteristics of life.
2. Man has developed various mental devices that assist him in dealing with his emotional needs and problems.
3. These methods of thinking, feeling, and reacting which people use in an effort to make life more tolerable and comfortable are known as mental mechanisms.
4. One rarely recognizes that he is employing these mechanisms yet they are important factors in determining what kind of person one is.
5. Since we usually do not recognize that we are employing these mechanisms or realize their significance or purpose, there is danger that they may be used to an unwholesome degree and create undesirable personality characteristics.
6. Mental mechanisms that are defensive or reality-evading in nature are apt to interfere with the development of a wholesome, balanced, and well-adjusted personality or even disorganize the personality to the point of mental disease.

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CHAPTER IV

PERSONALITY TYPES

Temperament and Ways of Classifying It. Whether certain types of physique or body-build tend to be associated with certain psychological bents, dispositions, attitudes, and types of personality has not been clearly established. Some psychiatrists believe there is a correlation between physical and psychological characteristics, but there is no unanimity of opinion concerning this. It is agreed, however, that, in respect to temperament, personalities may be classified by types. By temperament is meant the special quality which the individual's general feeling-tone imparts to his personality. It is his inherent and prevailing spirit or life mood, is peculiar to the individual personality, and is probably determined largely by the nature of the general biochemical processes of the body, particularly as they are influenced by the endocrine glands and the vegetative nervous system.

Temperaments may be considered with reference to their tempo, i.e., with reference to the relative speed and the degree of evenness of the individual's mental processes and of his activity. One's mental tempo is closely related to the state of his mood, habitual feelings, or, as it is technically known, *affectivity*. From another standpoint temperaments may be compared as to the degree of sensitiveness or of dulness or coldness in feeling or affectivity. They also may be classified as to relative cheerfulness or sadness. We shall presently see how certain types of temperament exhibit characteristic degrees of tempo, of cheerfulness or sadness, or of sensitiveness or coldness.

Temperamental differences have long been observed with the result that there have been various classifications, the oldest known being that of Hippocrates (460–359 B.C.) who classified them on the theory that there were varying proportions of four liquids—blood, phlegm, black bile, and yellow bile—in the body. He believed that as one or another of these four preponderated, the

individual would be of the sanguine, phlegmatic, melancholic, or choleric temperament. Although the theory on which such a classification was constituted was long ago shown to have no basis, yet in popular description the adjectives are still used. A classification that harmonizes well with observed personality patterns and their accentuations as observed in certain psychoses to be considered later divides temperaments into cyclothymic and schizothymic or schizoid types.

The Cyclothymic Temperament and Its Varieties. The cyclothymic (derived from two Greek words meaning "circle" and "emotion," thus indicating a tendency of the emotions to move in circles, i.e., changes in the character of the emotions follow one another in rotation or alternation) type of temperament is characterized by the prominence of mood and tempo as features of the personality. There is a natural inclination toward cheerfulness or dejection of spirits. The tempo of the personality varies from liveliness to sluggishness. There is a consistent relationship between the mood and the tempo of the personality. The cheerful cyclothymics are usually lively whereas those who tend to be melancholy are slower and more placid. While some cyclothymics are dashing and enterprising and others are staid and phlegmatic, yet for the most part both tend to be occupied with their surroundings, to live in the present, to be of an open, direct, sociable, kindly nature, usually with a sense of humor. Not rarely the individual shows apparently causeless fluctuations in mood and activity, being gay and active today but gloomy and sluggish tomorrow. If the cyclothymic individual develops mental disorder (if uncomplicated by toxic or organic disease of the brain), it is characterized by disturbance of emotion or affect. Manic-depressive psychosis, being in many ways but the cyclothymic personality exaggerated to a pathological degree, is therefore the type of mental disease which persons of this type of personality are prone to develop.

Hypomanic Temperament. Persons of the cyclothymic temperament tend to be either hypomanic or melancholic. Those of the hypomanic type are pleasure-loving, cheerful, vivacious, and sprightly, usually with sustained, buoyant, confident, optimistic, aggressive, perhaps exhilarated reactions with a certain urge to occupation. Some are boastful, argumentative, domineering, and

hypercritical. They are often bustling and full of plans, but their enthusiasms tend to be fleeting. They have a ready excuse for their failures and can often talk themselves out of any difficulties in which they may be involved.

Melancholic Temperament. Individuals of a contrasting or melancholic type of cyclothymia are usually kindly, quiet, submissive, unassuming people, inclined to grieve, to experience little of the normal joy of life, and tend to be self-depreciatory and easily depressed. They are often tender-hearted, overconscientious, pessimistic, take their work seriously, express feelings of inadequacy, and are easily discouraged under new conditions. As one expression of their inherent feeling of insecurity they may be hesitating, cautious, anxious, and find it difficult to make decisions. They are poor leaders, but often faithful, industrious, dependable followers.

The Schizoid Temperament. Like the cycloid, the *schizothymic* or *schizoid* temperaments present a sliding scale as to their feeling-life. Whereas at one pole the cyclothymes were jolly and at the other were sad, one extreme of schizoids shows a sensitiveness in feeling and the other a coldness.

The temperamental characteristics of the sensitive schizoid are often exhibited in childhood and become increasingly marked in adolescence. This sensitive plant is often teased by other children who look upon him as "queer." In school or college he rarely takes part in rough-and-tumble games but strives for a sense of security through success in studies. The teacher often points him out as a model of behavior. He chooses subjects of an abstract, perhaps philosophical, nature rather than those of a concrete, objective type, such as engineering. Those who have had cultural opportunities often show a rare aesthetic taste, gentle manners, and a degree of avoidance of the gross and common found in no other type of person. The sensitive schizoid's shyness may lead him into a world of his own from which he may seek to exclude anything that may disturb his thoughts or offend his feelings. What these thoughts and feelings may be are usually unknown to even his friends since he rarely admits others into his confidence. He feels that he is not understood by others. He may be almost painfully aware of himself and of his being "different" from others. He is incapable of emotional communication although he may des-

perately crave it in his loneliness. A few are able to transmit their daydreams into cultural values and as artists, mystics, poets, or philosophers contribute to society from their ivory towers. To some of these frail, sensitive individuals the harsh realities and frustrating experiences of life become unbearable, and they retreat into a world of psychotic phantasy.

Some schizoids with less delicacy of feeling than those described in the previous paragraph tend to be irritable, discontented, stubborn, and perhaps given to fitful moodiness. Some are reticent and reserved and present an attitude of proud distance. They usually shun competition and cannot tolerate criticism although in turn they will criticize and judge readily. Occasionally one with the rigid moral idealism not rare in the schizoid becomes an uncompromising reformer or revolutionary.

A third group of schizoids contains cold, unfeeling individuals lacking in humor and sympathy. In adolescence they may be wilful, disobedient, ill-tempered, "touchy," and lazy, resenting advice, supervision, or correction. They may shrink unhappily away into themselves retaliating, as it were, in daydreams, fancying how they might punish their alleged adversaries. An apparent self-confidence will, on scrutiny, be found to be largely assumed and to grow out of a feeling of insecurity. In an effort to bolster up this feeling the schizoid of this type may be headstrong and argumentative, or develop various other defensive attitudes and reactions that increase and complicate the problems of social adjustment. Some are dull loafers, neglect personal appearance, and disregard the amenities of life and the claims of family ties. Not rarely the cold schizoid is sullen and suspicious, a "lone wolf" who is occasionally brutal and antisocial.

While the schizoids tend to show the various gradations of feeling described above, in many one discovers a mixture of sensitive and unfeeling qualities. Not rarely, to our surprise, we find a sensitive and tender nature hidden under a cold and unresponsive exterior.

Mild Schizoid Traits Common. We have all met persons showing schizoid qualities of temperament. They are not to be looked upon as suffering from mental disease, although some of them subsequently develop schizophrenia, and in others the characteristics represent the personality change following a previous psychotic episode. Some of the traits, at least in a mild form, we meet daily

among our acquaintances. When we study schizophrenia we shall meet with exaggerations, distortions, and caricatures of these features of the schizoid temperament.

Extraversion and Introversion. It will be found, too, that people may often be classified as to the trend of their interests and the disposition of their energy. Depending on the direction of these we speak of extraversion and introversion. If it seems an inborn part of an individual's makeup that his interests and energy be directed toward objects and affairs outside himself he is spoken of as an *extravert* and his type of energy utilization as *extraversion.* The extravert is usually an energetic, aggressive, friendly, pleasure-loving individual. He is more interested in persons than in abstract ideas and therefore manifests a spontaneous, warm sociability. He deals with life through external objects, outgoing activities, and concrete facts rather than through thought or feeling. He frequently has an air of assurance and not rarely is the leader of his group. He deals with the world as he finds it and gives but little thought to any philosophy of life. In choosing a vocation he tends to select engineering or business and becomes a practical man of affairs.

If, on the other hand, the individual's interest and psychic energy flows, not outward toward objects and persons about him, but inward toward his own thought and feeling and the other aspects of his inner life, he is spoken of as an *introvert* and his type of energy utilization as *introversion.* The introvert lives within himself and does not form the free and easy contacts of the extravert. He need not, however, be selfish in the sense of regarding his own advantage at the expense of others. The introvert tends to be serious and sensitive, and is frequently lacking in vigor and directness of action. Objects and experiences are significant to him insofar as they touch the thoughts, feelings, and values of his inner life. He is often given to self-analysis and self-criticism.

Factors That Influence the Personality. The factors which determine that individuality we know as personality must be much more closely interwoven than we formerly believed. In so far as the factors that determine it are inborn, its type cannot be greatly modified. How far these are inherent in the organism we do not know. Of this, however, we may be sure, that the personality undergoes a certain evolution and that as one grows older its structure crystallizes, as it were, into forms that are relatively resistant

to change. It is quite important, therefore, that in childhood and adolescence the feeling and social aspects of the personality should undergo development along wholesome lines. Perhaps from birth these aspects have a natural tendency for development in a certain direction; if so, mentally unhygienic influences and experiences are apt to aggravate them and lead to such exaggerations and distortions of personality types that mental health is endangered. Feelings of insecurity, inadequacy, inferiority, chronic discouragement, shame, guilt, or remorse as well as jealousy, resentment, emotional conflicts, and thwarted desires may, through the need for defense or compensation, lead to an unwholesome accentuation of the original pattern of the personality. Through a knowledge of personality types the nurse will better understand her patients, and perhaps in children, at least, be able to encourage the development of such habits of thinking, feeling, and striving as will promote balance of the personality.

Summary

1. Temperament is the prevailing feeling-tone characteristic of the personality.
2. People who show a tendency to swings of mood from cheerfulness to dejection of spirits are said to have a cyclothymic temperament.
3. Those in whom cheerfulness predominates are called hypomanics; those who tend to be depressed and gloomy are known as melancholics.
4. The hypomanics also are overactive while the melancholics are slow and underactive.
5. Persons who tend to be shut-in and unsocial, to be oversensitive or cold and unresponsive emotionally and whom others feel they cannot understand, are said to be of a schizoid temperament.
6. Persons who are outgoing in their interests are known as extraverts. Those who tend to live within themselves and to be the direct opposite of the energetic, aggressive, friendly extravert are known as introverts.
7. The original type of personality may be exaggerated or distorted by mentally unwholesome influences and experiences with resulting maladjustments or even mental disease.

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CHAPTER V

THE CAUSES AND NATURE OF MENTAL DISORDERS

Difference in Causes and Nature of Physical and of Mental Diseases. In textbooks of general medicine one notes in the case of most of the diseases discussed rather definite statements as to the cause of any disease together with a description of the structural and physiological changes that take place in that particular malady. Definite causes, often clearly understood, produce definite bodily changes that may be demonstrated. The physician may say that in dealing with diseases he is dealing with an actual entity, with real bodily changes peculiar to themselves. When we come to consider mental diseases the situation is quite different. In a majority of cases one is apparently not dealing with entities, i.e., with fixed types of diseases having determinate causes, pathology, symptoms, and outcome but with unwholesome and blundering attempts to solve life problems, attempts that are unsuccessful in that they impair individual efficiency, and, in more serious cases, break down socialized adaptation. Some psychiatrists prefer to speak of these disturbances in inner situations and their effect on behavior as mental disorders rather than as mental diseases since the word disease tends to imply that there is an established derangement of definite structures and processes. Irrespective of the term applied, the problem is one of human behavior and adaptation.

Not Classification of Disease but Patient Himself Important. Textbooks of psychiatry contain certain classifications of mental disorders or diseases. While these classifications are necessary in order that there may be generally accepted designations for observed patterns of reaction, yet a knowledge of these classifications is not of great importance to the nurse. It is more essential that she realize that physical disturbances, psychological influences, and personality needs may in one case produce unmistakable mental disorder, and in another person lead to behavior, beliefs, and atti-

tudes which are short of gross mental disease, yet may influence the individual's whole outlook and philosophy of life. The more fully the nurse can appreciate the complex influences and forces that produce, now obvious mental disorder, now less dramatic results in the form of vague physical invalidism, embittered social attitudes, moods, dissatisfactions, and behavior problems, the less she will be a mere mechanical technician attending to the physical wants and comforts of her patient, and the more fully and intelligently will she realize the total needs of the individual and be able to minister to them. In this chapter we shall consider what some of these physical disturbances, psychological influences, and personality needs are which may produce burdensome character traits and at times mental disorders, shall discuss how they operate, and shall indicate the nature of the results produced.

1. Mental Disorders Due to Organic Causes. Mental disorders tend to fall into two general groups. In the first group are diseases produced by destruction or disintegration of brain tissue and also disorders caused by the action of toxins on brain cells. In these diseases due to organic causes there is an interference with the physiological functions of the brain, an impairment of the higher mental functions. In the earlier stages of these diseases, before the brain cells have suffered extensive injury, the inner equilibrium of the personality may be upset and subconscious factors produce hallucinations, delusions, or emotional disturbances suggestive of the symptoms seen in the second or psychogenic group. The disturbances in belief, emotion, and behavior occurring at this stage cannot be explained on the basis of the tissue changes alone. The particular content of abnormal belief, or the special change in mood or behavior, can be explained only by the past experiences and present needs and problems of the patient's inner life. As injury or destruction of brain cells progresses there occur, of course, a dulling of mental processes and an irreparable reduction of mental stock, often so severe that they become the predominant or single symptom.

2. Mental Disorders Due to Mental Causes. In the second group of mental disorders it has never been possible to discover any structural or toxic disturbance in the brain cells, and it is generally believed that the disorders are due to psychogenic causes, i.e., to the influence of emotional and other mental elements on the mind itself. Disorders in this group probably do not represent

a disease process but a reaction of the personality to special stresses. They represent an attempt on the part of the mind, or perhaps one should say, the personality, to adjust to troublesome mental situations, unsatisfied tensions, and baffling problems that have arisen, not rarely in part from without, but particularly from deep within the inner life of the patient.

Diversity of Unhealthy Reactions Due to Mental Causes. In addition to more or less obvious mental disturbances there is a great variety of unhealthy and maladjusted reactions that cannot be considered as mental disorders in the usual sense of the term and yet cannot be understood unless, in seeking their explanation, the same principles are applied as are employed in rendering more manifest mental disorders intelligible. The late Dr. C. Macfie Campbell * well described these unhygienic personality reactions and their motivations:

> A headache indicates a mental disorder if it comes because one is dodging something disagreeable. A pain in the back is a mental disorder if its persistence is due to discouragement and a feeling of uncertainty and a desire to have a sick benefit, rather than to put one's back into one's work. Sleeplessness is a mental disorder if its basis lies in personal worries and emotional tangles. Many mental reactions are indications of poor mental health, although they are not classified as mental disorders. Discontentment with one's environment may be a mental disorder, if its causes lie, not in some external situation, but in personal failure to deal with one's emotional problems. Suspicions, distrust, misinterpretation, are mental disorders when they are the disguised expression of repressed longings, into which the patient has no clear insight. Stealing sometimes indicates a mental disorder, the odd expression of underlying conflicts in the patient's nature. The feeling of fatigue sometimes represents, not overwork, but discouragement, inability to meet situations, lack of interest in the opportunities available. Unsociability, marital incompatibility, alcoholism, an aggressive and embittered social attitude, may all indicate a disorder of the mental balance, which may be open to modification.
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> In referring to a reaction as a mental disorder we do not necessarily mean that the condition is severe or serious. Mental disorders may be mild just as physical disorders may be. . . . Vomiting need not be due to indiscretion of diet nor to local irritation; it may be an expression of a deeply felt disgust. Headache may be caused by various organic conditions, but it may also develop when one has a disagreeable task to face or an embarrassing situation to digest. However the symptoms arise, they are apt to be woven into the life of the patient; they furnish a most potent weapon with which

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* Campbell, C. Macfie: Mental Hygiene in Industry, *Mental Hygiene,* vol. 5, no. 3, July, 1921, page 470.

to dominate a whole group. To many, chronic invalidism is a most important aid in adapting themselves to the difficulties of life, and any attempt to remove the invalidism meets with sturdy if concealed antagonism. These are disorders of personal adaptation, masquerading as physical ailments.

It will thus be seen that the range of what should be looked upon as mental and personality disorders is exceedingly wide and the manifestations are very diverse. Among them should be included many exaggerated or apparently unaccountable character traits, neurotic symptoms expressed in invalidism and other physical terms, and the extreme disturbances in mood, behavior, or belief seen in the major psychoses. The causes of mental disorder are also infinitely varied and complex—at one extreme are the obscure factors that predispose to the development of a weak personality structure, and at the other the acute emotional stress of some concrete problem too intolerable to be met except at the sacrifice of reality.

Heredity. There seems to be convincing evidence that heredity is a factor in producing, or probably more accurately, in predisposing to mental disorder. The extent to which it operates is unknown but there is an increasing belief that it has been overemphasized. Doubtless many personality disturbances which have been attributed to heredity have in fact been due to the distorting influence which the peculiarities and characteristics of older members of the family have exerted on the child.

Constitution. Undoubtedly determined in part by heredity is that exceedingly complex combination of structural, physiological, and temperamental makeup peculiar to the individual known as constitution. This inborn unity of physique and temperament was discussed in Chapter IV. Because of his special constitutional factors the individual seems prone to develop one particular type of reaction pattern rather than another. When the manic-depressive psychoses and schizophrenia are considered it will be observed that there tends to be some relation between the constitution and the form of mental disorder which may develop in case the impact of life experiences and the stress of adjustment become too great.

Early Emotional Influences. Probably many subtle emotional and other molding influences arising from the family situation and from family attitudes and patterns play a more important part in determining the personality makeup of the individual and his general pattern of life, and therefore his predisposition or resistance

to mental disorder, than does the strictly biological aspect of heredity. The existence of physical defect or disease or of other reasons that may lead the child to feel he is "different" from other children may have an unwholesome effect on personality development. It may lead to withdrawal from contacts, to resentment, overcompensations, or other reactions that constitute a favorable basis for later maladjustments or mental disorder. A feeling that he is not wanted or needed in the home may create in the child a similar sense of insecurity with results that are equally disturbing to future mental health and adaptations. Numerous other influences and experiences of the child during the successive stages of personality formation and development may be active agents in determining a distorted adult personality structure. Some of these are considered in Chapter XXVI, Mental Hygiene.

Age. The several periods of life from infancy to old age each offer special threats to emotional health. While various behavior disorders and neurotic traits arising from early psychological influences and experiences occur in childhood, yet frank psychoses are rare before adolescence. Their frequency increases sharply at that time followed by a less rapid but constant increase until senility approaches when the curve of incidence again rises abruptly. The rapid increase of psychoses in adolescence is due largely to the fact that as childhood is left behind there is an increasing intensity of conflict between the individual's emotional and instinctual life, with its urges and drives on the one hand, and the requirements of social and self-imposed standards on the other. In the student of high school or college age there may be an inability to deal satisfactorily with the unaccustomed urges of developing sex instincts, or a failure to attain a satisfying recognition and adjustment in the sphere of social life. New forces, aims, interests, and experiences during adolescence call for many new adaptations, some of which the personality may not be able to meet successfully. The involutional period brings an increase in the number of mental disorders due partly to the waning activity of physical processes, including the endocrine and the reproductive glands, but perhaps equally to a changing outlook as it is impressed on one that the zenith of life is passed and unfulfilled desires may never be realized. The sharp increase in the senium is due to the degenerative changes that may occur in cortical brain substance in old age.

Marital Status. Mental disease is much more common among the single than among the married. The development of mental disorder before marriage naturally decreases greatly the prospect of subsequent matrimony. Frequently, too, those whose emotional and other personality limitations are so great that they are predisposed to mental disorder are never sought as partners because of their obvious maladjustment. There is no reason to believe that sexual abstinence produces any physiological disturbances which in themselves tend to produce mental disorder. This is not to say that a marriage unaccompanied by normal and satisfactory biological and emotional expression may not constitute a major psychic problem in the lives of one or both partners.

There are several factors that contribute to the unusually high incidence of mental disorder that exists among divorced persons. In many cases maladjustments representing early stages of mental disorder lead to discord and divorce before the personality disturbances are sufficiently developed to be recognized as constituting mental disease. On the whole "divorced" persons represent a group confronted with emotional problems and conflicts unusual both in number and intensity. The same deeply seated factors tend to lead both to marital maladjustment and to mental disorder.

Childbirth. The mental disorders which occasionally develop during pregnancy or the puerperium are of the same general nature as those occurring under other circumstances of life. Most of them are schizophrenic or manic-depressive reactions, the form being determined by the particular constitutional and personality makeup of the individual. Not rarely the patient's delusions express hostility for either husband or child, thus reflecting a conflict about her married life or motherhood. A hostility toward the child may be expressed by the mother's statement that the child is dead, by abusive treatment, or by the exaggerated fear that something will happen to the child. Less frequently, toxic-confusional states follow from the toxemias or infections that may be associated with childbearing.

Alcohol. When the organism, probably the brain in particular, is affected by alcohol the desires and strivings of the personality are permitted to come to the surface more easily—most frequently in the uninhibited behavior of the intoxicated person, but at times disguised in the hallucinations, delusional beliefs, and disturbed emotional states of the psychosis. It would appear that some-

times both alcoholism and the psychosis spring from an inability to deal successfully with the same deeply seated but consciously unacknowledged impulses or arrest in personality evolution—at its homosexual level or aspect, for example. In such a case alcoholism is scarcely as much the cause of the mental disorder, as are both alcoholism and the psychosis different methods of dealing with the same problems and tendencies. Sometimes excessive alcoholic indulgence is one of the first symptoms of a psychotic episode and is therefore erroneously regarded as the cause. It is now known that many mental disorders associated with alcoholism are not, as formerly believed, due to the toxic effects of the alcohol itself but to deficiency in thiamin or vitamin B_1. If, as is often the case, the alcoholic largely limits his food intake to alcohol his diet may be so deficient in this vitamin that degenerative changes take place in the nervous tissue.

Drugs. Certain chemicals and drugs may give rise to mental disturbances, usually in the nature of a delirium of brief duration, although occasionally a delirious state due to external poisons may continue for several weeks. The most frequent chemical agents producing mental symptoms are the bromides, veronal and other barbituric acid derivatives, cocaine, cannabis indica, and morphine.

Injury to Head. Trauma of the head, if severe and accompanied by injury to brain substance, may be followed by delirium, by a subsequent change of personality, disposition, and mood, and occasionally by a permanent enfeeblement of previous mental capacity. The relatives of patients frequently ascribe any existing mental disorder to some accident in which a minor injury to the head was sustained. Rarely in the ordinary psychoses is there any connection between a head injury and the mental disorder. An injury to any part of the body may be followed, often after a period practically free from symptoms, by a traumatic neurosis. This sequel to an injury is characterized by physical disabilities and complaints produced through mental processes. In spite of this burden, even affliction, following from these disabilities, they are involuntarily and unconsciously developed for the sake of some advantage, financial or otherwise, that may accrue to the patient as a result of the injury.

Physical Disease and Mental Disorder. In the early part of the present chapter it was pointed out that certain types of mental disorders, particularly those that disturb consciousness, that im-

pair the patient's capacity for laying hold of and understanding the meaning of matters, or that injure memory, are due to structural or toxic changes in the brain. In the second group, described as psychogenic in origin, there is probably not any functional imperfection in the nerve tissue of the brain. It may therefore be asked if disease elsewhere in the body may not be the cause of such mental disorders. As to this one must remember that we are all biological organisms, yet that one aspect of our organism is an inner one made up particularly of thinking, feeling, and striving components having needs and satisfactions just as the flesh and blood aspects of our organism have physical and chemical requirements. These two aspects of one's organism—the inner and the physical—are inseparably interwoven. If these inner thinking, feeling, and striving aspects of the organism are harmoniously adjusted and blended (in more technical terms, *integrated*) they find expression in the form of a well-balanced personality even though the physical aspects of the organism be seriously diseased. If, however, these inner aspects lack the satisfaction craved or are in discord and constantly struggle at cross purposes, then physical disease may decrease the energy available for these inner adjustments with the result that unadjusted and discordant elements in the thinking, feeling, and striving parts of the personality may be released in the form of mental disorders.

Infections. Not rarely acute general infections give rise to delirium, and in a general way the tendency to develop delirium in case of infection measures the mental and personality stability of the patient. In individuals who only with much difficulty have been able to adjust to external situations or to instinctual, emotional, or other problems deep within their own lives, an infection or other serious organic disease may upset the equilibrium of the personality and lead to mental disorder. In such cases the type of mental disorder resulting will depend upon the constitutional makeup of the individual and the general mental patterns and mechanisms that have come to characterize his personality. The self-isolated individual who has evaded reality and been given to comforting fictions will be likely to develop a schizophrenic psychosis. The suspicious individual, inclined to blame others for his failures, will probably develop a paranoid psychosis while the individual given to waves of emotion will probably respond by an affective psychosis.

While certain other infections may cause mental disorder by producing organic changes in the brain tissue, there is none which does so as frequently as does syphilis. From 7 to 9 per cent of all patients admitted for the first time to public hospitals for mental diseases are suffering from psychoses produced by syphilitic invasion of the brain.

The theory that mental disorders are frequently caused or released by foci of infection in teeth, tonsils, gallbladder, colon, and elsewhere has not stood the test of clinical experience.

Endocrine Glands. Probably to a slight extent only do diseases of the endocrine glands act directly to produce mental disorder. Occasionally disturbances in these organs result in defects of physical development and growth that cause the individual to stand out unpleasantly from others in his appearance. This dissimilarity may contribute to self-consciousness and to feelings of inferiority or insecurity, with the result that unpleasant defensive or compensatory characteristics may be developed, and distort the personality or disturb social adjustment. Other physical anomalies or disturbances that occasionally provoke undesirable psychological mechanisms are genital deformities, clubfoot, kyphosis, cleft palate, and congenital defects of vision or hearing.

Stress of Life. Statistics show that in states where the facilities of psychiatric hospitals are most nearly adequate, one person in every twenty-two will at some time in his life be a patient in a hospital for mental diseases. With this high incidence of serious mental disorder the question may be asked if the intensity and struggle of modern life are not important causes of mental disorder. Probably this should be answered in the negative. Although the increase in number of mental patients under treatment has been greater than the increase in population, yet it does not appear that except for senile and arteriosclerotic disorders has there been any actual relative increase in major psychoses in recent years. The fact that there is a larger proportion of the population under hospital care is due to an increase in treatment facilities, to a wider recognition of mental diseases and of the desirability of their early treatment, as well as to the fact that an increasing percentage of the population lives to old age with its accompanying impairment of mental faculties. Probably more productive of mental disorder than the tempo of modern life is a narrow and restricted existence with lack of recreational and cultural activities as observed occasionally in

certain constrained individuals. Harmful factors lie less in overwork, in the speed and stress of work, distraction of noise, and the like than in dissatisfaction, insecurity, distasteful work, and lack of incentive.

Personal Factors. Among individual, personal factors that through their subtle operation tend to disorganize personality, disturb adjustment, and create unhealthy tendencies are significant experiences touching the instinctual and emotional life, painful tensions, conflicting impulses and tendencies, special emotional needs, and other unsuspected factors working beyond conscious awareness. Experiences and situations in the past, disillusionments, frustrations, and feelings of guilt may lead to disturbances in ideas, mood, and attitude. Social and personal relationships, including unhappy ones in the home, may play an important part in producing a breakdown.

Special Problems. The problems of life which the individual may have difficulty in meeting frankly and successfully are of various types but are the familiar ones of human nature. The methods—compromises—which may be adopted in an effort to deal with them may be quite dissimilar and produce varied effects on the personality. One problem which not infrequently causes difficulty is that of management of the sex instinct. The biological importance of perpetuation of the race is so great that Nature endowed man, like other species, with strong sex instinct. On the other hand, cultural demands rigidly require that any outward expression of this instinct be socially acceptable with the result that the personality may experience difficulty in harmonizing these conflicting claims and forces. Sometimes the sexual aspects of the personality never complete a normal and wholesome development with the result that they remain immature or perverse. Conflicts over masturbation may lead to emotional turmoil, exaggerated self-consciousness, withdrawal from social contacts, to feelings of guilt or of inferiority that may result in defensive or compensatory reactions, or even to misinterpretations of the outside world that become delusional. At times an atypical sexual constitution or tendency which is repressed with difficulty may give rise to inner feelings of discord and dissatisfaction which are referred to the environment and interpreted as hostility. Such feelings reflected back on one may lead to the formation of ideas of persecution. Early teachings and environmental attitudes may cause a woman to blind

herself to the existence of the sex instinct and lead her to look upon its normal promptings as destructive. While by no means confined to it there is no other topic with which anxiety and feelings of guilt are so common as that of the sex life. The intrusion into consciousness, even of the normal sex urge, may through early training create a feeling of guilt. Erotic phantasies may intrude and rouse feelings of shame, disgust, or horror that profoundly disturb self-esteem and equanimity. If repression of psychosexual impulses weaken they may produce much distortion of reality and obtain expression in various disguises. The prudish spinster, perhaps beyond the child-bearing age, may claim that she is the Virgin Mary and is pregnant through an immaculate conception, or that unknown men enter her room at night and subject her to sexual indignities while she sleeps.

Another topic that may offer difficulties relates to the sense of self-evaluation and to the recognition which one feels he is accorded by his peers. Unless a person feels that he is a part of his social group and that he has a certain security in it, and unless his feeling of personal value is reasonably satisfying, his personality may become seriously warped either through a sense of frustration or through disserviceable methods adopted in a struggle to attain self-esteem and recognition. The individual must derive a sense of support and satisfaction from the evaluation he makes of himself and from the recognition he feels he enjoys from others. If these do not satisfy one's personality needs, emotional disorders or delusional ideas may follow. In Chapter III mention was made of the soldier who was so awkward that he failed to execute military drills and in an effort to repair his wounded self-esteem came to believe he was a major general. Sometimes the individual's goals may be inherently beyond ordinary human capacity for attainment with the result that through wishful thinking and phantasy he comes to believe that he has reached goals which in fact are extravagant in the extreme. In addition to a satisfying self-estimate and a feeling of recognition one must have a sense of security as to those matters which constitute an essential part of one's life. The child, for example, who is reared in a broken home or in an orphanage where he lacks the feelings of confidence and safety which a mother's affectionate presence supplies, may develop a sense of insecurity that comes permanently to characterize the pattern of all his later life and perhaps leads to personality breakdown. A feeling on the part of the child that he is "different" may lead to shyness, sensitiveness,

daydreaming, suspicion, or other unwholesome reactions that tend to culminate in personality handicaps or even in the serious maladjustments of mental disorder.

Character Traits or Psychoses as Methods of Solving Problems. One often observes how some psychological goal, such as the need for a sense of security, of self-esteem, or of some other element necessary to personality satisfaction determines the objective toward which all the life energies are directed. The nature of the goal comes to determine the personality pattern that characterizes the life pattern of the individual, and may even lead to one so maladjustive and so distorting to the personality that the individual is considered to be suffering from mental disorder. The personality makeup, the character traits, and the psychosis, if it develops, are often but different methods of dealing with the same inner needs, are attempts to work out some solution for one's particular difficulties. If certain socially acceptable character traits, a certain personality pattern, developed in response to definite inner emotional needs of the individual, are successful in satisfying these needs then we merely deal with a socially adjusted person possessing particular characteristics. If, however, these inner needs are not satisfied by these personality characteristics and tendencies then these tendencies, characteristics, and behavior patterns, although remaining of the same general nature, become so extreme and so disturbing to the social adjustment of the individual that he is regarded as having mental disorder. The same psychological theme, as it were, runs through personality, character traits, and psychosis. The psychosis comes to have a logical place in the development or expansion of a life pattern. In such a case the psychosis, perhaps with a complete disregard of reality, represents an attempt to reach a certain goal when a socially adjusted and reality-observing pattern of behavior had at least temporarily failed. In mental disorders that have developed in the effort to meet certain personality needs one can follow the trail of the mental disease back through life patterns, character traits, and frequently to a poorly understood and badly managed childhood. Viewed in this way we see how certain traits of character have often been unwittingly developed for the sake of some useful role they play in the inner life of the individual. With most of us they play this role sufficiently well so that we need not modify reality to the extreme of a psychosis to make it tolerable and acceptable.

Other Methods of Solving Problems. It must be remembered that character traits and psychoses are not the only devices or methods adopted to attain certain psychological objectives or solve certain problems. As indicated earlier in this chapter chronic invalidism, numerous physical symptoms, and the psychoneuroses may also fulfil such a role. When one is physically ill, too, it is much more difficult to deal successfully with the deeper needs and problems of the inner personality or to maintain a balance among its conflicting tendencies. For this reason one often sees certain character traits accentuated among the physically ill, unpleasant qualities appearing, or even at times distinctly psychotic symptoms first emerging.

Repression, Conflict, and Symbolization Productive of Mental Disorder. There seems to be considerable reason for believing that much mental disorder results from the difficulty which the personality experiences in attempting to harmonize conflicting claims of the inner life. These conflicts tend to be between the ideals which the individual has absorbed from family and social standards and precepts on the one hand, and his instinctual and probably often unrecognized impulses, motives, wishes, and tendencies on the other. As a result the mind is not at peace with itself. The personality is no longer a homogeneous unit; contradictory motives impel the individual with the result that he is constantly disconcerted by unrecognized but insistent drives and urges. Normally the unacceptable motives are repressed or some harmonious compromise is effected, perhaps through sublimation. If repression and sublimation of instinctual and other rejected desires and impulses weaken, and the individual is no longer able to maintain a workable adjustment between the opposing strivings and tendencies that struggle to control the personality, then the unacceptable, repudiated wishes and drives may emerge in substitute, distorted forms so disguised that they appear meaningless. These apparently meaningless but really peculiarly significant productions of the patient, resulting from unsuccessful efforts of clashing aspects of the personality to dwell together harmoniously, often constitute the symptoms of mental disorder. Many symptoms, therefore, result from an intrapsychic conflict and express in disguised form some aspect of the struggle that is going on in the inner life of the individual. At times in their peculiarly symbolic form they may express a covert satisfaction of some highly emotional or instinctual impulse that has been denied undisguised satisfaction or even conscious recogni-

tion. Again, one discovers that the symptom indicates a repudiation of what would be intolerable to the conscious personality. Sometimes, too, the symptom may represent a compromise between selfish and instinctual impulses, wishes, and tendencies on the one hand and the demands of conscience or the limitations which reality imposes on these impulses on the other. Symbolization may, then, when the inner life is disturbed by conflicting motives, be an important mental mechanism in attempting to deal with the conflict, but with manifestations that are so striking in character or so disturbing to the patient's adjustment that he is called psychotic.

Compensation and Mental Disorder. While symbolization is one of the important mechanisms through which a solution is sought for the problems which vex the inner life of the individual, yet various other mechanisms may be employed to deal with these problems and lead to reactions or behavior which are so extreme or so maladaptive as to be regarded as psychotic. We know that bodily processes which normally operate for the welfare of the individual may, if carried to excess, produce morbid results. A wound of the skin, for example, is repaired by the production of connective tissue cells, but if, as sometimes occurs, the production of such cells does not cease when the missing tissue has been replaced, the result is an overproduction causing a disfiguring tumor known as a keloid. In an analogous way mental mechanisms designed to provide satisfactions or to protect and support the self-esteem of the individual may be carried to excess and result in symptoms to be regarded as psychotic. The mechanism of compensation may, for example, by overemphasizing opposite qualities serve to correct inadequacies and defects of the personality, give the individual a feeling of personal value, and prevent him from becoming aware of personality inferiorities. A sense of self-satisfaction and of security not otherwise obtainable may thus be provided, but if the mechanism is carried to excess it may lead to personality maladjustments so asocialized as to be considered psychotic. Delusions of grandeur, for instance, may result from a prolonged struggle for satisfying recognition.

Mental Disorder through Projection. By its method of rejecting or disowning, through attaching to others, those distinctly personal feelings, ideas, and tendencies that would serve to disturb or distress the inner self the mechanism of projection contributes to self-esteem. Never, however, a really wholesome mechanism, pro-

jection may lead to self-deception, hatred, and delusional beliefs. A man who was clearly guilty of stealing certain government property was sentenced to prison for a term of years. Later during his imprisonment he began to believe that far from being the guilty party he had been detailed to detect the persons who were stealing the supplies. At the cost of his sanity the mechanism of projection provided a defense which by attaching his unacceptable tendencies to others saved him from further distress and even afforded much satisfaction.

Mental Disorder through Phantasy and Regression. Phantasy, with its reveries unheeding of actuality, may create a new world in which the fondest wishes come true, but with a rejection of the practical facts of one's environment an acceptance of and adjustment to which are essential for effective adaptation. Regression is another mechanism that may lead to results described as psychotic. A retreat from difficult situations and personality problems occurs, the struggle to meet the demands of reality is given up, and infantile or primitive methods of thinking, feeling, and acting are substituted. Outgrown types of mental behavior are reanimated. Regression makes the patient comfortable by affording him a retreat back into a mental attitude and state comparable to some primitive stage of development before mature and self-determined adjustment was necessary.

Mental Disorder as Culmination of Customary Mechanisms and Personality. This consideration of the role of mental mechanisms in the psychoses suggests that the latter mean not so much the introduction of new mental processes as the disclosure of processes that were already operating unseen, that the psychoses are the final results of processes and tendencies that have long existed. One's mental health depends largely therefore upon the wholesomeness of his thinking and feeling and upon the methods which he habitually adopts in meeting the many emotional needs and stresses that life brings, in other words, upon mental hygiene. The individual's habitual manner of reacting in the various spheres in which life requires adjustment largely determines his mental health. The mental disorder is often the unfolding of a life-pattern. Attitudes which have been subtly developing for years in response to deeply seated psychological and personality needs have become intensified until they impair the individual's adaptation and he becomes a disturbed and unadjusted member of the family and community.

Thus there is a close relation between the patient's symptoms and the methods or patterns of his previous adjustments. As the nurse studies the histories of her patients she will often discover many facts indicative of long-standing maladjustments which progressed logically into the more serious maladjustments expressed in the form of the mental disorder and its symptoms.

Mental Disorder an Effort to Deal with Troublesome Problems and Needs. The point of view concerning mental disorders presented in this chapter suggests that both the minor psychoses, and the major psychoses that are apparently free from toxic or destructive brain changes, should not be regarded as "diseases" in the usual sense of the term but as modes of reaction to inner problems and dilemmas or to situational stresses and difficulties—as miscarriages of the patient's attempt to find a solution for his problem. It is usually not a matter so much of diseases and their symptoms as it is of people and their troubles. With the exception of those instances in which toxic or structural changes in the brain interfere with its physiological functions in a manner comparable to what follows when similar changes occur in other organs, the symptoms of mental disorder represent efforts on the part of the individual to satisfy or establish compromises with the needs and purposes of the personality, but with methods and results that lead to social inadequacy or maladjustment. Like more narrowly organic manifestations, such as fever, inflammation, and many other morbid processes of the body, mental disorders are defensive, protective, and reparative in purpose but since they deal with the feeling, thinking, and striving aspects of the organism they are in response to and concerned with what we call the inner or psychic life of the individual. This does not mean that the symptoms are consciously purposive efforts on the part of the individual to deal with the troublesome problems and needs of his emotional, instinctual and mental life—of his personality. Practically never is the individual aware of the purpose of his disordered behavior or beliefs. Rarely, in fact, does he recognize that his behavior or beliefs are in any way disordered. Usually if he did realize the need for his symptoms and their function in his life he could deal with the situation more rationally. Since, however, it is one of the functions of mental life to protect the conscious personality from painful or humiliating awareness, the individual successfully "resists" any efforts to inform him.

Causes of Mental Disorder Complex and Individualized. From what has been said as to the nature of mental disorder and the role it may play in the inner life of the individual it will be realized that its causes in any particular patient may rarely be regarded as simple. Mental disease like the behavior of the so-called normal person is the resultant of all the various forces acting upon the personality, the product of all the influences that have created and molded it. Among them are constitution, or the sum of the bodily and psychical qualities that have been received by heredity, together with the physiological state of the body, including the brain particularly. Of extreme importance also are family influences and attitudes during childhood, significant experiences touching one's emotional and instinctual life, the methods that have been habitually employed in dealing with handicaps and difficult life situations, the deeper needs and purposes of the personality, and the degree of success and harmony that follows attempts to reconcile conflicting factors and forces many of which operate below the conscious level. A successful search for the causes of mental disease, then, requires the maximum knowledge possible as to the personality of the patient, the variety and intensity of the influences that have molded it, and the concrete problems that have beset both his deeper and his conscious life. The psychiatrist attempts, as far as possible, a systematic scrutiny of the patient's hopes, sorrows, fears, and desires. He looks upon his patient, not as suffering from an impersonal disease process, but as a human being with problems of a highly personal nature.

Most mental disorder should therefore be regarded not as the result or expression of some "disease" but as a failure to meet the test of life, as a mode of behavior or of living that is the logical, although socially maladjusted, outcome of many contributing causes. Among them are the particular individual's hereditary endowment, the molding influences of his home, the special traits of his personality, the habits he has formed, the stresses and the problems that spring from deep within his emotional and instinctive life, his ability to meet these strains, and any bodily ailments that may impair the integrity or efficiency of his biological organism.

Line between Mental Health and Mental Disease Not Distinct. It is difficult if not impossible to define exactly any criterion of mental illness. The distinction between mental health and mental disease may at times be arbitrary. There is a widespread tendency

to look on those who have nervous or mental symptoms as being somewhat different in their essential organization from the so-called normal person. This is by no means the case, however. The nervous or mental upset simply reveals the problems common to all humanity and, in extreme degrees, the methods which to some extent we all are prone to adopt in dealing with them. We have learned much from our mental patients, especially as to those factors in the human personality which we usually succeed in repressing or ignoring but which still exert a great influence; facts as to the instinctive basis of human life and the profound influence of early experiences. A person's behavior, both that called normal and that called abnormal, is an expression, a revelation, of the forces lying behind it.

Summary

1. Mental disorders fall into two general groups: one group is due to structural or toxic disturbance of brain cells; the other group, produced by unwholesome mental influences and emotional conflicts, represents efforts on the part of the patient to satisfy or establish compromises with the needs and problems of the personality.
2. Formal classifications of mental disorders are of little importance since personality disturbances are not disease entities; of far greater importance is a recognition of the specific influences and experiences which in the particular individual have led to personality maladjustments and impaired social adaptations. The emphasis, therefore, should be on the patient as a person whose total life history must be studied as well as his mental and physical capacities in order thereby to understand his problems. With a knowledge of these facts one seeks to promote more wholesome, realistic, rational, and socialized methods in dealing with these problems.
3. Of varying importance are such factors as constitution, age, alcohol, drugs, trauma, and physical disease including syphilis and other infections.
4. Usually of greater importance are early emotional influences, difficulties in management of instinctive life, faulty thinking habits, feelings of insecurity, conflicting impulses, frustrations, undigested memories, feelings of guilt, unsatisfying self evaluation, and other disturbing experiences of the inner life.

5. In brief the causes of most mental, or better, personality disorder are the problems common to all humanity.
6. To a large degree the difference between mental health and mental disease is the difference in manner with which these problems are met, whether by methods that are constructive and promote adjustment with one's associates, or by such habits of feeling, thinking, and doing as disorganize the personality, disturb adjustments, and result in distress to oneself or others.

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CHAPTER VI

SYMPTOMS OF MENTAL DISEASE

Symptoms Have Meaning and Purpose. The symptoms of mental disease were formerly thought of as disturbances of different mental processes. We now know that the mind is not a collection of more or less independent functions or faculties, such as memory, will, association, etc. Although for convenience in discussing mental diseases we speak of disturbances of perception, memory, emotion, and so forth, as if they were disturbances of isolable capacities, yet such is not the case. These so-called disturbances are simply certain aspects of the personality's attempt to deal with various problems of the individual's inner life. (At least this is the point of view which most psychiatrists now prefer, except in those cases where toxic or organic changes in the brain interfere with the activity of the cells of the brain cortex just as injury to kidney cells interferes with the secretion of urine.) Through these symptoms the individual may be attempting to meet or to express various needs or purposes that intimately touch his inner life or they may represent attempts to reconcile conflicting desires. The symptoms often serve as clues to problems that are troubling the patient and indicate the way he is trying to meet them. They often give hints, too, of aims and strivings so deep in the patient's mental life that he is not aware of their existence. Repression usually locks up in the unconscious such wishes and strivings as are not permitted to appear in awareness. When, however, this is not successful a resort is made to compromises which find expression in the symptoms.

Although symptoms may be regarded as an outer portrayal of inner personality tendencies, yet it is not always easy to understand their meaning. To do so one must retrace the life history of the patient who shows them, have knowledge of the influences and experiences to which he has been subjected, study him and his personality needs, and seek to discover the meaning and purpose the symptom is playing in his life scheme. The meaning of symptoms cannot

be understood except in the light of the total situation in which they have originated and developed, including the experiences of the individual's inner life. Frequently they represent the results of various protective and safety devices adopted in order to serve the ends and aims of the personality. Among the purposes they serve are fictitious fulfilments of wishes, escapes from unpleasant situations, and various other functions related to the problems and purposes of the personality concerned. In many instances symptoms represent ways of behavior having for their purpose an evasion of the tasks and demands of life but without an accompanying loss of self-esteem. At times they may be the last desperate devices for dealing with anxiety or feelings of guilt. Through the fragments of information revealed by his symptoms the psychiatrist seeks to read the riddle of the patient's inner life. Not rarely insidious alterations of the patient's thinking, feeling, and acting are not recognized as mental illness until some stressful combination of circumstances releases symptoms of severe intensity.

Disorders of Perception

Definition of Perception. Since one of the mental expedients to which the personality may unwittingly resort in its attempt to deal with the problems and express the emotional and instinctual needs of the inner life is a disturbance of perception, it is first necessary to make clear what is meant by perception, then to consider some of its disturbances. Let us assume that there is an object on the table before me; I look at the object and recognize it to be a watch. The process by which the watch affects my visual sense and enables me to become aware of it is known as perception. I say that I perceive the watch. The process really consists of two successive steps. The first step in this process takes place at the physical, physiological level of the personality whereas the second step takes place at the psychic or mental level. In the first step waves of light reflected from the watch fall upon the ends of my optic nerve spread out in the retina in a manner exquisitely adapted for stimulation by waves of light. The impulse passes along nerve tracts to a certain area in the brain where it initiates the second step, a complex series of events whereby previous experiences, associations, and memories are revived and contribute to the interpretation of the impulse. Through this interpretation of the impulse the perception is completed and I become aware of the watch. The first step is a

physiological process involving a special sense organ and the nerve tracts associated with it. The second step is a mental, an ideational process in which the impulse is interpreted according to my previous experiences and interpretations.

In the same way impulses transmitted from the receptive ends of other special sense nerves to particular areas in the brain are likewise mentally interpreted, or the individual is said to perceive the object which produced the impulse by stimulating a sensory nerve. I may put the watch to my ear and the sensation created by the stimulation of my auditory nerve fibers prompts ideational processes and I have an auditory perception of the watch.

Imperception. Patients with mental disease not infrequently suffer from disorders of perception. One of these disorders is imperception, a partial or complete disability of perception observed in toxic and infectious psychoses and in cases of inadequate blood supply to the brain, as in cerebral arteriosclerosis. In this disorder the sensory nerve ending is stimulated and the impulse is transmitted to the brain but the sensation is not assimilated into consciousness. The physical or sensory part is carried out but the ideational or mental part is lacking. In such cases objects and events seem indistinct or incomprehensible. The patient is perplexed, bewildered, or confused. He either does not understand questions or fails in the effort until they have been repeated several times in a vigorous manner.

Illusions. In confused, toxic states due to poisons ingested or to infection, perceptions may be misinterpreted because the sensory stimuli and impressions are not sharply defined. Again, even in the absence of any toxic condition, misinterpretations may occur because of the influence of emotional states, ardent wishes, or instinctive urges. Such misinterpretations reflect some deeply felt emotional state, produce a deceptive fulfillment of some unsatisfied desire, contribute to the satisfaction of some compelling drive, or contribute to some other need of the personality. A patient depressed because of a subconscious sense of guilt may interpret the rustling of leaves as reproaching voices. Such incorrect, falsified interpretations of perceptions are known as illusions. Strained expectations or fears predispose to illusional interpretations. The normal mind may at times misinterpret what is perceived but the error is soon recognized and does not persist or influence behavior as may illusions in mental disorder. True illusions usually reflect

the prevailing mood and general mental situation of the patient, and have the same psychological significance as hallucinations, but may usually be regarded as less serious.

Hallucinations. In an illusion the image, the perception, is of some actual reality but because of the disordered state of the nerve processes or of the brain cells, or more frequently because of some tenseness in the feeling or instinctual aspects of the patient's personality, the reality is misinterpreted. In mental disorders a frequent and more serious disorder of perception consists of experiencing perceptual sensations that have no actual external cause. There is no stimulation of a special sense organ, such as the ear or eye, and consequently no impulse is transmitted along sensory nerve fibers to the brain, yet the same psychic or ideational process goes on as if a sensation were presented to the mind. As a result a perception is experienced just as would occur if some object, some reality, were actually producing a stimulating impulse. A hallucination is therefore often defined as an imaginary perception. Hallucinations are considered more serious than illusions since they represent a marked distortion of reality. As will be indicated more fully later this falsification of reality is usually for the purpose of expressing some phase of a troublesome problem existing in the inner life of the individual.

There may be hallucinations of any of the senses; there are therefore as many types of hallucinations as there are senses. The special sense in which the hallucination occurs is the one best fitted to express the particular material seeking expression. Feelings of guilt, for example, may best be expressed in spoken language, so the patient hears accusing voices. Fear of some undesirable aspect of the personality may well be symbolized by the sight of terrifying objects, so the patient sees frightful animals.

Hallucinations are more marked during the early and acute stages of the psychosis. This is as might be expected since the early, acute stage is the one when the tension of feeling, or affective tension as it is called, is greatest, when repression is failing and the struggle to find some solution for the troublesome problem is most active. Later, when through re-repression or some other suitable means a more or less successful solution is reached and improvement is therefore taking place there is less tendency to express the needs, strivings, and besetting problems of the personality in this abnormal way. Similarly if the patient becomes satisfied with the

psychosis with its socially maladjusted expressions as a method of dealing with his problems, the emotional tension and the struggle subside with a corresponding decrease of hallucinations.

Function of Hallucinations. The place that hallucinations may play in mental experiences is illustrated in the case of a woman whose love life had been much frustrated. One day as she was sitting on the banks of a river, preoccupied with her blighted hopes and seeking for comfort through wishful daydreaming, she heard the voice of a former lover who had ceased his attentions as her personality limitations had become increasingly apparent. In an hallucinatory experience she heard her former admirer with all the clearness of actual presence direct her to jump into the water from which he promised to rescue her and row her to the river's mouth whence they would sail to Egypt, there to occupy a beautiful castle. So convinced by the vividness of the message that she disregarded reality, the woman threw herself into the water where she would have perished except for some chance passers-by. A correct appreciation of her experiences would have been too distressing so she continued to believe in the reality of this hallucinated perception. Hallucinations do not always express such obvious wish-fulfilling tendencies as in the case of this woman. Frequently the hallucinations represent the re-emergence in a distorted and displaced form of repressed mental material.

Among the mental functions or purposes that may be expressed in hallucinatory form are those of criticism, censure, self-punishment, defense, promotion of self-esteem, the satisfaction of instinctual strivings, and the externalization or projection of various subconscious mental content not allowed in consciousness in undisguised form. The symbolic disguise that often conceals the real significance of hallucinations may be illustrated by the case of a man who complained of a constant odor of carbolic acid. The odor was entirely an hallucinated perception and when his full history became known it seemed apparent that the hallucinated odor of this sterilizing agent represented an attempt to cleanse his personality of certain disgusting tendencies, indulgence in which he had once permitted and by reason of which he had a feeling of guilt.

Auditory Hallucinations. Hallucinations of hearing occur most frequently. Usually auditory hallucinations are in the form of words arranged in more or less complete sentences. They vary

from "whisperings" to clearly phonated voices. Sometimes their content is comforting in nature but frequently it is unpleasant, derogatory, obscene, or accusing. That the contents should be disagreeable is not surprising since the hallucination frequently represents an attempt to repudiate disturbing thoughts or intolerable aspects, desires, and strivings of the personality by externalizing or projecting them. Auditory hallucinations are experienced most frequently at night or at such other times as the environment is free from disturbing activities that would interrupt preoccupation with vivid ideas. The patient may or may not realize that his experiences are abnormal. If he appreciates that they are unnatural he may fear they will be regarded as evidence of unsound mind and therefore persistently deny their existence. If such a patient is carefully watched his behavior will often betray the fact that he is hallucinated. Perhaps it will be noticed that his ears are stopped with cotton or paper; he may be heard talking to himself, or be observed with his head inclined in a listening attitude. The patient may attribute the voices to the radio, to dictaphones, or to persons concealed in the wall, or offer other explanations of varying degrees of absurdity.

Visual Hallucinations. Hallucinations of sight are not rare, but are much less frequent than auditory hallucinations, probably because conflicts and other material in the inner life of the patient cannot be so readily expressed in visual terms as in the form of the spoken word. They occur most typically in the deliria of acute infectious diseases or of toxic psychoses and then are often accompanied by varying degrees of clouding of consciousness.

In recording her observations concerning both illusions and hallucinations, the nurse should fully describe the behavior of the patient and note how the apparent disturbances in perceptions seem to influence mood or activity. She also should note whether or not the patient's consciousness seems clear.

Disorders of Thinking

For our present purpose thinking may be considered as the joining of ideas one to another by imagining, reasoning, inferring, and other processes, and the formation of new ideas by these processes. The disturbances of thinking that particularly concern the psychiatrist are those of: (a) type of thinking; (b) progression of thought; (c) content of thought.

Disorders in Type of Thinking. The various factors that direct and determine thinking are too complex to be considered in detail here. Briefly it may be stated that in mental health the principal stimuli in the production of thought are environmental and emotional ones. If need be, the product of normal thinking is corrected by reality and so is known as *realistic or rational thought.* Sometimes, especially in certain mental disorders, thought seems to be freely wandering without any conscious direction. Something, however, must of course be directing it. This something, there is reason for believing, consists of complexes, unrecognized wishes, instinctual drives, and other motivations of which the individual is not clearly aware. It is not guided by purposeful attention or directed toward reality, but wanders without correction by practical elements and expresses needs, wishes, and desires that lie below conscious awareness. Such thought is known as *autistic thinking* and is represented by the thinking sometimes observed in schizophrenia, where it may appear so strange that it does not seem understandable.

Disorders in Progression of Thought. We are familiar with the fact that as we think there is a certain connection or linking of each thought with the one that has preceded. These links that connect our thoughts are known as *associations.* We also observe that our thoughts follow one another in a certain logical sequence toward a more or less definite end. If, for example, a pupil nurse were asked to narrate the events of a day she would perhaps state that she arose at a certain hour, that she bathed certain patients, gave these or others their breakfast, gave certain medications, attended a lecture or demonstration, and so on until she had narrated the chief events and activities of the day. This progression of thought is often known as the *stream of thought* or stream of talk. In normal stream of thought related ideas pass from an initial to a goal idea without interruption or digression.

In certain mental disorders there occurs a disturbance in the progression of thought characterized by a rapid digression from one idea to another. This disturbance of the stream of thought in which the thinking processes appear to run too quickly, with the result that there is a rapid succession of superficially related ideas, is known as *flight of ideas.* One patient showing the usual volatile associations of flight of ideas was asked if he were sad, to which he replied, "Yes, you have to be quiet to be sad. Everything having

to do with 's' is quiet—on the q.t.—sit, sob, sigh, sin, sorrow, surcease, sought, sand, sweet mother's love and salvation. This is my first case—I am kind of a bum lawyer or liar—too damned honest to be a lawyer so had to be a liar."

Flight of ideas is usually accompanied by a distractibility of attention. The mind is in too much of a hurry, as it were, to make any detailed note of external objects. One will often observe a connection between the rapidly changing ideas and various objects or activities in the environment. The jingling of a bunch of keys may prompt an association related to them. Not rarely the uttering of a word similar in sound but not at all so in signification calls up a new association (as in the example quoted). This is known as clang association.

As already seen, the flow of thought in flight of ideas is abnormally rapid. In *retardation,* on the other hand, the initiation and expression of thought are slow. The patient may say that his thoughts come slowly or that he has difficulty in thinking. He usually speaks slowly and in a low tone. It is observed largely in emotionally depressed patients.

Another disturbance of the flow of thought is that known as *circumstantiality.* In this disorder the patient finally reaches his goal idea, but only after many unnecessary and trivial details have led him into tiresome digressions. Circumstantiality is shown largely by persons who do not form sharply defined ideas or who are unable to distinguish essentials from nonessentials. It may often be observed, therefore, among the feebleminded and epileptics and in mild cases of senile dementia.

Sometimes the progression of thinking is so disorderly that one idea or fragment of an idea shifts into another without any logical sequence. The result is a confused and meaningless mixture of disjointed sentences or phrases known as *incoherence.* If thinking is a little less disorderly than in incoherence it is often spoken of as "scattered."

In *blocking,* sometimes known also as thought deprivation, the stream of thought suddenly ceases. After the lapse of a varying period the apparent obstruction seems to be removed and the flow of thought is resumed. This interruption of the progression of thought is probably due to the presence of a complex with its associated emotion, in other words, to mental conflict.

The normal train of thought and some of its disturbances may be diagrammatically illustrated as shown in Figure 2.

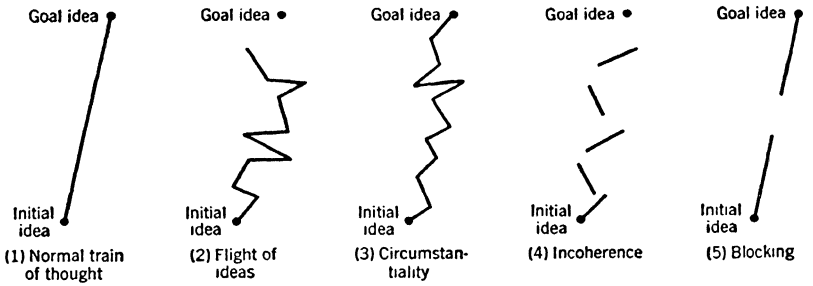


FIG. 2: NORMAL TRAIN OF THOUGHT AND SOME OF ITS DISTURBANCES.

In her ward notes as to the behavior of her patient, the nurse should record verbatim some of the verbal productions of the patient. She also should indicate the tempo and predominating mood associated with the stream of talk.

Disorders in Content of Thought. Among the simpler disturbances in content of thought is a *trend* which may be considered as a propensity for thought content to center around a special topic. This topic tends to dominate thought because of a strong feeling-tone attached to it. In case an idea comes to have an extreme feeling-tone connected with it it is spoken of as an *overdetermined or overvalued idea.* The importance or value of and the meaning attached to an idea are directly proportional to the inner need for such a belief. When an overvalued idea exists it blinds the individual to all else and only those observations and memories are selected which suit its purpose or confirm it. Anything which conflicts with it is denied entry into consciousness. The whole personality, its thought and feeling, are absorbed by the idea and placed at its disposal, so to speak, with the result that the overvalued idea becomes one of the most important mainsprings of action. Trends and overvalued ideas, like delusions, serve to satisfy some pressing inner need of the personality, such as a sense of security, defense, or self-esteem.

One of the most serious disturbances of thought is a *delusion.* A delusion is often defined as a false belief. When, however, we consider delusions and their meaning, value, and purpose in the patient's life we shall see that such a definition is inadequate. It is often said, too, that to be considered delusional a false belief must be one that a person of similar education and experience would consider improbable or impossible, and is not corrected in response to reason or logic. Even this definition is inadequate

since it ignores the important principle that the emotional needs of the patient's inner life rather than disorders of reason or logic are the real agent in producing the false belief. We are all prone to develop comforting and other psychologically useful fictions and to use beliefs to provide support and security to the personality. We continue, however, to see reality as it is to a degree that permits us to maintain a working adjustment with the world and our fellows.

Emotional Needs and Delusions. How inner needs may produce misinterpretations, misapplication of facts, and denial of reality in a way to be considered delusional is illustrated in the following case:

During World War I a woman (formerly a nurse, incidentally) was notified that her husband had been killed on a certain date and buried at a certain place in France. Several months later she visited the War Department and stated she was sure her husband was still alive and that the body which had been buried in France was actually that of no one known to her. The military authorities presented abundant evidence that no error had been made, but the widow remained unconvinced and demanded that the body of this man be returned to America and examined. Finally, to convince the woman, this was done. Examination showed that the identification number attached to his body and the location of the wounds corresponded with the records in the War Department concerning her husband. Still, however, the woman remained unconvinced and continued to annoy the Department officials until it became necessary to commit her to a hospital for mental diseases. Later the reason for her delusion transpired. Among the officer's papers collected after his death and forwarded to the widow were affectionate letters from another woman. By developing the belief that the man who had been killed and whose papers had been forwarded to her was someone other than her husband the patient had protected herself from two painful realizations: that her husband had actually been killed, and that she had not been first in his affections.

The principle that the wish is father to the thought is undoubtedly at work in all of us to a much greater extent than we are permitted to realize. We do not, however, allow it to dominate our lives or make its conclusions the central guiding motive of our activities. Such wishful thinking as well as many beliefs we entertain serve the same psychological ends as do the delusions of the psychotic, being similar in kind but different in degree

Types of Emotional Needs and Problems. From what has been said it will be seen that delusions are attempts to deal with the special problems with which an individual is confronted. These problems are often to be found in thwarted urges and drives, frus-

trated hopes, feelings of inferiority, physical inadequacies, teasing desires, gnawing feelings of guilt, and other emotional preoccupations. Often the meaning and purpose of the delusion and the particular need it is filling must remain a matter of speculation. This does not mean that the delusion is without significance or purpose but that we have not been able to interpret its meaning. Both hallucinations and delusions serve to set up an inner falsification of the outside world in accordance with the needs and wishes of the personality.

Since a patient's delusions are created in an effort to meet the stresses of his particular life situation their content tends to center around and represent the development of a special topic. When this central topic or theme is extensively elaborated into a group of ideas logically arranged and connected his delusions are said to be systematized.

Delusions of Grandeur. Delusions are classified in various other ways, especially in regard to the nature of their content. Delusions of grandeur arise from feelings of inadequacy, inferiority, or insecurity, any conscious recognition of which is prevented by the exaggerated, compensatory nature of the delusional ideas. The content of these ideas often affords considerable insight into the nature of the patient's previous frustrations. The private who was too awkward to perform successfully the routine drills of his squad and developed the delusion that he was a major general was protected by this delusion from an intolerable feeling of chagrin and humiliation. Such instances as that of this young man teach us how undesirable it is from the standpoint of mental hygiene to attempt to evade our weaknesses and limitations by means of phantasy and daydreams; rather should we promote a self-esteem and sense of security by developing in a sound, practical manner the particular strengths with which we are naturally endowed.

Delusions of Self-Accusation. Delusions of self-accusation are believed to arise because a weakening is taking place in the repression of inclinations and desires that are not consciously acceptable to the patient. The threat, as it were, that these forbidden tendencies might be indulged in causes the patient to have a vague feeling of guilt and therefore leads him to develop ideas of self-accusation.

Delusions of Persecution. Among the most frequent varieties of delusions are those of persecution. By the mechanism of projection

a threat to the patient's personality by those desires, tendencies, or qualities the repression of which is failing, is reflected as enmity and malevolence directed toward him from others. In much the same way the person unable to accept defeat, disappointment, or feeling of failure is apt to blame others for his frustrations and to feel that he is the object of ill will and therefore of persecution. Dissatisfaction with one's self may be projected as a dissatisfaction, and therefore as hostility, felt toward one by others. Ambitions in the absence of qualities essential for a satisfying success, especially if accompanied by an inability to accept defeat, may lead to brooding, distrust, suspicion, misinterpretations, resentment, and ideas of persecution. Delusions of persecution, then, may prevent injury to self-esteem, permit a shifting of responsibility, and otherwise serve as a defense for the personality. The patient with delusions of persecution may state that his food is poisoned, that scandalous calumnies are spread concerning him, his enemies follow him, he is hypnotized, or that the Catholics or the Masons are plotting against him.

Mental Habits That May Lead to Delusions of Persecution. It will often be found that persons who develop delusions of persecution have, often since childhood, been faultfinding, resentful, suspicious, and unhappy. Frequently they have been lonely, brooding, and insecure, and have lacked friends with whom they could share confidences. Ready to criticize others they have been unable to tolerate criticism themselves. Here again unwholesome mental habits finally culminating in actual mental disease teach strikingly the necessity for establishing those habits of thinking which are consistent with sound mental hygiene.

Ideas of Reference. Ideas of reference are closely related to delusions of persecution. The patient with such ideas may state that remarks or acts which, as a matter of fact, in no way refer to him have some special personal significance, often critical in nature. Usually in such cases the person is in reality projecting onto the external world his own self-criticism.

Depressive Delusions. As the term indicates, depressive delusions are characterized by an ideational content expressing dejection or lowness of spirits. Whenever repression weakens repressed wishes, memories or ideas which are of a nature such that they would cause emotional pain were they admitted to consciousness may give rise to depression. With his mood so depressed the patient's ideas are

naturally melancholy and are therefore often concerned with such topics as guilt, disease, or poverty.

Hypochondria. In hypochondria the patient's attention is abnormally concentrated on his own body; he is depressed and his thoughts are constantly preoccupied with some organ which he is convinced is incurably diseased. Often he has a changed feeling of self. Probably the emotional distress and preoccupation have their real origin in inner dissatisfactions and fears, in a sense of insecurity, and in a weakening of repression.

Obsessive Thoughts. Thoughts that persistently thrust themselves into the mind of the patient, often against his conscious wish, are known as obsessive thoughts. Sometimes such ideas are of a disagreeable or troublesome nature. One characteristic of obsessive thoughts is that the patient cannot logically account for their persistence. This characteristic and the apparent absence of meaning are due to the fact that through the mechanism of displacement the obsessive idea has come to serve as a substitute for another idea, memory, or wish that has been repressed and is not allowed in consciousness in undisguised form. The emotion that is attached to the obsessive idea really belongs to the one that is denied admission to consciousness. The obsessive thought that is consciously distasteful is often related to something unconsciously desired.

Phobias. Closely related to obsessive ideas are obsessive fears or phobias. Like the obsessive idea, a fear may thrust itself persistently into consciousness and cause the patient much distress. The varieties of phobias are numerous. A not uncommon form is that of dirt, a fear which may so beset the patient that as soon as he has touched an article he must wash his hands; at once he fears that the washing may not have been effectual and he must again wash his hands. The patient may be so tormented by his phobia that he must abandon his usual occupation.

Disorders of Consciousness

Perhaps "clear-mindedness" most nearly indicates what is meant by consciousness. If consciousness is unimpaired then the sensorium, i.e., the special senses and their functions, is clear, and the patient is fully aware of his surroundings.

Confusion. Confusion is a disturbance of consciousness characterized by more or less impairment of the powers of recognition and interpretation, by bewilderment, perplexity, disorientation, and

difficulty in association of ideas. Objects are perceived only in part and incompletely. The face of the confused patient presents a distressed, puzzled, and sometimes a surprised expression. Confusion may occur in infectious diseases, follow traumatism, and exist in toxic and highly emotional conditions and in hysterical and epileptic dream states.

Degrees of Impairment of Consciousness. Based on the extent to which consciousness is impaired we speak of clouding of consciousness, stupor, and coma.

Clouding of Consciousness. This is a disorder of consciousness in which clear-mindedness is moderately impaired because there are toxic or other changes in those brain cells or their connecting fibers which are essential for the association of ideas. Perceptions are not produced by such stimuli as ordinarily lead to sensory recognition. Psychic processes are retarded and the patient appears to be in a "mental fog." To make him understand a question it may be necessary to shake him, to shout the question, and perhaps to repeat this procedure several times before he sufficiently apprehends the question to reply. The patient's grasp of his environment is incomplete and inaccurate. Clouding of consciousness is frequently seen in general hospitals where it may occur in infectious diseases or in toxic states such as uremia. Following the clouded period there is a loss of memory for events that occurred during it.

Stupor. Stupor is manifested by a marked heaviness and deadening of consciousness associated with a dulling of perception and of other higher mental processes. It may occur in toxic states, in some organic diseases of the brain, and in certain psychogenic mental disorders characterized by intense apathy, profound depression, or overpowering fear. Stupor also is observed in epilepsy and at times in hysteria.

Coma. In coma the patient is so profoundly unconscious that it is impossible to arouse him.

Delirium. Although involving much more than a disturbance of consciousness this is perhaps a fitting time to consider the symptom known as delirium. Strictly speaking, a delirium is a syndrome, that is, a group of symptoms having a common origin. Delirium is characterized by clouding of consciousness, bewilderment, disorientation, incoherent or dreamlike thinking, illusions and hallucinations, restlessness or stupor, and is accompanied at times by fear. Not infrequently delirium may be limited to transitory epi-

sodes, usually occurring at night. The degree of clouding of consciousness often fluctuates. When the clouding has been marked and the delirium rather intense the patient after recovery has no memory of events occurring during it. Varying with the fluctuations of consciousness the memory may be uneven.

Causes of Delirium. Delirium may result from toxic or organic disturbances of the brain or it may be entirely psychogenic, i.e., arising from mental, particularly emotional, causes. The toxic-organic variety occurs particularly in acute infections accompanied by fever, after the ingestion of exogenous poisons, such as alcohol, or in toxic states of endogenous origin, such as uremia. The tendency of an individual to develop delirium under predisposing conditions is a measure of his personality stability. In toxic-organic delirium there is a tendency for the patient's muttering expressions to center about habitual topics of thought and customary daily activities. In both toxic-organic and psychogenic delirium latent personality traits as well as factors that have been exerting an unrecognized influence on the mental life of the patient may be revealed. Psychogenic delirium often represents the dreamlike realization of a wish.

Disorders of Orientation

The function by which we apprehend or grasp our environment and locate ourselves mentally in relation to it is known as orientation. If a person knows his position in reference to time, appreciates his situation both as to space and circumstances, and understands his relationship to other individuals he is said to be oriented. If he does not recognize his position relative to any one or all these three spheres he is said to be disoriented in the particular sphere of which he has an inadequate grasp. In order to find out if a person is oriented as to *time* one ascertains the degree of his acquaintance with the current year, month, and day. Orientation as to *place* is determined by the patient's awareness as to the city in which he then is, also by his knowledge of the building or institution in which the examination is being made. An individual who is oriented as to *person* will not only be correctly aware of his own individuality but will also be acquainted with the names, official capacities, and other identifying data concerning people with whom his associations have been sufficient to afford opportunity for acquiring the information. Disorientation may

occur in any mental disorder in which there is extensive impairment of the patient's memory, of the extent or accuracy of his perceptions, or of his attention. Disturbances of orientation may therefore exist both in toxic-organic diseases and in psychogenic disorders.

DISORDERS OF AFFECTIVITY

Definitions of Affectivity, Affects, Mood, and Temperament. By *affectivity* is meant a person's self-feeling, the prevailing character or tone of his feeling-life. It is determined by very complex factors, among them being instinctual tendencies, the vegetative nervous system, endocrine glands, and various chemical states of the body. The individual variations, modulations, and expression of this self-feeling as influenced by one's experiences, by conscious and unconscious groups of ideas, and by temporary changes in vegetative nervous system and body chemistry are known as *affects.* By the word "affects" one means substantially the same feeling-states as indicated by the less technical and less accurate word "emotions." By *mood* we mean a uniformly sustained affective state of considerable duration. *Temperament,* the general affective disposition that characterizes the entire personality and seems related to the physical makeup of the individual, has been discussed in Chapter IV. It determines the individual's prevailing mood and tempo.

Influence of Affectivity. Every mental experience is accompanied by affectivity or feeling. Success following persevering effort is accompanied by a feeling of happiness; the death of a beloved friend brings sorrow. The feeling-life is influenced, however, by experiences of a less conscious nature, by instinctual urges, wishes, and rejected thoughts and memories which have been repressed but still exert a profound influence upon the emotional state of the individual. The affects, too, influence the entire effort-tendency of the individual, the output and direction of his energy, its degree and goals. Thought-life and consciousness are equally influenced, also, by affectivity. The content of thought is strikingly determined by affective influences. Affectivity, then, penetrates and colors the whole mental life and all its processes, promoting those that are in harmony with it and inhibiting those in disagreement. Of no less importance is the fact that affective factors may influence not only psychic functions but often physiological ones also.

Variations in Affectivity. The principal variations in affectivity are in the fields of its intensity, duration, and appropriateness.

The deviations in intensity are in the direction of pleasure or of pain, of an elevation or a dejection of spirits. In *euphoria* the patient is of an optimistic attitude and is imbued with a subjectively pleasant feeling of well-being. In *elation,* a still greater raising of spirits, the patient's appearance is one of great happiness, enjoyment, and self-satisfaction. His circumstances may be such that unhappiness should naturally follow, yet everything that would normally produce that feeling is lightly brushed aside. Elation is often an unstable affect and may readily shift to irritability. In *exaltation* the patient's demeanor is one of extravagant self-esteem. He may exhibit a religious fervor containing qualities of mysticism and of ecstasy.

Depression. On the side of dejection of spirits depression may vary from a mild downheartedness to stupor. In the milder cases the patient is sad and pessimistic and has no interest in his usual activities. He lacks concentration and may complain of headache and insomnia. In deeper depression the patient is forgetful and preoccupied; his thoughts are confined to a few topics, often to forebodings and to ideas of remorse, unworthiness, or of self-accusation. Initiative and capacity for decision are lost. The eyes are downcast and the facial expression is one of extreme unhappiness, hopelessness, and perhaps of fear; the skin of the forehead is furrowed and the neck, trunk, and extremities are slightly flexed. All movements are executed slowly and with apparent difficulty. One appreciates how artificial are the distinctions between "mental" and "physical" as he observes the association of depression with poor appetite, loss of weight, coated tongue, foul breath, and constipated bowels.

Some depressions are precipitated by such difficulties in the patient's life situation as might naturally produce sadness, such as sickness, bereavement, or other misfortune. These depressions, usually spoken of as *reactive depressions,* are not of protracted duration. Other depressions, described as *autonomous depressions,* arise from factors deep within the personality beyond conscious recognition. Among these factors may be feelings of guilt, frustrated strivings, and thwarted wishes.

Tension. Certain emotional states are spoken of as "impure" affects. These include tension, fear, anxiety, panic, suspicion, and hate. The patient suffering from tension presents a strained expression, a certain abrupt haste and restlessness in movements,

tremulousness (particularly of the fingers), increased pulse rate, and vasomotor flushings. He may experience difficulty in concentration and complain of tightness or other unpleasant sensations in the head. Tension develops most frequently when one is torn between contradictory desires and strivings.

Anxiety. By anxiety one means a persistent fear arising from threatening factors deep in the mental life accompanied by vague, but disquieting, anticipatory ideas of prospective harm or disaster. Anxiety may occur when the security and safety of the personality are threatened by reason of the fact that the repression of forbidden wishes and instinctual tendencies is in danger of giving way. Ordinary fear is acute and does not persist since the danger by which it was caused is soon eliminated either through conquest or escape but in anxiety the danger is within the individual himself and so escape is impossible. The signs of anxiety are agitation, motor restlessness, rapid heart, palpitation, sweating, tremor, nausea, a sense of constriction or suffocation, and a feeling of impending calamity or death.

Panic. Panic is a sudden, overpowering feeling of terror resulting from prolonged tension and a feeling of insecurity. In panic the feeling of fear is so intense that the patient may attempt suicide in an effort to escape from the terrifying situation which, in his delusional state, he believes exists.

Apathy. In addition to disturbances of affect in the directions of pleasure or of pain, a pathological indifference known as apathy may occur. Apathy is characterized by an inadequate sensitiveness to those experiences that normally give emotional pleasure or pain. Interest is lacking in those matters that previously appealed to the patient. There is an indifference to aesthetic and other finer sensibilities. Such sentiments as gratitude, sympathy, hope, anticipation, grief, regret, pride, or shame are greatly blunted or no longer experienced. Disharmony of affect or of feeling-tones frequently occurs in schizophrenia.

Disorders of Motor Aspects of Behavior

The disorders to be considered here are those formerly described as disturbances of will or volition. We do not, however, deal with a separate faculty of the mind such as will was formerly conceived of. Rather are we concerned with the action tendency of the individual, the striving aspect of his personality as influenced by

affect and desire. (This striving aspect is technically known as conation.)

Increased Psychomotor Activity. An increase in pressure of occupation is known as increased psychomotor activity. Such activity is purposeful and not a mere pressure of motion, although frequently no objective is attained since the goal of the activity may constantly change. The result is that although the patient is very busy his activities shift rapidly from one object to another. A mild increase in psychomotor activity may be manifested by unaccustomed energy and zeal in one's occupation or by an officious meddlesomeness. In greater degrees with only furniture or clothing available as objects of utilization, the results of the patient's activities may be quite destructive. This increase of activity is common in the excited or manic phase of manic-depressive psychosis.

Decreased Psychomotor Activity. A distinct slowing up of all motor expression occurs in decreased psychomotor activity. Typically there is a prolonged delay before initiating an intended activity which, when once begun, is executed slowly and as if with painful effort. When an activity is suggested the patient may protest, "I can't do it." In extreme cases the patient is mute and motionless and does not spontaneously undertake any activity. A lessening of activity may occur in any depressed state but is most characteristically observed in connection with the depressive phase of manic-depressive psychosis.

Stereotypy. In certain mental disorders, especially in schizophrenia, it sometimes occurs that when an activity has been initiated there is a tendency to repeat it in the same manner for an indefinite time. Such a monotonous repetition is known as stereotype, and may be of attitude, movement, or speech. A constantly maintained immobility of position is known as *catalepsy.* Stereotyped movements, known as *mannerisms,* are common in schizophrenia. They may be in the form of grimaces, repeated gestures, or other oddities.

Negativism. A common disturbance in the motor aspect of behavior is negativism, manifested either by a refusal of the patient to do what is desired of him or by the performance of the opposite of what is suggested. Superficially, negativism so strongly suggests a purposeful obstinacy that an inexperienced nurse may mistake it for a premeditated recalcitrance. Negativism may occur in the form of mutism, refusal of food, or in resistiveness to all attempts

to care for the patient. Requests to show the tongue may, for example, result in firm closure of the mouth.

Suggestibility. An apparent counterpart of negativism is observed in suggestibility, a disturbance in which the patient shows an automatic obedience to suggestions received from others. This may be observed in *cerea flexibilitas,* or waxy flexibility, so designated because the patient's extremities may be flexed or extended with a waxlike rigidity, continuing to remain in the position in which they have been placed, as do the limbs of a jointed doll.

Compulsions. A morbid and often an irresistible urge to perform a definite act is known as a compulsion. The act may be of a simple nature, such as that the patient feels compelled to touch everything twice, or it may be complex and constitute more or less of a ritual—a certain significance of magic being attached to it. Compulsions are often accompanied by obsessive fears, as in the compulsive hand-washing associated with a fear of dirt.

Source of Volitional Disturbances. The explanation of the various disturbances of volition or the motor expressions of the mental life is usually to be found in the unconscious aspects of the mind. In mental disorder acts may be so foreign to usual behavior as to appear meaningless. Such acts, however, are really as meaningful as our own behavior. The motives that have prompted the behavior have their source below conscious awareness, and are therefore not apparent. As a result the behavior which has been induced appears illogical. Sometimes it is possible to expose mental material that is beneath ordinary awareness; in such cases the purpose and function of apparently meaningless behavior becomes clear. A pressure of activity may be a means of escape from troublesome elements in an intrapsychic conflict. A decrease in psychomotor activity may mean that the personality is being overwhelmed by forces deep within the mental life. Impulsive acts may express desires that are forbidden conscious entertainment. Mannerisms and oddities of behavior may be symbolic indications—dramatizations—of repressed desires or memories, of conflicting strivings.

Disorders of Attention

Various factors including association of ideas, individual tendencies, and particularly affectivity enter into what we know as attention. If a person has an unusual pressure of occupation, is

emotionally tense or elated, and has few associations connected with the subject presented for examination his attention will flit rapidly from one matter to another. This inability to hold a focus of attention is known as *distractability*. Profound depression, on the other hand, may cause too great *tenacity of attention*. No stimulus or experience can divert the patient's attention to a subject not related to his depressive content or not in harmony with it.

Disorders of Memory

The function by which the data acquired and presented to consciousness through the observations of attention are stored, later to be summoned and again presented to consciousness, is known as memory. For the purpose of description it may be considered as consisting of three successive steps or processes: the reception or registration of a mental impression; the retention of the impression; the reproduction or recalling of the impression. Emotional attitudes toward a given matter tend to promote or to interfere with memory relative to that topic, memory being influenced in accordance with the emotional needs of the individual.

Amnesia. The most important disorders of memory are: (a) loss or impairment of memory, a condition known as amnesia; (b) falsifications of memory. Amnesia may be due either to: (a) destructive or toxic disturbances in the brain cells, or (b) emotional influences that interfere with the recall of impressions incompatible with one's wishes or self-estimates.

Confabulation. One form of falsification of memory is that known as confabulation. In this disorder the patient fills the gaps in his memory with fabrications. He may relate various alleged experiences of the previous day, telling in detail where he went, whom he met, etc., whereas he may have been confined to his bed continuously for months. When making these fictitious statements the patient does not consciously regard his fabrications as false although they may change from moment to moment and may even be suggested or directed by a listener.

Retrospective Falsification of Memory. Another form of falsification of memory is known as retrospective falsification or illusion of memory. We all tend to embroider the truth in accordance with our special psychological needs, to forget our unworthy acts or to select those memories that suit our interests. To a certain degree, therefore, retrospective falsifications of memory may occur

in what we regard as mental health. Two persons, for example, who have intense but different emotional attitudes relative to a certain experience will relate quite different accounts of the incident. Both persons may be honest but each will remember those details which are in harmony with his emotional needs and forget whatever is not in accordance with them. In paranoid psychoses we may observe an abnormal extension of this tendency. The patient may misinterpret an actual event, append imaginary details, or even relate alleged experiences that have little or no basis on fact.

Function of Inorganic Disorders of Memory. It is apparent from the foregoing discussion that memory loss, in the absence of structural or toxic changes in the higher brain cells, is a selective process and not a matter of chance. It serves to promote the comfort and self-esteem of the individual.

The forgetting of intended action also serves a psychological purpose. The reason for forgetting to keep an appointment or to perform some task frequently lies in an unrecognized desire not to keep the appointment or perform the task.

Dementia

In any degeneration or destruction of the cells of the brain essential for higher intellectual functions there results an impairment of what may be described as the knowing activities of the mind, a reduction of mental stock and capacity known as dementia. There is a dulling of interest, a loss of ability to recognize or explain the new through previous knowledge. Impressions are taken in and assimilated slowly or scarcely at all; the ability to learn is reduced. It is difficult or even impossible for the patient to understand and follow conversation. Judgment and memory are defective and the patient may be disoriented and confused. True dementia is permanent and irreparable.

Summary

1. That aspect of one's life which we call mental and serves as a means of satisfying emotional and other needs of the personality and of adjusting one in his relations to others and to his environment may undergo changes in the methods which

it originally employed for these purposes. These changes are called mental symptoms.

2. Symptoms are of two types. One type is called organic since symptoms of this type are due to an impairment of the physiological function of brain cells through toxins, injury, or disease. Symptoms of the second type are usually called psychogenic since they are ways of thinking, feeling, or doing which are believed to be due to mental causes. They arise from problems of the inner life or personality and from emotional and other influences (often not recognized by the patient) acting upon it.
3. The psychiatrist seeks to determine to which of these two groups any mental symptoms belong. If they are of organic origin he endeavors to re-establish, if possible, a normal functioning of the brain cells. If the symptoms are psychogenic he endeavors to discover both the highly personal problems and influences which produced the symptoms and also the purpose that they play in the individual's mental life, in the hope that thereby more wholesome methods of meeting the personality needs or problems may be developed.
4. Psychogenic symptoms often reveal clues that make possible the discovery of problems that are troubling the patient and indicate the way he is trying to meet them.
5. Most symptoms are in the form of disturbances of perception, thinking, consciousness, orientation, affectivity or emotions, activity or behavior, attention, memory, and of those complex functions which we know as intelligence, judgment, and reasoning.

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CHAPTER VII

CLASSIFICATION OF MENTAL DISORDERS

The Aim: Understanding of Personality—Not Classification of Disease. The principles upon the basis of which mental disorders may be satisfactorily classified are not so clearly defined as with physical diseases. The latter easily lend themselves to classification according to such principles as pathogenic cause, anatomical system involved, or nature of the morbid process. Similar attempts to classify personality disturbances have not, for many reasons, been as satisfactory. To be sure, those disorders of personality which develop on the basis of such definite structural changes as exist in general paresis or in senile dementia fall rather readily into a classificatory scheme based on the presence of destructive changes in the brain. But even in disorders having such a definite organic cause there are often many features that cannot be explained by the changes in the brain structure itself, but require a knowledge of the earlier personality of the individual and his inner mental life. On the whole, however, personality disturbances cannot be looked upon as distinct entities as may such physical maladies as diabetes, but as the highly individual and poorly adjusted way in which a particular person has reacted to the special instinctive, emotional, and social demands that life has made upon him. For this reason the psychiatrist of discerning mental vision does not place the major emphasis on classification but on the influences and problems which have been insidiously operating in the inner life of the individual, on what the stresses of life have meant to him, and on the unwholesome methods by which he has attempted to deal with these influences, problems, and stresses. Therefore he is not as interested in attaching a name to a so-called disease as he is in measures that will assist the patient in dealing with his particular life situation, will enable him to restore inner harmony, and make possible a useful, socially adjusted, and satisfying life. With the increasing recognition on the

part of the psychiatrist that the formulation of a diagnosis is a matter of interpreting human behavior and one that must be expressed in terms of individual problems there is a corresponding feeling that the nurse, if her services are to be based on understanding rather than on mere experience, should also know how inner psychic situations may operate to disturb behavior, mood, and belief. The nurse, too, should think, not of names of diseases but in terms that make clear the personality needs of her patients and of the manner in which they are revealed.

Two Groups of Mental Disorders. Classifications are useful, especially for purposes of description, but fixed separations are arbitrary and in mental or personality disorders particularly they may obscure the fact that one is dealing, not with a psychosis but with a psychotic patient—not so much with diseases and their symptoms as with people and their troubles. As stated in Chapter V there are two general groups of mental disorders the distinctions between which the nurse should bear clearly in mind. One of these is known as the organic or, preferably, toxic-organic group. Disorders belonging to this group arise because of toxic or structural changes in the brain cells. No demonstrable chemical or structural changes have ever been found associated with the second group. It is believed that the disorders in this group arise through purely mental causes. They are therefore spoken of as psychogenic disorders. They can be understood only in the light and terms of the patient's individual life history.

Toxic-Organic Group. In the toxic-organic group, toxic or destructive disease processes affect the brain cells and impair their function. As a result there are disturbances in the sensorium, i.e., there is a dulling of the special senses with the result that the patient no longer grasps his environment and its activities quickly and clearly. There is apt to be either a temporary or a permanent impairment of the memory and other intellectual powers. Included in this group are the psychoses due to syphilis of the brain or to epidemic encephalitis, the senile psychoses, psychoses with cerebral arteriosclerosis, traumatic psychoses, psychoses due to infections, to disturbances of metabolism, to tumors of the brain, the alcoholic psychoses, and those due to drugs or other poisons introduced into the body.

Psychogenic Group. Disorders belonging to the psychogenic group apparently arise from perturbing experiences and problems.

They may be regarded as forms of behavior adapted to meet some special inner need of the personality—forms, however, which from a social standpoint are unusual, undesirable, and maladjustive. They represent impracticable or unsuccessful attempts to deal with the special needs and problems of the patient's inner life—his hopes, sorrows, fears, and desires, some of which may have been repressed but continue, nevertheless, to exercise their perturbing influence. In this group are the manic-depressive psychoses, schizophrenia, involutional melancholia, paranoid states, and the psychoneuroses.

The Problem: Why the Patient Meets Life in His Particular Way. As important as is classification for statistical purposes, yet so far as the individual patient is concerned, it is much more essential to learn what his problems are and how he has come to meet them in his particular way. To attach a diagnostic label to a person will not help him, but if it is determined how and why he has come into his present state we may be enabled to assist him. To determine these matters a detailed study must be made of the individual personality and its evolution including the various urges, frustrations, influences, and experiences to which it has been exposed. The real aim of diagnosis is not to classify the disorder, but to understand the patient.

"Insanity" a Legal Term. Perhaps at this time mention should be made of certain terms used in connection with persons suffering from mental disorder. Among those frequently heard are "insane" and "insanity." These are really social and legal and not medical terms. The terms are applied to the mental condition of a person whose behavior by reason of his mental disorder is such that the law steps in, certifies him as of unsound mind, and usually places him under some degree of supervision and control. The words are not synonymous with mental illness.

Definition of "Psychosis." The word "psychosis" is purely a medical term and in itself has no legal implications. The term is applied to a mental disease in which there is an extensive and serious disorder of the personality often involving mood, belief, and conduct. Not rarely the psychotic person comes to the attention of the law because of his inability to adjust to social demands. In that case the law often declares him "insane" and "commits" him to an institution for treatment.

Psychoneurotic Reactions. Because of certain striking differences it is not customary to include one large group of mental disorders among the psychoses. The group, known as psychoneuroses, or simply neuroses, includes several types of reactions to disturbing influences and experiences touching particularly some aspect of the patient's emotional life. The principal ways in which the psychoneuroses differ from the psychoses will be mentioned later, but in general while the psychoneuroses may greatly disturb the patient's personal happiness and efficiency they cause less disregard of reality and lead to less disorganization of personality and less disturbance in social capacities and adjustment.

Summary

1. While for statistical and other relatively unimportant purposes classifications of mental disorders are desirable, yet the attaching of a diagnostic name to the patient's illness usually tells us very little about him.
2. Mental disorders fall, however, into two general groups: one, in which toxic or destructive processes affect brain cells and impair their function; another, which consists of personality disorders brought about by various psychological factors including perturbing experiences.
3. The real diagnosis in disturbances of the personality is an understanding of the individual patient—a recognition of the various factors which have caused him to be the particular type of person he is and have led him to meet life in his special way, a way that has brought unhappiness to him and disturbed his relations with others. We should see behind superficial appearances into the deeper needs, impulses, and motivations of the patient's personality.
4. One seeks to discover the experiences and stresses which have been of significance to the patient, what they have meant to him, and to assist him in recognizing the unwholesome methods which he has employed in his struggle to acquire a sense of security, defend his self-esteem, and attain a feeling of emotional satisfaction.
5. In the light of the fullest knowledge possible concerning the patient's present difficulties and the factors that have produced

them, the psychiatrist and the nurse employ whatever measures will assist him in dealing with his particular life situation without resorting to reality-evading techniques, will seek to restore his inner harmony, and to aid him in resuming a useful, socially adjusted, and satisfying life. Attention is therefore directed not to an impersonal disease entity but to the individual and his problems.

CHAPTER VIII

GENERAL PARESIS AND CEREBRAL SYPHILIS

Three Forms of Neurosyphilis. This chapter and the following two deal with psychoses due to or associated with infection. Of all the infections which attack man syphilis produces the most devastating effects upon his mental life if the *Treponema pallidum* or *Spirochaeta pallida,* the micro-organism which causes this disease, invades the brain. If the principal part of the brain attacked by the spirochete is (a) the brain cells in the cortex, a form of neurosyphilis known as general paresis or dementia paralytica is produced; sometimes the invasion of the brain is confined largely to (b) its meninges, or to (c) its blood vessels. In distinction from general paresis mental disorders due to syphilis of either the meninges or the cerebral arteries are known as psychoses with cerebral syphilis. In this chapter general paresis will be discussed first, then cerebral syphilis, and last, briefly, tabes dorsalis and taboparesis.

General Paresis: Introduction

It is estimated that from 2 to 3 per cent of persons infected with general syphilis develop general paresis. If the treatment of syphilis were more prompt and thorough, fewer syphilitics would develop the disease. The reason why the brain escapes infection in a majority of persons suffering from syphilis and is invaded in others with a resulting development of general paresis is unknown. General paresis is from four to five times more frequent in men than in women due to the more frequent occurrence of syphilis in the former. It may develop from two to thirty years after the primary infection, but most frequently it occurs between ten and twenty years after infection. Syphilis is no longer contagious by the time the symptoms of paresis appear. There is therefore no danger of infection in nursing a patient suffering from general paresis. The reason for the development of the disease after so

long a period free from other symptoms of syphilis is unknown. If the patient is not treated persistently in the early stages of paresis there is progressive degeneration and destruction of those brain cells which are essential to the higher mental and motor functions.

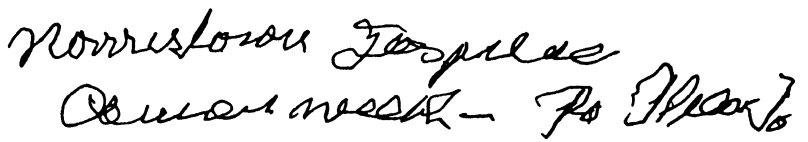
Manifestations of General Paresis

General paresis is manifested by (a) mental symptoms; (b) by physical symptoms and signs; and (c) by certain chemical and microscopic changes in the cerebrospinal fluid.

Mental Symptoms. Frequently there are such premonitory symptoms as irritability, fatigue, difficulty in thinking, depression, disturbed sleep, or headache. Early in the disease there is often an impairment of professional skill or craftsmanship. The business man may not only lose his former capacity for management, but because of failing judgment may dissipate the resources upon which the livelihood of his family depends. There is often an apathy and contented indifference that may be mistaken for laziness. The patient may become neglectful of dress, unkempt in appearance, forgetful of social amenities and proprieties, offensive in language, and deficient in a sense of ethical and aesthetic values. One whose previous life has been quite exemplary may not only show some surprising defect of character but feel no concern for his dereliction. Disturbances of mood are common, frequently assuming the form of an abnormal sense of well-being. Many patients are self-satisfied and declare that never before have they felt so well. Some, however, are depressed from the beginning and many more become progressively indifferent. Momentary periods of confusion or an inability to grasp a situation and act promptly and prudently may lead, in early paretics whose mental disorder has not yet been detected, to an automobile accident or other mishap. When the mental symptoms are well established, many paretics express delusions. These may be of any type but more frequently than in any other mental disorder they are of a grandiose nature. The patient may declare, for example, that he owns a railroad freight train each car of which is loaded with million-dollar treasury notes. As the disease advances dementia becomes progressive. The emotional life is impoverished, memory fails, there is a poverty of ideas, spontaneous activity ceases, and the patient is no longer able to understand simple questions.

Physical and Neurological Signs. Physical and neurological signs develop simultaneously with the mental symptoms. The lines giving facial expression become smoothed out and the associated blunting of emotional responses gives the facies a vacant look. Although occurring in other forms of neurosyphilis various significant pupillary disturbances are usually present. The pupils may be unequal in size, irregular in outline, much contracted (pinpoint), or widely dilated. In the intact nervous system the pupil contracts when the retina is exposed to increased light and dilates when the light is less intense (light reaction); it contracts also when vision is focused on a near object and dilates when fixed on a more remote object (convergence reaction). One or both of these reactions may be lost in general paresis. One of the most significant pupillary signs is the loss of light reaction with a preservation of convergence reaction, a sign known as the Argyll Robertson pupil.

Progressive weakness and inco-ordination of all voluntary muscles occur. In the face this gives rise to a tremor of the facial muscles, first observed in the lips when the patient attempts to speak or to show his teeth. As enunciation becomes more difficult there is an overactivity of all the facial muscles when speech is attempted. A coarse tremor of the protruded tongue is common. Disturbances of speech usually occur. The first to be noted is often a hesitation, drawl, or slurring. Speech disorders are usually best demonstrated by asking the patient to repeat polysyllabic words or phrases containing labial or dental types of consonants, as "ninety-eighth riding artillery brigade." Late in the disease articulation may be so disturbed that one cannot understand what the patient is attempting to say. Often early in the disease there is a tremor in finer movements of the hand. This may first be shown by significant changes in the patient's handwriting. The misshapen characters betray a tremulous hand; characters may be diminutive in size and, like syllables, are often omitted or repeated. One patient, when directed to write "This is the Norristown State Hospital," wrote the sentence as follows:



HANDWRITING OF PARETIC PATIENT

Exaggeration, diminution, or loss of deep tendon reflexes, such as the knee jerk, is common. As the disease progresses the gait becomes more uncertain, the patient loses weight, becomes weaker, and is finally confined to his bed. Trophic changes occur with the result that pressure sores develop easily and the bones become fragile, often breaking upon receipt of slight trauma.

It is not uncommon for the paretic to develop a sudden, marked rise of temperature without evidence of infection or other ascertainable cause. About three fourths of all paretics suffer from convulsions sometime during the course of their disease. Many paretics die during or soon after convulsions.

Laboratory Examinations. Certain laboratory examinations of the blood and particularly of the cerebrospinal fluid, afford information of much significance in the diagnosis of dementia paralytica. In nearly all cases of the disease the Wassermann reaction of the blood is positive. The presence of this reaction does not mean, of course, that the patient is necessarily suffering from general paresis, but as this disease is merely a localized, although late, form of syphilis a positive Wassermann reaction may be expected.

Cerebrospinal Fluid Changes. Since the cerebrospinal fluid bathes the paretic lesions it shows certain changes which, when considered as a group, are characteristic of the disease. Sometimes information of contributory value may be gained when the specimen of cerebrospinal fluid is secured for examination. In health the normal limits of pressure of the cerebrospinal fluid obtained by lumbar puncture with the patient lying on his side is from 90 to 160 mm. of water. Under this pressure the fluid drops slowly from the needle. In general paresis the pressure may be much higher and the fluid drop rapidly. Healthy persons often suffer from headache, dizziness, or nausea for a day or more after the withdrawal of 5 to 10 cc. of cerebrospinal fluid by lumbar puncture. The paretic, on the contrary, is usually free from such symptoms. In general paresis, as in other forms of syphilitic involvement of the nervous system, the cerebrospinal fluid shows a positive Wassermann reaction. In health the cerebrospinal fluid contains few lymphocytes, probably never exceeding 8 per cubic millimeter of fluid. In paresis the cells may not exceed this number, yet frequently 40, 50, or even 200 or more are present. Normally the cerebrospinal fluid contains 15 to 45 mg. per 100 cc. of albumin

but no globulin. In paresis globulin may be present and the protein be increased to 50 to 150 mg. per 100 cc. of fluid.

A diagnostically important but not specifically characteristic chemical reaction of the cerebrospinal fluid in general paresis is the Lange colloidal gold test. This test depends on the precipitation and varying degrees of decolorization of a solution of gold chloride by a series of dilutions of the cerebrospinal fluid. When properly prepared the gold solution is of a brilliant salmon color. Ten test tubes are used in making the test, each successive tube containing one-half as much spinal fluid diluted with 0.4 per cent salt solution as is contained in the previous tube, the dilution in the first tube being 1 part of fluid to 10 parts of solution and that in the tenth tube being, therefore, 1 to 5120. To each of the ten tubes is added a certain amount of the bright salmon-colored solution. Varying degrees of precipitation of this solution are produced by the different dilutions of spinal fluid. In general paresis the more spinal fluid in the mixture, the greater the degree of precipitation of the gold, while tubes containing the smallest amount of spinal fluid produce the minimum or no precipitation. Arbitrarily five degrees of precipitation are recognized. When precipitation is complete the brilliant salmon color becomes colorless and is represented by the number 5. Progressively less degrees of precipitation produce less decolorization and are represented by the numbers 4, 3, 2, 1, and 0, corresponding respectively to the colors pale blue, dark blue, lilac, bluish red, and the unchanged brilliant salmon in which no precipitation has taken place. A typical first zone or "paretic curve" indicating the degrees of decolorization that frequently occur in a series of tubes prepared as indicated from the cerebrospinal fluid of an untreated case of paresis might be indicated by the series 5555432100, as illustrated in Figure 3.

The following case history may be considered typical:

Three years before his admission to a hospital the manager of a chain restaurant was, because of progressive inefficiency and bad judgment, demoted to assistant manager. His services continued to be increasingly unsatisfactory and he suffered several demotions, being finally assigned to a minor position as night relief worker. He became irritable, assumed an air of self-importance, and while formerly somewhat penurious he began to spend large sums for foolish purposes and purchased and made small payments on four houses, one being in Hollywood, California, a place which he had never visited. He drove his automobile past a red stop-light and,

Degree of precipitation	Color	Dilution of spinal fluid with salt solution									
		1 to 10	1 to 20	1 to 40	1 to 80	1 to 160	1 to 320	1 to 640	1 to 1280	1 to 2560	1 to 5120
5	Colorless										
4	Pale blue										
3	Dark blue										
2	Lilac										
1	Blueish red										
0	Brilliant salmon										

FIG. 3: A First Zone or Paretic Gold Chloride Curve.

when arrested and released pending a hearing on the charge, wrecked his car in a collision with another automobile. He announced that he would, at the hearing, accuse the officer who had arrested him with having stolen fifty dollars since that "would be an easy way of making money." Formerly temperate, he began to drink heavily. He indicated his intention to secure a pilot's license and fly to Europe in order that he might take his son to visit an aunt. On admission he was noted to be careless in dress, expressed grandiose ideas, and was destructive and assaultive. The Wassermann reaction of both the blood serum and the cerebrospinal fluid was positive. The latter contained 8 cells per cubic millimeter, showed the presence of globulin, and the following type of gold chloride curve: 5554432110. In spite of malaria therapy followed by courses of tryparsamide and bismuth the patient became progressively demented and now leads an aimless stereotyped existence, unable to carry on any useful employment and taking no interest in the activities of his ward.

Juvenile Paresis. Mention should be made of a form of paresis due to congenital syphilis and known as juvenile paresis. In this disease the age of the child at the time paretic symptoms appear is approximately the same as the number of years that usually elapse in ordinary adult paresis between the time when primary infection occurs and the time when paretic symptoms are shown. The child may, therefore, be from 5 to 20 years of age when the disease develops. The most common form is of a gradually increasing dementia, often associated with convulsions. Physical symptoms including trophic and other neurological disturbances are more marked than in acquired paresis.

Course and Prognosis. Although temporary remissions often occur in the earlier stages of the disease, yet the course of untreated general paresis is on the whole unfavorable: no authentic case of

recovery is known, and most cases terminate in death from two to five years after the first appearance of symptoms. With modern treatment the paretic process can be arrested in a majority of cases if therapy is begun before the disease has progressed too far. In instances when treatment is instituted early many patients are apparently restored to their previous efficiency and some have continued to remain well for many years. The final prognosis depends upon the amount of damage that has been suffered before the activity of the paretic process is arrested by suitable treatment.

Nursing Procedures and Treatment. Some paretics, if the nature of their disorder is recognized in its early stages, may be cared for at home or in an outpatient clinic. If the disease is advanced, if judgment and behavior are greatly disturbed, or if, as is usually desirable, it is decided to employ one of the fever-producing methods of treatment, the patient should be cared for in a hospital. Often the paretic's family does not recognize the significance of his early symptoms, with the result that chagrin or severe financial losses may be suffered before hospitalization terminates unfortunate activities resulting from the patient's impaired judgment. The irritability of the paretic and what appears to him as an arbitrary and unjust deprivation of fundamental liberties often make him a difficult problem for the nurse. Fortunately he is often suggestible and therefore amenable to tactful management. As with other disturbed patients the sedative effect of the prolonged bath may be useful. In the early stages occupational therapy of a diversional nature may be employed, although frequently attention is not satisfactorily sustained. At a later stage, hand weaving or other simple employment of a stereotyped, routine nature may at times be followed successfully.

Physical Care. The problem of physical care is much less troublesome than formerly. With modern methods of treatment the disease is in a majority of cases arrested before the patient becomes so helpless as to require nursing care for elementary physical needs. Special care should be taken to prevent falls by the weak, ataxic patient who may easily sustain fractures because of trophic changes in his bones. At the time of a convulsion the patient should be handled as is the epileptic during a seizure. It should be remembered that repeated seizures may occur and lead to the death of the patient. Unusual care must be exercised in applying hot dressings or hot water bottles. Because of their untidy habits and

the trophic changes in the skin, few patients so readily develop pressure sores as do paretics. Once developed such ulcers are resistant to healing. Difficulties in swallowing or even severe choking attacks are common in late stages of the disease. Food must then be soft and the nurse alert to prevent any serious results. Because of his disease the patient may feel no urge to void or empty his bowel. Unless he is taken regularly to the toilet the bladder may become distended, resulting in a dribbling of urine due to an "overflow of retention." Because of the wet linen in such a case the possibility that the bladder is distended may not occur to the nurse, with the result that slight trauma may produce rupture of the bladder and subsequent death of the patient.

Fever Therapy. Some form of fever therapy and a preparation of arsenic known as tryparsamide are the most effective measures used at present in the treatment of paresis. The prime object in the treatment of general paresis is to check the syphilitic process in the brain before the *Treponema pallidum* and its toxins have irreparably destroyed those cortical cells necessary for intellectual processes. The two most effective forms of fever treatment are by inoculation of the patient with the malaria parasite and the artificial induction of fever by means of a fever cabinet. Both of these forms are discussed in Chapter XXVIII, Nursing Procedures and Treatments. Whichever form is employed its use is advisable as soon as the diagnosis is made since the results of treatment vary directly with the promptness with which the disease is recognized and treatment instituted.

Follow-up Treatment. Following either therapeutic malaria or artificial fever therapy the patient will receive prolonged courses of chemotherapy or treatment with drugs of a chemical nature. Frequently a course occupies a year and consists of the intravenous injection weekly for six months of 3 Gm. of tryparsamide dissolved in 10 cc. of sterile water followed by the weekly injection intramuscularly of some form of bismuth, such as bismuth salicylate 0.26 Gm. suspended in oil for four months. The course is completed by the weekly injection of neoarsphenamine 0.6 Gm. for a period of two months. This course, occupying one year, is given each year for three years or at least until laboratory examinations of the cerebrospinal fluid are negative. During the first twelve injections of tryparsamide the patient should be repeatedly questioned concerning disturbances of vision since at times this drug

may seriously impair or even destroy vision. When no form of fever therapy is available excellent results are often secured by repeated courses of the chemotherapy outlined here.

The forms of therapy employed in the treatment of juvenile paresis are the same as those used in adult paresis, but are less successful than in the latter.

Cerebral Syphilis

As already indicated the most important brain changes in general paresis are those found in the cerebral cortex where serious injury is done to cells exercising control over the higher mental and motor processes. Sometimes, however, the spirochete invades the meninges or the walls of the cerebral blood vessels rather than the brain tissue as in paresis.

Syphilitic Meningitis. Syphilitic meningitis develops much earlier after the initial infection with syphilis than does general paralysis. The meninges at the base of the brain are particularly likely to be involved. In that case the meninges become thickened and may pinch the cranial nerves as they leave the brain, especially those which supply the muscles that elevate the eyelids and those which supply the muscles controlling the movements of the eyeballs. The onset is often with severe headaches, dizziness, dulling of perception and of comprehension, mild disturbances of consciousness, and perhaps with confusion. These symptoms are soon followed by ptosis of the eyelid, strabismus, or other signs of cranial nerve paralysis.

Cases of syphilitic meningitis are common in general hospitals but on account of the paucity and nature of the mental symptoms, the conspicuousness of the physical signs, and the rapid improvement under antisyphilitic remedies they are not numerous in hospitals for mental diseases.

Vascular Neurosyphilis. Cerebral syphilis of the vascular type is found most frequently as a thickening and infiltration of the walls of the larger blood vessels. As a result of these changes thrombosis or occasionally hemorrhage occurs. Such an accident shows itself in a stroke of apoplexy similar in nature and results to the ordinary stroke due to arteriosclerosis. As in cerebral arteriosclerosis, too, this vascular accident most frequently results in damage to the fibers passing down through the great motor pathways and thus leads to a paralysis of one half of the body. Throm-

bosis of other vessels may give rise to aphasia, i.e., to difficulty in expressing one's self in words or in understanding the meaning of words. Apoplectic strokes in adults under 40 years of age always suggest syphilis as the etiologic agent. The mental symptoms are the same as in apoplectic strokes due to arteriosclerosis. Under appropriate treatment greater improvement, both mental and physical, occurs than if arteriosclerosis has served as the etiologic agent.

Spinal Fluid in Cerebral Syphilis. As in general paresis, examination of the cerebrospinal fluid reveals a positive Wassermann reaction. The Lange colloidal gold solution is precipitated upon an addition of cerebrospinal fluid from a patient with cerebral syphilis, but not with the decolorization "curve" usually seen in general paresis. In syphilitic meningitis the precipitation of colloidal gold is greatest in the middle tubes when they are arranged in order according to degree of dilution, giving what is known as the "luetic curve." A fairly typical reaction would be: 0123443210. In the acute form of luetic meningitis there is a marked increase in number of cells in the cerebrospinal fluid (100 to 500 per cubic millimeter).

Nursing Care and Management. The nursing care of a patient suffering from cerebral syphilis depends upon the particular group of symptoms or results produced. The problem to be met may be chiefly mental, as when delusions or dementia constitute the largest element in the picture. In general, the mental symptoms are less conspicuous than the physical, and since the personality is better preserved and the judgment less impaired than in general paresis the patient with cerebral syphilis is less of a behavior problem than is the paretic. Again, apoplexy or convulsions may be the most serious manifestations, in which case the patient must be nursed as one suffering from arteriosclerosis or epilepsy.

Tabes Dorsalis and Taboparesis

Tabes dorsalis. Sometimes syphilis of the nervous system, instead of involving the brain tissue, its blood vessels, or its meningeal coverings, causes degenerative changes in certain fiber tracts of the spinal cord and in the posterior roots of nerves coming off the cord. The disease produced by these changes is known as tabes dorsalis or locomotor ataxia. If the brain tissue is not also involved there are no mental symptoms but the patient does suffer from painful and disabling neurological ones. Among the most

important are sudden, severe, shooting pains in the legs, attacks of abdominal pain with uncontrollable vomiting known as gastric crises, and ataxia or impairment of co-ordination and balancing. The patient has difficulty in walking and often has trouble in starting urination together with dribbling afterwards. There may be various other symptoms such as diminution of pain sense, loss of tendon reflexes, and the existence of an extreme but painless swelling of joints, known as Charcot joints.

Taboparesis. Sometimes general paresis and tabes dorsalis may co-exist. In that case we find both the mental symptoms described in general paresis and many of the neurological signs and symptoms observed in tabes. General nursing care and management will be along the lines described for general paresis together with such special attention as may be required because of the tabetic process. Artificial fever followed by chemotherapy is usually employed.

Summary

1. General paresis is due to an invasion of the cerebral cortex by the micro-organism that produces syphilis. The first symptoms of the disease appear several years after the patient received his infection.
2. The disease is manifested by mental symptoms, neurological signs, and by certain changes in the cerebrospinal fluid.
3. Mentally there is an insidious change of personality, perhaps accompanied by delusions and an exaggerated sense of well-being, an impairment of judgment, and progressive dementia.
4. Without treatment the disease is fatal. Early treatment is most important. The degree of permanent mental and physical damage is usually determined by the promptness with which treatment is begun.
5. Treatment is by some form of fever therapy followed by a prolonged period of chemotherapy consisting of alternating courses of tryparsamide, bismuth, and neoarsphenamine.
6. Instead of attacking the cerebral cortex the *Treponema pallidum* may attack the arteries of the brain or the meninges covering it. The organism of syphilis also may cause degeneration of nerve tracts in the spinal cord and the posterior roots of nerves leaving the cord, producing the disease known as tabes dorsalis or locomotor ataxia. Sometimes paresis may co-exist, giving rise to the disease known as taboparesis.

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CHAPTER IX

PSYCHOSES WITH EPIDEMIC ENCEPHALITIS

Epidemic encephalitis, or "sleeping sickness," as it is often improperly called, is an inflammatory disease of the brain that first came to the attention of medical science about twenty-five years ago. An ultramicroscopic, filtrable virus, of which there are several strains, is the infectious agent.

Acute and Chronic Stages. The acute phase of the disease differs strikingly from its chronic phase. At times the acute attack is mild and if without obvious neurological symptoms the real nature of the disease may not be recognized. Typically the onset is with fever, headache, clouding of consciousness, delirium, double vision due to paralysis of some of the muscles of the eye, increasing apathy, and perhaps deep and prolonged sleep. Some patients exhibit choreiform or other muscular movements. A certain number of patients die, others recover completely, while others drift into a chronic form because the virus continues to live in certain areas of the brain in a manner comparable to that in which the *Treponema pallidum* continues to reside in the cerebral cortex of a paretic long after the patient's original infection.

Parkinson Syndrome. In the lower part of the brain are certain large groups of cells known as basal nuclei. Several diseases of these basal nuclei may produce a striking group of symptoms known, after the man who described it, as the Parkinson syndrome. Persons suffering from parkinsonism show a characteristic masklike and expressionless facies. This immobile appearance is accentuated by the infrequent blinking of the eyelids. The patient often drools due to his failure to swallow the salivary secretions; the voice is monotonous, speech is slow and perhaps unintelligible; the trunk is bent forward; the gait is slow and shuffling; the arms are flexed in front of the trunk. A tremor develops, first of the fingers and hands, then of the feet and head. The virus of epidemic encephalitis often persists in these nuclei long after the acute phase of the disease

has passed. After, therefore, a period varying from two to many months during which it is believed the patient has entirely recovered the symptoms of parkinsonism may slowly develop.

Not rarely postencephalitic patients suffer from spasms of the eye muscles. During these spasms, known as oculogyric crises, lasting many minutes or even much longer, the eyes are persistently turned upward.

Behavior Disorders. At times epidemic encephalitis produces disturbing changes of behavior in children. These changes may begin within a few days, weeks, months, or even a few years after the acute attack. The manifestations of these changes of behavior seem to be almost without limit. Among them are irritability, outbursts of temper, quarrelsomeness, disobedience, tantrums, restlessness, stealing, running away, teasing, lying, cruelty, impudence, destructiveness, "showing off," constant talking, profanity, boastfulness, shyness, sex perversions, setting fires, and many other emotional and behavior disturbances. The postencephalitic child may take advantage of a student or new nurse and attempt to secure privileges beyond those permitted. If his wishes are not granted he may fly into a tantrum, swallow pins, break windows, and behave in other undesirable ways. Intellectual defects do not seem to follow the disease except when the infection occurs at a very early age—4 years or younger.

The relation of these behavior disorders to the organic disease of the brain in encephalitis and the mechanisms underlying the change in behavior are unknown. There seems to be a loss of inhibition over the primitive emotions and the innate tendencies to instinctive behavior, with the result that impulsive and exaggerated responses occur.

Paralysis Agitans. While probably not due to the virus of epidemic encephalitis but to other, not clearly understood, processes acting on the basal nuclei, this is a convenient place to consider paralysis agitans or "shaking palsy." The most conspicuous symptoms of this disease, which is usually confined to elderly persons, are those of parkinsonism with its "pill-rolling" tremor of the fingers, masklike facies, and muscular rigidity. The so-called propulsive gait is characteristic. The patient, if seated, arises with difficulty; the first few steps are slow and shuffling, then they become progressively shorter and quicker until the patient must come

to a stop to prevent his falling forward. At times the patient may make short steps backward instead of forward (retropulsive gait).

Nursing Care and Management. In nearly every large psychiatric hospital the nurse will note several patients suffering from some form of postencephalitic disability. Frequently their mental condition is better preserved than their physical condition would suggest. The patient's physical disabilities often prevent him from performing activities which he would greatly enjoy. Sedative baths and massage will help relieve muscular fatigue and promote physical comfort. Since tremors make it difficult for the patient to eat, the nurse must assist him in his meals. The patient will require the assistance of the nurse in lacing his shoes and in performing various other personal services. As long as his condition permits, the patient should attend entertainments and other hospital activities. These handicapped, thwarted individuals often greatly appreciate having the nurse read to or converse with them. To help relax the muscles the physician may prescribe such drugs as atropine, stramonium, or benzedrine.

Experience has shown that the methods and environment suitable for the training of the normal child are not at all adapted for the education and training of children exhibiting postencephalitic behavior disorders. Many of them are intolerable in the home and in the ordinary school because of their vexatious, disturbing, and destructive behavior. The routine of the average home, too, is designed for adults, whereas the schedule for these "naughty, restless" children must be adapted to their needs. The greatest success in their training has been secured in schools and institutions with a psychiatrically trained personnel taught to recognize that behavior disorders are due to disturbances in the moving forces that determine personality adjustments. The emotional attitude of the home toward behavior disorders must be replaced by the unemotional attitude of the institution which will deal with the child not so much by criticism and punishment as by an effort to surround him with conditions that make it more desirable to behave than to misbehave. While such children are more easily handled in groups and by an institution with its impersonal attitude, yet each child must be dealt with according to his individual personality needs. Sometimes methods of reward or deprivation may be used to advantage. One of the most important steps in a program for the re-

education of the child in habits and attitudes is the establishment of a schedule that covers every hour of the day. There should be school work, manual training, gymnastics, perhaps farming, habit training, and carefully supervised recreational activities. Any improvement in the behavior of these patients is always slow and may even seem scarcely perceptible. Group treatment with its socializing influences combined with individualization and a somewhat elastic routine seems to accomplish most.

The nursing of adults with a chronic Parkinson syndrome requires understanding and cheerfulness. The mental impairment may be slight and the physical disability great. Depressed by his handicap the patient may be irritable. Diversion should therefore be provided. The nurse may read to him. If he is fond of music the radio or phonograph may give pleasure. Excessive salivation may be controlled somewhat by drugs.

SUMMARY

1. Epidemic encephalitis, or encephalitis lethargica as it was first designated because the acute stage is often characterized by extreme somnolence, is an infection of the brain caused by an ultramicroscopic virus.
2. There are two stages: the acute and the chronic.
3. The acute stage may assume many forms but tends to be characterized either by prolonged deep sleep or by restlessness and overactivity.
4. The chronic stage often presents the group of symptoms called the Parkinson syndrome that are the result of changes produced by the virus in certain large groups of brain cells known as the basal nuclei.
5. The chronic form may in children cause serious disorders of behavior without severe impairment of intelligence.

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CHAPTER X

PSYCHOSES WITH OTHER INFECTIOUS DISEASES

In this group of mental disorders are included: (a) those associated with infection of the brain or its coverings, such as the various forms of meningitis and acute chorea; (b) those associated with general infection, such as influenza, pneumonia, or typhoid fever; (c) those mental disturbances arising during convalescence from the infectious diseases or after their associated fever has subsided.

MENINGITIS

The meninges are serous membranes similar to the pleura or the peritoneum and are subject to the same types of infection, such as pyogenic, tuberculous, etc. In addition, however, to the serious toxic effects comparable to those produced in peritonitis or in pleurisy there is danger that the inflammatory exudates poured out within the cranial cavity with its inelastic bony walls may do harm by pressure or by producing inflammatory adhesions to the delicate brain structure beneath.

Symptoms of Meningitis. Whenever inflammation of the meninges develops, signs of their irritation and of irritation of the nerves passing through them occurs as shown by headache, pain in the course of the irritated nerves, and spasm of the muscles supplied by them. We therefore find retraction of the head, rigidity of the neck, squint due to paralysis of muscles moving the eyeball, spasm of the extremities, and perhaps opisthotonos. The compression of the brain by the exudate causes lethargy, stupor, clouding of consciousness, and delirium. Early in the onset we often find fever, irritability, and perhaps vomiting or convulsions. Often the slightest noise is painful, light may be intolerable, and any attempt to touch or move the patient may cause fear and agony.

Epidemic Meningitis. Because of its frequency and its contagiousness mention should be made of meningococcic meningitis. This is a bacterial disease often transmitted by carriers. After the onset

of what is considered to be an ordinary cold or sore throat, the meningococci invade the blood stream producing a general septicemia with chills, delirium, or stupor. Soon there is an infection of the cerebrospinal meninges with intense headache, rigidity of the neck, and other symptoms of meningitis. Because of the small petechial hemorrhages that frequently appear, the disease was once known as spotted fever.

Nursing Management in Meningitis. Since meningococcic meningitis is a contagious disease the patient will be isolated, careful precaution against transmission will be followed, and the nurse will use personal protective measures against infection. She will be prepared to assist in lumbar puncture. Since the special senses are painfully excitable the patient's room should be darkened and kept as quiet as possible. An ice bag may be applied to the head and cold sponges should be given with the least possible disturbance to the patient. The continuous bath is helpful, often easing the pain, promoting relaxation, reducing the temperature, and inducing sleep. The patient should be lifted into and out of the tub on a sheet. If the continuous bath cannot be employed cool, wet packs are useful. Adequate nourishment is important. With the introduction of sulphadiazine, which is given in large doses, the mortality of this serious disease has been greatly reduced.

Chorea

Acute chorea, Sydenham's chorea, St. Vitus' dance, as it is often popularly called, is an infectious disease of the central nervous system. The infecting organism, which is undoubtedly the same as that which causes rheumatic fever, by invading the basal ganglia produces the twitching movements that constitute the conspicuous symptom of the disease. The disease occurs mostly in children. The first symptoms consist of occasional twitchings of the hands, fingers, and face. Since the choreic patient is usually peevish, irritable, and wilful the real nature of the disease may not be recognized at first and the child is considered merely as nervous and disobedient. The movements become more frequent and extensive and finally disturbing. Most severe in the face and upper extremities the involuntary movements are aggravated by emotion. Arthritis and valvular heart disease may complicate a choreic infection. The disease persists for a period varying from six weeks to a few months and may recur.

The choreic child presents a wistful expression, is preoccupied, inattentive, sensitive, irritable, restless, and has difficulty in thinking.

Nursing Management in Chorea. It is highly essential that the patient have both physical and mental rest. He should therefore be protected from other children and confined to bed until his acute symptoms have subsided. He is best cared for in a hospital away from disturbing home influences. Artificial fever induced by a hypertherm has in recent years been found to be of great value in the treatment of this disease. Treatments are usually given daily, a temperature of 105 to 106 F. being maintained for two hours. Five to ten treatments are given. The nurse will closely watch temperature, pulse, and respiration and note any signs of circulatory collapse. Fluids and salt will be given freely to compensate for fluids and chlorides lost through perspiration. In the absence of means for inducing artificial fever, warm packs or continuous immersion are helpful. The patient should have an abundance of simple, nutritious food during convalescence. Since this is a long convalescence, interesting but not stimulating diversions should be provided.

Psychoses with Infectious Diseases

In this group are included those mental disorders which are primarily due to and associated with infectious disease, particularly during the febrile period.

Delirium. The mental symptoms most frequently seen in the infectious diseases are those occurring in the conditions known as delirium. This has already been described in Chapter VI. When delirium is associated with infectious diseases, the degree often varies with the height of the fever. In the mildest forms there may be merely confusion and inability to recognize familiar surroundings on awaking. The delirium may disappear during the day, to return with darkness or with an evening rise of temperature. Fluctuations in consciousness are common. Sometimes the patient may be quite lucid for an interval, to be followed by bewilderment or by vivid hallucinations and fear. Terror-stricken, he may at times leap from his bed and attempt to escape from imaginary danger. In the most extreme cases there may be stupor, muttering, and twitching, followed by coma and death.

Nursing Management in Psychoses with Infectious Diseases. Even in the absence of delirium the successful nursing of a patient

suffering from the toxemia of an infectious disease calls for high professional skill. The added existence of delirium will require further resourcefulness, since not only does the underlying disease require nursing, often without the co-operation of the patient, but the symptoms of the delirium itself may present problems. Since toxins are important agents in producing the delirium their elimination is important. Water, therefore, must be taken freely and frequently even though persistent effort is required on the part of the nurse. In the absence of marked restlessness no special hydrotherapy may be required and the daily baths and sponges will be sufficient. An ice bag to the head will often have a sedative effect. If there is difficulty in controlling activity, the prolonged bath may, if the patient is not weak or exhausted, have not only a valuable sedative effect but also assist in eliminating toxins. There must be assurance that both kidneys and bowel are eliminating freely. An abundance of fresh air is advisable. When practicable the patient's bed may be wheeled onto a porch. Feeding is often a vexatious problem. Were the appetite not destroyed from other cause the frequent tendency for the lips and mouth to become dry, the tongue coated, and for sordes to collect on the teeth would prevent any desire for food. For this reason, among others, the mouth and tongue must be cleansed with frequent regularity. Not rarely the patient is too intent in his restless activity or too dull from stupor to take food spontaneously. If urging and efforts to spoon-feed the patient are not successful, it may be necessary to tube-feed him.

Since it combats dehydration, cerebral edema, and acidosis the physician may order the intravenous administration of saline solution with glucose and insulin. Many physicians direct that 100 cc. of 50 per cent glucose in saline solution, 50 units of insulin, and 120 mg. of thiamin chloride be given intravenously through a 20-gauge needle. This is followed by large amounts of orange juice containing glucose and given by mouth. The intravenous medication may be repeated once after three hours.

Attention has already been called to the fact that one of the most important symptoms is confusion. This is true of delirium in general whether due to infectious disease or to some other cause. Because of clouding of consciousness the patient is apt to misinterpret situations. The nurse will therefore eliminate unnecessary noise, whisperings, and flickering lights and shadows. Especial

effort should be made to allay the fear of the apprehensive patient. The nurse should speak quietly, soothingly, and reassuringly. All procedures should be carried out with as little manipulation as possible accompanied by a simple, frank statement of what is being done. Because of the frequent fluctuations between clearness and confusion so characteristic of delirium the nurse may be taken off her guard, with the result that the patient suffers some accident during an unexpected return of confusion. The delirious patient must never, therefore, be left alone. Not a few patients in private homes or in general hospitals have fallen from an open window or down a stairway when the nurse's vigilance had relaxed.

Postinfectious Psychoses

Mental disorders characterized by mild confusion or by depressive, irritable, suspicious reactions occasionally appear in the early convalescence following the subsidence of fever associated with infectious diseases. In his weakened state the patient may be easily frightened, oversensitive to light and noise, morose, complaining, and preoccupied with his sense of weakness and debility.

Nursing Management in Postinfectious Psychoses. In these postinfectious, confused, irritable, melancholy states the emphasis should be on supportive measures. The nurse will see that the patient enjoys rest, abundant food, fresh air, and freedom from disturbing influences and experiences. As convalescence permits, occupational therapy of a type that makes but light demands upon physical strength will provide helpful diversion.

Summary

1. Infections that involve the brain or its coverings may be accompanied by acute mental symptoms. Likewise other infections, especially if associated with toxemia or high fever, may be the cause of similar symptoms.
2. Two diseases—epidemic encephalitis and acute chorea—of the first group are discussed.
3. Mental symptoms associated with the second group of infections are of the type known as delirium.
4. The treatment of delirium, whether associated with infectious disease or with some other toxic state, such as uremia, is pri-

marily that of the underlying disease, the nursing management of which is of great importance.

5. The elimination of the toxic agent, the promotion of the patient's physical strength, and his protection from accident in his clouded mental state are the primary nursing objectives.

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CHAPTER XI

ALCOHOLIC PSYCHOSES

Reasons for Desire for Alcohol. The relation between alcoholism and mental disorders has been the subject of much discussion. Careless thinking and prejudice on the part both of those who oppose and those who defend the use of alcohol as a beverage have led to many unwarranted conclusions. In considering this relation it should be recognized that observation and experience suggest some psychological need deep within the personality must prompt a practice as universal as the use of alcohol. Even in the moderate user alcohol creates a euphoria which tends to disregard the demands of reality. The consumer of large amounts is usually found to be one who has serious difficulty with his psychic conflicts, and seeks to escape from the problems of life rather than face them. Impulses not consciously acknowledged produce a sense of tension and uneasiness which the alcoholic seeks to benumb through drink. Alcohol assists the user to slip away from the oppression of reality and find a refuge in a world of his own where painful feelings do not enter. It produces a sense of well-being, blunts the user's critical power, and progressively relaxes his inhibitions and reduces his anxiety. Contrary to a widely held opinion alcohol, in spite of the feeling of self-confidence which it imparts, has no stimulant action on the brain or central nervous system. Its depressant action has been shown in both physical and mental tests. The reasons, therefore, for the excessive use of alcohol are psychological and are intrinsic in the personality, and the addict uses it as a means of adjusting to his problems. An understanding of the mental disorders associated with alcohol can only be obtained by taking into account the whole personality makeup of the individual, rather than by emphasizing any specifically poisonous properties of alcohol. As a matter of fact it is now realized that the organic damage to the central nervous system that follows prolonged and excessive use of alcohol is not due to the effect of alcohol itself but to avitaminosis,

a deficiency of the vitamin B complex without a liberal supply of which nerve tissue suffers degenerative changes. The chronic alcoholic restricts his diet and obtains most of his calories from alcohol which contains no vitamins. As a result his intake of vitamins is insufficient.

An interesting characteristic of the chronic alcoholic who enters a hospital for the treatment of either physical or mental illness is the fact that as soon as he is relieved of his acute symptoms he steadfastly maintains he will never again touch a drop of alcohol. His promises for reform are expressed with so much apparent sincerity that his confidence for future abstinence would be shared by both physician and nurse had they not learned by repeated experience that his promise will be kept only as long as alcohol is unobtainable. This failure is probably due largely to the relief from conflicts and problems afforded by his habit. In the mental hospital the alcoholic is, during his convalescence, one of the most likable and helpful of patients. He is dependent upon the approval of physicians and nurses and readily responds to attention and encouragement.

Delirium Tremens

Cause and Mental Symptoms. This is an acute psychosis that may develop in the chronic alcoholic following a severe or prolonged debauch and is probably due to various metabolic disturbances arising from excessive alcoholism. Fractures, surgical operations, infections, or other acute injuries or illness often precipitate an attack in the chronic alcoholic. It is characterized by delirium, confusion, tremor, visual hallucinations, and by an amnesia for the episode. The delirium is usually preceded by an aversion for food, restlessness, irritability, and disturbed sleep. Illusional interpretation of objects is common; ink spots become insects which the patient attempts to seize. Loathsome animals, often of diminutive size or fantastic shape, may so terrify the patient that he attempts to escape. The hallucinations are fleeting and changeable. Consciousness is clouded, and the patient may be greatly confused and disoriented. Persons about him may be misidentified. The delirium is often of an occupational type. The patient leaves his bed to attend to some imaginary detail connected with his usual occupation. Motor restlessness is marked and sleep is impossible. While the patient's mood is usually one of irritability, fear, and apprehension,

it is occasionally characterized by amusement, good-natured silliness, or grim humor.

Physical Symptoms. Physically the patient's conjunctivae and face are congested. The tongue, lips, and facial muscles may be tremulous, while the extreme and coarse tremor of the extended fingers is one of the distinguishing features of the disorder. Speech may be indistinct. The pulse is rapid, and often irregular and weak. The temperature is elevated, the skin moist, and the face often bathed with perspiration.

Course of Disease. Delirium tremens usually runs an acute course, terminating in from three to ten days. Convalescence is frequently preceded by a prolonged sleep following which consciousness becomes clear and the hallucinations disappear except that brief periods of delirium may occasionally recur at night for a short time. It should be looked upon as a serious disease, not infrequently leading to the patient's death. Occasionally, instead of terminating in death or recovery within the usual period, delirium tremens passes into Korsakoff's psychosis, to be described later.

Nursing Management in Delirium Tremens. The management of a patient suffering from delirium tremens is a matter of much importance. Leading medical authorities now advise that all alcohol be discontinued immediately. As in all cases of delirium the patient should never be left alone. Everything possible must be done to conserve his strength. Many a patient has been killed by exhaustion while struggling under mechanical restraint or by the depressing effects of drugs given to quiet him. The temptation in a general hospital or in a private home to use restraint or depressing drugs is so great that treatment in a hospital or ward for mental diseases is usually wisest. Of sedative drugs, sodium amytal or paraldehyde will usually be chosen by the physician. Two fluidrachms of the latter may be mixed with orange juice and crushed ice may be given by mouth. If given by rectum 3 fluidrachms may be mixed with 3 or 4 ounces of warm olive oil or starch solution, and given slowly through a small enema tube or catheter. After administration of the drug, pressure against the rectum with a roll of gauze will prevent its expulsion. Since it combats dehydration, cerebral edema, and acidosis the administration of normal saline solution with glucose and insulin is often helpful. The usual method is to give 100 cc. of 50 per cent glucose, 50 units of insulin, and 120 mg. of thiamin chloride intravenously at one time with a 20-

gauge needle. This is followed by large amounts of orange juice fortified by glucose by mouth. This procedure may be repeated in three hours. For a day or two longer the patient may receive 20 units of insulin before meals, which should contain a liberal amount of carbohydrates.

The sedative drugs and treatment outlined here will usually be successful in quieting the restless, wakeful patient. If they fail to do so the continuous bath helps greatly in quieting excitement and is comparatively free from depressing effect. The wet pack should never be used for the patient suffering from delirium tremens. It undoubtedly has a sedative effect, but it is depressing and acts also as a restraining measure with the result that the patient exhausts himself in his struggle for release. As the patient usually has a weakened myocardium, the pack may be the measure that determines a fatal outcome. The patient may strive to get out of his bath or his bed. Repeated, tactful urging will usually, however, succeed in keeping him in the desired place. Whether in the continuous bath or in his bed the nurse must see that the patient remains at rest. Slight exertion may cause death. There should be close observation for any change in pulse or respiration, and if noted the physician should be notified at once. Attempts to escape from terrifying hallucinations may lead to serious accidents. The patient should be constantly reassured concerning his fears and hallucinations.

Because many patients in an acutely alcoholic condition have sustained cranial injuries, the nurse will be alert to notice unequal pupils or any other signs suggesting the existence of intracranial injury. If the physician suspects this he may wish to do a lumbar puncture for diagnostic purposes. The nurse will also bear in mind the possibility of fractured ribs or extremities. Oral hygiene has usually been so neglected that it needs constant attention. The pulse should be carefully watched. Often the weakened heart requires digifolin or other digitalis preparation from the beginning.

The administration of food is an exceedingly important matter in delirium tremens. This should consist largely of carbohydrates which should be given in abundance. Yeast, molasses, and other foods containing vitamin B should be included. The patient should receive large quantities of liquids, particularly orange juice because of its high vitamin C content. Because the chloride content of the blood is low in these patients, they may receive capsules containing 30 grains of sodium chloride every four hours.

KORSAKOFF'S PSYCHOSIS

Cause. Sometimes it will be noted in what appeared to be an ordinary case of delirium tremens that the hallucinations disappear, but that the confusion and amnesia persist. This change and irregularity in the clinical picture often indicate the onset of a not extremely common form of mental disorder known as Korsakoff's psychosis, so named after the Russian physician who first described it. The disease is due to degenerative neuritis of the long peripheral nerves and to nerve cell degeneration in the cerebral cortex. It was formerly believed that these degenerative changes were due to the direct toxic effects of alcohol on nerve cells and fibers. Recent studies show, however, that the continued and excessive use of alcohol restricts the patient's diet and that the degenerative changes in nerve and cerebral cortex are due to the prolonged dietary deficiency, particularly of vitamin B.

Mental Symptoms. Superficially, consciousness may appear clear with the result that the extent of the mental disorder may not be apparent. On questioning the patient, however, one is often surprised to find he is disoriented and perhaps confused. Memory is lost, first for recent events and later for remote events also. Frequently after a moment he cannot recall what was just said. To fill in and conceal his lapses of memory the patient relates details of experience that never occurred. He may have been continuously in the hospital for months, but when asked as to his activities of the previous day he may relate how he went to town, met certain friends, attended the races, and so forth. The confabulations can often be suggested with the result that the patient will accept and narrate whatever fabrications are proposed. His attitude is usually one of genial sociability, but he frequently misidentifies persons about him.

Physical Symptoms. Physically, the patient often suffers from pain and tingling sensations, especially in the feet and legs, the calves of which are usually tender on pressure due to the neuritis. The patient may be unable to elevate the distal part of the foot (dropfoot) with the result that as he walks he is compelled to raise his feet far from the floor to prevent catching his toes (steppage gait). The muscles of the leg may atrophy and contractures develop.

Course of Disease. While occasionally in a case of Korsakoff's psychosis the condition clears up after a few weeks, usually the disease lasts many months at least, and the more severely ill patients never recover from the physical and mental disabilities. Usually there persist in varying degrees those permanent impairments of memory, apprehension, and judgment constituting what is known as dementia.

Nursing Management in Korsakoff's Psychosis. The first steps in treatment are to discontinue the ingestion of alcohol and provide an abundance of food rich in the various vitamins, especially vitamin B. Among foods to be recommended, therefore, are yeast, molasses, fresh fruits, fresh vegetables, cod liver oil, whole milk, butter, egg yolk, and liver or liver extract. When acute neuritis exists, rest in bed is desirable. Pressure on parts supplied by the inflamed nerves must be prevented. The feet should be protected from the weight of the bedclothes by a cradle. Since there is danger that the feet may become fixed in an extended position, they should be kept at right angles to the legs by splints or by a large sand bag against which the soles of the feet may rest. Acute pain may be relieved by hot fomentations. After the pain has ceased gentle massage, electric treatment, and both passive and active movements may be employed. As improvement takes place muscle training should be undertaken by means of handicrafts, walking, and light gymnastics.

Acute Alcoholic Hallucinosis

Cause and Symptoms. As in the case of delirium tremens this acute disorder develops only after the prolonged use of alcohol, although often immediately precipitated by an acute debauch. This form of alcoholic psychosis is characterized by auditory hallucinations occurring with clearness of consciousness and often accompanied with fear. In content the hallucinations are usually accusatory, or threatening, or both. The threatening voices typically refer to the patient in the third person, saying, perhaps, "Let's cut him up tonight." "Now shoot him."

The patient usually accepts the hallucinated voices as reality and therefore develops numerous delusions based upon them. He believes he is followed, that there is a conspiracy to kill him, etc. The patient's behavior is often determined by these delusions. He may

appeal to the police for protection or arm himself in self-defense. The accusatory voices may occasion so great distress that the patient may attempt his own life.

In contrast to delirium tremens, consciousness remains entirely clear, the hallucinations are largely auditory instead of visual, and after recovery there is no amnesia.

Recovery from acute alcoholic hallucinosis usually occurs in ten days to a month. Recurrences are common if the patient again indulges excessively in alcohol.

Nursing Management in Acute Alcoholic Hallucinosis. Prolonged continuous flow baths are very helpful. When not in the baths the patient should be kept quietly in bed. He should have plenty of fluids and an abundance of easily digested food rich in vitamins. Free elimination is important. During convalescence exercise and occupation are desirable. The patient should remain under supervision until there is assurance that hallucinations have permanently ceased.

Paranoid Type of Alcoholic Psychosis

The paranoid form of alcoholic psychosis occurs only in persons who have long indulged in alcoholic liquors. The prepsychotic personality of the patient has usually been characterized by stubbornness, suspiciousness, resentment, projection, and other defensive mechanisms. There is much to suggest that if a person having these characteristics becomes a chronic alcoholic the habit has been acquired because alcohol provides a relief from tension and anxiety arising from the same conflicts and problems against which the personality traits serve as defenses. The personality characteristics and the alcoholic habit supplement each other, both arising from the same unadjusted elements in the personality.

Symptoms. This form of alcoholic psychosis is usually characterized by delusions of jealousy and infidelity. The alcoholic husband is at first distrustful and obstinate. To these unpleasant traits are added accusations of marital unfaithfulness on the part of his wife, as evidence of which are cited the most insignificant and irrelevant incidents. The jealous husband devises various schemes by which to entrap his wife and her supposed paramour. One patient maintained that he was not the father of his youngest child, since the supposed gestation period of his wife had been two hundred and seventy-nine instead of two hundred and eighty days.

Basing his conclusion on the most absurd evidence, such as that on one occasion the doctor had not promptly submitted his bill, he declared that the family physician was the child's parent. On several occasions he threatened the life of the physician and finally attempted to shoot him.

Prognosis. The prognosis in alcoholic paranoid psychosis is not good. Often after treatment in a hospital and the withdrawal of alcohol the patient will deny his delusional ideas, but they are usually expressed again soon after his return home. Such patients are abusive, threatening, and often dangerous.

Treatment. Patients suffering from this disorder should be treated in a hospital for mental diseases. There they may often be given freedom of the hospital grounds and not infrequently they become useful members of the institution.

Alcoholic Deterioration

Some persons who consume large amounts of alcohol over a prolonged period finally suffer some degree of personality disintegration, the change ranging from an impairment of emotional stability and control to an obvious dementia.

One of the earliest results of the abuse of alcohol is an increased impulsiveness prompted by primitive instinctual forces or momentary mood. Ethical sentiments may remain but they are usually not sustained or applied, with the result that will is weakened, perseverance is lost, and the patient becomes untruthful and unreliable. He blames others for his failures and represents himself as abused or as the victim of circumstances for which he is in no way responsible. At the same time he exaggerates his own achievements. The drunkard becomes careless in dress, loses ambition and affection, and neglects his family. With his friends the alcoholic may be a congenial and welcome companion but at home be brutal, surly, and without shame. A defensive attitude is assumed toward those who are not alcoholic, while the patient is touchy, irritable, and critical in the presence of those whom he believes do not approve his excesses. In extreme cases there is an increasing poverty of ideas and a decreasing capacity for sustained attention and for finer discriminations. Memory becomes impaired and dementia insidiously renders the patient incompetent. This dementia, however, is not directly due to alcohol itself but to a deficiency of vitamin B complex, especially to a lack of vitamin B_1 or thiamine. Specialists in

nutrition have shown that the chronic alcoholic has an increased need for thiamine. Usually, however, he spends his money for liquor rather than for food with the result that his intake of thiamine is decreased. Since absorption is also impaired by the effects of alcohol on the gastrointestinal tract, a thiamine deficiency is prone to develop with resulting degenerative changes in the nerve cells of the cerebral cortex. An impairment of mental faculties necessarily follows this destruction of cells.

Nursing Care and Management in Alcoholic Deterioration. The alcoholic suffering from thiamine subvitaminosis should receive a diet rich in B_1. He should therefore receive liver, whole wheat bread, cereals, eggs, nuts, lean pork, legumes, wheat germ, and yeast. The demented alcoholic should be treated in an institution where he may no longer secure intoxicants and where both the patient and society may be protected from the defects of his mind and morals. He should have light employment, the nature of which must depend largely on the degree to which his judgment is impaired. If not deteriorated the addict may be helped by an organization known as Alcoholics Anonymous.

The nurse caring for an alcoholic patient should possess understanding, tact, and fortitude as well as cautious vigilance. In the case of the patient suffering from acute intoxication or from the acute alcoholic psychoses, she should remove from his reach anything containing alcohol. This will include bay rum, canned heat, ether, and rubbing alcohol. If nothing else is available wood alcohol may be drunk with resulting paralyses or blindness. Should this poisonous form be taken the physician should be notified at once. Pending his arrival, the stomach may be washed out with large quantities of tepid water and strong coffee be given.

At times the acutely alcoholic patient may be sexually excited. Should his speech or behavior become improper the nurse should meet the situation with an unruffled calmness, should avoid the attitude of seeming offended, and should treat the incident as a temporary alcoholic reaction, using such quieting measures as the physician may prescribe. As far as possible, employ him in some practical and interesting project at hand.

Although the alcoholic is often a genial fellow while drinking, he is prone to be an irritable, self-centered person on sobering up. The nurse should bear in mind his childish characteristics and avoid remarks or acts that offend him. Do not deny him opportunity

boastfully and egotistically to describe his exploits and powers of achievement. By patiently listening much can be learned concerning his inferiorities and mental trends. Do not "preach" or "moralize" to the alcoholic. It does no good. It is useless to tell him of disastrous physical or moral results. Rather with the guidance of the physician should the patient seek to discover the problems he has sought to escape in this way. He should be encouraged to meet these problems by more rational measures at the same time occupying himself with pleasant and productive activities. While stress should be avoided, and plenty of sleep be allowed, yet the mind should be kept alert both to the pleasures and the duties of the environment.

Summary

1. The manner in which a person reacts to alcohol depends largely on the basic nature of his personality. Alcohol strips off the veneer that conceals the natural personality characteristics and releases tendencies which repression has ordinarily stifled.
2. While probably some persons become alcohol addicts through the influence and custom of social associates, yet for the most part the excessive user of alcohol acquires his habit as a means of release from the tension and anxiety produced through emotional conflicts, as a source of refuge and a means of adjusting to his problems.
3. In some instances prolonged and excessive use leads to organic, degenerative changes in the brain, not, however, through any specifically poisonous properties of alcohol but through an avitaminosis to which, largely through his eating habits, the alcoholic is predisposed.
4. Characteristics frequently observed in the chronic alcoholic are described.
5. Acute and chronic personality disorders ordinarily considered as alcoholic psychoses are described and their treatment is explained.

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CHAPTER XII

PSYCHOSES DUE TO DRUGS OR OTHER EXOGENOUS TOXINS

Psychoses Due to Metals

Occasionally persons who in their occupation work for long periods with certain metals such as lead, arsenic, and mercury absorb amounts sufficient to produce toxic states resulting in mental disorder. Any mental symptoms are usually preceded by gastrointestinal disturbances and by weakness or paralysis of the wrists or other portions of the extremities. Among early mental symptoms are irritability, fatigability, prostration, depression, mild confusion, or even delirium, to be followed by loss of memory and other signs of dementia. At times persons engaged in the manufacture of rayon develop mental disturbances due to exposure to the carbon disulfide used in making that fabric. Such persons may suffer from insomnia, bad dreams, fatigue, depression, uncontrollable anger, and loss of memory. Occasionally delirium, delusions, and hallucinations occur.

Psychoses Due to Gases

The gas which most frequently leads to mental disturbances is carbon monoxide, especially in the form of illuminating gas and the exhaust from automobile motors. Following the unconsciousness produced by the gas there may be prolonged delirium after which the patient fatigues easily and has difficulty in concentration. Sometimes, after a period of several days or a few weeks during which the patient appears to have recovered, memory and other mental powers become permanently enfeebled, accompanied, perhaps, by speech defect and tremors.

Psychoses Due to Opium and Derivatives

How Morphine Addiction Is Acquired. Quite rarely do habitual users of morphine develop delirium, paranoid delusions, or suffer

some impairment of intellectual functions. The usual results of the prolonged use of morphine are an inveterate addiction to the drug, a gradual disintegration of personality and character, and the existence of certain physical symptoms, particularly on withdrawal of the drug.

A majority of young addicts contract the habit through curiosity or from other addicts, many of whom secure a certain satisfaction and perhaps profitable customers by enlisting recruits to the habit. Most middle-aged habitués become addicts through self-medication or through prolonged administration of the drug by a physician. Of habitués not recruited by addicts, nurses and physicians constitute a regrettably large percentage.

The continued use of morphine or other habit-forming derivatives of opium produces an artificial sense of well-being so intense that the desire for its return can scarcely be resisted. While the continued administration of small amounts of the drug will prevent the distressing withdrawal symptoms to be described later, yet increasing amounts are necessary to produce the desired exhilaration. The result is that the amount is gradually increased until many addicts take from 10 to 20 grains daily.

Morphine addiction is prompted by much the same motives as is the use of alcohol, viz., to secure relief from mental conflicts, to promote emotional relaxation, to alleviate deeply seated dissatisfactions, and to aid in difficulties of adjustment arising from instability of emotions, inadequacies of personality, and a feeling of insecurity. Rarely does a well adjusted person become an addict.

Ethical Effects of Addiction. As the use of the drug continues, an impairment of higher ethical and moral sense takes place. The addict becomes untrustworthy and notoriously prone to deception and untruthfulness. Many become sly and suspicious and may even have ideas of persecution. The patient disregards business obligations, neglects his family, and becomes indolent, seclusive, and asocial. While the morphine addict may steal or commit other offenses in order to secure his drug, usually through clandestine methods, he usually will not, contrary to a prevailing misconception, engage in major criminal activities. Many are morbidly interested in any disturbances of bodily feelings or functions and interpret them as the need for more morphine.

The results of heroin addiction seem to be even worse than those of morphine. The impairment in regard for ethical and moral

obligations is perhaps greater than in morphine addiction and the habit more difficult to cure.

Symptoms. The morphine or heroin addict may show few or no physical changes resulting from his habit. In some cases the skin may become dry, sallow, wrinkled, and senile in appearance. The patient may eat but little and often will not partake of food until he has had a dose of the drug. The mouth may be dry, tongue coated, digestion faulty, and the bowels constipated. If the patient has had the drug recently his pupils are contracted. The pulse may be small and extremities cold. If the drug has been administered by hypodermic syringe, the patient's skin often shows the scars of old infections and abscesses.

If within a few hours after the administration of a habit-forming derivative of opium the dose is not repeated the addict becomes restless, out of humor, irritable, and anxious. After twelve to eighteen hours he may suffer from anorexia, vomiting, abdominal cramps, diarrhea, muscular pains and twitchings, yawning, sneezing, hot flashes, and excessive perspiration. Sleep is fitful or impossible and there is a feeling of great prostration. These withdrawal symptoms reach their height about the third day and then gradually subside. If an addict does not experience uncomfortable withdrawal symptoms he should be suspected of illicit possession of the narcotic.

Prognosis. The prognosis for the cure of morphine addiction is unfavorable. A minority only of habitués discontinue the drug permanently. Some addicts have no sincere desire to cease its use, while even those who believe they wish to be cured return to the drug on the slightest pretext, the alleged occasion being actually a rationalization of their psychological need for obliterating reality and its problems.

Nursing Management in Drug Addiction. When the addict enters the hospital for treatment of his habit, it is well for the nurse to assume that he has brought a supply of morphine, even if he has voluntarily sought the hospital and expressed a wish to be cured of his addiction. Drugs may be craftily concealed in clothing, shoes, books, or other personal articles. Since drugs may be concealed even in body cavities, the nurse will be wise to give the patient an enema and a douche on admission. After these procedures and the routine admission bath, the patient, in order that access to any concealed supply of drugs may not be possible, should be given clothing not previously in his possession and, if possible, be placed

in a room not previously occupied by him. While earnestly professing a desire to overcome his habit the patient may try in every way possible to obtain the drug. Not rarely the patient will so excite the sympathy of relatives or friends that they lose sight of the purpose for which he entered the hospital and bring him the desired drug. The nurse will therefore see that visitors give nothing directly to the patient. The supervisor or head nurse should receive all gifts or packages. Mail should be opened by the patient in the presence of the doctor or supervisor. Since the drug can be easily secreted in candy, dates, figs, or other articles of food, it is advisable not to permit any food except that served by the hospital. Some addicts are such persuasive persons that they succeed in enlisting the services of paroled patients or even of attendants or nurses in securing the drug.

The withdrawal of the narcotic may be abrupt or by gradual reduction. Most physicians prefer the latter method because of the intense, even alarming, symptoms that may accompany abrupt withdrawal. Usually 3 or 4 grains of morphine daily are just sufficient to prevent withdrawal symptoms. The patient may receive an aliquot part of this amount every four hours. After four or five days this amount is reduced somewhat each day until after twelve or fifteen days the patient is no longer receiving any drug. The patient is not informed as to the amount of drug he is receiving; after the narcotic has been entirely stopped he may continue to receive hypodermic injections of saline solution until all withdrawal symptoms have ceased. It is well not to give the saline hypodermics for more than a few days after the discontinuance of morphine since each injection leaves the subconscious impression that the drug is necessary to control the symptoms. The patient tends, too, to prolong or exaggerate his symptoms in order to secure more injections of the real or the supposed drug. With his characteristic dissatisfaction and suspicion he often complains that he is not receiving sufficient or the prescribed amount of the narcotic.

At the beginning of the treatment the patient should receive 1 ounce of castor oil, and from time to time during the treatment ½ to 1 ounce of magnesium sulfate. The restlessness, muscular pains, and twitchings are best relieved by prolonged baths. Massage will also afford some relief. Sleeplessness is best relieved by 4 or 5 drachms of paraldehyde given in olive oil by rectum. As the patient is usually dehydrated an abundance of liquids should be given. Iced Vichy water helps to relieve nausea and vomiting. Diarrhea

should be treated with bismuth and tannalbin or similar preparations. Little food except iced milk or other cold drinks will be taken at first. As soon as possible, however, the patient should receive an abundance of nourishing food. Abdominal cramps will often be relieved by sodium bicarbonate or by a hot water bag on the abdomen.

Unfortunately the nurse has at times been influenced by the popular rejection of the drug addict and has failed to remember that while she must be firm in her attitude toward her drug addict patient, it is extremely important that she be gentle and sympathetic and obtain his confidence, co-operation, and friendship. All too often before his admission the patient has received unkind, perhaps harsh, treatment by public authorities. In the hospital he should be led to believe he is among friends and that he is regarded as a sick man, not as an evil one.

The addict will be wise to remain in an institution for three or four months after the discontinuance of all drugs. During this period he should receive physical exercise regularly and should have some interesting occupation, preferably in the open air. The nurse should attempt to aid him in facing reality, in maintaining a balance among his impelling drives, and in living at peace with himself.

Frequency of Addiction. It is estimated by the United States Public Health Service that about one person in every thousand is a drug addict. Because of the frequency of the habit, therefore, it is the duty of the nurse to acquaint persons with the danger of drug addiction. Particularly should she be watchful in the matter of repeated administration of morphine to neurotic individuals since they may easily become dependent upon it. Because of the stringent state and Federal laws forbidding the sale or possession of narcotics, drug addiction is gradually decreasing. Particularly helpful has been the Harrison Act, a law passed by Congress forbidding the "possession or control" of opium or cocaine or their derivatives except by persons registered with the collector of internal revenue. Nurses administering narcotics under the supervision of a registered physician are exempt from this law.

Psychoses Due to Other Drugs

Certain drugs following either long continued or brief excessive use may at times cause mental disturbances. Among such drugs are bromides, cocaine, chloral, acetanilid, sulfonal, trional, barbi-

turic acid compounds (particularly veronal), and various proprietary combinations containing these drugs. Following the use of these drugs, certain individuals may become dull and indifferent, with slurred and retarded speech. This apathy may be followed by delirium, confusion, perplexity, hallucinations of sight and hearing, flight of ideas, incoherent speech, confabulations, and misidentification of persons about the patient. These symptoms usually disappear within a few weeks after discontinuance of the drugs.

Psychosis Due to Bromides. Since physicians have developed methods of determining the amounts of bromides in the blood, it has been found that mental disturbances due to their administration as sedatives are much more frequent than had formerly been realized. Bromides are eliminated slowly and tend to accumulate in the body if given for more than two or three weeks. When their amount in the blood exceeds a certain limit, symptoms of intoxication may appear. If the intoxication is not severe there may be a feeling of tiredness or weakness, broken sleep, slowness of mental grasp, inability to concentrate, faulty memory, slurred speech, digestive disorders, and unsteady gait. If the intoxication is marked, the patient is delirious, disoriented, fearful, has visual hallucinations, and has much difficulty in grasping what is said to him. The face may be mask-like and expressionless.

In case of mental symptoms due to bromides their administration should be stopped at once. The patient should receive large amounts of liquids together with 100 grains of common salt each day. Patients disturbed by delirium may be placed in continuous baths. Laxatives may be required for the constipation that usually exists.

Much attention has been given in recent years to the increasing use of marihuana, a product of the flowering tops of the hemp plant. It is commonly used in the form of cigarettes, the smoking of which produces characteristic symptoms. It usually induces a feeling of well-being, but occasionally feelings of anxiety and apprehension. Things seem unreal, and the sense of time is disturbed. The patient may feel that his body is changing, such as that his limbs are becoming longer or his head swelling. Some patients become restless, excited, and confused, and may have visual illusions or hallucinations. The patient often feels that he is witty, even brilliant. The drug is usually smoked in parties or groups. There are no withdrawal symptoms on discontinuing its use.

Summary

1. One of the commonest drug addictions is the habitual use of opium derivatives.
2. Morphine addiction is developed as a means of securing relief from psychological conflicts, of promoting emotional relaxation, of alleviating deeply seated dissatisfactions, and of aiding in difficulties of adjustment.
3. Morphine addiction produces an artificial sense of well-being so intense that the desire for its return can scarcely be resisted.
4. If administration of opium products is suddenly discontinued the patient suffers from withdrawal symptoms that may be most distressing.
5. Withdrawal of drug should be gradual.
6. Distressing withdrawal symptoms may be relieved by physical measures.
7. Nursing management should be characterized by gentleness, firmness, and the establishment of a friendly rapport.
8. Other drugs, particularly bromides and barbiturates, may produce psychoses, of which delirium and confusion are among the most frequent symptoms.

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CHAPTER XIII

TRAUMATIC PSYCHOSES

Head Injury Not a Frequent Cause of Mental Disease. The opinion popularly entertained that injuries to the head are a frequent cause of mental disease is distinctly an error. Undoubtedly severe trauma to any part of the body may occasionally serve as the immediately precipitating cause in delirium tremens, schizophrenia, manic-depressive psychosis, and general paresis, as also of neuroses, but in such cases the trauma serves as a contributing cause only. Not over one-half of one per cent of admissions to hospitals for mental diseases are to be considered as traumatic psychoses in the correct sense of the term.

Symptoms Following Head Injury. Immediately following the receipt of moderately severe injury to the head the patient may be dazed and show difficulty in comprehension, clouding of consciousness, and confusion. At the same time he may become pale, stagger, and perhaps fall. Vomiting is not rare. Usually after a period of headache and disinclination for exertion, the patient recovers entirely. After sustaining a more severe blow the patient falls unconscious and suffers from surgical shock, with shallow respirations, rapid, feeble pulse, and subnormal temperature. The unconsciousness may be brief or may pass into a coma from which the patient never rouses.

Traumatic Delirium

In addition to the symptoms following immediately upon trauma of the head there are certain more remote disorders. Of these, traumatic delirium, if it occurs, usually begins during the gradual emergence of the patient from unconsciousness. It is characterized by confusion, disorientation, and by slight or even extreme restlessness. In contrast to the picture of ordinary delirium, hallucinations rarely occur. Replies are often irrational and more or less irrelevant. The patient may show a peculiar tendency to confabulate. If he

survives, he suffers from a memory loss for the period of the delirium. In case the patient lives, the delirium often lasts for several weeks and may be followed by one of the other types of traumatic psychoses.

Post-traumatic Personality Disorders

After concussion injuries of the head and with or without a preceding delirium, a change may occur in the injured person's disposition. The patient becomes irritable, easily fatigued, ill-tempered, readily given to anger or tears, is introspective, and often is inclined to solitary brooding. His capacity for work is decreased; he is less tolerant of alcohol and suffers from headache and vasomotor instability. Dizziness and other unpleasant sensations in the head are common and aggravated by bending over. Whereas the person suffering from a traumatic psychoneurosis as described in the following pages often recovers following settlement of compensation or litigation, the patient with postconcussion symptoms is not relieved.

Head Trauma and Behavior Disorder. In children severe injury to the head may be followed by personality changes and behavior disorders similar to those occurring after epidemic encephalitis. The behavior may be in the form of incorrigible delinquency but with no impairment of former intellectual ability.

Post-traumatic Mental Deterioration

If the brain tissue has suffered injury a gradually increasing mental enfeeblement may develop following a head trauma. Finer emotional feelings become blunted, intelligence and judgment impaired, and memory faulty. Flagrant change in manners and conduct may occur. If the injury has been serious, the dementia may be great and associated with epileptiform seizures, paralyses, aphasia, deafness, and other disturbances of the nervous system.

Post-traumatic Psychoneurotic State

Although this mental disturbance, sometimes known as traumatic neurosis, really belongs among the psychoneuroses or minor disorders rather than among the psychoses or major disorders, yet because of its apparent relation to trauma it is convenient to discuss it here. In our highly industrialized age with its liberal laws providing compensation for injuries sustained in one's occupation

the traumatic neuroses, following injury to the head or to other parts of the body, are common.

Symptoms and Mode of Development. As will be indicated in Chapter XIX the psychoneuroses are due to mental influences, do not seriously impair the patient's sense of reality, do not distort his personality, and do not upset his behavior to the degree that may occur in the major psychoses. In post-traumatic psychoneuroses following injuries to the head, the mental influences are usually fear and suggestion and wishful thinking. At such an interval after a head injury as recovery might reasonably be expected to be complete, it will be found that the patient, often apprehensive and suggestible in temperament, begins to be fearful that by returning to work and thereby forfeiting his compensation he will jeopardize his health by possible relapse of symptoms and his social security by inability to continue at his occupation. He then becomes nervous, tense, depressed, and querulous, and complains of poor memory, inability to concentrate, headache, and dizziness. In dramatic and superlative terms he pictures the seriousness of his injury and the acuteness of his suffering. As the physician attempts to examine the patient, he flinches, groans, and gasps. At times the onset is somewhat different. Perhaps as recovery seems about complete the patient becomes restless and begins to worry about his job, so he returns to work. The blood rushes to his head when he stoops over, he becomes easily fatigued, and suffers headaches when he lifts heavy objects. His friends, or perhaps his physician, warn him not to overstrain himself, so he ceases work to continue a longer convalescence. He begins to believe that he never will be able to return to his work and earn a livelihood. He becomes increasingly depressed, emotionally unstable, and develops mutiple and changeable complaints. If a liberal settlement of compensation is promptly made the patient may soon recover. If, however, payment is long delayed, or he has a feeling of discontent or a sense of grievance, complete recovery may never occur and the patient remain a chronic, complaining invalid. Unless one realizes how fear, suggestibility, and subconscious desire for financial compensation may produce such neurotic, hysterical disability, one may conclude that the patient is malingering, i.e., is practicing a conscious, deliberate, intentional deception for profit or gain. In the psychoneurosis, while the symptoms are produced for a gain, they are produced unconsciously.

Nursing Management in Post-traumatic Psychoneuroses. Following an injury to the head the patient should be placed carefully in bed and kept as quiet as possible. The patient's head should be elevated and usually an ice bag be applied. If the patient shows signs of surgical shock he should be warmly covered and hot water bags placed about the trunk and feet. The pulse, temperature, and respiration should be carefully recorded and the physician promptly notified should the pulse fall to 60 or below. Ears, nose, and mouth should be watched for bleeding, the limbs for weakness or paralysis, and the face and extremities for twitching. Restlessness in traumatic delirium may be troublesome. An ice bag and sponging may be helpful; restraint should be avoided if possible. Food should be light and frequently offered. Long-continued rest and quiet following the receipt of head trauma are important and should be insisted upon. An early return to work frequently prolongs and aggravates troublesome symptoms. It must be remembered that these patients fatigue easily. After the acute results immediately associated with the injury have passed off, the patient should not be encouraged to fix his attention upon annoying symptoms. Games, music, radio, reading, and occupational therapy may be used to prevent morbid preoccupation with the thought that the disability is extreme and if sustained should be compensable. Careful thought should be given to the prevention of a post-traumatic psychoneurosis. The attitudes of nurse, employer, and of any firm that may be liable for compensation insurance should be friendly. As physical effects of the injury lessen, the patient should be treated as a convalescent and not as a potential malingerer. The nurse should discourage any tendency on the part of the patient to exaggerate his complaints, teach him to overcome difficulties, incite his ambition, and constantly hold before him the fact that recovery is fostered by a return to normal life and activity. The most important measure in preventing the development of a post-traumatic psychoneurosis is an early return by the patient to his work. If his regular occupation is laborious he should at first be assigned such employment as will fit his physical capacity, care being taken that it satisfies him mentally and will promote the belief that he is on his way back to complete health.

Summary

1. Relatively few mental disorders are the result of injury to the head.
2. Mental symptoms that result immediately from injury to the head are described.
3. Among the more remote results of head injury may be delirious states, a change in personality, or varying degrees of dementia.
4. After the immediate organic effects of a head injury sustained in course of employment have practically ceased some persons develop a psychoneurotic state.
5. The factors underlying a post-traumatic psychoneurosis are mental, operating subconsciously, and consist largely of fear, suggestion, and wishful thinking, particularly in respect to financial compensation for the injury.

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CHAPTER XIV

PSYCHOSES DUE TO CIRCULATORY DISTURBANCES

Cerebral Arteriosclerosis

Of the mental disorders due to circulatory disturbances, that resulting from arteriosclerosis of the cerebral vessels is by far the most frequent. Cerebral arteriosclerosis may be part of a general arteriosclerosis or the sclerotic changes may be largely confined to those of the brain. The blood pressure may or may not be elevated.

Size of Vessel Involved. Mental disorders caused by cerebral arteriosclerosis occur in both middle-aged and elderly people, most frequently, perhaps, between 55 and 65 years of age. In older people symptoms due to senile degenerative changes are often associated. Roughly speaking the nature of the symptoms resulting from cerebral arteriosclerosis depends upon the size of the vessels involved, the large and the small vessels having, to some degree, their respective pathologic changes. If the small vessels are principally involved, degenerative changes occur in various cells scattered throughout the cerebrum. If the larger vessels are particularly affected one of them may become occluded by the formation of a clot or thrombus, in which case the cells in the area supplied by that vessel "soften" and die. Similarly if a vessel breaks because of the sclerotic changes in the wall, a hemorrhage occurs, tearing the delicate brain structure apart and by pressure destroying the nervous tissue adjoining. In case of thrombosis or hemorrhage the symptoms are what are known as focal, their particular nature depending upon the special function of the cells or fibers destroyed. Sometimes both small and large arteries are involved.

Symptoms of Small Vessel Sclerosis. In case of a diffuse sclerosis of the small vessels the mental symptoms develop slowly and may be accompanied by headaches, dizziness, and unpleasant sensations in the head. Sometimes the symptoms suggest neurasthenia, with the result that the real nature of the disease is at times overlooked.

Among early mental symptoms are easy mental fatigability, diminished capacity for intellectual work, lessening of initiative, irritability, moodiness, impairment of self-control, slight delay in comprehension, slowness in acquiring interest in new objects and situations, together with some memory loss. In contrast to the patient suffering from senile dementia, the sclerotic person usually recognizes that there is a decline in the quickness and accuracy of his mental processes. Arteriosclerotic patients are prone to laugh or cry at slight cause. Occasionally an early symptom is a surprising breach of conduct, the foreign behavior being due to decrease in powers of inhibition. Some patients develop definite delusions of a depressive or of a paranoid nature. Ideas of jealousy may be distressing to members of the patient's family. Occasionally the sclerotic patient may show a tendency to fondle little girls or to be sexually aggressive. Periods of confusion are not infrequent. Instead of confusional episodes, spells of violent excitement may occur, especially at night. Another episodic manifestation may be the occurrence of epileptiform seizures. As might be expected, the sclerotic changes tend to be progressive and to lead to more or less dementia. Somewhat characteristic are fluctuations in memory, orientation, and other mental capacities.

Symptoms of Large Vessel Sclerosis. The symptoms suggestive of sclerotic disease of the large blood vessels of the brain are usually preceded by some of the phenomena already noted, such as headache, dizziness or fainting attacks. Involvement of the large vessels often leads to hemorrhage or to the occlusion of a vessel by a thrombus. The disturbances manifested by such accidents are grouped under the term *apoplexy*. In about half of these vascular accidents consciousness is either lost or much disturbed. If coma develops it may be of brief duration or it may continue until death. With the appearance of the "stroke" respirations become slow and stertorous and the pulse slow and full. The temperature rises and in cases that prove fatal may be quite high. The site of the hemorrhage or the thrombus will determine the character of the functions disturbed. An artery particularly liable to rupture or to thrombosis is one that supplies the great bundles of motor fibers as they pass down from the cerebral cortex en route to the spinal cord. When torn apart by a hemorrhage or shut off from nourishment by occlusion of this vessel, the motor fibers can no longer transmit impulses so paralysis results. Since the fibers, where they are sup-

plied by this artery, have not yet crossed to the side of the body they later occupy in the spinal cord, the paralysis is of muscles on the side of the body opposite to that on which the vascular accident has taken place. Such a paralysis of the face, arm, and leg on one side of the body, these being the parts usually paralyzed, is known as hemiplegia. Similar accidents to arteries in other parts of the brain may cause aphasia, a loss of the power of expressing oneself in words or of understanding the meaning of words. An inability to recognize by touch the nature of objects placed in the hands, or blindness of half of each retina, are other so-called focal symptoms.

Course and Prognosis. The course of cerebral arteriosclerosis is progressive but the rate of progress varies greatly. Some patients live for years, their capacity for adjustment gradually failing, while others soon suffer from a fatal apoplectic stroke. In not a few cases death is hastened by an arteriosclerosis of the vessels in other parts of the body, associated with serious disease of the heart and kidneys.

Nursing Management in Cerebral Arteriosclerosis. The milder cases of psychoses with arteriosclerosis may be cared for at home; the severe ones require institutional treatment. In either case a carefully regulated mode of life is a fundamental requirement in treatment. While neither heavy manual labor nor mental tasks involving burdensome responsibilities or emotional strain should be permitted, an agreeable occupation of a simple type should be continued as long as possible. Without permitting it to be obvious, the patient should be relieved of responsibility. Social recreation such as playing cards, chats, or walks with others may help to keep the patient's general interests alive. Previous hobbies and interests which have been neglected because of a busy life may be encouraged. The patient should be urged to pay attention to personal appearance and habits. Since many of these patients suffer from associated disease of the heart, the amount of exercise should be subject to the advice of the physician. Massage is of value. Hydrotherapy in mild forms carefully supervised may be helpful. Great care should be exercised in the employment of hydrotherapy as too long or too vigorous methods may do harm to the patient. There should be regularly established periods of rest.

Diet. The diet of the arteriosclerotic patient is a matter of importance. Moderation in eating is the first essential. Perhaps in

some instances there has been unnecessary rigidity in exclusion of a number of articles of diet. It is well, however, to limit the amounts of meat and of salt. Arteriosclerotics tolerate alcohol poorly and should abstain entirely.

Apoplectic Paralysis. If apoplexy is suspected the nurse should note any particular attitude which the patient tends to assume. She should note if he moves the limbs of one side more than those of the other; if the muscle tone is the same in all limbs; if any extremities are abnormally flaccid or unusually stiff. The nurse should also observe if the head is kept turned to one side; if the eyes are habitually turned in one direction; if the pupils are equal; if one cheek blows out more than the other on expiration; and finally if the wrinkles are more pronounced on one side of the face than on the other.

Nursing Management in Apoplexy. No matter how slight the stroke, absolute rest in bed is imperative. Clothing should be loose about the neck so there will not be interference with the return of blood from the head. An ice bag should be applied to the head and heat to the extremities. The head should be kept slightly raised. The mouth of the unconscious patient will require careful attention. If the mouth of such a patient is kept open, the lips and tongue become very dry and must be moistened frequently with a mixture of glycerine and water. Like the mouth, the eyes of the unconscious patient may remain open with the result that the conjunctivae become dry and inflamed. The lids should be cleansed frequently with cotton and sterile saline solution. The conjunctival sac should be irrigated several times a day with boric acid or sterile salt solution.

The nurse should remember that after an apoplectic stroke the patient may experience difficulty in swallowing. At first no attempt should be made to give food, but later liquids may be prescribed in small quantities if the patient is able to swallow. If the patient remains unconscious and is becoming weak he may be tube-fed.

Even in the mildest cases the patient should remain in bed for many days. Because of the danger of hypostatic pneumonia the unconscious patient must be frequently turned from side to side. Care must be taken to prevent pressure sores in the patient with serious paralysis.

Nursing Management in Hemiplegia. Immediately after the onset of hemiplegia the paralyzed extremities are flaccid but they

soon become stiff or spastic. After the first ten days great care must be taken to see that the paralyzed extremities are not permitted to lie motionless lest adhesions form in the joints and the extremities suffer contractures that cause permanent disability. As soon as the acute symptoms incident to the stroke have subsided, attention should be paid to the paralyzed limbs. Passive movements should be made at all the joints and the limbs should be systematically massaged. As soon as voluntary power returns active motion should be encouraged. The degree to which the original function of the limb is restored will depend in no small part upon the amount of care and persistence with which attempts at re-education are carried out.

Psychoses with Cerebral Embolism

Cerebral embolism is due to the occlusion of a cerebral artery by a mass of material lodged within the vessel. This material usually arises from vegetations that have broken loose from a heart valve or from a thrombus within the cavity of the left side of the heart. The result is an apoplectic stroke similar to that due to cerebral hemorrhage or thrombosis. The patient should receive the same nursing attention as recommended in apoplexy resulting from those causes.

Psychoses with Cardiorenal Disease

Occasionally mental disturbances are associated with serious heart disease, particularly during periods of decompensation. The most frequent symptoms are anxiety and fear, associated at times with delirium or temporary periods of confusion, often worse at night. Many patients with heart disease suffer from distressful and frightening dreams or from a sudden starting in alarm after falling asleep. There is difficulty in concentration. Paranoid delusional trends may be expressed.

Delirium may occur in acute uremia while in chronic uremia the most frequent mental symptoms are drowsiness, confusion, and emotional indifference progressing into coma. Sometimes the uremic patient is depressed, anxious, suspicious, and perhaps has delusions of persecution.

Nursing Management in Psychoses with Cardiorenal Disease. Since the heart is a most vital organ its disease may not only produce physical incapacity but also tend to undermine the spirit and

morale of the patient. Frequently there is the fear and dislike of being dependent on others and perhaps the fear of death as well as the constant sense of physical distress. In the case of the younger patient the feeling of frustration and disappointment may lead to discouragement or irritability. The nurse will so guide the patient that he does not develop an unwholesome attitude toward the handicaps imposed by his illness. She will remember that fear, repressed anger, or resentment may seriously aggravate the patient's cardiac disability.

Inasmuch as the mental symptoms in uremia are due to the retention of metabolic products that should have been eliminated, treatment must be directed toward their removal. This will be accomplished through increasing the activity of the sweat glands by means of hot packs, by producing frequent movements of the bowels, and by the ingestion of much water. As elimination increases the mental symptoms disappear. Milk will be the principal article of food. If the heart shows signs of weakness every effort must be made to conserve the patient's strength.

Summary

1. Arteriosclerosis is the most frequent cause of mental disorder due to disturbances of circulation.
2. The various symptoms resulting from impaired circulation in the brain are described, among the more striking ones being periods of confusion and attacks of apoplexy.
3. General management of arteriosclerotic patients is outlined.
4. Symptoms and management of an apoplectic "stroke" are discussed.
5. Mental symptoms occurring in decompensation of heart and in uremia are described and their nursing management stated.

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CHAPTER XV

PSYCHOSES WITH CONVULSIVE DISORDERS (EPILEPSY)

Convulsions are frequently symptomatic of organic disease of the brain or of irritative or toxic agents acting on its cells. The term epilepsy, or idiopathic epilepsy, is not applied, however, to such seizure disorders but is limited to unexplained, recurring impairments or losses of consciousness many of which are associated with convulsive manifestations.

Frequency and Heredity. It is estimated that there are between 400,000 and 500,000 epileptics in the United States, less than 5 per cent of whom are in institutions. While presumably many more would profit by care and training in an institution most epileptics may wisely remain at home.

Causes. Since the discovery in 1929 that electric currents are constantly produced in the brain and that these currents and any variations in their frequency and strength may be recorded by means of a delicate instrument known as the electroencephalograph, there has been much study of epilepsy and the modifications of these currents in that disease. Those who have studied epilepsy most by this method believe that its fundamental cause is a peculiar physicochemical makeup or reaction of the cells of the brain. It is suggested that this makeup is due to a congenital defect or to a failure of the brain to grow normally, to malnutrition or defective circulation that injures the fetus before it is born, to injury at birth, to infections of the brain or its coverings, or to other causes. The extent of heredity as a factor in causing epilepsy is uncertain. It is doubtless true, however, that it is more frequent among the relatives of epileptics than among others. The greater frequency of characteristic electric brain waves among the near relatives of epileptics reveals, too, an increased predisposition to the disease.

The Electroencephalograph. The electroencephalograph is similar to the electrocardiograph which is used to register the electric

currents generated in the heart. The electric pulsations of the brain are, however, so weak that they must be amplified a million times before they can be recorded by writing a line on moving paper. These electric impulses arise from the cortex or surface layer of the brain and occur in rhythmic waves, the normal number of discharges being about ten per second. The record of these electric impulses is known as an electroencephalogram, or familiarly as E.E.G. or "brain waves." While the pattern of these waves may in normal persons be modified by brain activity even so slight as that involved in opening and closing the eyes, by pain, or by attention, yet the wave pattern in respect to its height and rate remains an individual characteristic for each person, much the same as does his smile. In epilepsy and other organic diseases of the outer part of the brain the normal pattern or record of the electric waves is disturbed. The waves may then be too large (increased voltage), too fast, or too slow. Frequently the abnormal waves show changes both in size and frequency. Figure 4 illustrates the general characteristics of a normal encephalogram.

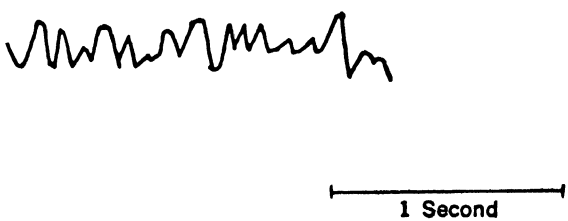


FIG. 4: SCHEMATIC PATTERN OF NORMAL BRAIN WAVES.

For a discussion of the technique of electroencephalography the student is referred to Chapter XXVIII. It will be noted that there are no great variations in the rhythm of the beats. Disturbances in the rhythm, or dysrhythmias as they are known, and as they occur in epilepsy, are illustrated in the succeeding discussion of different types of epileptic seizures. Each type of seizure is accompanied by a characteristic pattern of dysrhythmia. Even during the periods between seizures most epileptics show transient disturbances of rhythm indicative of the type of seizure from which they are accustomed to suffer.

Grand Mal Seizure. Of the various epileptic manifestations the grand mal seizure is the most dramatic. From a moment to several

seconds before the loss of consciousness that always accompanies this type of seizure, many patients have an *aura* or warning that a convulsion is directly imminent. The nature of this aura varies in different patients; some describe it as a feeling of distress in the epigastrium, to some it appears as flashes of light or stars, while others hear certain noises or have olfactory hallucinations.

The loss of consciousness is sudden and complete. At the same time the patient falls, and as there is rarely any opportunity to protect himself he may sustain serious injuries. As the patient falls all the voluntary muscles of the body pass into a state of fixed contraction, remaining in this tonic state or phase from ten to twenty seconds. The muscles of the chest contract at the same time as do those of the larynx with the result that air may be forcibly expelled, producing the peculiar sound known as the epileptic cry. At first the face is pale but as the muscles rigidly contract the superficial veins become engorged. At the same time the chest is fixed by the muscular constriction so that aeration of the blood ceases, thus increasing the cyanosis of the face. During the general muscular contraction the bladder is usually emptied. Following this tonic stage there is the so-called clonic stage characterized by alternate contraction and relaxations of the muscles. These alternating contractions and relaxations are frequently described by the epileptic's family as a "jerking" or "working" on the part of the patient. If the tongue happens to fall between the teeth during the relaxation it may be severely bitten when a moment later the muscles of the jaw rigidly contract. The saliva cannot be swallowed and because of the alternate relaxation and contracting of the muscles of the mouth it is churned into a foam, which leads observers to say that the patient "froths at the mouth." The periods of muscular relaxation become longer, the duration of the contractions becomes less, and the latter finally cease. Following the convulsive movements the patient is sleepy or stuporous. Perhaps for fifteen minutes he can be aroused with difficulty only or not at all. If left undisturbed he may sleep for an hour or two, and complain of headache and fatigue on awakening.

Figure 5, showing abnormally fast waves, usually sixteen to twenty per second, is representative of the wave pattern occurring in a grand mal seizure.

Many patients have convulsions during sleep as well as in their waking hours, while in the case of some patients the seizures are

always nocturnal. One woman had occasional nocturnal convulsions for years, and her family never realized the real nature of the disturbance she at times created at night.

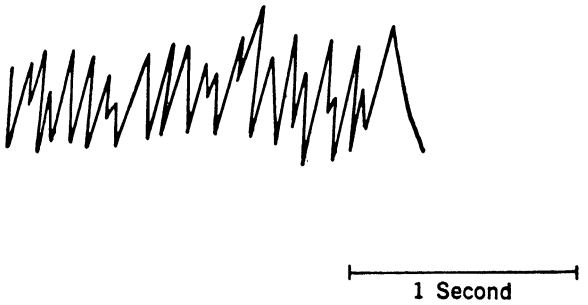


FIG. 5: SCHEMATIC PATTERN OF BRAIN WAVES IN GRAND MAL.

Status Epilepticus. Sometimes a patient may pass from one convulsion into another without regaining consciousness between seizures. As the convulsions continue the patient's temperature may rise to alarming heights. This state, characterized by rapidly recurring seizures, is known as status epilepticus and often involves danger to life.

Petit Mal Seizure. Abortive seizures of various degrees and types occur, in all of which there is usually some disturbance of consciousness. The most frequent of the minor forms is that known as petit mal. The details of these minor attacks differ greatly. Often the patient becomes pale, his eyes are staring, his attention cannot be secured, and he may momentarily suspend his occupation or drop whatever article may be in his hand. After a few seconds consciousness returns and the patient resumes his activities,

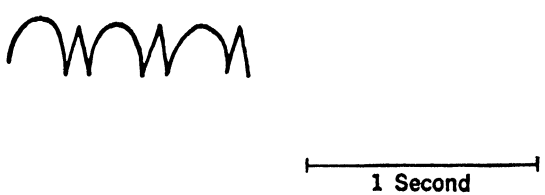


FIG. 6: SCHEMATIC PATTERN OF BRAIN WAVES IN PETIT MAL.

perhaps quite unaware of his "absence." Not rarely petit mal attacks increase in severity and are replaced by grand mal seizures.

Figure 6 shows the general type of brain waves recorded by the

encephalograph during a petit mal seizure. The tracing illustrates the alternating fast and slow rhythm producing the type of pattern known as "wave and spike," repeated three times per second and characteristic of petit mal.

Psychomotor Seizure. At times epileptic patients, instead of having seizures of the grand mal or of the petit mal types, may suffer from psychomotor seizures or psychic equivalents, as they are sometimes known. Although the patient appears to be conscious during the seizure he later has no memory of what occurred during it. In the milder attacks the patient may be merely morose and irritable, mumble incoherently, or in a confused manner do such things as button or unbutton his clothing. In more severe attacks the patient may be bewildered, hallucinated, destructive, and even commit crimes. Some patients manifest an ecstatic mood with religious exaltation. These clouded states may continue for several hours or even a few weeks. During them the patient may wander far from home, have no memory of his former or usual

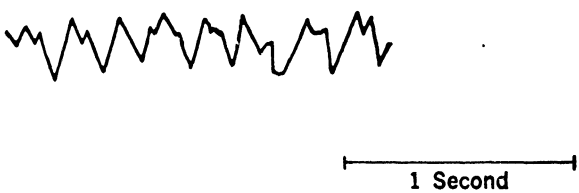


FIG. 7: SCHEMATIC PATTERN OF BRAIN WAVES IN PSYCHOMOTOR SEIZURE.

self, and yet not behave in a way such that strangers observe anything strikingly peculiar in his behavior. This wandering is known as an epileptic *fugue*.

In the psychomotor seizure or epileptic equivalent the record of the encephalograph is in the form of slow flat-topped, or sawtooth-topped waves occurring three to seven times per second. The diagram of Figure 7 represents a type frequently observed in this form of seizure.

Epileptic Deterioration. In the case of many epileptics there is a gradual development of mental dullness and a progressive narrowing of interests. Associations and thinking become slow, comprehension and memory suffer impairment, while emotionally the patient is irritable or apathetic. Often the deteriorated epileptic is careless in personal appearance, is selfish, boastful, and lazy.

His face is often vacuous and expressionless. Speech becomes slow and monotonous. The degree to which dementia progresses, if it occurs, varies greatly; in some instances it is extreme, the patient existing at a vegetative level with apparently complete loss of ordinary intellectual capacities. While deterioration is not uncommon among institutionalized patients, it should be remembered that most epileptics do not require institutional care and that many of them deteriorate but little if at all. Many epileptics have their convulsions and get on with their lives no worse than anyone else. There are plenty of examples to show that epilepsy is not incompatible with ability.

Observation of Seizure by the Nurse. Since the physician, particularly in the absence of an encephalogram, occasionally finds the diagnosis of epilepsy quite difficult in the absence of personal observation of a seizure, it is often of great importance that he be provided with a carefully recorded description of the attack as observed by the nurse. She will note if the patient appeared confused or showed unusual behavior immediately before the attack, if there was a sudden disturbance of consciousness, and if there seemed to be complete loss of awareness. Note should be made of any cry or sound, of any change in the color of the face, if the contraction began in any particular extremity or muscle, and if the head was turned in any special direction. The nurse will observe if there were both tonic and clonic spasms, their duration, if the lips or tongue were bitten, if froth appeared at the lips, if urine or feces were passed involuntarily, and if the patient breathed heavily. It should be observed whether or not the pupils responded to light and if they were dilated or contracted. If the patient fell at the onset of the seizure he should be examined for bruises or other signs of injury. The nurse should observe how long the patient remained unconscious after the spasms ceased, if he appeared bewildered or behaved strangely after regaining consciousness, if he fell asleep after the seizure, and if so, how long he slept.

Mental Hygiene and Nursing Treatment in Epilepsy. The ignorance and resulting prejudice of the public in respect to the epileptic and his disease place a serious social and occupational handicap upon him. All too often epileptic children feel that they are stigmatized, and are therefore at a disadvantage among their schoolmates. Nurse as well as physician should seek to create a practical and healthy attitude toward this disorder both in the

patient and among those with whom he is associated. Schoolteachers should be encouraged to take a sensible view toward the condition, and parents be taught to avoid too much solicitude and to understand the despair which is at the bottom of the defiance or the unruliness sometimes seen in the epileptic child. Seizures tend to isolate a person from stimulating contacts. As social outlets close, activities and interests become contracted and a state of inertia combined with despondency and hopelessness develops. Maintenance of the patient's emotional equilibrium and of his morale, and the possibility of preventing mental deterioration through intellectual, social, and moral stimulation are all too often neglected. The patient must not be infected with shame and anxiety because of similar attitudes on the part of parents and their wish to protect their own social position.

The irritable, selfish, stubborn, and rigid personality not infrequently seen in the epileptic often dates back to childhood. The epileptic child manifesting such tendencies should receive wise and sympathetic guidance in learning to meet environmental stress. He must be taught not to avoid routine that may strike him as burdensome. He should learn that his environment cannot always be molded to suit his fancy and that it is to his disadvantage to fail to meet its demands; that tantrums and similar episodes mean personal loss to himself. He should be encouraged to play freely and naturally with his fellows and not be too exacting and insistent that his methods be followed. Selfishness should be discouraged, as should also suspiciousness or resentment. Discipline should not be harsh and unsympathetic, neither should it be changeable or overindulgent. Some children of an epileptoid temperament are quite dependent on a parent. In such cases self-reliance and independence should be encouraged. Interests should be as varied, concrete, and objective as it is possible to make them. Education and employment should be stimulative. Pride of personal achievement will not rarely compensate for the derogatory attitude of others.

Temporary care in an institution may be wise for the mild cases and usually permanently advisable for many of the more severe ones. Definite routine and judicious discipline, measures which often will not be carried out at home, are helpful. In so far as is possible the same mental habits that were recommended for the potential epileptic should be encouraged, with especial attention

to self-control. The patient's entire life should be arranged with regular hours for rising, eating, working, and playing. The regulation of the epileptic's diet is of considerable importance. Doubtless in the past there has been a tendency to eliminate an unnecessary number of articles from his diet, which should be well balanced and contain plenty of fruit and vegetables with a moderate amount of meat. When a ketogenic diet is prescribed, a specimen of urine should be sent to the laboratory weekly because of the frequency of acidosis. Fried foods are undesirable. Most important of all is moderation in eating. As the epileptic is likely to eat to excess, the nurse should pay especial attention to the quantity of diet. The patient should be closely observed during his meal to prevent possible choking should a convulsion occur at that time. Since constipation seems to increase the frequency of seizures the bowels must be kept regular. Baths, packs, and massage are helpful. Active participation in out-of-door games such as baseball is beneficial.

Every epileptic not suffering from disabling physical disease should be employed. The epileptic is prone to rationalize his desire to avoid working by saying his disease incapacitates him. Employment, however, should be regular, not so much for its material products as for the sake of its discipline. Perhaps in no other type of mental disease is it so important for the nurse to stimulate a genuine interest on the part of the patient in a variety of activities and amusements. If left to himself the epileptic tends to daydream and indulge in idle dissipations as a result of which his seizures become more frequent and deterioration hastened. He should be encouraged to plan his own work, studies, and activities. The nurse should assist with personal direction and attention, offering encouragement and preferably providing the stimulus furnished by her own participation. Sustained effort is difficult for the epileptic to attain, but it accomplishes more than drugs so the nurse should not weary in her attempts to cultivate useful, industrious habits. Patient and tactful assistance by the nurse will enable the epileptic to create his own interests which may find expression in acceptable and helpful ways, thus retarding deterioration or even securing some improvement from the deterioration already suffered.

If the epileptic in his occupation is using any instrument by which he might be injured during a seizure, he should be carefully watched. Bone needles are advisable in crocheting. Blunt scissors are to be preferred to pointed ones. Working in the kitchen or at

a height should not be permitted. In institutions, women may assist in simple ward work or care for plants and flowers, while men may work about farm or garden. Radiators in quarters occupied by epileptics should be covered. The patients should sleep in low beds and if possible be housed on one floor so that there will be no stairs to climb. Cement or terrazzo floors are inadvisable. Epileptics should always be attended during bathing. Shower baths are to be preferred to tubs. Every person of long experience in caring for epileptics will recall instances when a patient has been drowned while attempting to take a tub bath in the absence of supervision. Since not a few patients have been suffocated by burying the head in a pillow during a seizure while asleep, patients subject to such attacks should be carefully watched.

When the patient suffers from a convulsion the nurse should loosen the clothing about the neck and chest to permit free respiraration. In order to prevent the patient from biting his tongue she should place some protecting article, such as a spoon handle around which a handkerchief is wrapped, between the patient's jaws. It is as well to let the patient lie where he has fallen provided there are no objects against which he may strike the head or extremities in his convulsive movements. A pillow or folded coat may be placed beneath his head. The nurse should not try to restrain the movements. It is well to turn the patient's head to one side so as to help clear the mouth of saliva. If the patient has eaten just prior to the seizure, care should be taken to remove any food from his mouth. He should be kept under observation until he is sleeping quietly or has become clear mentally. After the convulsive movements have ceased an ice bag may be placed on the head. After awakening dry clothing may be required because of the excessive perspiration or the incontinence during the seizure. A record should be kept of each seizure. This is known as a "convulsion chart."

Success in caring for the epileptic requires that the nurse possess or cultivate a genuine interest in her patient and his problems. This is not always easy since frequently he is not an amiable individual. Many are irritable, moody, quarrelsome, stubborn, and inclined to express dissatisfaction with the nurse and to charge her with neglect or abuse. The nurse will never argue with the epileptic. To some epileptic patients the nurse comes to represent a parent, and if she will judiciously accept this position of surrogate she may do much in re-education of the personality. Many patients

are eager to be helpful in nursing procedures and ward housekeeping. Such employment is beneficial to the patient and often of assistance to the nurse, who should offer commendation and encouragement for any efforts to that end. A simple, uniform routine of life is advisable.

Although formerly nearly all epileptics receiving medication were given bromides these have now been largely superseded by phenobarbital (luminal) given in doses of 1½ to 2 grains three times a day. Its sudden discontinuance will sometimes lead to status epilepticus. This alarming condition may often be checked by means of chloroform or by luminal in 2 per cent solution, or by sodium luminal in 7½ grain doses given intravenously. Sodium diphenyl hydantoinate (dilantin), a drug which has less hypnotic effect than does phenobarbital, is also extensively employed. It is given in doses of 1½ grains two or three times a day.

SUMMARY

1. Recurring convulsive seizures (epilepsy) may be symptomatic of organic, irritative, or toxic agents acting on brain cells or may be due to unknown causes, in which case they are called idiopathic.
2. The seizures of idiopathic epilepsy are of three types: grand mal, petit mal, and psychomotor or epileptic equivalents.
3. The rhythmic pulsations of electric currents in the brain are disturbed in epilepsy. This disturbance in pulsations is known as paroxysmal cerebral dysrhythmia and can be recorded by an instrument known as the electroencephalograph. Each of the three forms of seizure produces a distinctive record or electroencephalogram.
4. Problems of adjustment faced by the epileptic are discussed.
5. Advisable mental hygiene attitudes are presented.
6. Management of seizure is outlined.

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CHAPTER XVI

SENILE PSYCHOSES

Lengthened Span of Life. With the increased control of infectious diseases and the added knowledge of hygiene and other branches of medicine, there has been a remarkable increase in the life span, or the expected duration of life. One hundred years ago the average anticipation of life for newborn babies was to the age of 40. Now their expectation of life is over 60 years. Because of this fact and because of a declining birth rate, geriatrics, or that branch of medicine which deals with the diseases of old age, is becoming recognized as a subject of much importance.

Mental Hygiene Factors in Old Age. The increasing practice whereby employers establish retirement benefits for aging employees, and recent legislation providing for old age pensions and other social security aids, are desirable measures for meeting the social problem arising from a population containing a considerable percentage of persons beyond a productive and self-supporting age. Such measures alleviate the economic hazards of old age and promote the feeling of security, which is highly desirable for the maintenance of mental health in the aged. The more the elderly person can be relieved of feelings of financial insecurity, of worry and anxieties, the more public and social contacts are maintained, the more outside hobbies and interests are developed, and the less he yields to indifference and selfishness, the more likely will his old age be free from mental senility. If, too, he is assured that he is a part of the world of affairs, if he is convinced that he is loved and useful, and if he possesses that asset invaluable in senility, a cheerful disposition, the less will abilities and adaptations be impaired.

Varying Retention of Mental Capacity. Many persons, particularly those whose mental habits have been wholesome and stimulating, remain mentally vigorous until advanced age. Other elderly persons become increasingly self-centered, slightly forgetful, are inclined to manifest an accentuation of personal peculiarities, to

dislike change, to show a narrowing of interests, to reminisce, and to be childish in emotional reactions. Still other old people suffer an insidious impairment of mental faculties even to the point of dementia. Rarely before 60 years of age are the symptoms of waning mental capacity sufficiently marked to consider a person to be suffering from senile dementia. Its essential pathology is an atrophy and loss of those brain cells necessary for higher mental functions. When a considerable degree of dementia exists the convolutions appear smaller, and there is even some loss in the weight of the brain.

Symptoms. As the rigid and accentuated personality characteristics not uncommonly observed in old age become more marked and as difficulty in dealing with the ordinary problems of life increases, the memory for recent events may become progressively impaired. Past experiences are related in tiresome detail and without discrimination as to what is important and what is irrelevant. An elderly person may no longer clearly apprehend his own age and may speak of parent or grandparent as if still living. Any deviation in the daily routine is stubbornly resisted. The patient resents suggestions, particularly those of younger persons whom he may accuse of neglect or even of abusive treatment. Many patients are careless with fire or unconcernedly permit gas to flow from an unlighted jet. They are often restless at night and may wander about the house in a confused way, perhaps fumbling awkwardly and purposelessly at various objects. Worthless articles are hoarded. Persons are accused of having stolen belongings which the patient has mislaid. Friends are misidentified and the patient may declare that he is in strange surroundings, that he wants to "go home" even though he be in the residence he has occupied for years. Many such patients wander away from home and become lost. Indifference to dress, cleanliness, and excretory habits is not uncommon. Altruistic sentiments are often lost while egoistic, selfish, and instinctive tendencies may be intensified and expressed without restraint or sense of impropriety. Occasionally a tendency to exhibitionism or to sexual play with children makes hospitalization necessary. Querulousness and irritability are common. Many senile persons are distrustful, prying, and suspicious. Ideas become progressively more limited and attention more impaired.

Clinical Types. According to the predominance of certain groups of symptoms various clinical types are described. The most fre-

quent form is a simple deteriorating type characterized by extreme loss of memory, particularly for recent events, sluggishness of thought, and defects of attention and concentration. Deterioration of mental processes may become so extreme that the patient lives merely a vegetative existence.

In the presbyophrenic type the patient is disoriented and has serious defects of memory and retention. At the same time there is a surprising preservation of mental alertness and attentiveness, with ability to grasp immediate impressions and conversation quite well retained. Without realizing his marked memory loss the patient supplies the deficiencies with fabrications.

Another type is characterized by marked confusion or delirious states. Still another group shows not only defects of memory and of grasp of recent occurrences, but a pronounced depression and persistent agitation. The paranoid group is distinguished by the beliefs of the patient that he is badly treated and by obvious delusions of persecution or of grandeur. Memory may be fairly well preserved.

Physically patients with senile dementia usually show obvious signs of old age. The special senses are less acute, movements become awkward, and the gait may be tottering.

Prognosis. The prognosis of the senile psychosis is manifestly hopeless. Brain cells that have suffered degeneration or destruction cannot be replaced. Remissions are not to be expected although subsidence of excitement may occur. The course is progressive, but life may continue as long as ten years before death supervenes.

Nursing Management in the Senile Psychoses. In her contacts with elderly patients the nurse should be alert to, and combat in every way possible the fears, depression, self-depreciation, loss of confidence in ability, and failure of memory from which they often suffer. These characteristics may be increased or brought into prominence by overwork or fatigue in complicated situations which they could once handle with ease, but which now become almost impossible burdens. Many old people become sad, disillusioned, and disappointed, and life may become empty and miserable as they grow more or less incapable of playing useful roles in the family. Unfortunately they are not infrequently prevented from making themselves useful by impatient relatives who neglect to make special arrangements necessary to aid adjustment. Old

people are too often regarded as a burden upon the finances and emotions of other members of the family with the result that they become the objects either of open antagonism or of suppressed and subtle ill will. Frequently an important problem is the patient's feeling that he no longer holds the place of importance and of recognition he formerly enjoyed. To be replaced by others, whose points of view may be quite different, is a blow to one's self-esteem that may be met by various mechanisms of defense such as irritability, suspiciousness, miserliness, a tendency to criticize other persons, or to develop exaggerated ideas of one's own abilities. Some persons are more or less overwhelmed by the unpleasant change in their status, feel that they are no longer of any use to the world, and lose interest both in their personal appearance and the activities of their environment. Changes add to the feeling of insecurity. Sensitiveness concerning an increasing deafness may lead the patient to believe others are talking about him. Impaired vision and uncertain physical movements may contribute to an already existing feeling of bewilderment.

From what has been said the nurse will recognize that one of her important functions in caring for the senile patient will be to make him feel he is wanted, that the successful performance of some task depends upon him, and that he can derive pleasure from the opportunities life still permits. If memory is becoming poor the senile patient dislikes to have his attention called to its loss. The nurse will not injure his self-esteem by telling him he is mistaken. Argument and unnecessary irritation should always be avoided. Her attitude will never be patronizing. Pride in personal appearance should be stimulated—perhaps in the case of the elderly woman by a visit to a beauty parlor. Occupational therapy or other employment is to be encouraged. The pursuit of some hobby developed during younger years may do much in sustaining mental health. The elderly should be made to feel that recreation should constitute a part of their lives. The nurse may read to the patient, join in simple puzzles, or in games of cards. Because of the feeling of insecurity that comes with old age the attitude of the nurse will always be one of reassurance. She will seek to make the environment cheerful and comfortable. Through suggestion, persuasion, infinite patience, and ingenuity she will succeed in having the irritable, egocentric, resistive patient who has no intention of doing what he is told to do carry out desirable or needful activities.

Modern social conditions often make it difficult to care adequately in his own home for a patient suffering from advanced senile dementia. In urban surroundings, for example, many families reside in apartments where it is not easy to set aside rooms for older members. Relatively minor lapses of behavior may, too, disturb neighbors, or the absence of constant supervision may expose the patient to traffic or other dangers. If circumstances permit the patient should be cared for in the home. He is usually happier there than in an institution where all is strange and where the habits of a lifetime must be reconstructed. Wherever the patient receives care the accustomed routine of living should be preserved as far as possible. In the hospital elderly patients should if possible remain in the same ward and even in the same bed. Articles of furniture in their rooms should not be needlessly changed in position. If a change is to be made, the nurse will first attempt to explain it fully to them lest confusion result. As far as possible senile patients should be housed on the ground floor so as to avoid the danger of falling on stairs. Unless the patient's condition definitely requires it he should not be confined to bed. Even if he cannot walk about he may be taken up, dressed, and placed in a chair, supported, if need be, by a sheet. Canvas strips may be attached to the sides of the bed to prevent falling out when confused or restless. Old persons should not be hurried. Their hearts and musculature are no longer fit for rapid movements. Often, too, they feel insecure and are afraid of falling. In wards occupied by old people handrails may be placed on the walls of dormitories and of exit and other passages which may be used by them. In the event the patient falls he should be carefully examined for fractures because of the extreme fragility of his bones. Fractures of the hip may occur as a result of apparently insignificant accidents. The death of many a senile patient has been indirectly due to such a fracture.

Since the digestive functions of old people are often impaired, their food should be simple and easily digestible. Milk and soft foods are particularly suitable. If the patient is toothless the nurse must be sure that he receives food that requires but little chewing. Usually dinner in the middle of the day is preferable for the elderly patient. A little warm food at bedtime may help to prevent restlessness and insomnia. A cup of hot malted milk given during wakefulness in early morning hours may promote sleep. The elderly are often subject to constipation or diarrhea, condi-



FIG. 8: POSITION FOR ASSISTING A PATIENT TO WALK.

tions which the nurse should be alert to discover. Diarrhea in the aged is at times misleading, being really due to fecal impaction. In case of urinary incontinence the patient should be taken to the toilet frequently.

Many senile patients object to bathing; careful attention to this matter of hygiene is therefore necessary. The daily bath should be used as an occasion for observing the state of the patient's body.

Frequently senile patients are especially sensitive to cold. For this reason extra clothing is often necessary; on the other hand, excessive amounts should not be permitted. The elderly patient requires, too, a warmer room than do younger, more vigorous persons.

The skin of the elderly patient is thin and is bruised or punctured with surprising ease. Extreme care must be taken with the bedridden patient to prevent pressure ulcers. If the skin breaks down, rubber inflated rings and quartz lamp treatments with ointments containing cod liver oil are to be advised. Senile pruritus may be a distressing complaint. Olive oil or olive oil and lime water in equal parts may give relief. Lanolin containing ¼ to ½ per cent of phenol may also be used. Soap should be avoided.

Summary

1. Increased expectancy of life means an increasing number of old people with physical and mental disabilities.
2. Many psychological factors may influence the mental health of aged people.
3. The symptoms of senile dementia and the degenerative brain changes that accompany it are discussed.
4. Special mental and emotional problems which arise in old age are mentioned; ways in which the psychiatric nurse may help to relieve them are noted.
5. Physical disabilities associated with old age are described; the special nursing which they require is pointed out.

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CHAPTER XVII

PSYCHOSES WITH METABOLIC AND OTHER SOMATIC DISEASES

There are several physical diseases which may have associated mental symptoms, including: (a) those of the ductless or endocrine glands; (b) disorders of nutrition, as in pellagra; and (c) disturbances of body chemistry, as in diabetes.

Psychoses with Diseases of the Endocrine Glands

Myxedema. A disturbance in the functions of the endocrine glands produces disorders of development, chemistry, or other bodily processes, the exact nature of the disorder depending on the particular ductless glands affected. Similarly there may be disturbances in the development and expression of the mental aspect of the organism. The thyroid is a ductless gland the disorders of which are particularly apt to be accompanied by mental disturbances. The secretion of this gland may be either insufficient or excessive in amount and perhaps altered in quality. A deficiency in secretion gives rise to an associated group of physical and mental symptoms known as myxedema. In well-developed cases there is thickening of the skin, dryness, coarseness and falling of the hair, subnormal temperature, slow purse, and fatigability. Mentally such patients are slow in thinking and in grasping ideas. They are usually listless and sleepy, their memory is impaired, and their speech slow. Some are irritable, fretful, faultfinding, or even paranoid in their ideas and attitude. Mild degrees of thyroid insufficiency are often seen in middle-aged persons who complain of fatigue, pains, and headache, and are pessimistic.

Cretinism. Congenital insufficiency of the thyroid gland results in a disease known as cretinism in which there are defects both of physical and of mental development. The body of the cretin is short and broad, the forehead low, the nose flat, the nostrils large, the eyes small, the lips thick, the tongue large and often protruding. The neck and thorax are short, the abdomen large, the legs short, the

skin chalky, thick, cold, and often in folds. The body temperature is low; the gait weak and waddling. Cretins are always dull mentally, some not having a mental development above that of an idiot. If recognized in early childhood, great improvement follows the administration of extract of the thyroid gland.

Exophthalmic Goiter. Excessive secretion of the thyroid gland gives rise to a group of symptoms known as Graves' disease or, because of the prominence of certain physical symptoms often accompanying this excess, as exophthalmic goiter. In addition to the enlarged thyroid gland the cardinal physical symptoms of hyperthyroidism are prominence of the eyeballs, rapid pulse, tremor, a warm, moist skin, and other signs of an increased rate of metabolism—the antithesis of symptoms found in the hypothyroidism of myxedema and cretinism. Persons with a slightly excessive secretion of the thyroid are highly sensitive and emotional, but have no obvious enlargement of the gland and little or no prominence of the eyeballs. With greater degree of secretion they are overactive, emotionally excitable, are alert to every sound and impression, walk, talk, and eat rapidly, are irritable, anxious, and apprehensive to the degree often described as "nervousness." In acute thyroid intoxication occurring either in thyroid disease or after operations on the gland, there may occur an acute delirium accompanied by hallucinations, restlessness, insomnia, and incoherence. This intoxication may lead to coma and death.

Hypoglycemia. From her study of internal medicine the nurse has learned that hyperglycemia or an excessive amount of sugar in the blood occurs in diabetes mellitus. Since the treatment of diabetes calls for the administration of insulin she should remember that the administration of large amounts may result in hyperinsulinism or hypoglycemia and accompanying mental symptoms. In hypoglycemia the patient may be irritable, anxious, lack emotional control, be confused, hallucinated, and even maniacal. Occasionally coma follows. Associated physical symptoms are weakness, fatigability, tremor, hunger, twitchings, disturbances of vision, unsteadiness of gait, faintness, and convulsions. The administration of sugar quickly relieves the symptoms of hypoglycemia.

Psychoses with Pellagra

Pellagra belongs among the so-called deficiency diseases, i.e., diseases due to the absence of certain food elements necessary for

health. The element the absence of which produces pellagra belongs to the vitamin B group and is known as nicotinic acid, niacin, or sometimes merely as the pellagra-preventive factor. The disease occurs largely among people whose dietary is restricted because of their poverty. Isolated cases occur among chronic alcoholics whose food has consisted largely of alcohol and has therefore been deficient in the pellagra-preventive factor. Occasionally it occurs in persons suffering from intestinal diseases which prevent the absorption of food.

Nerve tissue in particular seems to require the presence of the missing element responsible for pellagra. Neurological and mental symptoms are therefore present in many cases. Among the more important mental symptoms are delirious states and confusion. Irritability, distrust, anxiety, and depression are common. Many patients complain of insomnia, vertigo, numbness, and a feeling of inability for mental or physical effort. In the final stages there is difficulty in grasping and elaborating impressions. Dermatitis and gastrointestinal disturbances are among the most important physical symptoms.

Nursing Management in Pellagra. Both the preventive and the remedial treatment of pellagra call for a diet rich in vitamins, such as the juice of citrus fruits, strawberries, apples, rare or lean meat, salmon, eggs, milk and cream, cod liver oil, and such green vegetables as spinach, lettuce, asparagus, fresh peas, cabbage, and tomatoes. The patient should be encouraged to take an abundance of liquids, especially in the form of lemonade and orange juice. Because of its high content of vitamin B, the physician will probably prescribe powdered brewers' yeast; two thirds of an ounce may be given four or five times daily in iced milk. Most patients receive intravenous injections of liver extract. Of all drugs nicotinic acid is the most valuable. This is given by mouth five or six times a day in doses of from 50 to 100 mg.

Psychoses with Pernicious Anemia

Another physical disease which the nurse should remember may have associated mental symptoms is pernicious anemia. While most patients with this disease do not have any frank psychosis, yet many show mild mental symptoms such as failure of interest, easy mental fatigue, somnolence, patchy memory, irritability, crying spells, and a complaining, discontented, faultfinding attitude with a tendency

to be verbally abusive of persons caring for them. More serious but less frequent mental symptoms are depression and apprehension, or confused, delirioid states. Adequate liver extract therapy tends to relieve the mental symptoms.

Postoperative Psychoses

Occasionally the nurse will observe the appearance of a psychosis following an operation. Doubtless various organic factors such as infections or the absorption of toxins as well as psychological factors often contribute to these mental aspects, but since psychological influences of much importance to the patient are present in nearly every operation, attention will be called to them. Among them are fear and apprehension preceding the operation. The fear of mutilation, of loss of part of one's body, and of possible death are important. The strangeness of the setting, the sights and sounds in the operating room, and all the other preoperative procedures including anesthesia with the fear of losing consciousness contribute to the tension and apprehension. The importance to the patient of the particular organ operated upon will affect the possibility of a postoperative psychosis and will influence the character and content of any psychotic ideas. Psychoses are most frequent following operations upon the eyes and the genitalia. There is usually a postoperative interval of three to ten days before the onset of the psychosis. The most frequent symptoms are confusion, disorientation, hallucinations, paranoid delusions, apprehension, agitation, and restlessness. A not uncommon postoperative psychosis is that which occasionally follows the removal of a cataract. The patient becomes suspicious and confused and manifests fear and panic-like excitement, particularly at night. The loss of familiar landmarks adds to the sense of insecurity.

Nursing Management in Postoperative Psychoses. The role of the nurse both in preventing and in treating postoperative mental disturbances is an important one. She will seek to alleviate the fears of the patient, will protect him from disturbing sights and sounds, and will explain the nature and purpose of proposed nursing procedures. She will be watchful lest word or deed on her part be misinterpreted by the patient. Explanation and reassurance are particularly necessary if his mind is clouded by an anesthetic or toxic state. In the event of confusion or delirium she will be most vigilantly alert to prevent the removal of dressings or attempts to

escape from imaginary danger. At times patients look upon their illness and any attending operation as a punishment for some previous supposed lapse from ethical or moral standards. In that case the nurse will seek to allay any feelings of guilt. She will, if possible, prevent the patient from developing the feeling that there is an implication of inferiority, abnormality, or incurability associated with his disease or the results of any operation. Such feelings often stimulate mentally unwholesome compensatory or defensive reactions that lead to unpleasant personality characteristics or even to actual mental disease.

Summary

1. Congenital deficiency of thyroid secretion interferes with mental and physical development. Acquired deficiency produces mental dulling and physical changes.
2. Excessive thyroid secretion produces a mental excitability.
3. Excess of insulin with resulting hypoglycemia may cause confusion and even loss of consciousness.
4. Pellagra results from one form of vitamin deficiency. The deficiency causes both mental and physical symptoms which are relieved by niacin or nicotinic acid.
5. Patients suffering from pernicious anemia may show mental changes.
6. Rarely does serious mental disorder develop following surgical operations.

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CHAPTER XVIII

PSYCHOSES WITH TUMOR AND OTHER DISEASES OF THE BRAIN

Brain Tumor. The symptoms of brain tumor are usually both physical and mental. The physical or neurological signs and symptoms are due in part to the increased tension caused by the growth of the new tissue within the unyielding cranial walls, and in part to the pressure of the tumor on the areas of the brain having special functions, producing so-called focal signs. The physical symptoms produced by this increase of pressure within the skull are headache, dizziness, vomiting, slowing of the pulse, and an edema and inflammatory swelling of the optic nerve as it enters the eyeball known as choked disk. This choked disk may finally lead to atrophy of the optic nerve and resulting blindness. The focal signs depend upon the functions of the particular part of the brain injured by the growth of the tumor. If, for example, the tumor is in the motor area there will be paralysis of the opposite side of the body, if in the speech area there will be aphasia, if in the occipital lobes hemianopsia, and if in certain parts of the parietal lobe there will be disturbance of sensation on the opposite side of the body. When the tumor produces irritation of the brain, convulsions may be produced. The part of the body in which the spasm begins may indicate the location of the tumor in the brain.

Among the mental symptoms due to the increased pressure with its interference with the circulation of the blood and the spinal fluid, are failing attention, loss of interest in one's usual vocation, a loss of sense of responsibility, intellectual dulness, drowsiness, difficulty in comprehension, irritability, slowness of thought, impairment of memory for recent events, and confusion, particularly after fatigue or on awakening. Many patients show a peculiar indifference and failure to appreciate the seriousness of their condition. As the tumor continues to grow and the brain tissue is increasingly injured, the patient may become much demented.

Sometimes cells break away from tumors, especially cancers, in other parts of the body and lodge in the brain, giving rise to metastatic brain tumors. As these increase in number and size they cause mental symptoms, although less readily than do primary tumors.

Multiple Sclerosis. The symptoms of this disease are often exclusively physical and neurological, although mental changes occur in some patients. For some unknown reason patches of sclerotic degeneration appear at widely scattered spots in the brain and spinal cord. The disease begins in early adult life and usually progresses very slowly. Spasticity of the legs often makes walking difficult, speech may become indistinct, and the eyeballs show a back and forth twitching movement known as nystagmus when the patient turns them to one side. These and other symptoms vary widely according to the situation of the sclerotic foci.

Many persons never show mental symptoms. If symptoms appear they may be of numerous types and varying degrees of severity. Some patients are dull and indifferent while others are silly, laughing or crying without apparent reason. Some patients are depressed and others unjustifiably euphoric. The impairment of intelligence varies widely.

Paralysis Agitans. In Chapter IX, in which epidemic encephalitis was discussed, mention was made of a peculiar group of symptoms known as the Parkinson syndrome. Sometimes at middle age or later, practically the same group of symptoms may appear although the patient may never have suffered from epidemic encephalitis. Such cases are known as ones of paralysis agitans or "shaking palsy." Probably degenerative changes occur in the same nuclei at the base of the brain as are affected in the Parkinson syndrome of encephalitis. The symptoms of this syndrome may gradually increase in severity, and the muscular rigidity become so great that the patient becomes practically a helpless invalid. Some patients show few or no mental symptoms while others become depressed. Intellectual capacities and functions may become impaired although usually to a less degree than the slow movements and retarded replies of the patient may suggest.

Huntington's Chorea. Huntington's chorea is an organic disease of the brain accompanied by certain striking physical symptoms and a gradual mental change. The disease is not common, although every large institution for mental diseases usually contains one or

more cases. The disease is always of hereditary origin. The first symptoms consist of clumsy, jerky, irregular movements usually beginning in the upper extremities while later the legs and entire body are involved. At first the patient is thought to be merely inattentive or careless in his movements. These irregular actions of the muscles result in grimaces, a shuffling, dancing type of gait, and a hesitating, explosive type of speech. The patient appears absentminded, becomes irritable and morose, has outbursts of anger, and is no longer observant of dress and of social proprieties. The amenities and ambitions of life are disregarded. Many patients become faultfinding and irascible. Others become suspicious and jealous and even have ideas of persecution. There is an impairment of attention, memory, and judgment. As the disease continues there is a progressive poverty of ideas. The average duration of life is fifteen years.

Nursing Management in Psychoses with Diseases of the Brain. In brain tumor this will depend largely on the degree of disability produced by the tumor. Many patients will require rest in bed. When the headache is severe the patient should be in quiet, semidark surroundings with a minimum number of visitors. An ice bag may be applied to the head. Moderate catharsis by magnesium sulfate may afford some relief to the headache. If dementia and prostration are great the patient may not be able to attend to any of his own needs. If he suffers from convulsions it is highly important that the nurse make careful record describing the seizure, noting accurately where the twitching begins and the successive order by which it spreads to other parts of the body and whether or not all parts are finally involved. She will note if the contractions are severe or mild and how long they continue, and also will note if the head or eyes are turned in any particular direction.

There is no effective treatment for multiple sclerosis, paralysis agitans, or Huntington's chorea. All three disorders are slowly progressive. The attitude of the nurse will, nevertheless, be one of reassurance in respect to physical and mental handicaps. The psychiatric approach to her patient may be much like that outlined for the management in senile dementia.

Summary

1. Brain tumors, either because through their growth they increase the pressure within the unyielding cranial walls, or because of their location in special parts of the brain, or for both reasons, may produce mental and neurological symptoms.
2. Certain other organic disorders of the brain of unknown origin, such as multiple sclerosis, paralysis agitans, and Huntington's chorea, may be accompanied by mental symptoms produced by associated degenerative changes in the brain cells.

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CHAPTER XIX

PSYCHONEUROSES

Psychoses versus Psychoneuroses. Up to this point the various mental disorders considered have been characterized by the fact that there has been associated with them some type of physiological or structural pathology either in the brain or elsewhere in the body. In none of them have mental forces and influences alone been the factors which have been operative in producing the disorder, although in some of them such forces and influences from the patient's inner life have served to determine the particular form of the symptoms. In the remaining groups of disorders no physiological or structural changes have ever been demonstrated in the brain and no constant bodily disturbances have been observed. The disorders of this division appear, then, to be the outcome of psychic factors that have been subtly acting in the inner mental life of the individual. Certain of them seem designed to meet rather obvious emotional needs or conflicts, while others serve more obscure purposes. Based rather largely on the extent to which the patient's inner experiences upset his external behavior or distort his personality, these disorders are divided into two groups, the psychoses and the psychoneuroses. The psychoses tend to involve a much larger part of the mind than do the psychoneuroses and often incapacitate the patient for ordinary social life. The psychoneuroses affect only certain limited functions of the mind, and the patient never completely loses his grasp of reality. In this chapter the psychoneuroses, or the neuroses as they are sometimes called, will be discussed, while the psychogenic psychoses will be considered in the subsequent three chapters.

Neuroses Serve Some Useful Purpose. While the patient does not recognize the fact, yet broadly speaking the symptoms of the psychoneuroses play some useful role in his mental life. These symptoms serve their useful purpose without resulting in behavior that is regarded as particularly strange or abnormal. Often the symptoms

constitute disguised gratifications of inner stirrings and strivings that may not come to awareness as conscious desires, intentions, and fulfillments. Again the symptoms may represent defenses against these desires. Although the patient's symptoms often appear to be but unpleasant inflictions, yet in reality they serve also as disguised means of protection or satisfaction. In general the neuroses arising in civil life are the expressions of deeply seated dissatisfactions, frustrations, and emotional distress produced by a failure to live harmoniously with one's self and one's fellows.

For various reasons, partly because of their tendency to an admixture of symptoms, the psychoneuroses do not easily lend themselves to a classification of types. Perhaps an adequate classification would divide them into hysteria, anxiety neuroses, obsessive-compulsive neuroses, and neurasthenia. These psychoneuroses are discussed in the four succeeding sections, following which there is a section covering their nursing management, and a separate section on the war neuroses.

Hysteria

Hysteria may be defined as a disorder in which purely mental forces produce some special physical or mental disturbance peculiarly adapted for the solving of some particular problem, or for realizing some particular wish of the patient's inner and emotional life. The nature of the disturbance thus produced is usually determined by the type of disability that will be most useful in accomplishing the subconscious purpose. The part or purpose which the hysterical symptom may play in the life of the patient may be exceedingly varied. In one case it may offer a means of escape from a physically dangerous situation, in another from one that is irksome. Again it may produce a face-saving but neurotic invalidism in a person who, finding the world too hard a place, desires exemption from effort and responsibility without loss of self-respect or the stigma of incompetence. A hysterical disability following a slight injury in a workman who finds his occupation tedious and unsatisfying may serve as apparently justifiable grounds for a claim for compensation insurance. A hysterical loss of memory may make possible the maintenance of self-esteem by preventing recollection of a humiliating or otherwise painful experience. In general the hysteric has found the demands of society too heavy for him, and through his symptoms is seeking ways of evading them.

Hysterical Symptoms Simulating Physical Disease. The forms in which hysterical mechanisms may find expression are exceedingly varied and may be in the nature of either physical or mental disturbances. The expressions in terms of physical disorder may involve sensory, motor, or visceral systems. Hysterical disturbances of sensation may be in the nature of anesthesias and abnormal sensations and in disturbances of the special senses such as blindness. Hysterical anesthesia does not follow the distribution of a nerve, but what might appear to one without knowledge of anatomy as the natural area for an anesthesia to cover. In an extremity, for example, it extends up to a sharply defined line above which sensation is normal and therefore outlines the so-called "glove" or "stocking" anesthesia. Among motor disturbances are various types of paralyses, such as of one extremity, one half of the body, or of both legs. Hysterical paralysis of the vocal cords resulting in aphonia (loss of voice) is not uncommon. Hysterical mutism in which the patient can neither speak nor whisper may occur. Spasms or tremors of various parts of the body are often of hysterical origin. Seizures which may imperfectly imitate epileptic convulsions are occasionally observed. Among visceral disturbances which may be hysterical in nature are vomiting, headache, retention of urine, dysmenorrhea, and various forms of chronic invalidism.

Hysterical Delirium. Sometimes ideas and wishes that have been repressed become split off or dissociated from the usual personality and obtain expression in hysterical delirium or dream states. The repressed material may gain expression through hallucinations. Earlier highly emotional experiences may be relived, or wishes which cannot be realized in fact may be attained in the delirium. Again, the wish-fulfilling delirium may efface or transform some intolerable experience or situation. At times a neurotic sense of guilt or the gratification of a wish forbidden by the patient's conscious ideals may be accompanied by some painful or disabling symptom representing self-punishment, as it were. A loss of memory for circumscribed periods of time is not uncommon.

Unconcern of the Hysteric. The attitude of unconcern which the patient often adopts toward his physical disturbances and disabilities is significant, and is in itself symptomatic of a hysterical reaction. His mood is one of contentment and he serenely accepts the handicaps arising from his illness. The hysteric's complacence is more suggestive of relief than of distress.

Personality Characteristics of Hysterics. Frequently persons who manifest a tendency to escape from reality through the mechanism of hysteria or by the same expedients to solve some problem that deeply touches the inner life will be found to exhibit certain character or personality traits. Often they are emotionally unstable and given to laughing and crying spells on apparently small cause, are impulsive, petulant, offended by trivialities, show a tendency to be suggestible, and are easily influenced. Many are vain, self-centered, crave sympathy, and exaggerate or even simulate disabilities. If they are not the center of attention to the extent desired they may seek it in various dramatic ways. They may show the emotional capriciousness that often characterizes adolescence. They are often immature in the emotional aspects of their sex development. Hysteria is prone to develop in persons in whom evasions were allowed to flourish and become habitual in early life.

Conversion Hysteria. There have been many theories formulated to explain how psychic processes may produce the great variety of physical and mental disturbances observed in hysteria. Just what the steps are by which functions may be suspended or altered for subconscious mental purposes cannot be said. In some way disturbing mental problems, tantalizing urges, and teasing desires may be converted into physical symptoms which serve some subconscious but highly useful purpose in meeting the needs of the patient's inner life. For this reason hysteria is often spoken of as conversion hysteria.

Two Case Histories. Perhaps some illustrations of how an idea or impulse heavily loaded with emotion may be transformed into an abnormal physiological function will be helpful. The following case illustrates how the actual form of the patient's hysterical symptom is often determined by the needs of his situation:

A young man who had been an acrobat and a dancer in a circus enlisted in the Army long after World War I. Here he found the discipline rigid, his duties irksome, and his experiences monotonous. He longed for travel, excitement, attention, and the opportunity for exhibition he had enjoyed in his former life. The situation became increasingly intolerable. To leave, however, meant that he would be disgraced as a deserter. Prompted by the two conflicting motives, one to conform to the code and traditions of military life, the other to secure release from a hated situation, the troublesome emotional conflict was converted by hysterical mechanisms into a paralysis of both lower extremities.

On arrival at the mental hospital to which he was transferred he could

neither walk nor stand, and his paralyzed legs were anesthetic to even vigorous prickings by a pin. Although as far as he was aware his legs were completely and permanently paralyzed, yet he did not seem particularly concerned by his disabilities, an attitude to be explained by the fact that to him the penalty was less than the gain, although it must not be concluded that this weighing of advantages and disadvantages was at all a matter of conscious reflection. A few months later the man was discharged from the Army on a surgeon's certificate of disability. Soon the suspended motor and sensory functions began to return. Persistent efforts to walk met with increasing success, and in three months he left the hospital practically recovered.

Another case of a type less dramatic but more common, and one which illustrates the "flight into illness" when emotional and other problems of adjustment are converted into a physical disability which affords a means of evading responsibility and of providing a morbid gain, is the following:

For some years before World War I a nurse, because of personality and other handicaps, had succeeded in making but an indifferent economic and professional adaptation. Her war experience was without especial significance. After her discharge from the Army she found herself confronted not only by her previous handicaps, but approaching an age when the struggle for a livelihood would be more intense. It was a period when a grateful government was providing generously for those who had been disabled in the war. As failure followed failure the nurse began to suffer from headache, gastrointestinal disturbances, and other disabling complaints. Repeated, careful examinations revealed no organic pathologic changes. Purely mental processes produced the disabling symptoms which entitled the nurse to financial benefits from the government, provided a comfortable home in a hospital, and thus relieved her of the struggle for a somewhat insecure livelihood. She developed symptoms which in themselves were undesirable in order to gain an end that was desirable—a phenomenon that is constantly met in hysteria. The fact that she showed no improvement under treatment is as to be expected since, as long as the psychological needs which created them continue to exist, there is a subconscious reluctance to be cured of disabilities serving some valued purpose.

Hysterical Symptoms in Physical Disease. It should be remembered that hysterical or other psychoneurotic symptoms may exist in the patient who is suffering from some genuine organic illness. The clinical picture of the existing organic disease may be complicated by many puzzling symptoms, the origin of which will be found to lie in emotional factors. The hysterical patient will welcome and stress unduly any existing organic illness and attribute to it any hysterical symptoms which he may exhibit.

Compensation Neuroses. Brief mention should be made of the traumatic and compensation neuroses which are often included among the hysterias. Usually the underlying but consciously unrecognized motive for the accident neuroses is a desire for compensation. Such neuroses rarely occur when the victim of the injury must bear the brunt of the financial responsibility for the accident, as in the case of injuries sustained in sports. In the case of traumatic neuroses the original injury is usually slight. There is usually an interval nearly free from symptoms, between those really incident to the injury, and the chronic, mentally determined symptoms appearing somewhat later. During this comparatively latent period the injured person is given to vague ruminations about his injury and readily accepts any chance suggestions as to its seriousness while an unconscious desire for compensation begins to develop. Presently disabling symptoms of increasing severity appear. Sometimes the neurotic symptoms do not become seriously troublesome until after the patient has returned to his employment, when they become so aggravated that he gives up work. The symptoms may include pain, tremors, weakness, paralysis, and various other motor and sensory symptoms usually referred to the region of the injury. The symptoms often include irritability, anxiety, depression, sleeplessness, headache, dizziness, and frequently poor memory and inability to concentrate. The patient remains unaware of his real motive and denies that he desires compensation, declaring that he would gladly forego any compensation could he be restored to health. Even though, as is usually the case, the patient recovers after the receipt of damages, he still fails to recognize the real reason either for his disability or for his recovery. Workmen's compensation acts and accident insurance have greatly increased the incidence of traumatic neuroses. This does not at all mean that persons suffering from them are malingerers or that the compensation was not merited. The disability, it is true, would not have occurred had the results of the injury not possessed potential benefits in some form. The difficulty was that the injury in these so-called "damage suit" hysterias occurred in a person of an unfortunate constitutional basis, poorly equipped to deal with such experiences.

Anxiety Neuroses

Symptoms. In anxiety neuroses the patient is in a more or less constant state of tension and emotional excitability. He suffers from

insomnia and an apprehensive expectation often accompanied by paroxysms of increased intensity even to the point of acute fear and apprehension. During these acute anxiety attacks the patient suffers from rapid heart, palpitation, nausea, diarrhea, desire to urinate, dyspnea, and a feeling of suffocation. The pupils are dilated, the face is flushed, the skin perspires, and the patient is tremulous, feels dizzy, and fears he is about to lose consciousness. Restlessness is acute, and the patient may express beseeching and apprehensive appeals.

Factors Causing Anxiety Neurosis. Anxiety states are especially prone to arise in association with frustrations in some major life problem related to such topics as vocational, sex, or marital adjustment. Not rarely anxiety states are connected with faulty technique in birth control, particularly if associated with sexual excitation without adequate satisfaction. Anxiety states may also arise when mental conflicts and unrecognized threats to the inner mental life endanger the security of the personality and the moral and social standards that have become organized as part of it. As will be observed in the discussion of war neuroses, an anxiety state is one of the commonest forms of nervous disability occurring under conditions of modern warfare.

Obsessive-Compulsive Neuroses

Patients suffering from obsessive-compulsive states are constantly beset by a persistent idea or emotion, or they experience an almost irresistible urge to carry out some act. The patient finds, for example, that he *must* think the unescapable thought even though he consciously would like to thrust the idea from his mind. The intruding thought may be of various types. Sometimes it is a ruminative preoccupation and speculation on such matters as creation, infinity, or other philosophical or religious questions. It may be of an indecent or other painful nature. The obsessive emotions include particularly doubts and feelings of uncertainty. Perhaps the patient cannot decide between two courses of action, or if he has chosen, he questions if he has not erred. He may, for example, lock a certain door before retiring, but no sooner has he reached his bed than he is in doubt about the security of the door so must return and try the lock. Even then after he is again in bed his doubts return and require further visits to verify that the door is locked. Among the urges are those to count (steps, certain objects, etc.); to say

certain words, often indecent ones; or to make other irrational repetitions.

Obsessive Characters. The obsessive-compulsive neuroses occur largely among persons who are often referred to as obsessive characters. Such people are punctilious, rigid, fastidious, and have to go over things again and again. They are in constant doubt what to do. They have an exaggerated sense of duty, are burdened by responsibility, and cannot make decisions. The difference between such personality characteristics and a compulsive neurosis is one of degree, of the amount of anxiety associated.

Phobias. Phobias and fears are usually included among the obsessive-compulsive states. Among the common phobias are fear of crowds, of being in a closed or confined space, or the fear of syphilis, of cancer, or of dirt. As is true of other obsessive-compulsive states, fears are often accompanied by anxiety. A not uncommon compulsion is that of handwashing. The patient is obsessed with the belief that his hands must be unclean. Immediately he experiences an overwhelming compulsion to wash them. Scarcely, however, has the vigorous scrubbing of the hands been completed before the patient feels that there may have been dirt on the towel or some other object. The procedure must therefore be repeated to every scrupulous detail. Such compulsive acts may be extremely complex and come to possess all the ceremony of a ritual.

Function of Obsessive-Compulsion Neurosis. We have seen that in hysteria the symptom often represented a means of escape from an intolerable situation, the gratification in disguised form of a wish that could not be openly realized. Like hysteria, obsessive-compulsive states represent attempts to deal with troublesome conditions, but they do so in a different way. Although their symptoms serve various purposes, yet frequently, through the substitution of something apparently meaningless for what is really exceedingly troublesome, the obsessive-compulsive neuroses serve a protective or defensive purpose. The compulsive handwashing, for example, is an effort to remove from the mental life something that would be regarded as contaminating to it. Compulsions are often associated with many phobias, e.g., handwashing with the fear of dirt. At times fears are really but disguised wishes. An unreasonable fear of injury to one's child, for example, may be a concealed wish for the death of an unwanted baby. An obsessive doubt may conceal

some ardent but consciously unrecognized wish. In general the symptoms, often by a mechanism of disguise or concealment, aid in repression.

NEURASTHENIA

Many psychiatrists consider that the group of symptoms often described under the term neurasthenia should not be given a special classification, since they believe these symptoms arise in the same manner as do those of conversion hysteria. These symptoms consist of easy mental and physical fatigability, various painful sensations, nervous tension, irritability, and depressive emotional tendencies. Many neurasthenics are unhealthy-looking persons who find all exertion, mental or physical, too great. They often complain of a sense of pressure in the head, scalp, or neck and perhaps of dizziness. There is an excitability of the special senses (intolerance of noise, bright lights, cold, etc.). Many neurasthenic women complain of pain in the lumbosacral region. Gastrointestinal discomfort and disturbances are common. Cardiac palpitation often increases the patient's alarm. Because of vasomotor instability the skin is at times flushed and again is sweaty or cold. Many patients with this vasomotor instability wrap themselves up in mufflers and are in constant fear of catching cold. Frequently they are characterized by irresolution, indecision, and irascibility. Some develop a complaining attitude and may appear to take pleasure in finding fault with and annoying others. Varying degrees of anxiety may exist.

It would appear as if emotional tension arising from persistent conflicts and deep-lying personality maladjustments produce in the neurasthenic a subjective feeling of weakness and exhaustion. Fatigue, perhaps, may be the equivalent of repression of feelings of guilt, or of the frustration of satisfying personality objectives, or may be the projection of a sense of inadequacy.

Nursing Management. Since the psychoneurotic has no apparent physical disability and lacks the irresponsibility of the psychotic, the nurse is often tempted to look upon the patient's illness as imaginary. The illness, however, is not imaginary even though nothing organically wrong be at the basis. These patients with their vague pains, backache, sleeplessness, and other indefinite symptoms should therefore not be told that their troubles are imaginary and

that they should "brace up," "use their will power," or "forget it." Equally futile is the advice to take a rest or go for a trip. The pains and other symptoms are not merely real to the patient; because of his associated mental attitude they hurt and incapacitate him even more than if there were an organic basis for them.

Nurses' Attitude toward the Patient and His Neurosis. While the nurse should never encourage the patient's belief that his symptoms are serious and even at times may ignore them, yet she should never be harsh with the patient or offend his self-esteem by implying that his discomforts and disabilities are unreal. The attitude of the nurse, in fact, is a matter of great importance. While she should listen sympathetically to the patient's story of his life, its disappointments, frustrations, and desires, she should also discourage concern as to his symptoms and should not make solicitous inquiries as to his feelings. Any hint as to the possibility of physical disease is accepted as conclusive of its existence. It also is unwise to adopt any unnecessary nursing procedures or permit the family to humor every whim and notion. The nurse should remember that the neurosis is fulfilling some purpose in the life of the patient and that in every way possible she should encourage the patient to deal frankly, hopefully, and without evasion with all problems that confront him. She should be alert to see any advantage or useful role the illness may be playing in the patient's life and attempt to reduce its attractiveness. The incentive for recovery must be greater than the gains incidental to the illness. In severe neuroses where the tension has produced great fatigue and perhaps loss of weight, some physicians recommend an initial period of perhaps two or three weeks spent in bed. Many physicians prefer that a careful and detailed daily schedule be followed for this period. There should be a certain hour for meals, for resting, for massage, for occupational therapy, for physiotherapy, etc., the entire day being filled by this schedule.

Psychotherapy. Since the psychoneuroses are produced by psychological forces and not by bodily disturbances, it is obvious that the agencies for their relief must be mental and that medicines and other measures which modify bodily processes will not exert a curative effect. To be sure, through the influence of suggestion which often accompanies their use, the employment of hydrotherapy, electrotherapy, diathermy, massage, or other form of physiotherapy may be helpful. Because they act through suggestion they may be considered as a form of psychotherapy. By psychotherapy we mean the

use of measures which by acting upon the patient's mind will aid him in adjusting to the particular problems which have disturbed his happiness or impaired his social adjustments. It should enlarge the patient's understanding of himself. Among the more clearly defined methods of psychotherapy are suggestion, hypnosis, persuasion, and psychoanalysis.

Suggestion. In suggestion the physician attempts to remove the unpleasant or disabling symptoms by subtly, often indirectly, inducing the idea or belief that the symptoms are disappearing or do not exist. Because of his confidence in the physician the patient tends to accept the idea presented until finally it may be so fully accepted that mental influences which have produced the disability are neutralized. It is largely through suggestion that mentally produced disabilities are sometimes quite dramatically cured by "faith cures," visits to shrines, etc. Suggestion often is not permanently successful since the mental conflict or psychological need which produced the disability is not resolved or satisfied. If, however, the nurse has an understanding of the psychological forces and influences that have produced the neurotic disability and of the purpose it serves in the patient's life, she may often through discreet suggestion be of assistance to the physician in his efforts to cure the patient.

Hypnosis. Hypnosis is an artificially induced state resembling sleep brought about by suggestion and characterized by a greatly increased suggestibility as a result of which lost memories may be revived or even at times disabling symptoms be removed. Hypnosis may be undertaken only by physicians trained in psychotherapy. Even by them it is used only occasionally.

Persuasion. Persuasion as a means of psychotherapy consists of attempts to convince the patient, by appeals to his intellect, of the unreality of his symptoms, of the groundlessness of his anxiety or fears, or of the continued existence of apparently lost functions. Such a type of psychotherapy may superficially appear to be a rational one, but logical reasoning has little power to modify what goes on in the mind, particularly in neurotic illnesses, since in them the disturbing activities are determined by factors below the threshold of consciousness. For this reason persuasion and the other types of psychotherapy mentioned are apt to prove disappointing.

Psychoanalysis. Because of certain important principles involved, psychoanalysis, both as a type of psychotherapy and as a psychological theory, is discussed separately, in Chapter XXIX.

Discovery of Factors Producing Neurosis. From earlier discussions in this chapter the nurse has doubtless come to realize that neurotic illnesses—emotional illnesses—spring from disturbing inner psychic situations and are often expressed through a disturbance in a special organ or a group of related functions. To effect a cure, the psychiatrist must ascertain the various factors that have been operating in the life of the patient and discover whatever material has been causing tension and perhaps anxiety. He will study the patient's personality, its development, and its reactions to the particular life situations which the patient has been called upon to meet. One of the first essentials for the psychiatrist, therefore, is to secure sufficient data concerning the patient to reconstruct his inner life history. With this reconstructed the psychiatrist can frequently guide the patient in such a way that he will discover for himself the factors that have been subconsciously operating to produce his illness. When once recognized for what they are, the disabling symptoms tend to disappear. It is essential, however, for the patient to discover and interpret these himself since he will successfully resist any effort on the part of others to convince him that certain factors have been subconsciously operating in his life, or that his symptoms have arisen to serve certain psychological needs. Sometimes in giving a very full story of his life the neurotic patient may disclose material that bears directly on his illness, and in the telling of it may even himself discover certain bits of relationship between past experiences and present symptoms. Often, as a subconscious defense against unwelcome recognition, the patient may fail to recollect certain material that is really particularly significant. If the patient has confidence in the nurse, he will at times relate material which has not been told the physician although it would be of great assistance to him. The more fully, therefore, the nurse understands the sources and meaning of the patient's symptoms, the greater should be her usefulness.

When the neurosis is not serious and the factors are relatively simple, the reconstruction of the patient's inner life history from the story given by the patient and interpreted by him under the guidance of the psychiatrist may enable him to deal successfully with his problems and cure the neurosis. If the factors that have resulted in the neurosis are less easily accessible the psychiatrist may decide to employ psychoanalysis.

How the Nurse Aids in Psychotherapy. From what has been said it will be seen that success in the nursing of the psychoneurotic patient depends largely upon the extent to which the nurse can promote wholesome emotional and other mental attitudes and habits on the part of her patient. She will try to understand his makeup in order that she may more readily recognize why certain situations constitute a strain and cause him to react with his complaints. It will be helpful to her if she is aware of the environmental influence to which the patient was exposed in childhood and later life. She will encourage the patient's confidence in his physician and will not be resentful or impatient with his tendency to find fault, to be uneasy, anxious, apprehensive, or to express hypochondriacal complaints. She will aid the patient in assuming a passive attitude toward disturbing situations and will encourage him to let thoughts and sensations appear and disappear without paying special attention to them. Through her presence the nurse should contribute a helpfully distracting companionship. It is often necessary to stimulate self-confidence and self-reliance. An attitude characterized by a quiet but convincing reassurance will do much to allay tension and anxiety. The nurse should be resourceful in providing occupational and recreational therapy for the psychoneurotic. Avocations and hobbies should be developed. The patient should be guided in cultivating interests instead of permitted to indulge in unhealthy thinking. The development of a carpentry shop where he can make and feel and see his own creations, photography, the care of a garden, or the raising of pets will be helpful to those who brood over their aches and pains and fears. Movies, the theater, concerts, or travel will be particularly helpful to those who have been largely denied these diversions.

War Neuroses

Because of the high percentage of casualties due to neuroses in both World Wars I and II and because the psychiatric nurse participates in the treatment of them, she should have a clear idea as to their nature. It is frequently assumed that the neuroses arising in war, particularly those appearing under combat conditions, constitute a special type of nervous or mental disorder. There is, however, no evidence that any new clinical entity arose during either of these wars, although the symptoms often have a military color-

ing. For this reason and because the use of such terms as "shell shock" and "war neurosis" has caused much confusion, the Surgeon General of the Army has formally directed that the use of these terms is not warranted. Since the so-called war neuroses are in general of the same nature as those already described as occurring in civilian life, it is usually believed they should be classified in the same manner.

Causes. The degree of stress to which the soldier must be subjected before he develops a neurosis is, with some exceptions, directly proportional to the extent to which his previous personality had manifested neurotic characteristics. The neurotically unstable soldier may, under even the relatively slight stress of the training camp, develop a neurosis that disables him for any further military duty. While under the extremes of stress and fatigue of modern combat the most stable individual probably has his breaking point, the well-integrated person may be subjected to most intense physical and emotional stress before suffering even a temporary nervous disability. Among the factors that contribute to the development of neuroses are separation from family, the existence of domestic difficulties at home, regimentation, lack of freedom, lack of privacy, lack of feminine companionship, a feeling of not being appreciated, lack of confidence in leaders, and perhaps the discouragement of defeat. In combat are added extreme fatigue, danger of death and mutilation, exposure to cold, heat, and disease, isolation, confusion and hunger. Insufficient understanding and conviction regarding the need to fight are also factors. In the average soldier, underlying fear and a mental conflict—usually unconscious—between the instinct of self-preservation on the one hand and his sense of duty, code of honor, and other forces of idealism on the other, are important causes.

Types of War Neuroses. If one excludes combat fatigue most psychoneurotic casualties occurring in a combat zone may be classified as anxiety states or as hysteria. In the training camp or in other conditions in which the individual's personality and not combat is the main etiologic agent, the psychiatrist observes neurasthenia, hypochondriasis, obsessive-compulsive reactions, and mild depression.

Combat Fatigue. Some psychiatrists would include as a specialized form of psychoneurosis the acute physical and nervous state known by this name. Others, because it usually occurs only among

soldiers (or combatants in other branches of the armed services) who have never previously manifested neurotic traits and only under conditions of the most extreme physical and nervous stress, feel it is an injustice to the soldier to designate the reaction as a psychoneurosis. Combat fatigue arises in men who have endured exceptionally severe or prolonged combat under the most trying conditions of shell-fire, hunger, noise, fatigue, deprivation, tropical heat, and the sight of mutilation or death of their companions. The symptoms are exhaustion, a startle reaction in which noises produce a sudden start accompanied by tremor, dilated pupils, sweat, flush or pallor, dry mouth, palpitation of the heart, and perhaps panic. The patient also suffers distressingly from repetitious catastrophic nightmares or night terrors and repeated dreams in which terrifying experiences are relived and are accompanied by a childlike fear in its emotional pattern, the effect of the fear persisting after awakening.

Anxiety States. The first symptoms observed may be sullenness, irritability, and discourtesy to officers or friends. To these are soon added acute emotional tenseness, restlessness, insomnia, anxiousness, breathlessness, palpitation, dilated pupils, difficulties in attention and concentration, tendency to startle at any noise or sound, variable confusion, tremors, and perspiration. In more severe cases, the soldier, on noting any sudden sound or movement, may immediately run or seek cover of some sort and exhibit all the symptoms of a minor panic state.

Hysteria. The hysterical reactions occurring in the armed services are of various forms. Among the most frequent are rhythmic tremors, repetitive dodging and avoiding movements, loss of memory, and stupor. These reactions are often expressed in an extremely dramatic manner. At times the soldier may wander about the battlefield in a fuguelike state. In World War I the usual hysterical reactions were in the forms of paralysis, anesthesia, deafness, blindness, and loss of speech. These were not frequent in the recent war. Hysterical reactions occurred most frequently in privates and anxiety states in officers.

Malingering. Persons not familiar with the war neuroses, particularly those of the hysterical type, not rarely err in mistaking psychoneuroses for malingering, or the feigning of disability. The two conditions are, however, entirely distinct, and the treatment effective for one is utterly useless and even harmful for the other.

Malingering is the conscious, deliberate exaggeration or pretense of an illness for the purpose of escaping duty, whereas a psychoneurosis is an actual illness. A person with psychoneurosis either tells the truth or what he firmly believes is the truth. It may be that neither the psychoneurotic nor the malingerer wants to return to duty, but the malingerer is aware that he could go back if he chose, whereas the psychoneurotic either is actually unable to return to duty or sincerely believes he is unable to do so. Malingering occurs only in unstable personalities.

Nursing Treatment in the War Neuroses. It is well for the nurse to have a general knowledge concerning the treatment of the war neuroses. One of the cardinal principles of their treatment is promptness. Experience has shown that treatment should be given well forward toward the combat zone. Rest and large quantities of good food are of the utmost importance. Heavy sedation is initiated when the patient is first seen. This renders him less susceptible to disturbing and fear-producing stimuli, decreases his anxiety and abnormal suggestibility, and facilitates rest. An initial dose of 7.5 grains of pentothal sodium is given with a total amount up to 15 or 20 grains in twenty-four hours, so that for the first two or three days most of the patient's time is spent in sleeping. The patient is required to be up for each meal, to stand in line for meals, and to keep his bed and immediate part of his ward in order. These and other routine requirements are deliberately adopted to maintain discipline, to eliminate any idea of serious or physical illness, and to promote the assumption that return to duty is a matter of course.

The reassuring and continuous presence of the nurse when the patient wakes from his nightmare is helpful. As soon as the patient has recovered from exhaustion and deprivation he receives exhortation, reassurance, and support and is encouraged to relate his fears and any intolerable stress. An effort is made to help him see and understand what happened to him, what the psychological escape and protection value of the neurosis is, how his fear-controlling mechanism broke down, and how it may be restored. Planned recreation, drilling, and other activities of a military nature are resumed as promptly as feasible. There should be a minimum opportunity for sitting or lying alone and brooding over preoccupations. Those cases who do not enjoy an early recovery will acquire the additional burden of chronicity and greater fixation of symptoms, plus the important secondary gain or "sickness profit" of

escape from danger and duty and return to safety through illness. Face-saving mechanisms will require that they not recover too fast, while considerations of pensioning and discharge will further complicate the situation and retard recovery. If the patient has not recovered before this point, the "advantages" of being neurotically ill, of being relieved from responsibilities, of being protected and cared for, and of receiving compensation payments to continue until recovery may prevent restoration of mental health.

SUMMARY

1. The differences between psychoses and psychoneuroses are discussed.
2. The psychoneuroses may be classified as hysteria, anxiety neuroses, obsessive-compulsive neuroses, and neurasthenia.
3. In hysteria mental forces produce physical or mental disturbances peculiarly adapted for the solving of some particular problem.
4. Hysterical symptoms often simulate physical disease.
5. The process by which perturbing emotional problems and situations produce physical symptoms that often provide some solution for these problems and situations is known as conversion hysteria.
6. Following industrial accidents an unacknowledged wish for compensation or other benefit may produce a neurosis in the form of disabling physical and nervous symptoms that is known as a compensation neurosis.
7. Frustrations and apprehension-producing situations may lead to a state of emotional tension, fear, and restless expectation accompanied by attacks of acute anxiety that is known as an anxiety neurosis.
8. In obsessive-compulsive states, the patient may be constantly beset by a persistent thought or fear, or experience an almost irresistible urge to perform some act.
9. Many psychiatrists apply the term neurasthenia to a group of psychoneurotic symptoms characterized by easy mental and physical fatigability, painful sensations, tension, irritability, and depressive emotional tendencies.
10. The attitude which the nurse should assume toward the psychoneurotic patient and his symptoms is indicated.

11. Suggestion, hypnosis, and persuasion as forms of psychotherapy, or treatment by mental or psychological measures, are discussed.
12. Ways in which the nurse may be psychotherapeutically helpful are pointed out.
13. The war neuroses are of the same nature as those of civilian life, being merely modified by the terrifying conditions under which they arise.
14. The factors which contribute to their development are discussed.
15. Most psychoneurotic casualties occurring in combat zones are of the nature either of anxiety states or of hysteria. Their symptoms are described.
16. The distinction between malingering and a neurosis is indicated.
17. The treatment of war neuroses is discussed.

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CHAPTER XX

MANIC-DEPRESSIVE PSYCHOSES

Contrasting Nature of Symptoms. Under the designation manic-depressive psychoses are included certain mental disorders which superficially may present such contrasting symptoms as to make it appear illogical that they be classified in the same group. More careful examination, however, will show certain common characteristics not only in the course and outcome of the psychoses and in those aspects of the personality which suffer disorder, but also in the types of personality disposed, when under stress, to react in these contrasting methods. Since in all the apparently dissimilar reactions of the personality occurring in this group of disorders there is always some, often extreme, disturbance of emotions, the various disorders included are often spoken of as affective psychoses.

Causes. The causes of the manic-depressive psychoses are complex and in certain respects obscure. Constitutional factors seem to be of importance, and the makeup of the individual apparently helps to determine the form they assume. While many attacks seem to arise out of a clear sky, yet not rarely a disturbing situation or experience, added responsibility, a threat to one's sense of security, or frustrations in career or love serve as precipitating factors. The manic-depressive psychoses occur twice as frequently in women as in men.

Two Types of Episodes. Manic-depressive psychoses most frequently assume the form of psychotic episodes separated by intervals of mental health. These episodes may be characterized either by exuberance of spirits and by pressure of activity and of speech, or by depression and by reduction of speech and of activity. Episodes of the former nature are known as the manic type and of the latter as the depressive type.

Manic Phase. The manic type or phase is usually preceded by a short period of mild depression, often lasting for only a few days and either not noted by the patient's family or not considered sig-

nificant. Following this initial downheartedness and feeling of inadequacy the patient seems unusually happy, becomes self-assertive, has an exaggerated opinion of himself and his abilities, and has a tendency to develop ambitious but ill-considered schemes. Sometimes the first symptoms to attract the attention of the family may be a surprising impropriety of speech or manners in one usually carefully observant of social proprieties.

Hypomania. Occasionally the psychotic episode continues in the form of this relatively mild excitement known as hypomania. In this state the patient is capricious, self-confident, boastful, spends his money extravagantly, is bored by routine, and lacks a sustained interest in any activity, which soon fails or which he soon abandons. Typically he manifests a careless gaiety and breezy affability. His mind flies from one thought to another, and like the Walrus in *Alice in Wonderland,* the patient hastens—

"To talk of many things:
Of shoes—and ships—and sealing-wax—
Of cabbages—and kings—
And why the sea is boiling hot—
And whether pigs have wings."

He may be boisterous, full of pranks, indulge in coarse, unseemly jokes, and make facetious, frequently impertinent remarks about associates or others. The patient's good humor, which is often infectious, may continue as long as every whim is gratified, but is frequently replaced with outbursts of anger and verbal abuse if his plans are opposed or his wishes thwarted. Instead of this good humor some hypomanics show a mood characterized by sustained anger, demanding irritability, argumentativeness, haughtiness, arrogance, sarcasm, and querulousness. Sudden oscillations of emotion are common. In the midst of an apparent exuberance of spirits the hypomanic may burst into tears and express anger or dejection, yet after a moment be as cheerful as ever. Any wound to self esteem may be greatly resented. The hypomanic may work with eager, but capricious, energy and enthusiasm. He is often so officious and meddlesome that he is intolerably vexatious to his associates. He may write numerous letters, often in a flowery style, underscoring many words and phrases and introducing various parenthetical remarks and witticisms. No sooner, perhaps, has he posted a letter than he decides that the mail is too slow for his

urgent business so he dispatches a telegram to his correspondent. He discusses with strangers and without reserve, matters of an intimate, personal nature. Sex drive is increased; the hypomanic man may be unrestrained in sex activities, while a previously chaste and modest young woman may become sexually promiscuous or marry a man far below her social level.

Mania. In many instances the intensity of a hypomanic state constantly increases until the clinical picture becomes one of well-defined mania. The tempo of the whole personality is greatly quickened. The patient sings and whistles and may be exhilarated to the point of noisy hilarity. His former pressure of speech develops into a flight of ideas with puns and rhyming and an association of words through their sound rather than through their meaning. He meddles with ward activities and teases other patients. He decorates himself with trinkets and improvised badges and medals. In more excited states the patient may tear his clothing into ribbons with which he decorates himself in a grotesque manner. In extreme excitement he is denudative, takes his bed apart, destroys the mattress, digs the plaster from the wall, and even smears himself and his room with excreta. The excited manic sleeps but little, yet does not appear fatigued. He may sustain cuts and abrasions to which he pays no attention and for which he will permit no treatment. Rarely is the manic so excited that he does not eat and may require tube-feeding; more frequently he bolts large quantities of food with complete disregard of manners.

The attention of the manic is greatly disturbed, being constantly diverted by environmental noises and activities. Not rarely he misidentifies persons, frequently identifying a stranger as a former acquaintance. He usually remains well oriented although at times his grasp of his environment is faulty because of an absence of sustained and discriminating attention. Hallucinations may occur but are not common. Fleeting ideas of an expansive and wish-fulfilling nature are rather frequent. Many times the patient half recognizes that his ideas are imaginary and will smile in a sheepish manner when their correctness is questioned. Some manics show a definite paranoid trend and are prone to be sarcastic and verbally abusive to the person toward whom, for the moment, some resentment is felt. Occasionally a manic has well-formed ideas of persecution. Impatience or lack of tact upon the part of nurse may lead the manic to make charges of abuse.

Physical State. Physically the milder cases appear in excellent health. The eyes are bright, the face flushed, the head erect, the step quick, and weight may be gained. In great excitement the patient loses weight. Such patients may not only develop infection at the site of some minor injury, but even pneumonia, acute nephritis, or other infections which may not be recognized because of the difficulty of examining a person so greatly excited. The nurse should watch such patients carefully for signs of weakness or for any change in physical condition.

Depressive Phase, Mild. The depressive, like the manic phase of manic-depressive psychosis, is manifested by disturbances in the emotions, in psychomotor activity, and in the flow of thought. Just as in the manic type we find all degrees of excitement, so in the depressive type we meet with varying degrees of depression. The mild episodes may be characterized by an apparently causeless feeling of weakness, inertia, and inadequacy, and by difficulty in planning. During these "blue spells" the patient lacks confidence in himself and every task seems a burden. He has doubts and fears and has an attitude of hopelessness and perhaps mild ideas of unworthiness. He shows indecision, avoids social contacts, and his ideational content becomes confined to a few topics, usually of a gloomy nature. In another form, there may occur periods during which the patient is mildly downhearted and has physical complaints for which no organic cause can be discovered. He feels fatigued, suffers from insomnia and from headache, and expresses various hypochondriacal complaints. The patient, and consequently his friends, believe that the real disability is physical and that his stubbornness, peevishness, and lack of consideration for others as well as his downheartedness are the natural result of his physical ill health, whereas the physical complaints are really but the patient's rationalization of his depressive mood. Unfortunately it not rarely happens that the real nature and the seriousness of these mild depressions are not recognized, with the result that occasionally patients suffering from them commit suicide.

Depressive Phase, Severe. While some depressions never develop beyond the mild forms just described, others pass into a profound emotional distress. Posture, muscle tensions, and various physical signs and symptoms present a composite picture indicating profound depression. The body is stooped, the head flexed, the facies immobile, the forehead furrowed, and the patient looks fixedly down-

ward. The nasolabial folds are marked, the angles of the mouth are turned down, and the face may have a troubled, perplexed expression. As the depression becomes more profound, everything is interpreted in terms of hopelessness and despondency. It seems difficult for the patient to think; he speaks slowly and in a low tone. He may begin, but not complete the reply to an inquiry; perhaps he may merely move his lips, but fail to utter any intelligible response. The patient protests that he is unable to perform suggested activities; all movements are slow and inhibited and carried out as if with great exertion. Most depressed patients lose weight.

Delusions in Depression. Since the patient's ideas tend to represent a projected expression of his inner feelings and a rationalization of his emotional depression, it is natural that his mental content should often be delusional. He may therefore have ideas of guilt, remorse, unworthiness, self-accusation, and even of death. Occasionally a patient is suspicious and complaining and presents an attitude of gloomy hostility. Ideas of reference and illusionary falsifications are common—a pounding in the basement is that of workmen constructing the patient's coffin. Hallucinations occur in about one third of the cases and since they represent a projection of the patient's affective distress he may hear accusing or threatening voices. Many patients are fearful and some show a troubled perplexity and bewilderment. The depressed patient has little or no appetite and some would even starve if not encouraged or forced to eat. A feeling of unworthiness or a desire for self-punishment may lead to suicidal attempts.

In the most intense form of the depressive type, the patient's picture may be one of stuporous brooding (benign stupor). In this profoundly inhibited state there is practically no spontaneous motor activity. The patient is mute, his attention cannot be secured, and consciousness appears to be somewhat clouded and the patient confused. The face is either masklike or rigidly anxious.

Theoretical Explanations of Mania and Depression. Mention has been made of the more important symptoms observed in the two principal types of the manic-depressive psychoses. Many interesting theories of which space limitations do not permit mention have been suggested to explain these contrasting types of reactions. Perhaps one of the most readily accepted theories is that the manic reaction represents a flight from feelings of guilt, of insecurity, or other unadjusted aspects of the patient's inner life, while depression

represents a surrender, a giving up of all efforts to deal with these unadjusted and therefore threatening aspects. Viewed slightly differently, the depression might be regarded as a general inhibition designed to afford withdrawal of the individual from an ill-adjusted situation, the general inhibition affecting all aspects of the personality—vegetative, motor, affective, and ideational.

Prognosis. The prognosis as related to a given episode is good, but recurrences are common. The duration of an episode varies greatly. The average length of manic episodes may be estimated at six months and of depressive episodes at nine months, but in individual cases this period may be much shorter or much longer. Many depressions terminate with a brief period of hypomanic elation. Little is known concerning the factors that determine recovery.

During his illness the patient usually has little or no insight, i.e., understanding of the existence or nature of his mental disorder. Even after his recovery the patient's insight is usually deficient, especially following a manic episode when he will often offer various plausible but entirely erroneous explanations of his previous behavior.

Manic-depressive psychosis is not a disorder that leads to dementia. Even after repeated episodes no disorganization of the personality takes place, and the patient remains unimpaired intellectually.

Nursing Management; Vexatious Behavior of Manic Patient. Successful nursing of the manic-depressive patient requires a degree of alertness, tact, and resourcefulness demanded in few other disorders. The manic patient is usually so unrestrained in his behavior that care in an institution is wise. It is extremely important that he be removed from all exciting and disturbing influences. In the milder, hypomanic forms there is so little that is strikingly eccentric in conduct or speech that the patient's capricious and exasperating behavior may appear to persons unfamiliar with mental disorder to be a matter of wilful perversity. His exuberance of spirits, pressure of activity, and volubility, while greater than formerly, are not unnatural or "unpsychological," with the result that the inexperienced nurse is sometimes slow to believe that the hypomanic is really suffering from mental disorder. Under no conditions should she be incensed by the patient's unconventional and vexatious behavior, nor should she protest or attempt to argue with

him concerning it. Such an attitude almost invariably arouses resentment and incites the highly irritable patient to anger. Firmness is necessary in the approach to the manic patient, yet force defeats the purpose for which it is employed. Under all circumstances the nurse must retain her equanimity and refrain from hasty answer or peremptory command. While some hypomanics in their contacts with other persons are merely mischievous, teasing and annoying other patients or meddling with ward activities, yet some seem to seek ways in which they may be disagreeable either through undesirable conduct or by cutting remarks. Many hypomanics are quick to recognize the fact if any particular behavior on their part causes discomfiture to the nurse and will thereafter secure a certain satisfaction in repeating it. With cheerful good humor and yet with a certain dignity the nurse will avoid discussions and direct attention and questions to subjects that interest and do not irritate the patient. The nurse will make her supervision of the hypomanic as unobtrusive and unapparent as possible. Since, however, the patient's detention in the hospital is usually against his wishes, the nurse must be alert, otherwise she may be outwitted by him through his tendency to mischief or his desire to escape from the restraint of the institution. The patient will offer most plausible reasons why he should be permitted to do this or do that. Long experience, but most of all a wise discrimination, will assist the nurse in deciding what requests may be granted and what ones must be denied. The manner of their denial and the composure with which the patient accepts the refusal of his wishes will often be a test of the nurse's fitness for psychiatric nursing.

Management of the Overactive Patient. The furnishings of the patient's room should be limited to the simplest essentials since the hypomanic will be mischievously meddlesome while the more disturbed may be destructive. Destructiveness may represent a protest against an undesired detention in the hospital, may be due to irritability or to a feeling of strength, may be a means of outlet for aggressive tendencies, or have other psychological motivations. Since the excitement of a manic patient stimulates a similar state in other manics he should not, if possible, be closely associated with them. Frequently the manic's behavior may be made more acceptable by some discreetly chosen form of discipline, such as the withholding of privileges in the case of troublesome behavior or their ex-

tension as a reward for desirable conduct. Should he become disorderly in the dining room, for example, he may be returned to the ward and required to eat the next two or three meals there. Rarely, if managed tactfully, will the excited patient be so aggressive or resistive that he must be handled forcibly. Should this become necessary it should not be undertaken until an abundance of nursing assistance is at hand. Struggles between a patient and one or two nurses or attendants result all too often in personal injury. If the patient must be seized he should be grasped from the rear, pinning his arms to his sides. Frequently by studying her patient the resourceful nurse can do much to prevent his removal or destruction of clothing when excited. One nurse discovered, for example, in the case of a patient who constantly tore off her clothing, that if the patient were made up, her hair dressed in a becoming manner, and rouge and lipstick applied, she not only remained dressed but her general behavior became less troublesome. In this connection it may be said that the successful psychiatric nurse is one who by her objective attitude and some simple expedient suitable to the individual, renders the behavior of the disturbed patient more socialized, and through an understanding of his emotional problems allays the fears and restores the confidence of the troubled patient. Likewise the medical or surgical nurse should remember that all too frequently her patient has mental and emotional needs and problems as well as physical ones, and that these merit as much consideration and attention as do the physical ones.

Restraint, Seclusion, Hydrotherapy. To return to the disturbed, excited patient. Isolation, or the locking of a patient in his room, or the use of mechanical restraint should be employed only under the most urgent circumstances and then only upon order of the physician. Their employment is usually an acknowledgment of failure to have met the medical and nursing needs of the patient. If such measures as recreation, occupation, and hydrotherapy have been wisely and adequately employed, an emergency calling for the use of restraint or seclusion will rarely arise. Quite apart from the consideration that seclusion and restraint are merely forcible methods of control, rather than measures meant for relief or remedy, there is the important additional fact that their employment often leads to serious neglect of the patient. Many a patient in seclusion has developed pneumonia or other acute infection, and the illness been overlooked until the patient was practically moribund.

Patients in restraint have become exhausted and the nurse failed to discover their serious state. Patients in restraint should not be left unattended and those in seclusion should be observed every half hour. Infinitely preferable to seclusion or restraint in the case of the disturbed patient is some form of sedative hydrotherapy, particularly the cold wet pack or the continuous flow bath as described in Chapter XXVIII. These two forms of hydrotherapy constitute the most valuable and frequently used forms of sedation employed in excitements, and the nurse should be familiar with their application.

Food and Sedation. Mildly excited patients will take sufficient or even excessive amounts of food; the most excited are too busy to do more than snatch a bite. Because of their constant activity manic patients require an abundance of nourishment. If necessary, therefore, the nurse should encourage the taking of food or even spoon-feed the patient. The excited manic usually does not receive sufficient liquids unless they are administered regularly by the nurse. The mouth may become dry and the lips parched and crusted. The former should be cleansed frequently, and the latter kept soft and moist by the application of glycerin or cold cream. Greatly disturbed patients often sustain abrasions which may become infected unless cleansed and protected. Many manic patients do not receive sufficient sleep. The nurse, however, can do much to promote rest both by the intangible influence of her personality and by her active nursing measures. The calm, sympathetic, tactful nurse will have fewer wakeful patients than she who fails to secure the confidence and respect of those under her charge. In public institutions where for convenience of administration the evening meal is often served at an undesirably early hour, wakefulness is sometimes due to hunger. In that case a little warm food may assist in producing sleep. The sedative effect of the warm pack or the continuous bath may at times be required. While an occasional dose of a sedative drug such as paraldehyde may do no harm, yet when its use is permitted there often develops an insidious tendency to an excessive employment of hypnotics. Sedatives should not be used during the daytime.

The manic patient with his pressure of activity will occupy himself in some way, desirable or undesirable. Efforts should therefore be made to direct his activity toward constructive ends. The tactful and kindly nurse who secures the co-operation of her pa-

tients will utilize the energy of the hypomanic patient in occupational therapy or ward housekeeping. Occupation for the destructive manic is not so easily found, yet his destructive tendencies may often be used in picking hair for mattresses or in tearing strips for rugs. During convalescence, music, dancing, and participation in games and amusements which do not have a stimulating effect are to be recommended.

Special Treatments. While less beneficial than in depression, treatment by electric shock often produces a speedy termination of a manic episode. The procedure and the nursing management of this form of treatment are described in Chapter XXVIII. Another measure sometimes employed in the treatment of active and disturbed patients is the production of narcosis or prolonged sleep by sodium amytal. The use of this method also is described in the same chapter.

The Depressed Patient. If the physical condition of the patient permits, the physician will frequently use electric shock for the treatment of the depression. The two outstanding problems for the nurse responsible for the care of the patient ill with the depressive phase of manic-depressive psychosis are the prevention of suicide and the administration of sufficient food. The nurse must constantly bear in mind that the patient with self-destructive tendencies—and every depressed patient is potentially suicidal—may be capable of the most surprising ingenuity in the execution of his purpose.

Prevention of Suicide. The prevention of suicide by the patient cared for in a private home is rarely successful if he has firmly decided to destroy himself. At times the patient by an assumed air of cheerfulness, by a denial of his desire to die, or by other means will induce the nurse to relax her vigilance and thereby secure opportunity to end his life. The patient regarded as suicidal should never be left unsupervised for a moment, even to go to the bath or toilet. In institutions it is customary to place the patient's bed at night in an open space where it will be constantly within the range of vision of the night nurse. Both room and clothing should be frequently but unobtrusively searched for articles which might be secreted for suicidal purposes. Great care must be exercised in permitting the use of sharp or cutting tools in occupational therapy. The patient will therefore not have scissors, steel knitting needles, or crochet hooks. Frequently the most dangerous

period of the depressed patient's illness is during convalescence. At that time his volitional power is returning and his retardation disappearing, yet he has occasional days of depression and of self-accusation when he desires death. Previously his psychomotor inhibition may have prevented suicidal attempts, but it no longer does so.

Feeding the Depressed Patient. As a rule the depressed patient has lost weight by the time he has reached the hospital. It will usually be found that he has taken insufficient food or even refused it altogether. Should the patient have failed to eat because of the belief that by doing so he would deprive others of food, the nurse will reassure him and urge that he eat. The depressed patient's metabolism is faulty, and many functions under the control of the vegetative nervous system are disturbed. Every effort should therefore be made to improve his nutritional state. Food should be offered at frequent intervals. Small doses of insulin are often given to improve nutrition. Frequently the patient will not eat unless encouraged and it may be necessary to spoon-feed him. If all other efforts to feed the patient are unsuccessful he should be tube-fed. Unless the patient is well nourished he should not be permitted to go without food for more than twenty-four hours before resorting to tube-feeding. Sometimes after having been tube-fed once he will, with a little encouragement, eat voluntarily. Should he still refuse food tube-feeding must be continued. It would doubtless be better for patients who require tube-feeding if they were fed three times in twenty-four hours, instead of twice as is customary in many hospitals. Depressed patients who eat voluntarily should usually receive additional nourishment between meals. Nearly all depressed patients are constipated and require laxatives, of which cascara and mineral oil are probably the best. These are often added to the food prepared for tube-feeding. Unless attention is paid to the amount of liquid the depressed patient receives, he may become greatly dehydrated.

Clothing for the Depressed Patient. The nurse should be alert to notice if the patient is adequately clothed and warm. She should also be watchful for any signs of developing physical disease. The patient's entire conscious mental life may be so preoccupied with its depressive content that he does not complain of feeling cold nor does he speak of other discomforts which a normal person would call to the attention of his physician or nurse. Attention should be

paid to care of the nails and hair and to other matters of personal hygiene.

Cheerful Surroundings. The depressed patient should be encouraged to notice the normal and cheerful features of his environment. His room should be sunny and attractively furnished, yet in choosing the equipment one should remember the possibility of suicidal tendencies and therefore not sacrifice safety for pleasing surroundings.

Rest for the Depressed Patient. If the patient is weak and dehydrated rest in bed is recommended until after the more intense features of the depression have subsided. Frequently the patient feels incapable of exertion and is the better if not constantly urged to activity or forced to undertake it. The nurse will refrain from attempts to hurry the slowly moving, retarded patient. Since the depressed patient is usually lacking in self-confidence, the nurse should constantly offer encouragement and reassurance. Since many depressed patients are fearful and apprehensive, care should be taken to explain to them the purpose of any nursing procedure about to be undertaken.

Occupational Therapy in Depression. If of a simple type and continued for brief periods only, occupational therapy may often be prescribed from the first in mild depressions. It tends to stimulate flagging interest and prevent morbid introspection. The fact, too, that it helps to convince the patient that someone is interested in him is often of great therapeutic benefit and may open the way for the therapy of the psychotherapist. Usually occupational therapy will appeal much more to the depressed patient if it is obvious to him that the results of his labor are useful. As convalescence continues, reading, games, attendance at amusements, and dancing are helpful.

Relief from Responsibility. In describing the symptoms of the depressive phase, attention was called to indecision as a frequent characteristic. It is well therefore to relieve the patient of the necessity for making decisions or for concentration until he is well on the road to recovery. As convalescence progresses, however, he should be encouraged to exercise initiative. Usual duties and responsibilities should not be resumed until at least three months after recovery seems complete.

Insomnia. Sleeplessness is frequently a troublesome symptom among depressed patients. This may often be relieved by the con-

tinuous bath. Care should be exercised in the use of hypnotic drugs although occasionally paraldehyde or sodium veronal may be given. Opiates should never be employed.

SUMMARY

1. The manic-depressive psychoses are characterized by contrasting emotional states—elation or depression.
2. The principal symptoms of the manic form are elation or extreme sense of well-being, flight of ideas, and pressure of activity.
3. The characteristics of the depressive form are depression, slowness and difficulty in thinking, and underactivity.
4. Complete recovery from the psychotic episode is the rule but recurrences are common.
5. In the case of the manic patient both the environment and the nursing management should be quieting and restful.
6. In depression the prevention of suicide and the administration of sufficient food require first attention.
7. Cold packs, continuous flow baths, and electric shock are among the most useful special treatments employed in manic-depressive psychoses.

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CHAPTER XXI

INVOLUTIONAL PSYCHOSES

Psychoses Increase at the Involutional Period. As middle age begins to pass there occurs a decrease in the functional activity of the body including the ductless and the reproductive glands; this is a time of life often known as the involutional period. As the activity of these glands subsides there also are changes in the chemical, metabolic, and vegetative activities of the body. This ebbing in basic functions belonging to the physical aspect of the personality has its reverberations in its mental aspect since the personality is an indivisible unity. As these physical processes wane it is less easy for the personality to adjust either to the problems of the inner life or to the stresses that weigh on it externally. Ways of thinking and feeling that formerly characterized the personality and were useful in lending aid and comfort to it become inadequate since with the decline in the vigor and security on the physical side its need for support increases. The former mechanisms and devices of the mental life may no longer be sufficient with the result that psychotic methods follow. The involutional period, therefore, is one when psychoses are prone to develop. Its mental disorders seem apt to fall into one of two groups, the melancholic and the paranoid types; the particular form being determined by the personality's previous tendencies and characteristics.

Melancholic Form and Earlier Personality. Frequently an inquiry concerning the melancholic's personality makeup and habits of life prior to his psychosis will show that he was an inhibited individual inclined to be serious, sensitive, frugal, self sacrificing, prone to feelings of guilt, lacking in humor, stubborn and reticent, of stern, unbending moral code, and with a tendency to depressive apprehensions. His life has been narrow and devoid of diversions. Some have always been of a worrying, fidgety, fretful, or overanxious disposition. These characteristics seem to have had their origin in a deeply seated sense of insecurity.

Psychological Factors. By the time the involutional period is reached adjustments to new situations and circumstances are no longer easily made. At this period, too, the more or less conscious realization that early dreams and desires cannot now be fulfilled, that the zenith of life has been passed, that ambition and life's forces are waning, and that the opportunity no longer exists for correcting old errors or achieving new successes wounds self-esteem and leads to depression. Regrets and a sense of failure may contribute to the mood. In women the realization that the most highly cherished biological possession, that of childbearing, perhaps long frustrated, is now a lost capacity may mean for the patient not only the loss of the most fundamental of functions, but may give her a feeling that the ends of life itself have failed. In some women the menopause is accompanied by a fear of diminishing femininity or the loss of physical attractiveness. While any unwholesome emotional reaction to such feelings will usually express itself in tensions, jealousies, or misgivings, yet occasionally it may be a contributing factor in involutional melancholia. As the flush of maturity fades, thoughts of death are suggested and contribute to the anxiety so common in the disease. With the decrease of physical strength, unconscious forces and old conflicts and complexes become relatively stronger and return to threaten and torment.

Symptoms. For several weeks before the development of the more serious symptoms of melancholia the patient often is irritable, peevish, and pessimistic, shows a disinclination for effort, and may be given to spells of weeping. She (the psychosis is more common in women) eats poorly, loses weight, and becomes apprehensive and restless. Doubt, indecision, depression, anxiety, agitation, poor appetite, and insomnia are the rule. The patient wrings her hands, paces back and forth, rubs and picks at her face, perhaps moaning and in a whining voice repeating over and over, "Oh, God, help me! What will become of me?" Some patients constantly besiege doctors and nurses with inquiries, complaints, or requests. Suicidal attempts are frequent.

Misinterpretations and delusions are common. Ideas of guilt or unworthiness are particularly frequent. A trifling indiscretion of earlier years becomes an unpardonable sin. The patient is convinced, she says, that she is about to be put to death in some horrible way, a fate she deserves but awaits with fear and pleas for mercy. Distresses and dissatisfactions of the patient's inner life

are rationalized as physical disease with resulting hypochondriacal delusions concerning her body. Her intestines are obstructed, she has no stomach, or her brain is "dried up." Hallucinations may occur but usually are not numerous. Illusions and misinterpretations are quite frequent. Food is often refused, sometimes because of a desire for death, at times because of the patient's belief that she is unworthy of food, or again because of the hypochondriacal idea that she has no gastrointestinal tract. The facial expression is one of fear and distress. Most patients lose weight and some become seriously dehydrated. The hands are usually cold and cyanotic. The pulse is rapid and the respirations shallow while the bowels are constipated and the urine is scanty.

Prognosis. Prior to the use of shock therapy about 40 per cent of cases of involutional melancholia recovered. Convalescence, however, was slow, and those with a favorable outcome were often ill for two or three years. With the introduction of shock treatment, usually now in the form of electroshock, recoveries occur more promptly and in much larger numbers.

Paranoid Form. Occasionally persons who because of the changes in the physical aspects of the organism at the involutional period can no longer deal successfully with the gnawing conflicts and unadjusted needs of their inner lives react, not with the depression and agitation of an involutional melancholia, but with a paranoid form of mental disorder. Such persons are usually ones who have always been somewhat egotistic with various defensive characteristics, such as a tendency to blame others, to see slights where none were intended, or to believe their merits were not appreciated. Frequently for years before she became psychotic the paranoid involutional patient was regarded by her associates as being obstinate in opinion, jealous, unforgiving, secretive, unhappy, dissatisfied, and perhaps suspicious. Such characteristics were unwittingly developed as a sort of defense against a feeling of inadequacy for the demands of life, or against a fear that she might yield to repudiated desires or strivings. These traits seemed to supply sufficient support for the personality until the involutional period was reached, when with the added physiological and psychological burdens that may attend that period, they were no longer adequate, and resort was had to the more extreme defensive measures provided by the psychotic symptoms about to be mentioned. Such personality characteristics with their occasional final outcome in

the form of a serious psychosis make one realize how essential it is to develop wholesome habits of thinking and feeling—in other words to cultivate a mental as well as a physical hygiene. As characteristics such as we have just described blossom into a paranoid involutional mental disorder, they culminate in extreme self-satisfaction, spitefulness, misinterpretations, suspiciousness, surliness, and delusions of persecution. The patient may believe that the Masons or the Catholics are plotting against her or that members of her family are poisoning her food. Again she may claim that men enter her room at night and abuse her sexually while she sleeps; slanderous references to her are broadcast by radio. Some of these paranoid reactions are temporary, but many are prolonged or permanent.

Nursing Management in Involutional Psychoses. Since there is no other form of mental disorder in which the danger of suicide is as great as in involutional melancholia the nurse must be constantly alert and take every precaution to prevent attempts at self-injury. The patient should never be left alone even for a moment. Attempts at suicide are sometimes the result of clever, premeditated plans, but occasionally are impulsive. Second only to the prevention of suicide is the importance of seeing that the patient receives an adequate amount of food. Even though encouraged the patient will frequently not take sufficient nourishment and so must be spoon-fed or even tube-fed. The nurse should keep an accurate record of the patient's elimination. If this is not regular and sufficient, cathartics or enemata should be employed. Prolonged baths may be helpful in relieving insomnia and agitation. Warm packs are often too depressing for the weaker patients. The sense of restraint imparted by the pack may aggravate the agitation. Because of the fear and apprehension from which the patient with involutional melancholia often suffers, the nurse should carefully explain what is desired in order to allay fear and prevent resistiveness. She should avoid struggling with resistive and unco-operative patients, but with persuasion and without haste tactfully attempt to accomplish what is desired. Not a few patients manifest a dislike for and a rejection of the help which the nurse and the physician wish to offer. Care should be exercised to prevent falls or other injuries, and to see that the patient is always adequately dressed. Ulcerations resulting from an agitated picking or rubbing of the skin should be kept clean and dressed. Agitated patients who injure

themselves in this way may at times be given light manual employment. In the acute stages of melancholia it is often difficult to secure the co-operation of the patient in occupational therapy. Usually, however, an attempt should be made to encourage interest in some simple craft. The surroundings provided for these patients should have an air of cheerfulness and the attitude of the nurse be one of encouragement and optimism. She will avoid argumentative discussion, but will seek to guide the patients from repetitious complaints and self-accusation by encouraging them to notice the normal and cheerful features of their environment.

Since 1940 electric shock, or the production of convulsions by brief stimulation of the brain by faradic electricity, has largely superseded the use of metrazol and other chemicals in the production of shock in involutional melancholia. The benefit resulting from electric shock is presumably due to some unknown physiological change produced in the brain cells. The details of its application and the nursing management of the procedure are discussed in Chapter XXVIII. It is of little value in the treatment of the paranoid form of involutional psychosis. Occasionally in the case of the melancholic patient who in spite of every other treatment remains tense, agitated, and so persistently preoccupied with fixed ideas of contamination, guilt, persecution, or incurable disease, that there seems to be little chance of recovery, the psychiatrist may recommend the operation of prefrontal lobotomy or the cutting of large groups of nerve fibers in the frontal lobes of the brain.

Summary

1. The involutional period is one of special mental stress because of both physical and psychological factors.
2. Most persons who develop involutional melancholia have always been characterized by a tendency to be serious, worrisome, overconscientious, prone to feelings of guilt, perfectionistic, rigid, lacking in humor, apprehensive, and prudish, and to have few interests.
3. Among the most important symptoms of involutional melancholia are indecision, insomnia, depression, agitation, fear, anxiety, hypochondriasis, and delusions of sin and unworthiness. Suicidal attempts are not uncommon and must be carefully guarded against.

4. Electric shock is now widely used in the treatment of involutional melancholia if the physical condition of the patient permits. Its use often shortens the illness and increases the recovery rate.
5. Persons who have been jealous, suspicious, secretive, critical, inclined to blame others, resentful, and dissatisfied develop a paranoid psychosis more frequently than a melancholia at the involutional period.

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CHAPTER XXII

SCHIZOPHRENIA (DEMENTIA PRAECOX)

Basis of the Name Schizophrenia. In the normal, well-adjusted individual we find a certain orderliness and unity in the expressions of his mental life. There is a harmonious blending of behavior, emotional manifestation, thought content, and other expressions of the personality. We can apparently understand his feelings which seem natural and appear to determine and guide the action tendencies of his life. In one group of mental disorders, however, we find a form of personality maladjustment characterized by certain defects of inner harmony and by inconsistencies of behavior, thought, and emotion. As a result it is difficult to "feel" ourselves into the patient's place. Mental disorders characterized by this disorderliness of feeling and thinking, by an absence of harmonious blending of the various aspects and expressions of the personality, and by the consequent disturbance of the patient's relations to his environment have until recently been grouped under the name dementia praecox. This name was chosen on the assumption that the disorder had its onset in early life, particularly during adolescence, and that it soon led to dementia. It is now known that the onset is often not until adult maturity, and that the word dementia does not accurately indicate the unmodifiable deterioration in interests and habits characteristic of the unfavorable outcome of many cases. More appropriate is the name schizophrenia (from two Greek words, the one meaning "to split" and the other "mind"), since it indicates the breaking up of the former harmony and unity of the personality and of its expression in thought, feeling, and activity.

Causes Mental in Nature. Although the possibility that organic factors may be operative in causing schizophrenia cannot be denied, yet their existence has never been demonstrated, and as a rule one finds enough pernicious factors in early environmental influences, in mentally unhygienic characteristics of the personality, and in per-

turbing problems of the patient's inner life to offer a logical explanation for its occurrence. More and more are psychiatrists coming to think of schizophrenia, not as a disease in itself, as in the case of diabetes, cancer, or pernicious anemia, and therefore having a structural or chemical basis somewhere, presumably in the brain, but as a method of thinking, feeling, and acting which some individuals unconsciously adopt under conditions of stress in an effort to deal with baffling problems of their inner lives. There is much to suggest that persons having a special makeup of constitution and personality are predisposed to this type of thinking, feeling, and acting when confronted by problems, situations, and experiences that touch and disturb their inner lives. A characteristic result of this schizophrenic method of reaction to these individual stresses is the deterioration of interests and habits already mentioned and an accompanying disharmony, distortion, and disorganization of the personality with impairment of social adjustment.

Schizoid Personality. The special makeup that seems predisposed to schizophrenia is the schizoid type of personality described in Chapter IV. In a strikingly large number of cases one finds that long before the development of their psychosis many schizophrenics exhibited the oddities and inconsistencies that usually accompany temperaments clearly schizoid in nature. The sensitiveness and tendency to daydreaming and to withdrawal from social contacts so frequently seen in those of schizoid temperament render them poorly prepared for dealing frankly and successfully with gnawing mental conflicts, insistent but consciously rejected urges, and other troublesome problems and frustrations. Such persons, therefore, are prone to give up the struggle with a harsh reality, to adopt evasive and substitute ways of meeting problems, to secure satisfactions, not from the real world but from a world of their own making produced through phantasy, projection, delusions, hallucinations, and other devices which constitute the method of adjustment we know as schizophrenia.

Frequency. Schizophrenia is one of the most frequent forms of the major psychoses, constituting from 15 to 20 per cent of first admissions to public hospitals for mental diseases. Because when once established schizophrenia often becomes a permanent life reaction, it will usually be found that 60 per cent of the population of state hospitals is made up of schizophrenics. It is estimated that more than 50 per cent of persons suffering from schizophrenia re-

quire frequently repeated or permanent care in a hospital. About one third of schizophrenic patients entering a hospital for the first time will continue to need permanent hospital care.

Symptoms of Schizophrenia

Change of Personality. In a majority of cases the onset of schizophrenia is gradual, a year or two often elapsing before the patient's relatives realize the significance of his early symptoms. There is an insidious change in the patient's mood and outlook, a progressive shutting-in of the personality. Sometimes the patient notes that he is losing interest in external matters, that he is withdrawing from reality and becoming introspective. His friends may speak of him as "far away." The patient loses ambition and becomes careless of social requirements. An inner turmoil, particularly in the emotional and instinctive life, may arise and the patient become ill at ease, restless, and taciturn. Often he wonders what interpretation others are putting on his behavior. He may see "hints" in their comments and behavior, a fact that may make him suspicious and perhaps depressed. He often feels rejected by others. With the listless apathy and dulling of finer feelings an emotional disharmony may appear, manifested by inappropriate laughter or silly giggling. The feeling manifested may not be in keeping with the content of the idea expressed. The impoverishment of emotional expression and the inadequate and inappropriate emotional responses are illustrations of the disorganization or splitting of the personality which gave rise to the term schizophrenia.

Disturbance of Thinking. Normally ideas are associated with an orderly, unbroken connection progressing logically until a thought is completed. In schizophrenia associations are often disturbed. At first there may be merely a slight irrelevancy, an odd sequence of ideas as if the patient had missed the point. Later associations may be so shortened, fragmented, or incomplete that the thinking becomes disconnected, illogical, or even incoherent. The lack of unity, clearness, and coherence that may occur in schizophrenic thinking is illustrated by the following sentence taken from a vague and involved letter written by a well-educated patient:

> A patient or a citizen may promote co-operation and its compulsion or concept among those concerned may regenerate the path of progress but the average responses to the individual purpose and attainment should be aside from the selfish or altruistic raw materials of the human animal when applied to the mass.

Many schizophrenics show a poverty of ideas. They are often given, also, to casual and trifling remarks and replies, a condition so peculiar to the disorder as to have diagnostic significance. They may coin new words (neologisms). Blocking of associations may occur as they approach subjects that are psychologically painful or forbidden.

Delusions. The ideas, the mental content, of the schizophrenic patient are often delusional in nature. Because the psychological needs which the delusions were created to satisfy are often not apparent, and because the beliefs created to deal with these needs are so highly disguised by symbolism, the delusions of the schizophrenic often appear grotesque and meaningless. His delusional beliefs are never meaningless, however, since their content meets some particular need in the patient's mental life. They represent attempts to deal with some handicap or conflict in his inner life. The tendency of the schizophrenic's delusions to be fanciful, distorted, loosely organized in their ideational content, and scattered in their associative connection is shown by the following excerpt from a letter addressed by a woman patient to one of the male physicians on the staff of the hospital in which she was under treatment:

Dear Dr. ——,

"My Plan," or as mother used to call you, "The Little Plant," or else one little plant for I was the other Plant, called "Tante." Will you please see that I am taken out of this hospital and returned to the equity court so I can prove to the court who I am and thereby help establish my identity to the world. Possibly you do not remember or care to remember that you married me May 21, 1882, while you were in England and that I made you by that marriage the Prince of Wales, as I was born Albert Edward, Prince of Wales. I am feminine absolutely, not a double person nor a hermaphrodite, so please know I am England's feminine king—the king who is king.

Sincerely,

"Tant" (Mary Frances Benton Carter)

Queen of Scotland, Empress of the World, Empress of China, Empress of Russia, Queen of Denmark, Empress of India, Maharanee of Durban, "Papal authority" as a Protestant.

A study of this patient's life previous to the onset of her mental disorder showed how, by her adoption of certain unusual religious beliefs, she had long been seeking for a sense of security. Apparently unsuccessful by those means she then sought by her psychotic delusions of grandeur to attain the feeling of security for which

she had been vainly striving. In her delusions, too, one finds evidence that she had failed to make satisfactory adjustment in her sex life. As in the delusions of other forms of mental disorder the delusions of the schizophrenic represent attempts to deal with thwarted urges and drives, frustrated hopes, physical inadequacies, feelings of insecurity, disowned traits, gnawing feelings of guilt, or other problems that deeply touch the patient's inner life. In no other type of mental disorder are the patient's problems, strivings, and conflicts so thoroughly dramatized and disguised in fantastic delusional beliefs.

Hallucinations. Another common symptom in schizophrenia is hallucinations. Psychological needs and inner experiences are projected into the external world in the form of perceptions having to the patient the same appearance of being based on reality as do the perceptions of normal life. Disowned desires or feelings of guilt, for example, may be projected as auditory hallucinations, as voices expressing accusatory or critical remarks. The same problems, desires, and conflicts which led to the development of delusional beliefs break through, as it were, and find disguised expression in auditory, visual, tactile, or other hallucinations. Hallucinations may be said to collaborate with delusions in giving disguised expression to troublesome material from the patient's inner life, in satisfying some deeply seated need or some repressed pleasure-seeking tendency. In no other mental disorders except delirioid states are hallucinations as common as in schizophrenia. During their early occurrence hallucinations often cause the patient to become quite tense, but later they may neither cause much concern nor greatly influence behavior. The patient rarely recognizes that the hallucinations are the product of his own mind.

Disturbance of Activity. Among frequent symptoms of schizophrenia are disturbances of impulse, action tendencies, and the striving aspects of the personality. The schizophrenic is often given to odd, unexplained, and sudden activities. Conflicting forces and motives (a condition known technically as ambivalence) may seem to prompt the patient's behavior. Sometimes the patient has a feeling that he is forced or controlled in respect to his behavior. One of the commonest disturbances in schizophrenia is a loss of initiative and purpose and a tendency to passive inaction accompanied by a waning of interest and a withdrawal from the world of activity and reality. Many schizophrenics exhibit negativism in the

form of resistiveness, contrariness, mutism, and refusal to eat or even to void urine. Although in certain respects it may appear the opposite of negativism, one occasionally notes a pathological suggestibility which has for its object the same purpose as does negativism—a lessening of disturbing contacts with reality. The patient may automatically follow verbal directions without reference to their appropriateness or significance. Instead of answering a question he may repeat it in a parrot-like manner—echolalia. The waxy flexibility of the catatonic patient represents an extreme and passive acquiescence to suggestions, the patient maintaining his extremities for an almost incredible period of time in whatever position they may be placed. Other disturbances of the volitional aspect of the personality are mannerisms consisting of affectations of manner, speech, or gait, of grimaces, sniffing, blowing out the cheeks, wrinkling of the forehead, etc. Fitful behavior and impulsive, apparently unpremeditated, acts are not infrequent.

Four Types of Schizophrenia

Based on the prominence of certain groups of symptoms, schizophrenia is often divided into four types. The distinctions between the various subtypes are only relative and transitions from one clinical form to another are common.

Simple Type. This type is characterized by a progressive dulling of feeling, interest, and spontaneity. Hallucinations and delusions probably never occur. In adolescence a youth who has perhaps manifested much promise shows an insidious change of personality, the significance of which is not understood by his friends. He loses interest in school or occupation and becomes moody, irritable, and indolent. He manifests shallowness of emotions, and indifference or callousness. Appreciation of aesthetic and moral values is lost. Some patients become vagrants, tramps, prostitutes, or delinquents. In milder forms the social maladjustment of the patient is less serious, yet he is looked upon as queer and is usually able only to perform some simple routine labor under supervision.

Hebephrenic Type. This type receives its name from two Greek words, one meaning "puberty" and the other "mind," and was so designated since many of its features are those of an immature state of emotional development such as is often observed at puberty. The onset is insidious and the early symptoms may consist of fatigue, irritability, withdrawal from social contacts, staring, pre-

occupation, and perhaps depression. Prominent among later symptoms are shallow and incongruous emotional reactions, silliness, unexplained smiling, and a laughter which seems out of keeping with the ideas expressed. Hallucinations which appear pleasing to the patient are common; peculiar, often bizarre, ideas are expressed. Mannerisms and impulsiveness are frequent. Many patients are superficial and disconnected in their talk. Wetting and soiling are common.

Catatonic Type. This type receives its name from two Greek words meaning disturbed tonus or tension, a name suggested by the apparent disorder of muscle tension seen in the stuporous phases. Although often preceded by discontent and dreaminess the frank symptoms of this type frequently develop more acutely than those of other schizophrenic reactions. Typically there is a stage or phase of stupor with immobility, mutism, negativism, and refusal of food alternating irregularly with stereotyped or impulsive activities, the latter sometimes being destructive or violent in nature.

In *catatonic stupor* the facial expression is vacant, the head is bowed, spontaneous initiative is lost, there is no apparent interest in the environment, and the patient sits as idly as a mummy for indefinite periods. He has to be dressed and undressed, resists every effort to do anything for him, and may have to be tube-fed for months. Pinpricks and other painful stimuli are disregarded. Many patients show the sustained immobility known as catalepsy. While apparently unheeding and insensible the consciousness and sensorium of the stuporous catatonic are actually clear, and after his recovery he may relate various incidents occurring during his stupor. Mannerisms, strange attitudes, and flexibilitas cerea are common. Urine and bowel contents may be retained, or the patient may seem to show an incorrigible wilfulness in his annoying disregard of all cleanliness in his excretory habits. Cyanosis and even edema of the extremities are common. In spite of the apparent dearth of ideas there seems every reason to believe that thoughts are by no means absent, but rather are centered about some theme intimately related to the patient's psychotic experience.

In *catatonic excitement* the patient's behavior is characterized by impulsive and stereotyped activities poorly co-ordinated and often lacking apparent purpose. Hostility and feelings of resentment are common and unprovoked outbursts of violence or destructiveness

may occur. Negativism, nudity, and untidiness in excretory habits are often manifested. Hallucinations are frequent, and the flow of speech may vary from mutism to a pressure suggesting flight of ideas. Some excitements are in the form of short panic reactions.

Paranoid Type. In this type the disturbance of the personality is not so much in motor activity, accessibility, and emotional life as it is in thought content and interpretation of the outside world. We therefore find that delusions occupy a prominent place in the symptomatology. Many of the schizophrenic's delusions are the products of phantasy which in the absence of all critical faculty supply what real life has denied. Such patients may lead a day-dreaming existence with disregard for or with distorted interpretation of the world of reality. They ignore whatever is incompatible with the delusional satisfaction of their needs. In another group of paranoid schizophrenics the patient's delusions may be traced to discordant components of his personality. The patient lives in a world projected from himself. Rejected aspects and qualities of the personality are seen not as belonging to the patient himself, but as hostile and threatening forces in the outer world. Ideas of persecution are therefore common. The patient states that detectives are after him, men dressed in women's clothing follow him, an instrument is used to read his mind. Associated with the delusions are hallucinations. Voices accuse the patient of perverted acts or make critical or threatening remarks. Not a few paranoid schizophrenics cease friendly human contacts and become discontented, irritable, resentful, aggressive, and even combative. Some show a surly aversion to being interviewed. In some instances the patient's utterances are so disconnected and fragmentary and his phraseology so incoherent that his delusional expressions seem meaningless. It may therefore be difficult for the psychiatrist to interpret the patient's inner life—to read the riddle of his inner world.

Prognosis and Course. While a schizophrenic disturbance of the personality must always cause apprehension, yet its permanent disorganization does not invariably follow. Occasionally an acute schizophrenic reaction may not be followed by any apparent injury to the personality although even in the so-called "recovered" schizophrenic a careful observer will usually discover that the patient has suffered a bit in spontaneity, sense of humor, breadth of interests, and in freedom and ease of social contact. The more harmonious and the better adjusted the prepsychotic personality, the richer the

patient's interests, and the greater the physical or mental stress that apparently precipitated the psychotic episode, the better the prognosis. The more rapid and stormy the onset, the more favorable will the outcome usually be. The more the previous personality characteristics have insidiously shaded into the psychosis, the less encouraging the prognosis. The more rigid, introverted, and eccentric the prepsychotic personality and the more numerous its defensive mechanisms, the less favorable the prognosis. Not infrequently the course of schizophrenic disturbances is one of remissions and relapses which insidiously lead to a permanent deterioration of interests and behavior so destructive to socialized adaptation that it becomes necessary for the patient to spend much or all of his remaining life in a hospital for mental disorders. Patients with this disorganized state of the personality are often described as deteriorated. Mention should be made of the fact that the incidence of tuberculosis among schizophrenics is strikingly high, especially among those of long residence in a mental hospital.

Nature of Schizophrenia. As already indicated earlier in this chapter, there is an increasing tendency to regard the term schizophrenia as a name applicable to certain disorganized and extreme types of patterns of personality expression and response occurring when the harmony of an individual's inner life is perturbed by tensions arising from diverse desires, unadjusted impulses, unattained goals, or other disturbing influences and experiences. According to this point of view there is no organic disease process taking place in the brain as in the case of general paresis, nor any chemical or toxic disturbance of cerebral cells as in delirium tremens. If schizophrenia does not result from a disturbance in function in brain cells impaired by disease or toxin but is merely a mode of behavior, an attempt to meet particular situations in the patient's life, then somewhat comparable although less extreme behavior should be manifested by persons who are not psychotic.

Transition into Schizophrenia. A comparison of the schizoid type of personality as described in Chapter IV with the behavior of the schizophrenic patient will, it is believed, often reveal a subtle transition of the behavior characteristics of the former into those of the latter. The daydreaming of the one may insidiously merge into the phantasy and delusional beliefs of the other. The unapprehending, impassive response with which profound, overwhelming bereavement

or catastrophe may at times be met suggests the stuporous reaction of the catatonic schizophrenic, both serving, it would seem, as methods of meeting situations too crushing to be met by active, resolute measures. It is not difficult to conceive of highly significant material in the schizophrenic's inner life as assuming hallucinatory vividness. It is but a step from the figurative "voice of conscience" to its audible perception. So, too, with other material in his inner life highly charged with feeling. Among nonpsychotic persons it is less easy to find verbal expressions comparable to the new-formed words and apparently unmeaning utterances of the schizophrenic. Even here, however, we find analogies. That verbal expressions in the dreams of normal people may be curious has long been known. The poet, too, often gives words a connotation that would appear meaningless in the conventional speech of everyday life. To the schizophrenic in his self-isolation and with the chaotic state of his inner life, words may assume meanings beyond the interpretation of his fellows. One way by which the normal person may deal with difficult and threatening situations is by minimizing or ignoring them. It is conceivable, therefore, that the emotional dulness and indifference of the schizophrenic is a defensive reaction to all life. Although this blunting of feeling arose as a mechanism of defense against a certain troublesome situation in the inner world of the patient, it irradiates and becomes a general behavior pattern of the personality.

Schizophrenia a Method of Dealing with Problems. While these explanations of the clinical pictures of schizophrenic patients can scarcely be proven, yet careful observation of these pictures suggests that schizophrenia represents exaggerations and other caricatures of behavior patterns existing in the nonpsychotic, rather than the altered functioning of nerve cells affected by some impersonal disease process. Such an explanation gives meaning to the symptoms of schizophrenic patients since it conceives of schizophrenic behavior as the method adopted by a particular person in his effort to deal with the needs and troublesome situations in his inner life. The more the psychiatrist comes to know of the life experiences of any particular schizophrenic patient, the easier it becomes to bridge the gap between the patient's earlier life and his psychotic life, to trace step by step the continuous transition between his earlier and his schizophrenic experiences.

Early Treatment Desirable. Unfortunately the services of the nurse are frequently not requested during the early stages of the psychosis when active personal attention on her part might do much in preventing or retarding an asocialized disorganization of the personality. In spite of every effort many patients will become permanently isolated within their own self-made world with such an indifference to dress, manners, and the ordinary pursuits and amenities of life that socialized adjustment in the community is no longer possible. There is reason for believing, however, that in many other instances an early and active promotion of socialized interests and habits would accomplish much. Frequently the patient's friends will not permit hospital care until his behavior becomes so disturbing that he can no longer be tolerated in the home. As a result asocialized habits become so fixed that later efforts of the nurse and hospital are in vain. In the early stages, too, a certain number of patients are given to morbid rumination and end their lives by suicide if not promptly hospitalized. Not infrequently the patient's family rejects the physician's recommendation of early hospital care, partly because hospitalization seems an acknowledgment that the illness is more serious than they are willing to concede, and partly because of the unfortunate persistence of ignorance and misunderstanding concerning psychiatric hospitals as well as the alleged stigma connected with treatment in them. The patient's relatives usually fail, also, to recognize that not rarely mentally unwholesome influences in the family, the tenacious devotion of a mother or discordant relations with a father, may have contributed to the psychosis and that therefore the removal of the patient from the home environment is wise.

Nursing Management: Promotion of Interests. Frequently the tendency of the schizophrenic is toward a progressive self-isolation and to a deterioration of habits. It follows, therefore, that one of the most important tasks of the nurse is to promote wholesome interests on the part of the patient, to direct these interests to the practical affairs of everyday life, to encourage him in maintaining normal socialized relations with others, and to stimulate pride in dress and personal habits. The extent to which idleness and deteriorated habits develop depends to no small degree upon the initiative, patience, and perseverance of the nurse in stimulating wholesome activity. The patient should be encouraged to seek his satisfactions from the world of reality rather than from a self-

constructed world of phantasy. The usual inclination of the schizophrenic to shun the company of others and to lounge about in idleness in the obscurity of the chronic ward must be discouraged.

Occupation. Occupation is one of the most valuable methods of stimulating interest in objective reality. Since the patient usually has no desire for useful employment, ingenuity and great persistence will be required on the part of the nurse. Some patients manifest particular interest in weaving, basketry, wood work, or leather work along the lines so highly developed by the schools of occupational therapy. Other patients prefer and derive equal value from farming, gardening, animal husbandry, or other hospital industries. While extremely simple types of occupation are often necessary at first, those of a too stereotyped character, such as sandpapering, should either not be adopted or should not be continued too long. The participation of the nurse in the work is often stimulating. Encouraging results are often obtained by providing work in which several patients may take part. The nature of the employment should always be such that it will be obvious to the patient that the products of his labor are useful. Pride in the results of his work should always be encouraged. The nurse should realize that occupation is a real form of therapy, and deserves as careful and thoughtful attention as the procedures employed by the nurse in a general medical ward. The successful psychiatric nurse devotes as much thought to the mental therapy of her patient as does the surgical or obstetrical nurse to the physical needs of those under her care.

Recreation. Calisthenics and group games, especially those played out of doors, not only provide necessary physical exercise, but retard introversion and bring the patient into stimulating contact with others. Such forms of exercise are much more desirable than the custom of having patients walk in groups accompanied by attendants. Under the latter practice the patient may continue to shuffle along in a slovenly manner, his imaginary world remaining quite undisturbed. Music, dancing, and moving pictures are of much value. The improvement that often follows participation in dramatics is frequently surprising.

Personal Hygiene. Patients suffering from schizophrenia are notoriously careless of personal hygiene. Frequent and regular bathing must be insisted upon. The teeth are almost invariably neglected unless given special attention by the nurse. The nurse

should see that the patient is adequately dressed and that the clothing is properly arranged and clean. Many schizophrenic patients soil clothing and bed linen with excreta. Much can be done by the nurse to correct this unpleasant habit. If she will insist that each patient visit the toilet regularly both day and night, a surprising improvement may be secured. The amount of untidiness on

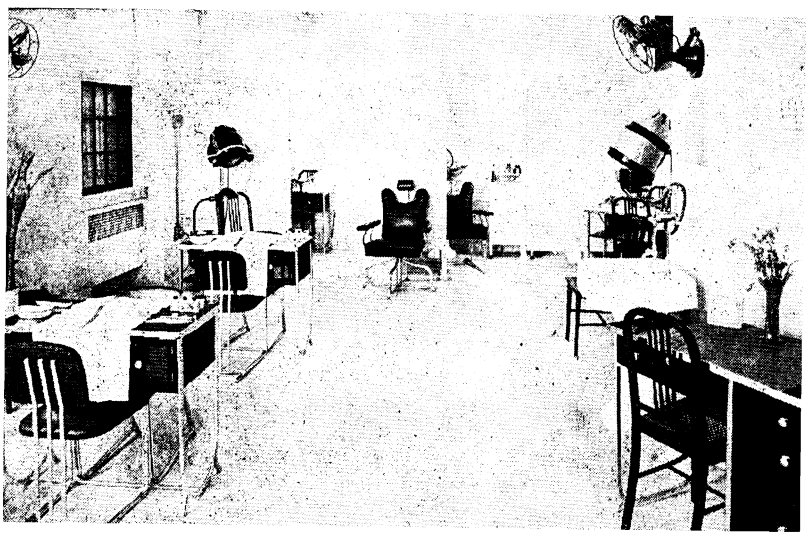


FIG. 9: BEAUTY PARLOR IN A MODERN PSYCHIATRIC HOSPITAL.

a ward is largely determined by the energy and resourcefulness of the nurse. Bad sex habits are common among continued treatment cases. Scolding accomplishes little in preventing such habits, although a healthy daily routine with plenty of employment of a practical, objective nature may accomplish much.

Value of Self-Respect. The absence of a sense of self-respect and of self-esteem is one of the most serious deterrents to recovery. A very helpful means adopted in recent years for promoting these qualities is the practice of establishing "beauty parlors" for women in hospitals for mental disorders. Provisions for hairdressing and other facilities for improving the personal appearance of the patients stimulate a desirable sense of self-respect that improves behavior and promotes socialized habits. The improvement that not rarely follows the establishment of a sense of pride in personal ap-

pearance prompts the comment that in dealing with schizophrenics, as indeed with all mental patients, the nurse should scrupulously avoid the slightest sign of depreciation or of underestimation. An inner need which not infrequently contributes to the development of psychotic behavior is that for self-value. The indignities which mental patients all too frequently suffer not merely injure pride, but impede recovery.

Nourishment. Not infrequently the schizophrenic fails to take sufficient food or may even refuse it entirely. Such patients must often be spoon-fed. If refusal of food continues more than forty-eight hours the patient should be tube-fed. Occasionally such a method of receiving food becomes a habit, in which case an attempt should be made to stop it.

Disturbed Outbursts. Outbursts of irritability, excitement, or violence more frequently spring from causes arising from within the patient, especially from hallucinations or delusions, than from events within the environment. Sometimes, if given without implication of a threat, a calm, unemotional statement that such conduct can be permitted only upon a disturbed ward will be sufficient to correct the behavior. Continued or marked excitement is best treated by continuous baths or wet packs. Usually patients suffering from catatonic excitement remain in the baths surprisingly well.

Catatonic Stupor. In the case of catatonic stupor attention must be paid to bowels and bladder, also to the skin lest pressure sores develop. The patient should not be permitted to occupy one position for long periods of time lest the extremities become edematous and easily subject to infection should abrasions occur. The nurse should remember that the catatonic's powers of apprehension in spite of appearance to the contrary are not greatly impaired and that he may therefore be cognizant of all that is said and done in his presence. Some catatonic patients stand fixedly in one position for such long periods that feet and ankles become cyanotic, edematous, and swollen. If walking and other exercise guided by the nurse do not relieve this condition the patient should be placed in bed until it has subsided.

The Complaining Paranoid. At times the patient suffering from paranoid schizophrenia with his constant dissatisfaction and frequent complaints and charges may be a source of annoyance and apprehension to the nurse. Perhaps a word as to such a patient's

point of view will assist in understanding him. He finds that in spite of his protests he has been placed in an institution and stripped of many of his personal rights. His new environment fills none of his mental needs, but on the contrary appears hostile to him. His belief in his persecutions continues, while misunderstandings and refusals are met on every hand. The nurse because of her position and constant contact may become the personification of his frustrations. For this reason her attitude should be kindly, friendly, and tolerant. One should never argue with paranoid patients concerning their delusions. As in other paranoid reactions, including that sometimes seen in manic-depressive psychosis, poise, self-control, and a scrupulous truthfulness without even the appearance of deceit will go far to persuade the patient that the nurse is a friend in whom he may have confidence. Having once gained this confidence she may do much to make the paranoid patient a useful member of the hospital community, even though rehabilitation to a degree permitting a return to his previous environment be impossible. Frequently he becomes a useful hospital citizen.

Special Nursing Treatments: Insulin Stock. A form of treatment which was developed by Dr. Manfred Sakel in Vienna and has been extensively employed since 1936 is insulin shock. While the results of this treatment are by no means as remarkable as at first hoped, yet in many cases when the treatment is used during the first six months or year after the onset of the disease the duration of the episode or attack is definitely shorter than when other forms of treatment are employed. Perhaps, too, the percentage of recoveries is slightly larger and the period before recurrence somewhat longer. The details of nursing treatment in insulin shock are discussed in Chapter XXVIII.

Electric Shock. The greatest usefulness of electric shock treatment is in the affective disorders, such as involutional melancholia and manic-depressive psychoses, but in cases of schizophrenia accompanied by depression this form of treatment is often helpful. The nursing treatment in electric shock also is discussed in Chapter XXVIII.

Follow-up Care. When the schizophrenic patient so far recovers that he may return to the community the need for psychiatric counsel and guidance frequently continues to exist. While at this point the nurse will usually transfer to the psychiatric social worker the function of supplementing or assisting in the work of the

psychiatrist, yet she will rarely fail to note with interest the progress of her former patient in the task of social rehabilitation. Usually before the patient leaves the hospital the social worker will study the family situation in respect to conditions favorable or harmful to mental convalescence and future mental health. Jealousy or rivalry may exist between the patient and brother or sister, or the presence of an unloved husband or wife may constitute a mental hazard. Often some interpersonal relationship or other mentally unwholesome factor exists in the setting in which the patient was placed at the time his psychosis developed. Just as the patient who has been made physically ill by unhygienic conditions of living or of working should not return to the same noxious conditions that produced his illness, so if possible the mentally convalescent patient should not return to a situation to which an emotional adjustment is a constant problem. Besides endeavoring to modify favorably the conditions under which the patient previously lived, the social worker may often be helpful by interpreting the patient to members of his family. She may explain to them the meaning of unpleasant habits and the desirability of tolerance for them. The worker may point out to the family the assets in the patient's personality, the interests and tendencies which give promise of constructive development, the topics toward which a sensitiveness exists, the situations which will call forth unwholesome mental mechanisms and the way they may be avoided. The family will be instructed how by the encouragement of group contacts and of recreational activities a tendency to withdrawal in daydreaming may be combatted. In brief, the worker attempts to establish and maintain the patient as a socially adjusted individual both by modifying favorably the environment in which he must live, and by guiding the patient in the promotion of wholesome methods in meeting the emotional and other problems to which he experiences difficulty in making successful adjustment.

Another agency which has come to be an important factor in maintaining the maximum possible degree of mental health for the patient who has perhaps suffered some impairment of personality through a schizophrenic illness, is the outpatient clinic conducted by many hospitals. The patient may visit such a clinic periodically in order that with the assistance of the psychiatrist any troublesome problems may be analyzed and guidance in meeting them be secured.

Summary

1. Schizophrenia is a term applied to a group of psychotic reactions characterized by disturbances in the harmonious blending and co-ordination of the various aspects of the personality. Mood tends to be inappropriate, thoughts disorderly, and behavior maladaptive.
2. Persons of a schizoid makeup are predisposed to the disorder, which is believed to be due to mental and not to organic causes.
3. Among the prominent symptoms are blunted and inappropriate emotions, withdrawal from association with other persons, negativism, mannerisms, delusions which are often fantastic in nature, hallucinations, and impulsive behavior.
4. Four rather poorly differentiated types are usually described: simple, hebephrenic, catatonic, and paranoid.
5. More than half of the patients who suffer from a schizophrenic psychosis will require frequently repeated or permanent hospitalization. About one third of first admissions will never leave the hospital.
6. A rapid onset following some disturbing situation in an individual of previously normal personality offers the best prognosis.
7. An onset characterized by an insidious and slowly progressive change in personality and without apparent cause offers a poor outlook.
8. Among general forms of treatment are promotion of wholesome interests and acceptable personal habits, occupation, recreation, the rendering certain that nourishment is ample, and if behavior is disturbed the use of wet packs and continuous flow baths.
9. Of special forms of treatment insulin shock is frequently of much value in early cases. Electric shock treatment may be helpful if the patient is depressed.

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CHAPTER XXIII

PARANOIA AND PARANOID CONDITIONS

Paranoid Personality Traits and Their Relation to Paranoid Psychoses. Under the designations paranoia and paranoid conditions are included chronic mental disorders characterized by fixed and in many respects logically elaborated delusions. The word paranoia is derived from two Greek words meaning disturbed mind or reason. As this name would suggest, the symptoms are largely in the field of thought. The patient's emotional and behavior reactions remain in keeping with his delusional beliefs which become the uppermost and guiding topic of his mental life. The same experiences and handicaps and the same needs of the emotional life which in some persons result in paranoia may in others lead to allied mental mechanisms and give a paranoid quality to the personality. The mental mechanisms and reactions we observe in the psychosis are but exaggerations of ones we note constantly among persons whom no one thinks of as psychotic. Not a few individuals who suffer from a vague or unrecognized sense of fear, inadequacy, or inferiority develop such common defensive personality traits as pettiness, suspiciousness, oversensitiveness, irascibility, seclusiveness, resentment, or cynicism. Many a person is at times inclined to think that his merits are unrecognized, to blame his environment for what are really dissatisfactions with self, or perhaps to fulfil his wishes in phantasy. Real or imagined injuries to pride tend to result in feelings of resentment and bitterness of variable duration, while feelings of guilt may lead to misinterpretations and false references to one's self. Such unpleasant character traits not infrequently result from attempts to bolster up the personality and acquire a comfortable sense of satisfaction, self-esteem, and security by the mechanisms of projection and compensation. The individual may be prone to satisfy his need for a sense of security by achievement at the expense of others. Should the mechanisms mentioned become quite unrestrained in their effort to satisfy psychological

needs of the inner, emotional life, they may lead to the development of the fixed, systematized delusions of paranoia. Sometimes various unhappy life situations such as illegitimacy, crippled limbs, deafness, poverty, lack of education, inability to learn as quickly as one's associates, physical unattractiveness, and ambition beyond the possibility of achievement may conduce to feelings of inferiority and insecurity. Such factors may help lay the basis for a paranoid trend in the personality, and in some instances be potent factors in creating a paranoid psychosis.

Causes of Paranoia. From what has been said it follows that the causes of paranoia are to be sought in a need for protecting particularly vulnerable aspects of the personality, in vague fears, feelings of guilt, in the craving for a recognition greater than acquirement can command, and in the particular conflicts of the individual. A strikingly large percentage of cases of paranoia occur among persons of superior intelligence.

Symptoms of Paranoia

Prepsychotic Personality. As we study the mental life of individuals and the methods by which they meet the conflicts within and the frowns of fortune without, we often find it difficult to say where a paranoid type of personality stops and illness begins. Anomalies of character become continuous with the psychosis, both, to a large degree, going back to early experiences and to personality patterns in the individual's makeup. Not rarely the psychiatric history reveals that prophetic signs of the future psychosis existed in childhood. At that time the future patient may have been stubborn, sensitive, suspicious, secretive, resentful of school or parental discipline, moody, given to daydreaming and sulking, and unable to play harmoniously with other children. As he grew older the defensive and compensatory characteristics became accentuated.

Ideas of Persecution. Occasionally it is possible to recognize certain stages in the development of the manifest psychosis. At first there may be a period of depression during which the patient is hypochondriacal, preoccupied with his sensations, and inclined to brood. An attitude of bitterness and resentment becomes accentuated, and a stage of persecution sets in. Suspicion is constant; incidents are misinterpreted and considered as evidence of hostility. The tendency of the paranoiac to misinterpret the motives of others is illustrated by the case of a woman who soon after graduation from

a law school, the faculty of which had awarded her the annual prize for the greatest improvement in scholastic work during her professional course, sued the school for damages, alleging that in awarding her such a prize the faculty had sought to represent her as having been more poorly fitted than her classmates for the study of law. With the stage of persecution, ideas of reference occur. The patient believes enemies are conspiring against him; people point at him on the street; the newspapers refer to him; spies follow him; people make peculiar noises to annoy him; attempts are made to poison him; his thoughts are read and his body abused at night. He changes positions of employment frequently, but his enemies pursue him. Unimportant incidents of the past are discovered to have had marked significance, usually of hostility, to the patient—a process known as retrospective falsification. By a clever misinterpretation of facts the paranoid often offers quite plausible evidence in support of his delusions. Because of the intense hatred which may be felt by them and may be directed toward certain individuals, some paranoiacs must be looked upon as dangerous persons. Others become intolerably annoying through litigation or other troublesome activities.

Ideas of Grandiosity. Although they usually either precede or are accompanied by delusions of persecution, ideas of grandeur are common in paranoid states. Doubtless the patient has long had an attitude of superiority and believed that people were jealous of him. Finally he may discover that he is extraordinarily talented; he has made remarkable inventions which will revolutionize industry and bring untold riches; he has discovered the long-sought secret of perpetual motion; he is of royal or other distinguished blood. The delusions may be of religious grandeur: he is the chosen one of God, is Christ, has been entrusted with a special mission. He may wear a beard and long hair in an attempt to imitate the supposed appearance of Christ. Some establish new religious sects and even secure adherents. An attempt is made to disguise an egotism and self-satisfaction by affected modesty and humility.

Nursing Management. In one respect the nursing of the patient suffering from paranoia or paranoid condition is simple, yet in other ways it is extremely difficult. Accompanying physical disease is rare and if present is incidental only; the patient takes adequate nourishment and there is little danger of suicide. Usually, however,

these patients chafe under the restraint of institutional life, as a result of which the maximum of tact and diplomacy is required of the nurse, upon whom the patient may focus the resentment which he feels toward the hospital because of his detention. Hospital rules and habits of ward procedure are constant sources of irritation. Many compromises in their application are therefore usually advisable. As much freedom of choice and as many privileges as possible should therefore he granted paranoid patients. The nurse must remember, however, that paranoids are most plausible in attaching their own desired interpretations to remarks made by others or to privileges granted to them. In some instances the nurse must be watchful to prevent the surreptitious posting of letters or the effecting of escape. Some patients delight in devising methods for securing the discomfiture of a nurse whom they may dislike. The wise nurse will therefore exert every effort to secure the confidence of the paranoid patient. She will scrupulously avoid deceiving him. Her authority must be exercised in a quiet, unassuming, yet firm manner. Tact, courtesy, and consideration will be rewarded not only by their beneficial effect upon the patient, but by the avoidance thereby of a thousand unpleasant and irritating incidents which such a patient knows so well how to produce. Because of their superior intelligence these patients may often be profitably employed in some useful occupation about the hospital. Many are glad to do typing or clerical work, such as assisting in store records, marking clothes, etc. Opportunities for reading should be provided those who care to avail themselves of it.

As in other delusional states one wishes to help the patient see and accept reality as far as possible. This cannot be done by insistence, protest, or argument. Attempts by such means will merely arouse antagonism and defeat one's purpose. The nurse will listen patiently to the delusional story without, however, leading the patient to believe she accepts it. Frequently she can offer an alternative version or point of view as to the patient's observations, with the result that he may come to see the possibility of varying interpretations. If the nurse is aware of the particular mental problems and needs of the patient, she can often help guard against his exposure to troublesome situations and topics. Finally she can often point out a way of life that permits getting along with facts without too much friction.

SUMMARY

1. Paranoia is a mental disorder characterized by delusional beliefs.
2. In many respects paranoia and paranoid conditions are but the extreme degrees of such personality traits as suspiciousness, oversensitiveness, secretiveness, resentment, stubbornness, and a tendency to misinterpret, to entertain feelings of superiority, or to indulge in phantasy without regard for reality.
3. The paranoid psychoses seem to arise through the mechanism of projection by ascribing to others one's own unrecognized but repudiated qualities and wishes, and through the mechanism of compensation for subconscious feelings of insecurity, inferiority, and guilt.
4. Paranoia is a fixed, permanent method of meeting life problems.
5. The principal nursing problem is tactfully to guard the patient against exposure to troublesome situations and topics and to aid him in adjusting to hospital life and to other circumstances with as little friction as possible.

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CHAPTER XXIV

PSYCHOPATHIC PERSONALITIES

Definition. There are certain people who, while neither psychotic nor feebleminded, are nevertheless of such a personality makeup that they cannot adjust with others and fit harmoniously and effectively into the organized social environment. The variations in their personality structure are in the fields of impulse, temperament, and character rather than of intellect. Such a personality deviation with the resulting impairment of social adaptation is known as a psychopathic personality. There is neither satisfactory criterion nor common agreement as to just what constitutes or should be included in the term. Although admittedly vague, too comprehensive, and often loosely used it is, nevertheless, a convenient designation for certain variances, distortions, and discords of personality which lie in the wide zone between mental health and mental disease.

Manifestations. The abnormalities in psychopathic personality are usually manifested either in the social sphere in the form of social inadequacy or antagonism or in the psychosexual sphere in the form of deviations of sex impulse. There has at times been a tendency to include as of psychopathic personality practically all habitual delinquents and criminals or even to limit the term to the antisocial. Neither of these practices should be followed although it must be recognized that the psychopathic personality does not develop either the type or degree of social qualities necessary for successful adaptation. His responses to moral, ethical, and aesthetic considerations remain inadequate. While his behavior often brings him into conflict with the law, it even more frequently violates the sensibilities, amenities, and conventions of society.

Psychopaths Were Problem Children. Even in childhood the future psychopath usually shows unwholesome personality traits and is regarded as a problem child. Socialized types of behavior are not learned, the failure not being due, however, to lack of intellectual capacity. Neither persuasion nor punishment is of avail. The dif-

ficult, psychopathic child may be sensitive, stubborn, given to tantrums or to outbursts of rage. He may steal, run away, be destructive, cruel, quarrelsome, sulky, deceitful, boastful, shameless, and given to varied forms of erratic conduct. In contacts with other children he may be overbearing and a bully. He is often resistive or openly rebellious to parental authority. Many are sexually precocious. As adult years are approached there is no corresponding development in the emotional and volitional aspects of the personality.

Personality Characteristics. There are no behavior or personality characteristics common to them all, yet in general psychopaths tend to manifest certain qualities. As already indicated undesirable personality traits are the most prominent. Usually the psychopath is moody, impulsive, restless, unreliable, superficial, self-satisfied, opinionated, and does not conform to accepted social conventions. He is prone to be aggressive, eccentric, or inadequate. His sex life is often poorly organized. He shows poverty of sentiment, instability of emotions, lacks fixity of purpose, and is unresponsive to training, discipline, or treatment. Naturally a person with qualities such as those just enumerated is constantly at odds both with family and society in general.

Classification of Types. Various classifications of psychopathic personality have been made. Such classifications have but little to recommend them since such groupings are based merely on some single outstanding quality whereas the defects of personality are extensive. Based on the prominence of certain defects, classifications somewhat like the following are often made:

The Excitable Personality. The excitable psychopaths are characterized by the explosive intensity of their emotions in reaction to relatively slight external stimuli. Between their outbursts those psychopaths are usually outgoing and friendly, happy, and likable. Normally at a somewhat high pitch their emotional tension may burst out suddenly and violently in uncontrolled anger or other extreme emotional display. At such times they may shout, bluster, threaten, or even become destructive or assaultive. Suicidal gestures may be made, often, one suspects, for the purpose of attracting attention. Jealousy and quarrels with persons of the opposite sex are common. Doubtless the outbursts of the excitable psychopath are often poorly concealed attempts to disguise a weakness of personality.

The Antisocial Personality. These psychopaths show a moral and ethical blunting and a lack of sympathy for others. Their behavior is destructive to social welfare. As children they are self-willed, play truant, commit petty thefts, are often cruel and untruthful, and as they grow older are characterized by a brutal egoism and emotional coldness. They are without sense of honor or of shame and are lacking in affection, gratitude, and other social and aesthetic sentiments. Their offenses constitute the whole register of crime—theft, forgery, robbery, and acts of violence.

The Inadequate Personality. In spite of average educational and other favorable opportunities, and although of normal intelligence as measured by psychometric tests, the psychopaths of inadequate personality fail in economic, occupational, and social adjustments. They are often good-natured and easygoing, but dreamy, unsound in judgment, and lack ambition and initiative. Even if it be clear that effort would be rewarded, they lack the persistence necessary to achieve the results already in sight. The pleasure of the moment satisfies; they can neither work nor wait for deferred pleasure or reward. Improvident and shiftless, they include many of the ne'er-do-wells. They may exhibit a certain sentimentality, but possess no genuine appreciation of cultural and aesthetic values.

Pathological Liars and Swindlers. In this group are individuals whose social maladaptation consists of extravagant, often apparently purposeless lying, frequently combined with swindling. They show a marked excitability of imagination associated with an instability of will. They are usually good-natured, of agreeable manners, optimistic, of a light-hearted geniality, and make social contacts easily. These qualities combined with a ready tongue, self-confident manner, a frequently assumed dignity, and a misleading appearance of knowledge readily enable them to convince the credulous as to their statements. They often acquire a smattering of art, literature, or technical parlance which they employ to their own profit and to the expense and humiliation of their victims. They spin remarkable tales as to their past experiences and paint their future with a careless disregard for reality. When discovered in their delinquencies they profess amnesia, and if charged with legal offense they often stage some affected and emotional exhibition designed to impress observers and arouse sympathy. They are restless and unstable, and are incapable of exertion or responsibility. They never learn to

meet the struggle for existence with industry and persistence, but live in a world of imagination and seek to acquire the necessities of life by deceit and fraud. Their theatrical imitation, their tendency to daydream, to boast, to avoid realities, and to surround themselves with an imaginary world suggest a childish immaturity of personality, while their wish-fulfilling fabrications have much in common with the phantasy of childhood.

The Sexual Psychopath. Sexual psychopaths may have abnormalities of sex life in matter of degree, as in eroticism or frigidity; or abnormalities in nature of impulse, as in sexual perversion or inversion. In sexual perversion the patient seeks sexual pleasure by unnatural methods. In sexual inversion the patient's sex instincts are directed toward one of his own sex. In such cases the patient may have the personality and the physical characteristics suggestive of the opposite sex.

Not All Delinquents Are Psychopathic Personalities. It must not be concluded that all delinquents are criminals or even that many guilty of repeated offenses should be looked upon as psychopathic personalities. Defects of character may be due to social and environmental influences as well as to psychobiological forces. Asocial and antisocial behavior may be the expression of a psychopathic organization of the personality, but it is not always such.

Causes. At present there is no unanimity of opinion as to the precise causes that lead to those types of personality which we call psychopathic. The personality may be regarded as the product of constitutional, psychological, and social factors, yet our knowledge concerning the relative part played by each of these factors is exceedingly limited. Perhaps, as is the case in both the normal and the psychotic personalities, there is a tendency to lay less emphasis on constitutional, hereditary factors and an increasing stress on instinctive urges and drives, on the feeling-life of the individual, and on the early methods he was encouraged or permitted to adopt in an attempt to satisfy its needs.

No Sharp Line between Normal and Psychopathic Personality. There is no sharp dividing line between the normal and the psychopathic personality, just as there is no clear line of demarcation between the normal and the neurotic or psychotic personality. The behavior of all these various types of personality—the psychopathic, the neurotic, and the psychotic—may be thought of as modes or patterns adopted to deal with irreconcilable, intrapsychic demands

and to satisfy instinctive and emotional needs. In the case of the psychopathic personality the mode or pattern of behavior followed in dealing with these conflicting demands and satisfying these needs approaches more nearly in some respects to the usual or normal method than to the neurotic or psychotic methods, but is not one that is compatible with social assimilation.

Psychoses More Frequent among Psychopaths. If, according to the view just expressed, the maladaptive behavior of the psychopathic personality is fundamentally an effort to satisfy instinctive and emotional needs and a reaction to mental conflicts, then we should expect a higher incidence of psychoses among these poorly integrated, maladjusted individuals than among harmoniously integrated, well-adjusted persons. This is found to be the case. The majority of the psychoses occurring in psychopathic personalities represent the usual types of schizophrenic, affective, or paranoid reactions. Occasionally, however, the psychoses occur under circumstances involving great emotional distress or tension and represent attempts, through falsifications of belief or sensorium (delusions or hallucinations), to escape from the hard, uncompromising reality of some specific, difficult situation and are therefore called *situation psychoses.*

Prison Psychoses. Since usually the most difficult situation in which the psychopathic personality finds himself is confinement, occasional situation psychoses observed among these persons are the prison psychoses. This does not mean that all psychoses developing among prisoners are true prison psychoses. Most of them, in fact, are schizophrenic and paranoid reactions in which, at most, imprisonment merely acted as the releasing agent. Many prison psychoses take the form of transient confusion, periods of irritability, or episodes of anxiety or of sudden excitement accompanied by intense emotional outbursts, perhaps with destructiveness.

A form of prison psychosis occurring among long-term prisoners is that characterized by delusions of innocence or of pardon. The patient experiences auditory hallucinations in which he is told that he has been exonerated of his alleged guilt and is to be liberated. Various other delusions or hallucinations which fulfil some wish concerning the prisoner's unhappy situation may exist.

Nursing Management of Psychopathic Personalities. Occasionally a court before which he has appeared on a charge of some crime or misdemeanor commits a psychopathic personality to a hospital for

mental diseases for purposes of observation. Ordinarily, however, the psychopath who is not psychotic is not admitted to a mental hospital. Should the psychopathic personality also be psychotic his nursing care will be that of the disorder which it most resembles. Most psychopaths suffering from acute prison psychoses recover after transfer from prison to the mental hospital where the attitude is one of helpful treatment rather than of rigid discipline. Occupation, games, and amusements are beneficial. Although often necessarily firm, the attitude toward the patient should be friendly and obviously one of desire to help. Continuous baths are of value in confused or excited states. Depression calls for the usual watchfulness to prevent suicide.

Summary

1. Although not psychotic, psychoneurotic, or feebleminded there are people, termed psychopathic personalities, who are persistently unable to adapt themselves to social requirements because of peculiarities of impulse, temperament, or character.
2. Any classification is arbitrary but the following is suggested: (a) the excitable personality; (b) the antisocial personality; (c) the inadequate personality; (d) pathological liars and swindlers; (e) the sexual psychopaths.
3. Probably factors that in one person produce psychoneurotic symptoms may in another person produce the character deviations of psychopathic personality.
4. Many, but not all, psychopaths commit misdemeanors or crimes. Not all who commit such offenses are psychopathic personalities.
5. Many psychopaths are only partially responsible for their conduct, a fact which renders them more dangerous than the person of better balanced personality pattern.
6. Most psychopaths bear frustrations and difficult, inflexible situations poorly. If confined to prison some of them develop a situation psychosis known as prison psychosis.
7. The nursing treatment required by the psychotic psychopath is determined by the symptoms he presents. The treatment of the symptoms that will be observed has been described in previous chapters.

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CHAPTER XXV

MENTAL DEFICIENCY

Definition. The mental disabilities previously considered have either been those which arise from toxic or structural changes in the brain and thereby cause an impairment of previous mental competency, or have been those which apparently represent forms of behavior adopted to meet some inner need of the personality. In the former group would be delirium tremens, general paresis, and senile dementia, while in the latter would be hysteria, schizophrenia, and paranoia. There remains to be considered a third type of disability resulting from an arrested or imperfect mental development and known as mental deficiency or feeblemindedness. The feebleminded person either never possessed a normal capacity for mental development or else disease or injury of the brain caused an arrest of such development. As a result of this arrested or imperfect mental development, "the person so afflicted is incapable of competing on equal terms with his normal fellows or of managing himself or his affairs with ordinary prudence." * The feebleminded person lacks normal ability to learn, to reason, to calculate, to plan, and to construct; he manifests defects in judgment and foresight, is suggestible, and shows poverty of information.

Frequency. Probably less than 1 per cent of the total population is so defective as to require constant custodial care. In addition there is a group of approximately 1 per cent that require extensive supervision either through permanent residence in an institution or through adequate supervision in the community. Probably about 3 per cent of the school population is suffering from mental defect so serious as to make it impossible for such children to benefit by the educational procedures suited to those of normal intelligence.

Causes. The causes of mental deficiency may, for convenience, be divided into those existing prior to birth, into those due to in-

* From a definition adopted by the American Association on Mental Deficiency.

juries at birth, and into those resulting from injuries or disease occurring after birth but before mental development is completed. It is considered that the maximum possible mental development is reached at about 16 years of age. Of the causes acting before birth, heredity is perhaps the most important although other poorly understood factors act also. Probably from 75 to 85 per cent of mental deficiency is due to heredity. "Impressions," sudden frights, and other emotional shocks of the mother during pregnancy do not cause feeblemindedness in the child. It is believed that in less than 5 per cent of cases is feeblemindedness due to congenital syphilis.

Causes Arising during Birth. Prolonged, difficult labor during which the supply of oxygen to the child's brain is reduced (anoxemia) with the result that cells of the brain suffer injury may result in feeblemindedness. Intracranial hemorrhage caused by prolonged labor or instrumental delivery may result in mental defect. Such hemorrhage with consequent mental defect may occur when birth is premature, the vessels being particularly fragile because of their underdevelopment.

Causes Arising after Birth. Injury to the child's head after birth, but before mental development has been completed, may be followed by mental deficiency. To be followed by feeblemindedness the injury must have been sufficiently severe to have injured the brain substance or to have ruptured blood vessels of the brain. Epidemic encephalitis, meningitis, or other infections of the brain occurring in childhood may be followed by an arrest of mental development.

Intelligence and its Measurement. Since by mental deficiency is really meant deficiency of intelligence, the nurse may ask what is meant by intelligence. Although no one knows exactly what electricity is, physicists can measure it accurately. Comparably no one can satisfactorily define intelligence although we now know it can be measured by the ability a person is found to have in *applying* his knowledge in new situations. It is not, of course, the same as the mere possession of knowledge.

A method of measuring intelligence was first developed by a French psychologist, Alfred Binet, and his psychiatric associate, Thomas Simon. Their means of measurement are therefore known as Binet-Simon tests. These tests together with later modifications of them were devised after studying the abilities of children of all

ages up to 16 years, after which age it was found that there is little increase in native intelligence as distinguished from knowledge. These serial tests are arranged according to their increasing difficulty and thus constitute a measuring scale of intelligence. One group of tests is of such a degree of difficulty that the tests should be solved by the normal average child 3 years of age. The next group in this serial scale of difficulty should be solved by the normal child of 4, and so on. If the mental development of the child has been imperfect or arrested he cannot solve the tests which the average child of his age is expected to pass, while on the contrary children of superior mental development may pass tests more difficult than those solved by the average child of the same age. When there has been ascertained the most difficult group of the serial tests that the patient can successfully solve, he is said to have the same mental age as is the actual age in years of the average child who would be expected to pass that group of tests. If, for example, the patient, be he child or adult, can pass that group which it has been found would be the one just passed by an average child of 7 years, the patient is said to have a mental age of 7 years. When this mental age is compared with the actual chronological age of the patient we secure a measure of his intellectual development. This degree of development is measured by determining the patient's intelligence quotient.

Intelligence Quotient. The intelligence quotient, or I. Q., as it is customarily abbreviated, is obtained by dividing the mental age by the chronological age and multiplying by 100 for the sake of eliminating decimals. Thus if a 6-year-old child is found to have a mental age of 6 years, his I. Q. will be 100. If he is found to have a mental age of 9 years his I. Q. will be 150; and if he is found to have a mental age of 4½ years, the I. Q. will be 75. Ordinarily an I. Q. of below 70 is considered indicative of feebleminded-ness. There are many persons, who, while not definitely feebleminded, are very seriously retarded mentally and consequently present problems similar to, though perhaps less intense in some cases than the actually feebleminded.

Degree of Mental Defect. According to their degree of mental defect feebleminded persons are classified in one of three groups. The most highly developed of the feebleminded are known as morons and have a mental age between 7 and 12. Those of a next lower group in respect to intelligence are known as imbeciles

and have a mental age of from 3 to 6 inclusive. The most defective are the idiots, whose mental age is 2 years or below. As measured by intelligence tests persons having an I. Q. below 20 are classified as idiots, those having an I. Q. between 50 and 20 as imbeciles, and those between 70 and 50 as morons.

Morons. Morons are able to make some progress, although slow, in the lower grades of school. With a little supervision they can perform routine work such as operating automatic machines. Much unskilled work not sought by those of average mental development is performed by morons. Often the lack of an ability to plan is what superficially distinguishes the higher grades of morons from persons of normal intellectual development. The lower grades of morons can wash dishes, run errands, and perform other simple tasks. The majority of morons are honest, sober, industrious citizens capable of partial and often of total self-support if properly trained and supervised. A minority of them become social delinquents. In some parts of the United States 20 per cent of the inmates of prisons and reformatories have been found to be morons and 22 per cent to be of borderline intelligence (I. Q. from 70 to 80). Only a minority of the feebleminded, however, are antisocial in behavior. Much of the world's work can be and is done by persons of a low level of intelligence, many of whom are useful, obedient, industrious citizens.

Imbeciles. Higher-grade imbeciles learn to read words of one syllable, can dress themselves, follow simple instructions, and can assist in simple tasks. Those of the lowest grades can perform practically no useful work. None of the imbecile group are capable of supporting themselves, but all of them realize and can avoid ordinary physical dangers such as those from street traffic, etc.

Idiots. The mental defect in the case of idiots is so great that they cannot guard themselves against common physical dangers, and only those of the higher grades learn to eat spontaneously even when food is placed before them. Low-grade idiots are not capable of any training. High-grade idiots may, to a limited extent, be taught habits of cleanliness, but do not learn to bathe or dress themselves. Only the high-grade idiots are able to understand even the simplest commands. None but the higher grades ever learn to utter intelligible words and none can form sentences. Many exhibit sustained rhythmic movements of the body such as rocking.

Fields in Which Feeblemindedness Is Manifested. Although mental or, as they are often called, psychometric tests are valuable and even, at times, indispensable aids in determining the degree of a person's intellectual development, yet the psychiatrist insists, particularly in doubtful cases, upon having additional information before expressing an opinion as to whether or not the individual should be considered feebleminded. Dr. Walter E. Fernald, one of the most distinguished of the pioneers in the study, care, and training of the feebleminded, outlined ten subjects of inquiry, knowledge concerning which furnishes a comprehensive survey of the patient's mental competency. If a person is feebleminded, corroborative evidence will be found in most of the following fields of inquiry which Dr. Fernald recommended should be investigated:

1. Physical examination.
2. Family history.
3. Personal and developmental history.
4. School progress.
5. Examination in school work.
6. Practical knowledge and general information.
7. Social history and reactions.
8. Economic efficiency.
9. Moral reactions.
10. Psychometric test.

Behavior Not Determined by Intelligence Alone. One must not conclude that because a feebleminded adult has the mental age of a child he is therefore a child in all other respects. His low mental age means merely that he has the intelligence of a child. He has had the years of conditioning experiences and possesses the physique, the instincts, and the emotions of an adult. On the other hand because he is an adult in appearance it is assumed that he should be treated as an adult. As a result he develops a sense of insecurity and often builds up an attitude of defense and resistance that may be troublesome to those about him.

Prognosis. In spite of every effort directed to the education and training of the feebleminded person a normal mental capacity can never be developed. Fortunately in many instances his mind can be so trained that the effects of its limitation will be less serious to the individual and to society.

Care and Management. As soon as it is ascertained that a child is mentally defective, systematic training progressively adapted to

its development should be instituted. Whether the higher-grade defective is purely a social liability or whether he possesses worthwhile social assets will depend more upon his training and upon the nature of the emotional reactions established than upon the particular degree of defect as measured by the intelligence quotient. At the earliest practicable age, training should be directed toward habits of cleanliness and of self-help in feeding, dressing, undressing, etc. In the younger defectives and the lower grades of those who are somewhat more deficient, training should be directed toward cultivation of the special senses and toward muscular coordination and control.

Idiot and Low-Grade Imbecile. The problem of treatment of the idiot and of the low-grade imbecile is simple and consists largely of physical care and custody. In the low-grade imbeciles efforts should be directed at training the child to dress and undress himself, at improving his habits of feeding himself, at bathing, at curbing destructive tendencies, in teaching the child to avoid ordinary dangers, to associate common objects with their names, to pronounce a few easy words, and to express simple wants. At best the object can be merely to train the child so that his care will be less burdensome. Whether this simple training will be undertaken at home or in an institution will depend on many factors, such as the capacity of the mother for training, the size of the family, its economic status, and other considerations.

High-Grade Imbecile and Moron. When we come to the high-grade imbecile and the moron the types of treatment fall into three groups: segregation, sterilization, and socialization. After a period in which permanent segregation in an institution was thought to be the solution of the problem of the feebleminded, we have now come to one in which socialization is emphasized both as means and end. In some instances sterilization may be of individual or eugenic value. Because the moron or the child of borderline intelligence may easily become a serious problem, it is important that training suited to his ability and needs be instituted early.

Type of Education. The practice adopted in some states requiring that all children retarded three years or more in their school classes be examined by a psychiatrist and if found feebleminded be placed in a special class composed of retarded children is a wise provision. Those found defective should have manual training and education

of the special senses, and especially guidance and training in emotional and behavior responses. While such academic instruction as he may readily absorb will add to the child's happiness, yet the important object is that the high-grade defective shall develop useful, socialized patterns of behavior. The emphasis, therefore, should be on manual and social training, since without the manual training the feebleminded child cannot earn his living, and without the social and behavior guidance he may drift into that troublesome group made up of defective delinquents. In addition to the fact that in the special classes emphasis is, or should be, on manual and social training there are what may be called incidental benefits, which, however, may be of greater value than the formal training. By assignment to a special class the child is removed from too difficult a curriculum in which he has no interest, from critical classmates, perhaps from an antagonistic teacher, and from other conditions that create feelings of inferiority, destroy a sense of security, and lay the foundations for the easiest method of defense, that of overt, disturbing behavior and unpleasant compensations. Since the child in the special class can compete with his fellows the undesirable reactions mentioned are not only not stimulated, but there is created a feeling of security, self-reliance, satisfaction, and success that has much constructive value in personality formation. Feebleminded children should be encouraged to take part with normal children in all those games in which the defective can compete on equal terms. Sometimes occupational therapy or training in some craft will provide the child a means of becoming superior in some line of endeavor and therefore prevent the disappointment and feelings of inferiority that frequently arise from a recognition of intellectual limitation. Approbation, attention, and praise afford great satisfaction, and within reasonable limits may produce a desirable, stimulating effect. The development of a normal personality requires not only a certain native intelligence, but also such emotional essentials as affection, security, social recognition, achievement, and new experiences.

Institutional Training. High-grade defectives who are sent to institutions for the feebleminded are usually committed because they are either burdensome or unmanageable. The majority of those in the former class, if protected from bad training and associations during childhood, will after they have passed adolescence be able to return to the community. In the institution with its em-

phasis on training they will acquire such habits of industry and behavior as will make them self-respecting and largely or entirely self-supporting. Not a few of the unmanageable will, if placed in an institution during childhood, acquire habits of obedience, good behavior, self-control, and industry that will permit them to leave the institution under supervision. When trained the feebleminded are best placed out in emotionally sound, but from a financial standpoint, rather poor homes. Here they often make good mothers' helpers and good farm workers. They should have opportunity to meet and associate with congenial people. Fortunately most mental defectives find it as difficult to "unlearn" as to learn, with the result that when desirable habits have been acquired they are continued.

SUMMARY

1. Feeblemindedness is a defect in ability to learn and to exercise other intellectual functions because of arrested or imperfect mental development.
2. This defective mental development may be due to: (a) heredity or other factors operating before birth; (b) prolonged, difficult labor and injuries sustained at birth; (c) brain injuries and infections occurring after birth.
3. The measurement of intelligence and intelligence quotients is discussed.
4. A person of the very lowest degree of intelligence is called an idiot; if somewhat less defective, an imbecile; one of still less defect, a moron.
5. Attention to his physical care and needs is all that can be offered the idiot.
6. The education of the high-grade imbecile and the moron should be largely manual and social; the former in order that the defective may be self-supporting, the latter that he may acquire socially desirable habits.

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CHAPTER XXVI

MENTAL HYGIENE

Definition of Mental Hygiene. The preceding pages have been largely devoted to a discussion of the various forms of mental disorder. Probably comparatively few nurses who have been studying the manifestations of these personality disturbances as there described will devote their professional lives to the care of persons rendered socially incompetent by reason of these disturbances. It is hoped, however, that through a study of these personality disorders the nurse will have discovered many of the principles essential for the development of a healthy, happy, and effective personality. Just as sound physical health requires that one avoid infection, eat food suitable in content and amount, protect the body, and otherwise observe the laws of physical hygiene, so mental health and efficient life adjustment require that thinking be rational, emotions be untroubled, and strivings be harmonious. Mental health demands the gratification of such strivings as those for security, for self-assertion, for companionship and love, for satisfactions in work and play, and for the attainment of individual development and creativeness in accordance with one's resources. There is a hygiene of the personality as well as of the body, and its principles are those that promote an adjustment of human beings to themselves and to the world at large with a maximum of personal and social effectiveness and satisfaction. Mental hygiene would provide such influences and promote such habits as will best fit the individual to meet the issues of life successfully. Mental health implies much more than an absence of delusions, hallucinations, intellectual deterioration, or other symptoms that we associate with actual mental disease. Rather is it "the nearest approach to a state of mind through which we may achieve maximum efficiency and greatest happiness, unhampered by habits and attitudes towards life that lead to varying degrees of failure." It affords an extensive and buoyant ability for adjustment.

Maladjustments are Matters of Cause and Effect. In the preceding paragraph it was said that there is a hygiene of the personality as well as of the body. In seeking its healthy development, we must remember that the personality is the product of an evolutionary process passing through various stages of development from conception to old age and death, that the most decisive period in its development is infancy, childhood, and early youth, and that the emotional relationships between the various members of the family exert an important influence upon the growing personality. Modern psychiatry studies the whole personality, physical, mental, emotional, and social, together with the evolution of its different aspects. Such studies show that in the various maladjustments which the psychiatrist meets there is an orderly working out of cause and effect. This fact makes it possible to understand maladjustments whether of psychotic or lesser degree, and thereby to establish principles of mental hygiene that help to prevent the development of these maladjustments.

Knowledge of Mental Hygiene Increases the Usefulness of the Nurse. While it is the duty of many professional groups to spread a knowledge of the principles which will enable more human beings to live more efficiently adjusted lives, yet it is in many respects a duty for which the psychiatrically trained nurse with the mental hygiene point of view is especially fitted. She should recognize and be able to harmonize many emotional maladjustments and thereby prevent the development of serious nervous and mental disorders. A mental hygiene training, for example, should enable the nurse to appreciate more fully the unwholesome results which physical defects and diseases may have on the personality development of the child and on his general emotional pattern. She may enable him to convert a handicap into a constructive stimulus. When private or district nursing brings the nurse into the home she will sense the fears, jealousies, feelings of guilt, dominations, resentments, and hatreds that may complicate the family relationships, and with her knowledge of the personality distortions to which such emotional maladjustments may lead she will seek to establish a more wholesome emotional atmosphere. Not the least of the services which the psychiatrically trained nurse will render is that of breaking down some of the most common misconceptions relative to mental illnesses and mental patients and in promoting a more sympathetic and understanding attitude toward them.

The question of heredity in relation to mental health is very complicated and the full facts concerning it are by no means known. It has long been recognized that children born of a parent suffering from some psychotic disturbance of the personality are predisposed to mental disorders. Often, however, the results of environmental forces that have warped and distorted the personality and finally have led to psychotic behavior are erroneously attributed to hereditary, constitutional factors. Persons suffering from familial types of feeblemindedness may be expected to beget feebleminded children, but feeblemindedness due to accident or disease does not predispose to mental defect. To say just who in the interests of mental hygiene should not contemplate marriage and parenthood is not easy. In most instances it is not wise for those who have suffered from a psychotic episode. One would hesitate to deny marriage to the child of a psychotic parent, particularly if the former had shown evidence of being well adjusted. Perhaps arbitrarily one might say that all persons who it is believed would be able to give their children a wholesome environment and training should be permitted to marry. While in no way underestimating the value of eugenics, there is much to suggest that more instances of mental disorder and social inadequacy are due to harmful personal experiences and to emotionally unwholesome influences of home and school than to heredity. With careful attention to their emotional life and to their developmental possibilities, children upon whom heredity has placed a handicap may often become useful and adjusted members of society. Efficient adjustment does not depend upon intellectual endowment alone.

Sterilization in Prevention of Mental Disease. In recent years there has been on the part of some persons an enthusiastic advocacy of sterilization as a means of reducing mental disorder and feeblemindedness. In 1934 the American Neurological Association appointed a committee to evaluate in a critical manner the problems of various mental abnormalities and neurological disorders. Its report shows that the possible benefits of sterilization have often been exaggerated. The Committee reports there are no valid reasons for supposing that an increase in mental disorders has taken place. They therefore deny the contention often made that such an increase constitutes a need for sterilization. The Committee recommended that any law concerning sterilization passed under the present state of knowledge should be voluntary

and regulatory rather than compulsory. They regard the measure as appropriate in selected cases to the following conditions in the order given:

1. Huntington's chorea and certain other disabling degenerative diseases of the brain recognized as hereditary.
2. Feeblemindedness of the familial type.
3. Schizophrenia.
4. Manic-depressive psychosis.
5. Epilepsy.

The Committee concluded that sterilization applied to manic-depressive patients and their relatives "might well cut off from the race some of its most valued and valuable members."

Mental Hygiene Begins in Infancy. Mental hygiene, like physical hygiene, should begin in infancy. There is an increasing belief among psychiatrists that problems connected with such fundamental physical functions as nursing, weaning, feeding, and excretion may permanently influence emotional and personality patterns. Many believe that the way the child is emotionally affected by the reluctant relinquishment of the breast at weaning is of importance in determining personality characteristics. If cleanliness of toilet habits is established through fear, and if blame and guilt are encouraged in event of lapses, unhealthful emotional patterns may be created. The ways in which mother or nurse meets the infant's earliest needs and his emotional responses to them may be of great importance in forming patterns of behavior that repeat themselves throughout life. If, for example, the child is nursed because he cries it will not be surprising if in later life he employs tantrums as a means of gaining his ends. Having learned that his emotional outbursts are rewarded, that his desires will be met if he makes enough fuss, he may never use earnest endeavor as a means of attaining desired goals. Infancy should not be made too attractive a period, otherwise its pleasures and its methods of securing them will be continued. An emotional immaturity with its resulting difficulties in adjustment will follow.

Influence of Mother on Mental Health of Child. The fact that the prospective arrival of the child was unwelcome may make the mother feel guilty for having entertained such a thought; as a reaction to this she may be overprotective and go to other extremes to prove to herself and the world that she is a good mother. A

parent may try to work out through the child the fulfilment of the ambitions denied the parent, who therefore overprotects and overguides the child. The mother who clings to her child with extravagant devotion may do so for various reasons. Because her own life has been frustrated and unsatisfactory she may be emotionally parasitic. She may postpone weaning the child, may bathe and dress him long after it is necessary. By anticipating his every desire and shielding him from all unpleasantness she may vicariously secure the satisfaction that her own life has failed to bring. Again, in the case of the deeply selfish mother this affection for her child may be a disguised admiration of herself. If, as usually results in such a case, the pampered child meets life unprepared for its demands it is plain that what the mother sought was not the efficient adjustment of her child to a world of reality but the feeding of her own self-love. The child whose mother encourages undue dependence upon her will finds it difficult to effect that emancipation which is essential to self-development and resourceful adjustment. Such a child, usually shielded from the consequences of his errors, may never acquire an ability to meet squarely and courageously the hard facts of reality. Because of overprotection or excessive babying the child may not develop the desire or impetus to make adaptations at a more mature level and obtain satisfactions from mature achievement. Unpleasant experiences are met with evasion, a method that leads him still further away from reality and successful adjustment. The oversolicitude is often accompanied by overvaluation of the child, a feeling that may be easily transmitted to the latter. He may therefore be unable to see in himself the causes of his failure and come to attribute hostile motives to others. As the unemancipated child reaches adult life he may be unable to free himself sufficiently to marry, or if he does so he may choose as his mate a woman who represents a mother-substitute. Emotional satisfactions prove disappointing, and the unhappy marriage only adds to the problems of adjustment. Not rarely it will be found that the son of an oversolicitous mother and of a stern, forceful, and successful father will have a passive and effeminate approach to life.

Because of her own unhappy marriage a mother's attitude to her child may at times be one of rejection. This rejection may be expressed by undisguised forms of neglect or cruelty, by impatience or disparagement, by oversolicitude as a reaction to feelings of guilt,

or by a capricious handling characterized by a mixture of these methods. The child thus suffers from an unstable environment and inconsistent handling which lead him to feel insecure. This resulting sense of insecurity may, in turn, make the child seek for attention and for expressions from others that he is important, or lead to various unwholesome defensive or compensatory traits of character. A sense of security is exceedingly important for the child, but will not be possessed unless he feels that he is loved and wanted. Its frequent absence in the children of broken homes or in those reared in orphanages often contributes to the high incidence of adjustment problems among such children. The child raised in an institution often suffers from the absence of a sense of belongingness with a resulting solitary type of personality characterized by unsocial behavior and hostile aggression. He may be deficient in giving and receiving affection. Such a child may become destructive, cruel, jealous, resentful, quarrelsome, disobedient, restless, and stubborn. The child who finds himself frustrated and threatened may take recourse in phantasy. In order to grow emotionally an individual must feel that he is a worth-while person, that he is needed by someone, and that there is a place for him in his family group, in his social group, in a vocation, and in the world.

Influence of Father on Mental Health. The mother is not the only parent whose influence may distort the child's personality in such a way as seriously to disturb his capacity for adaptation. The dominating father who is rigidly severe or who continues his authority too long may create in the son a hatred and attitude of revolt which extends not only to the father but to various father substitutes. Thus in later life such a child may come to hate all authority and all persons who represent it. This emotional reaction to a tyrannical father may lead the boy to engage in a constant struggle and protest against organized society, its institutions and laws. The role of rebel or agitator is sometimes only a continuation of the child's fight against parental tyranny.

Influence of Parents' Adjustment. The parents' attitude toward a child is determined largely by the degree of satisfaction and contentment they have been able to achieve in their own lives. The child of contented parents rarely develops into a problem or later into a psychoneurotic or psychotic person. On the other hand, unsolved emotional problems of the parents and distortions and mal-

adjustments of their personalities may be the source of unwholesome personality traits and unadjusted social attitudes in the child. Unhealthful emotional habits are acquired, not inherited. The problem child is often the result of parental problems. Disobedience, nervousness, tantrums, and other unwholesome methods of meeting situations may have their origin in the emotional reactions and personality difficulties of the parents. The children of unhappy marriages are particularly apt to be nervous children. The father's and mother's attitude toward each other may greatly influence the development of the child's personality. Frequently helping the parents to better adjustments to each other and to their own problems is prerequisite to a readjusting of the child. With a surprising frequency it is found that it is the parent who needs treatment, not the child. It is often said that one task for mental hygiene is to develop "parents fit for children to live with." When a nervous, unadjusted, or problem child or adolescent is referred to him, the psychiatrist seeks first of all to learn the home situation, the emotional reactions of the parents to each other and to the child, and the problems of their own personalities. Problem children are often the children of those who have problems.

From the preceding paragraphs it will be seen that the experiences of the child within the family circle produce a deep impression on his adult personality and therefore are of the utmost importance in determining his destiny and his value to the community. It is indeed true that a happy family is one of the best preventives of neurosis and delinquency.

Harm of Too Great Repression. Fortunately it is becoming increasingly realized that the child should not be constantly repressed, that he is an individual who has his own life to live, and that while he must be guided in his choices yet his desires and views and convictions are entitled to respectful consideration. An overcritical attitude, threats, or punishment by parent or teacher tend to destroy a sense of security and prevent self-expression. Patient instruction with commendation and an endeavor on the part of parent and teacher to understand the motives prompting the child's behavior will prove helpful in promoting a feeling of security and protection. The child is likely to respond to such instruction by regarding authority as a force friendly to him, working with him, giving him opportunity for self-realization, and aiding him in reaching the goal set before him. Harshness and constant repression

may, on the other hand, drive the child into a world of phantasy as a means of escape. While discretion must be used, yet the child must learn to be independent, to think for himself, and to get along with and be respected by his peers. He must learn to face obstacles and discouragement without retreating, giving up, or using alibis. Emotional maturity and personality richness are attained by progressively and successfully passing through increasingly difficult situations. If the child succeeds in the face of difficulties, his personality development will receive the stimulus which results from the feeling that he has achieved something. When he fails he should be made to realize that his failure is usually the logical result of the unwisely chosen methods he employed, and that the punishment for behavior prompted by selfish motives or characterized by evasions is the thwarting of one's own desires.

Meeting Reality. The habits the child forms in meeting difficulties may greatly influence his future mental health and will materially determine the success of his adjustment. He must learn that only through difficult work can dreams or ambitions be realized. An evasion of unpleasant or difficult situations by mental subterfuges easily becomes a habit with the result that one becomes quite unable to meet facts and reality. Escape mechanisms exert an insidiously disorganizing effect on the personality and at times lead to a psychosis which is often but a means of escape from difficult problems. The manner in which the simple difficulties of childhood are met is important from the standpoint of mental hygiene. In the training of the child one should guard against introduction of the idea of shame and guilt. Mental clinics are replete with examples of the distorting and paralyzing effects on the evolution of the personality of intense feelings of fear, shame, guilt, and remorse. Many feelings of guilt probably originate in an overstrict upbringing by the parents in early years, especially in the matter of masturbation. Though this is a natural habit in children, the more they are shamed about it by their parents the stronger becomes their sense of guilt.

Self-Esteem. Even in early life the child begins to place an estimate upon himself, to feel more or less consciously that he is superior or inferior in comparison with others. This appraisal of self and the reactions stimulated by it have a great influence in determining the personality and its types of adaptation patterns. These estimates may be made by the child after a more or less

conscious comparison of himself with other children, or they may result from the attitude of other persons, particularly adults, toward him.

Children with physical or mental handicaps are faced with many serious problems of emotional adjustment which do not exist in the case of their more normal companions. Byron, the poet, was born with a clubfoot to which he grew up so sensitive that even at the height of his fame he would not willingly have it noticed. At social gatherings he would arrive early and so take his position in the room that the other guests present might not see him limp. Such marked handicaps as blindness, deafness, or mental defect may call forth strong emotional reactions from the parents in the form of anxious overprotection, excessive pampering, or a shielding of the child from effort or competition. Again, parents unable to accept the blow to their pride which their defective child represents, may react with feelings of resentment, criticism, antagonism, and rejection. The handicapped child may experience great difficulties in adjusting himself emotionally to the restrictions of activities, the thwartings of desires, and the limitations of recreation, social participation, and vocational opportunities that result from his defects. At times handicapped children are subjected to ridicule, humorous remarks, or mimicry on the part of thoughtless or unfeeling associates. Some children frankly recognize their handicaps and strive in wholesome, constructive ways to overcome their disadvantage or compensate for it. In one child a conspicuous birthmark that greatly disfigured his face proved to be a spur to efforts which in adult life enabled him to become an outstanding leader in his profession. In another child a similar but less disfiguring nevus led to rebellion, resentment, hopelessness, and bitterness. His morbid sensitivity increased, he withdrew from social contacts, became suspicious, and gave up all effort to be self-supporting. Even minor, not uncommon defects may influence the development of the personality. Nearsightedness may prevent a child's taking part in games and foster the creation of a "shut-in" personality. Deafness, especially in one ear, may be the origin of misunderstanding and conflict with the teacher and lead to defiance and truancy. In connection with the subject of deafness it may be added that the deaf adult (especially if a woman) is apt to narrow her life to her own self-centered world, to become oversensitive, emotional, and suspicious.

Sometimes handicapped children seem to escape from their misfortune by indulging in phantasies in which they picture themselves as excelling in abilities and performance, as objects of admiration. Peculiar and affected manners which they wish others to regard as evidence of superior qualities are sometimes adopted by persons with an underlying sense of insecurity or inferiority. Boastfulness and a blustering manner are usually but overcompensations developed in an effort to conceal a real or fancied inferiority. The mechanisms of defense and of compensation adopted for the purpose of dealing with unsatisfying valuations of self may lead to a great variety of behavior disorders or personality distortions. In an effort to secure a satisfying recognition from his fellows a boy with feelings of inferiority or discouragement may become defiant of authority and come to be the leader of a street or criminal gang. As one observes the psychogenic psychoses and seeks for the psychological forces that may have produced them, he not infrequently finds that physical or mental handicaps have led persons to feel that they stood out from others in undesirable ways and that the existence of such defects may have prompted the reactions constituting the psychosis.

School and Mental Health. The transition from home to school constitutes for the child a change of the greatest importance to his future personality development. For the first time the child leaves the shelter of the home and the constant, tender care of the mother and ventures into an untried world containing new problems and responsibilities. Important as is the home in laying down those patterns of thinking and feeling that determine the future adjustment of the individual, it is now realized that the school also is an exceedingly important agency in molding the personality and in determining the degree of mental health. Most persons receive no instruction in the important task of being a parent, whereas many schools for teachers and schools of nursing include courses dealing with dynamic psychology and the moving forces of human behavior. For this reason many feel that the school presents a more hopeful opportunity for the promotion of mental hygiene than does the home. It is increasingly realized that the preservation of mental health is no less a duty of preventive medicine than is the preservation of physical health, and that the opportunities for preventive psychiatry are greater in the community than in the institution for mental disorders. To the nurse who understands

mental laws and the sources of human behavior, the opportunities in school nursing for promoting mental hygiene are unusually attractive. The task and opportunity for such a nurse are well described by Dr. Arnold Gesell, professor of child hygiene in Yale University. In outlining a program for mental hygiene for public schools in the magazine, *Mental Hygiene,* he says: "This psychological school-nurse would be a counterpart of the medical school-nurse and work in close contact with her; but she would revolve in a different circle of problems. Instead of pupils with discharging ears and deteriorating molars her clients would be the child with night terrors, the nail biter, the overtearful child, the oversilent child, the stammering child, the extremely indifferent child, the pervert, the infantile child, and the unstable choreic, and a whole host of suffering, frustrated and unhealthily constituted growing minds, that we are barely aware of in a quantitative sense, because we do not have the agencies to bring them to our attention as problems of public hygiene and prophylaxis." Both school and public health nurse should be as able to deal with the psychological errors they meet in the children under their care, as they now are competent to deal with the physiological errors they meet in the fields of growth, nutrition, and infection.

Opportunity of the School Nurse. Such a nurse, knowing that the symptoms described have arisen from emotional and other mental experiences of the child and from a violation of the laws of mental health either by the child himself or, as is more probable, by those whose contacts with him are closest, will seek to find their origin. The source will most frequently be discovered in the home, where various psychological conflicts and perplexities may have arisen: in the attitude of the parents toward the child or toward other children of the family, in discordant parents, in poverty, in dislike of a step-parent, or in other elements of the home atmosphere. Sometimes it will be found in physical defect, mental handicap, discouragement, or in the emotional or other personality immaturities of the teacher, or in the child's attitude toward her.

School Problems of the Child. In an ideal state of affairs an investigation of the child's mental life would be made during his preschool years, since at that period the signs of future maladjustments may be detected. When one remembers that upon arriving at a certain age prescribed by law we bring together all children to

compete with each other, to adjust to entirely new and untried situations regardless of their intellectual and emotional development or their previous mental experiences, it is no wonder that the early school years present many problems of adjustment. Since the teacher with too many and too large classes will have little time to devote to the problems of the individual child, the school nurse should be able to interpret his behavior and discover why certain children lie, play truant, are timid, daydream, are nervous, or present imbalance of the emotions. She may discover that a retardation in a child's studies is due to factors other than mental dulness; that at times it may be due to emotional conflicts or in other instances to more definite physical reasons, as in the case of the child who cannot see the blackboard because of defective vision, or who cannot hear the teacher because of deafness, or whose nutrition is disturbed by diseased tonsils or adenoids. The handicapped should be distinguished from the feebleminded.

Competition with Others. The success the child meets in competing with others may have a profound influence upon his behavior and adaptations. Although the modern school system is making increasing provision for the child of borderline intelligence, yet often the subnormal must compete with the normal. The comparative failure on the part of the child less well endowed calls attention to his deficiencies and may lead to apathy, chronic discouragement, morbid feelings of inadequacy and inferiority, hypochondriacal complaints, a sense of isolation from his fellows, self-consciousness, timidities and fears, habits of evasion, deceit, or bluffing, or may lead to the development of unhealthy compensatory behavior such as truancy, bullying, lying, or stealing. Other personality reactions that may follow repeated failure in school are tearfulness, depression, poor sleep, seclusiveness, and even episodes of bewilderment or panic or the gastrointestinal and cardiovascular symptoms of anxiety states. Many educators rightly question whether the practice of awarding competitive prizes for distinguished excellence in some branches of schoolwork is a wise one. A prize awarded to the scholar of highest accomplishment means that all others must feel that they have relatively failed, perhaps with injury to their self-valuation. Stress should be laid upon the attainment of a satisfactory result rather than upon a demonstration of the superiority of one child in comparison with others. In discussing the subject of mental hygiene in the schoolchild one should not

forget the child of superior intelligence. With him the lack of challenge in a school system designed for the average child may result in boredom, chronic undereffort, daydreaming, indifference, and laziness.

When the child enters school he begins, perhaps for the first time, to be judged by persons of his own age and group. Naturally these judgments are less lenient and more impartial than those received at home. As they are of the type he must expect to face through life he should learn to meet them frankly. If he has not already done so the child must learn to play and work with others.

Mental Hygiene a Part of Education. The more that nurse and teacher alike can realize that the duty of educators is not merely the communication of information, but the solution of conflicts and the guidance of instincts, emotions, self-expression and self-control, the less will the graduates of school have to be re-educated in sanitaria and hospitals. Too often teachers are more concerned with the subject matter of the curriculum than with the development of emotional and other personality reactions which will promote a happy and effective life functioning at maximum social capacity. Unfortunately many teachers lay more emphasis on violations of general standards of morality and integrity, transgressions against authority, violations of school and classroom regulations, than on pupils' difficulties with other children or on undesirable personality traits.

The Teacher and Mental Health. Attention should be called to the fact that occasionally the source of a child's school maladjustment is to be found in the personality of the teacher. Perhaps she has been unable successfully to sublimate her biological maternal instincts with the result that her own emotional development has been frustrated and unsatisfying. In such a case the child in an attempt to meet the teacher's reactions may develop undesirable and unhealthy reactions of his own. Irritable, prudish, repressed, suspicious, and ill-tempered teachers exercise a destructive effect on the mental health of their pupils. Sometimes the teacher by the mechanism of identification becomes a parent substitute, in which case the child may adopt the same attitude toward her that he has toward the parent. If by reason of her position of authority she comes to represent a father who is disliked because of excessive domination, the child may be rebellious and constitute a disciplinary problem.

Emotional Problems of Students. With the older student, usually in his adolescence, other problems may arise. He may direct all his powers to an effort to surpass his associates in intellectual achievement in order to make up or compensate for small stature, personal unattractiveness, racial extraction, social status, or some real or fancied inferiority. If he secures all his emotional satisfaction from his studies or finds that a sense of security is obtained from them alone, his academic strivings should be looked upon as a danger sign. A high intelligence alone will not assure the maximum of life. For this a rich and well-balanced emotional life is also necessary. High school students who show excessive shyness, timidity, seclusiveness, inability to make friends or to participate in social relationships or group activities, who are absorbed in daydreams, in reading, study, or other solitary, passive pursuits, or who give expression to peculiar ideas or eccentric emotional responses, are usually in need of psychiatric study and treatment.

Many persons drop out of school and college not because they lack intellectual ability to continue, but because emotional problems and conflicts prevent them from using successfully the intellect they possess. The neuroses found among students often result from difficulties of adjustment and are usually developed as an evasion of some emotional problem with which the student is confronted.

Emotional Problems and Delinquency. In view of the increasing role that the public health nurse is coming to play in the social service of the community, she should have an understanding of the causes of those socially undesirable reactions that are classified as delinquency and of those more serious social offenses included under the heading of crime. If one is inclined to question whether such social problems come within the province of the psychiatric nurse he should remember that psychiatry, dealing as it does with the sources of behavior, is concerned with all those social problems that spring from disturbances of behavior. Even the nurse with psychiatric training who confines her professional practice to that specialty should remember that she is not so much nursing a "disease" as she is dealing with a disorder of behavior that implies more or less social maladjustment. The public health nurse in her visits to the home will recognize undesirable character traits and if she understands human behavior, the sources from which it springs, and the objects which it seeks, she will be in a position to advise many people who struggle unwisely with the problems and

conflicts they have to meet. She will recognize that when a child steals, runs away, sets fire, has outbursts of temper, or is sulky, cruel, quarrelsome, or boisterous, he is behaving in this way because of factors which we are now beginning to understand. She will know that an attempt should be made to discover any emotional conflicts with their failures of satisfaction, any repressions, frustrations, feelings of inferiority, compensations, and the cause of any moods and grudges. Perhaps she will find a desire for attention, a misunderstanding of the child's emotional needs by his parents, a dominating and unjust father, a lack of provision for the child's interests, an absence of outlet for his energies, a conflict with his instinctive life, overvalued ideas, or unwholesome phantasy, together with mechanisms and tendencies that should have been left behind in the course of development.

In sources such as these is to be found the origin of many of those patterns of behavior which characterize the delinquent and the criminal. To such conflicts within and maladjustments without is to be attributed most antisocial behavior rather than to the moving picture, the decline of religion, or to other facile explanations. Of the girls and boys appearing before the juvenile courts of New York City, 69 per cent were found to be suffering from some nervous or mental abnormality. Doubtless if opportunity had been afforded for detailed examination of these delinquents and their environment, psychological causes going back into early life would have been found in most of them.

Child Guidance Clinics. The remedy for this unfortunate state of affairs is plain although its efficient employment is still Utopian. It is in such an understanding and application of the principles of mental hygiene that distorted, arrested, and crippled personalities will no longer be found. Such social liabilities are the result of human agencies and should therefore be preventable. The State advises its citizens how to care for its pigs; some day it will concern itself more wisely with the development of the personality of its citizens. Already the disciplinary classes in the public schools are seeking to understand problem children and train them for social usefulness. The child guidance clinics originally founded and conducted by the National Committee for Mental Hygiene also are engaged in work the value of which is being increasingly recognized. These child guidance clinics are devoted to the study and treatment of incipient emotional and conduct disorders, not only with

the hope that mental diseases and delinquency may thereby be prevented, but that under supervision and guidance the children may achieve healthier and happier lives. Such clinics meet with a great variety of factors that give rise to emotional and conduct disorders, but among the most frequent are questions of relationship with brothers or sisters and of parental rejection or overprotection.

Increasing instances are to be found when the law, especially in the juvenile courts, tries to study the delinquent rather than the offense and to ascertain the factors that have helped to make the offender the particular kind of person he is. These juvenile courts and their probation officers recognize that a child beginning to show conduct disorder should be understood rather than punished. If possible the causes of his social maladjustment should be cured; if they cannot and his behavior continues destructive to social institutions he should be restrained before he commits serious crimes. Even in adults, punishment provided by the criminal law should not be based on the old principle of social revenge or retaliation—"so much punishment for so much crime." Prisons should be places for the study of the offender's mental and personality equipment, his disabilities and needs, with provision for educational, recreational, and vocational training.

Emotional Origin of Social Problems. In addition to delinquency and criminality numerous other social problems such as economic dependence and much industrial inefficiency must in the final analysis be traced to purely mental causes in the form of intrapsychic conflicts, unsatisfied desires, evasions of unpleasant situations, mental compromises, and various substitutes for reality. The industrial nurse with sufficient psychiatric training to enable her to look beneath the surface and to seek for the fundamental causes of maladjustments, unrest, disability, and other social, labor, and employment problems, will be surprised to find how extensive is the role played by mental factors. Not a few people whose intellectual capacity would enable them to do work of conspicuous excellence are found to be engaged in mediocre tasks or to be rendering service of an ineffective nature because they are handicapped by emotional problems or conflicts. In order that the worker may achieve the highest results, his task and its products must satisfy his emotional needs. The absence of such satisfaction may result not only in inferior products of the worker's labor, but may lead to numerous symptoms, sometimes of a clearly nervous nature, sometimes dis-

guised as physical disabilities. The extent to which disabilities in industrial organizations are of mental origin is indicated by a psychiatric survey of a large department store made by Dr. H. B. Elkind, who found that 10 per cent of all disabilities occurring among the employees was due to nervous disorder and that 9 per cent of the total time lost by all employees was due to the same cause. Dr. Elkind also found in another industrial organization that of the funds disbursed as sick benefits, 14 per cent was paid for disability caused by nervous disorders. Significant as are such figures they do not indicate the impairment of efficiency resulting from conflicts and unsatisfied desires; neither do they show the industrial unrest, embitterment, and discontent resulting from similar causes. Dissatisfaction of employees is often the result of mental causes which the industrial nurse may be able to discover and may thereby contribute to a healthier mental and social atmosphere. Prevention of these numerous lesser mental maladjustments would strike at the very root of our most pressing social problems—suicide, divorce, delinquency, crime, and industrial maladjustment.

Emotional Problems and Physical Complaints. In this chapter considerable emphasis has been laid on the fact that many symptoms of mental disorder are social in their manifestations, that their ultimate mental origin is not always obvious. Other symptoms due to faulty mental habits, such as a desire to evade responsibility, as well as to other personality disorders, are physical in their manifestations. When normal emotional or instinctive reactions are blocked the reactions, by substitution, may be expressed in physical rather than mental symptoms. Physical complaints that not rarely are of mental origin are frequently chronic in nature and may assume the form of headaches, insomnia, dyspepsia, or vague invalidism. Many people learn that by somatic complaints they become able to dominate their environment. Particularly do we find that the neurotic girl develops physical symptoms when called upon to meet difficult situations. The president of a large college for women found that about one half of the students who leave college give health as a cause. Undoubtedly careful examination would show that a large percentage of the disabling symptoms arose from a desire to evade difficult situations, from disappointing estimates of self, and from other emotional problems. Sometimes neurotic physical symptoms result from a feeling of shame and represent efforts to restore self-esteem.

Doubtless much future obscure invalidism could be prevented if minor illnesses of childhood were not permitted to become attractive. If a child escapes some duty because of illness he should not be allowed to have too good a time during the sickness. His physical complaints should be permitted to interfere with routine duties as little as possible lest disabilities become an established means of evading whatever is difficult or unpleasant.

Evasion and Defense Techniques. In addition to bodily complaints and psychoses or psychoneuroses there are many other methods that the individual may adopt to evade difficult and unpleasant problems. Irritability, suspicion, fears, depression, and self-depreciation, together with stammering and other speech defects, may represent attempts to evade unpleasant situations and problems. It is difficult to draw a line between those forms of evasion and of defense that we call mental disorder and those which we ordinarily look upon as personality peculiarities. The extreme views entertained by radicals or by their opposites, the ultraconservatives, represent defensive mechanisms designed to serve as a protection against tendencies and aspects of their own personality of which they are afraid or to which they find difficulty in adjusting. Other mental danger signals which may arise from a fear of squarely facing one's self or one's conflicts are unusual interest in religion or occult subjects, ardent and unusual enthusiasms, or other eccentric views of conduct. Somewhat similar are those feelings of self-satisfaction that we enjoy when we criticize other persons or condemn certain qualities they exhibit. Perhaps our self-satisfaction would be less if we always remembered that the conduct we condemn most strongly is that which we are most in danger of imitating, or if we realized that our bitterest hates and disgusts are directed against those things that require such emotions to keep us from seeing something attractive in them. Sometimes what we believe are our greatest virtues are but marked defense reactions. We should also remember that we can never use our intellects to their fullest capacity as long as our judgment is more or less unconsciously directed and led to false conclusions by such defenses as prejudices, emotions, and moods. It has been said that the longer we live the more like ourselves we become. We should therefore make sure that our personalities are established on the principles of sound mental hygiene.

Mental Hygiene and Mental Disease. The student has doubtless already recognized that mental hygiene is not concerned merely with the care of the psychotic and feebleminded. Important as is their care in institutions for mental disorders, yet perhaps the greatest need of the community as a whole is a program for preventive measures along mental lines as well organized as is the program for prevention in general medicine. This should cover a field extending from the recognition and correction of undesirable personality traits in children to a study of such social problems as criminal behavior and pauperism.

All life experience, physical and mental, is important in molding personality and behavior patterns, but the patterns of thinking, feeling, and behaving laid down in childhood are almost certain to persist. For this reason childhood is the period when the foundation for mental health or mental disorder is laid. If a fraction of the attention now given to the bodies of children were given to their minds, there would eventually be a decrease of maladjustment and mental disorder and an increase in efficiency, adjustment, and happiness. Many believe that one half of all cases of mental disorder now admitted to mental hospitals could have been prevented, chiefly through guidance of thinking, feeling, and striving during childhood and adolescence. The desirability of employing every known means of prevention will be recognized if one remembers that 1,000,000 of the young people now in school and college in the United States will presumably be inmates of mental hospitals at some time in their lives.

Persons interested in lessening mental disability and personality maladjustments might well take a leaf from the experience of those active in combatting tuberculosis. The marked decrease in deaths from that disease has been largely due to such a dissemination of knowledge as has enabled the public to understand the nature of the disease, the manner in which it is spread, and the measures necessary for its control. The nurse should assist in disseminating similar knowledge concerning mental disorders, and should play as important a part in preventing mental disability as she now does in preventing physical disease. Not all mental disorders can be prevented. To what extent prevention is possible we do not know, but undoubtedly if people could form the habit of meeting problems frankly and honestly and could learn to focus their interests upon

concrete, unselfish, and satisfying ends, there would be a real decrease in mental disability. Psychoses and other personality difficulties do not arise so much from the situations to be met as from the way one tries to meet them. Personality traits and attitudes are the product of a process as slow as growth itself. Similarly people should be led to realize that mental disorders do not suddenly strike persons like a bolt of lightning, but are years in developing, although during that time they have been known as seclusiveness, daydreams, suspiciousness, delinquency, or by dozens of other names. One finds no sharp transition as he compares the methods of thought he sees employed daily by those about him with those exhibited by persons with mild disorders of personality, or finally as he examines the methods adopted by the psychotic. Mental health like physical health is a relative matter. One person with a diseased heart may be able to perform all labor except such as is most strenuous, another person with heart disease may not be able to perform the lightest work. Impairment of mental health may range from a childish method of obtaining satisfaction or from a mental subterfuge designed for evading an unpleasant situation, to a loss of all conscious direction of behavior. To assist in the formation of mental habits that make for health we should learn to settle our daily problems as they arise, to face honestly the facts of our lives, to attempt to understand our difficulties instead of repressing them, and to secure satisfaction from our work and accomplishment. We should remember that because we have always entertained certain beliefs is not in itself sufficient reason for continuing them unchanged. As we approach middle age we should subject our opinions to a careful criticism and decide if new values should not be placed upon them. We must remember that human values and customs have perhaps never changed so rapidly as now, that we must not blindly reject new standards, otherwise prejudices, exaggerated emotional attitudes, and rigidity of personality will add to the burden of adaptation.

Mental Hygiene Essential for All. The message of mental hygiene is for all who have difficulties to face, for the child and for the adult, for the delinquent and for him who works for social betterment, for the sane and for the psychotic. It seeks to strengthen the personality equipment of the individual and to promote the health and happiness of the race. An understanding of the forces underlying human behavior should teach us how and why people fail in

the process of adaptation, as well as why it behooves us not to be too captious of those who have not succeeded when called upon to face problems beyond their ability. It would be well, too, for us to remember that one never portrays his own character more vividly than in his manner of portraying another's.

Summary

1. Application of mental hygiene is essential to mental health.
2. The nurse has an unusual opportunity to promote mental hygiene.
3. The adjustment and emotional attitudes of parents largely determine the future mental health of the child.
4. Habits of meeting difficulties, self-estimates, and reactions to physical handicaps established in childhood should be consistent with mental hygiene.
5. Emotional problems of the schoolchild, their sources and manifestations, are indicated. The opportunity of the school nurse for discovering and relieving them is discussed.
6. Much delinquency and many other social problems are the results of emotional and other personality problems and unwholesome methods of dealing with them.
7. Physical complaints without organic basis are frequent and are often the sequels of poor mental rather than of poor physical hygiene.
8. Both maladjusted personalities and actual mental disease should be less numerous if the principles of mental hygiene were observed.
9. Mental hygiene clinics aim to reduce personality maladjustments and mental disease through promoting better mental hygiene.

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CHAPTER XXVII

PRINCIPLES OF PSYCHIATRIC NURSING

Value of Psychiatric Training. One of the most encouraging features in the development of nursing education in recent years has been the increasing appreciation of the fact that all nursing has a psychiatric aspect. Whereas one formerly thought of this branch of nursing as being concerned solely with the care of psychotic persons, usually confined to hospitals for mental disorders, it is now realized that practically all physical illness has associated mental and emotional aspects and that therefore in the nursing of almost any illness these factors must be taken into account. Science has greatly increased the number and the refinements of nursing techniques but the most important science of all is the science of man and the most important technique of all is the technique of understanding. No other branch of nursing will to the same degree assist the nurse in understanding her patients as does psychiatric nursing. For this reason instruction in its principles should constitute a part of the education of every nurse. Since these principles cannot be clearly acquired and made a part of the working knowledge of the nurse except through opportunity to observe mental patients and receive training from instructors and physicians familiar with their special needs and the means by which they may be met, a student should spend at least three months of her undergraduate course in a hospital for mental diseases. Should the nurse wish to specialize in this branch of her profession she should either pursue a postgraduate course of six months' to a year's duration offered by a recognized psychiatric hospital, or her undergraduate course with affiliations in other special subjects should be taken in the nursing school of a mental hospital.

All Nursing Has a Psychiatric Aspect. Since but few patients in general hospitals are psychotic, both nurse and physician are prone to overlook the fact that many of them are also psychiatric patients in the sense that their handicap or disability cannot be adequately

studied or interpreted until their individual personalities and their personal situations are taken into account. Emotional needs and problems constantly arise in connection with physical disease; in fact it is known that many physical symptoms are often not of organic origin, but are due to unsolved problems of the inner life. The physical and mental spheres of the personality are so closely interwoven and interdependent that practically all physical disturbances create some emotional problem, while a surprisingly large number of personal difficulties give rise to symptoms which suggest a physical origin. Symptoms that arise from mental and emotional difficulties may therefore be expressed either in physical or in mental terms. It is estimated that one third of all persons under medical care for ailments apparently physical are ill not because of organic disease, but because of emotional and mental conflicts and maladjustments within the personality of the patient. Underlying needs and tensions of the personality are not, however, confined to individuals suffering from frank mental disorder, but are often associated with physical illness also. Frequently a striking improvement follows in the physical field after the solution of a personal problem over which the patient has been fretting. Much ill health may arise from long-standing dissatisfactions.

Psychiatric Problems in Physical Disease. Among the many things therefore which should be learned through an affiliate or graduate course in psychiatric nursing, probably the least important is the direct nursing care of patients who suffer from the various major psychoses. It is true that an understanding of such mental disorders is important and that the nurse should be prepared to give skilled care to persons suffering from them, but easily surpassing these in value and usefulness to most nurses is the acquiring of an awareness and an understanding of the mental component of organic disease, a recognition that in every physical illness there is also the reaction of the patient's personality to his illness. Bodily disease of any kind may be accompanied not only by such reactions as depression, fear, or anxiety, but even by distrust or suspicion. These and other mental components of organic disease often deserve as much, or possibly more nursing attention than the fever or other physical symptom. The presence of physical disease may not only create new psychological problems, but aggravate old ones which the patient is often poorly equipped to meet. The nurse should therefore realize that the patient has personality needs as well as organic

ones, and that the personal factors in disease require consideration and attention no less than the impersonal and organic. She will apply the same principles in trying to understand the beliefs, attitudes, and behavior of all her patients whether they be frankly "mental" or suffer from such definite physical diseases as tuberculosis or cancer.

In the behavior, strivings, and beliefs which the nurse encounters daily in her physically ill patients she will find the same types of personality makeup, the same individual problems and similar methods of dealing with them as are found in the mentally disordered. If the general nurse is acquainted with the nature of the conflicts, needs, and problems that most frequently beset the inner lives of people, and with the mental mechanisms with which they attempt to deal with these dilemmas, she will find that in a surprising number of her patients the principles of mental hygiene and of psychiatric nursing may be applied. She will frequently find that the physically ill patient cannot meet and adjust as smoothly and successfully as previously to the deeper problems of his life. He may revert to various forms of childish behavior and to a childlike dependence on pampering care and indulgence such as he may have once received from his mother. He may be jealous of the attention received by others. A weakening in the repression of rejected aspects of his personality may result in a tendency to projection, with the result that he becomes critical, irritable, and faultfinding. Because an illness provides an escape from uncongenial work or affords some other gain it may be unconsciously prolonged or even lead to chronic invalidism. By an undue protection of her patient or by permitting him to develop an unnecessary dependence on her, the nurse may unwittingly prolong his convalescence. Occasionally the nurse will discover the reason for unexplainable physical complaints or for persistence of disability is the devoted attention accorded a wife by husband and friends who have shown less solicitude in her days of health. A covert wish for a livelihood without labor may lead the victim of an industrial accident to develop ideas of resentment, a conviction of unjust treatment or of inadequate compensation, or even result in chronic disablement. A child's headaches or other indispositions requiring frequent absences from school may arise from the fact that the solicitude and care of an overdevoted mother make illness a pleasurable experience. Nor should it be forgotten that clear-cut physical disease is not free

from psychological attitudes, and that emotional problems exercise a direct influence on both physical and mental health. Thwarted ambitions, concern over outcome of the illness, burdensome expense, loss of income and possible loss of employment, all may constitute a threat to the patient's sense of security and act unfavorably on both physical and mental health.

The nurse who has learned to apply her psychiatric knowledge and therefore bears in mind the mental implications inherent in physical illnesses and in the procedures attending their treatment will recognize that they exist to a surprising frequency. Many a person has a deeply seated sense of insecurity of personality, manifested perhaps by some character trait the significance of which is recognized only by one trained in psychiatric observation. In such a person the commonplace procedures of medicine and surgery may cause fear and apprehension. The extreme care with which the site of the awaited operation is scrubbed, shaved, and treated with antiseptics may seem, for example, to imply that some mysterious hazard lurks in the proposed operative procedure. The strange bottles, gauges, and other paraphernalia which the masked anesthetist has at hand suggest that some grave emergency is expected to arise. The nurse who explains each step in preparation for the anesthetic and operation may do much more than afford temporary reassurance—she may allay fears that might otherwise have led to an increasing and perhaps disturbing anxiety. A fear of mutilation or disfigurement or of loss of vital structure or capacity may threaten the patient's sense of security. While frequently this results merely in an apprehensive preoccupation, yet if its significance to the patient is not recognized by nurse or surgeon it may lead to anxiety, depression, mild panic states, or to exaggerated and unpleasant expressions of previous personality tendencies. The presence and reassurance of the nurse may do much to prevent a panic reaction of a delirioid nature in a patient with bandaged eyes in a darkened room following an ophthalmological operation. A word of explanation from the nurse before the operation may do much to prevent conflict and anxiety in the case of a woman who is a victim of the many erroneous beliefs concerning the effects of a pelvic operation upon personal charm, mental stability, and attractiveness to the opposite sex. The fuss which seems disproportionate to the seriousness of the patient's illness may not be due so much to the pain and discomfort of her gynecological disorders as to the expected influence

upon marital adjustment or the frustration of a lifelong desire for motherhood.

Attention has been called to the misinterpretations, fear, and apprehension that mark the reactions of many patients to the existence of physical disease or disability. In some instances this may proceed to a state of tension and anxiety with sweating, flushed face, restlessness, palpitation, and actual fear of dying. Some patients respond to their illness not with fear or anxiety, but with gloominess, discouragement, or definite depression. They may blame themselves for their illness and state that they do not deserve the sacrifices which relatives may be making on their behalf. As in the more extreme depressions seen in the mental hospital these patients are only irritated by the frequent habit of telling them to "cheer up" or "snap out of it." In such cases the nurse can usually be helpful by shifting the patient's attention in a tactful and indirect way to more cheerful interests. Any expressions on the part of relatives should be of affection but not of pity.

Mental Defenses in Physical Illness. Another response to physical illness is irritability coupled, frequently, with complaints by the patient concerning the nursing and medical care he is receiving. It is often not easy for the nurse not to respond with dislike, irritation, or resentment. She should remember, however, that these are really defensive reactions unconsciously serving the purpose of concealing the dissatisfaction felt by the patient concerning himself. His physical illness has rendered him less able to deal with the inadequacies and rejected phases of his own personality. The nurse will maintain an unruffled attitude free from any tendency to criticize the patient, and will endeavor to foster confidence and optimism and to help him to get at peace with himself and his world.

Another escape mechanism sometimes adopted by the patient who is physically ill is a refusal to face the fact that he is sick. He may refuse examinations or decline to take medicine or other form of treatment, declaring it is unnecessary. Argument with such a patient accomplishes nothing. For some reason he feels that illness would place him in an unbearable situation; he therefore cannot accept the knowledge of it. If it can be learned why such knowledge is unendurable the nurse may seek to make the illness more tolerable.

Unity of Physical and Mental Disease. From what has been said it will be seen that mental and emotional factors complicate or even create much illness. Since unwholesome mental mechanisms

are not rarely associated with or evoked by physical disease, the nurse should not consider the physical and mental aspects of personality as two separate and unrelated spheres but rather as an interrelated and interpenetrated whole. She should be able to recognize and evaluate psychological factors and her efforts should be directed toward the promotion of mental health as well as toward the relief or removal of physical disease. She should remember that her real task is to nurse human beings, not diseases. The medical and nursing care of the patient cannot be considered adequate unless his mental and emotional difficulties as well as his physical disorders are considered. In every case of physical disease, therefore, the nurse's notes should contain observations concerning her patient's emotional relationships and expressions, and his behavior and personality reactions. She should note by what methods he appears to be meeting the problems that arise directly and indirectly from his sickness. The nurse should bear in mind that the patient's personality contains unseen, nonphysical, inner aspects and should note if and in what way they appear to be influencing the picture he presents, including those manifestations which are physical.

Experience in a Psychiatric Hospital Desirable. The frank psychoses and the well developed psychoneuroses afford the nurse the clearest pictures of personality disturbances. For this reason the nurse should have an acquaintance with them, since it will give her an insight into the less obvious, but more frequent disorders which constantly complicate nursing practice. Inasmuch as such an acquaintance with the major forms of mental disorder is usually obtained in a psychiatric hospital, a consideration of some of the problems involved in the nursing of the psychoses is in order.

Hospital Versus Home Care. The nurse will not usually be called upon to decide whether her psychotic patient should be cared for at home or in a psychiatric hospital. Occasionally, if she has had experience in psychiatric nursing, her advice may be sought in the matter. While there is no absolute criterion by which to determine the most suitable place for treatment, yet a disturbed or a depressed patient should rarely if ever be cared for in a private home. A patient of the former type will throw the entire household into disorder, while in the latter the danger of suicide is too great. Any patient who is determined to do so will almost invariably succeed in destroying himself if cared for at home. While in a minority of

instances the treatment of a psychotic patient may properly be undertaken in his home, yet observation and care in a hospital for mental disorders is usually wise. Although frequently unrecognized either by the patient or by his relatives, there are often disturbing influences and attitudes as well as unresolved conflicts having their origin in the family relationships. Even though psychological factors arising from the family constellation have not been important in producing the mental disorder, yet removal from the environment in which the psychosis developed is usually wise. Freedom from domestic responsibilities is beneficial, as also is removal from oversolicitous relatives or, in some instances, kinsmen who through lack of understanding ridicule or argue with the patient. It is of great importance that the psychotic patient should, early in the course of his mental disorder, be observed and treated by physicians and nurses experienced in the management of personality disturbances. Not a few patients end their lives and more suffer long-continued or permanent mental invalidism because of ignorance or prejudice on the part of their families concerning the subject of treatment in hospitals for mental disorders. The hospital affords, too, a protective environment adapted to the limited resources of the patient's capacity for adjustment. Many patients for whom complete recovery is not possible may, after a study of their personality tendencies and adaptive capacities, return to their homes if the hospital continues to accord such psychiatric guidance as their condition requires. Frequently the patient's return must be preceded and followed by instruction of his family regarding the nature of his mental disorder, and how the difficulties in his adjustment may be rendered easier.

Methods of Securing Admission to a Psychiatric Hospital. No patient may be admitted to a hospital for mental diseases except in a manner prescribed by the laws of the state in which he resides. It should be as easy to secure hospital treatment for mental illness as it is for physical illness. For various reasons, however, especially because of the mistaken belief that the patient's "rights" must be protected lest he be "railroaded" into an institution by enemies or unscrupulous relatives, legal procedures, sometimes of a nature that render it difficult for the patient to secure care, are required. Fortunately some states have laws which permit the voluntary admission of a patient, if the superintendent of the hospital believes the patient is mentally competent to sign an application; this ap-

plication usually stipulates that the patient will, ten days before he plans to leave the hospital, give written notice of his desire for discharge. Many patients are either not mentally competent to make voluntary application for their admission, or do not realize that they are mentally ill and in need of hospital care. For such patients some states have an excellent law which provides that a superintendent of a mental hospital may, upon the written application of a friend or relative and the certification of two physicians that the patient is mentally ill and in need of hospital care, admit a patient and detain him until recovery, or as long as he believes care and treatment are required. Other states provide for commitment through the community health officer. In some states admission is possible only upon order of a court the judge of which may require such evidence as he believes is necessary to convince him that the patient is of "unsound mind." In a few states the patient may not be admitted until after a lay jury has rendered a verdict declaring him to be "insane." Naturally both the patient and his relatives resent such distressing publicity with the result that desirable treatment is often long delayed. Such a procedure has, not inappropriately, been characterized as about as sensible as calling in the neighbors to diagnose meningitis or scarlet fever. It is doubtful if patients are ever committed for improper purposes, but if the patient or other interested person believes that the former ought not to have been committed, legal proceedings can be brought to have the case reviewed. Usually arrangements for the transportation of the patient from his home to a public mental hospital are made by his family, although in some states the law directs that he be transported by the local sheriff. This method is, of course, a humiliating one to which sick people should not be subjected. In several states the law requires that, upon request, the hospital must provide an attendant or nurse to accompany the patient to the institution. This method, in which the perplexed and perhaps suspicious, antagonistic, or disturbed patient is accompanied by an experienced and understanding person, is the most desirable.

Secure the Confidence of the Patient. When not accompanied by such a psychiatrically trained person, it will all too often be found upon the patient's arrival at the hospital that he has been willfully deceived concerning the purpose and destination of the trip which led to the institution. When he discovers the deception to which he has been subjected, it is but natural that he should be angry and

resentful and feel that he can no longer trust even those who profess to be his friends. One of the first tasks of the admitting nurse, therefore, will be that of gaining the patient's confidence. She should greet the patient pleasantly and tactfully and do all in her power to make him comfortable. Since the impressions obtained by the patient during his admission and shortly thereafter are often lasting, their nature is important. He may be told frankly that he has been sent to the hospital for observation and care, that he is among friends who will treat him kindly, that there will be no attempt to deceive him, that he will receive every courtesy and consideration possible, that the physicians and nurses are interested in his welfare and wish to give him such care and treatment as may be beneficial.

Admission Procedure. A modern psychiatric hospital has a well ordered admission suite with a special entrance. This suite will have an admission office, a bathroom with shower and tub, toilet, scales, basins, etc. There will also be a physician's examining room. Adjacent to the suite there will be single rooms and one or more small dormitories. During the bath the nurse should observe the condition of the patient, looking especially for rashes, bruises, scars, nits, and pediculi. Record should be made at once of any signs of recent injury, otherwise a charge may be made that the injuries were sustained subsequent to admission. A recording of the patient's temperature, pulse, respiration, and weight should be a routine procedure. Money or other valuables should be delivered to the hospital administrative office. A receipt for their delivery should be secured from that office and filed in the nurse's office. Record should be made of dentures and glasses, but they may be returned to the patient if authorized by the physician. All clothing should be listed and marked with the patient's name. The patient's relatives should be instructed not to bring additional clothing or other articles except as clearly needed. Relatives should not give clothing directly to the patient but to the nurse, to be marked and recorded. After other admission procedures have been completed a chart will be prepared for the patient, also such request forms, as for urine examination, Wassermann test, etc., as the administrative procedure of the hospital directs.

Supervision. The newly arrived patient should be under the constant supervision of the admitting nurse. Without obviously indicating that she is doing so the nurse should be alert to note

suicidal attempts by the patient or to observe if he secretes any weapon with which he may later destroy himself. In every large hospital an attempt at suicide is occasionally made by a patient before his admission has been completed. Patients should be advised of the routine procedures and activities of the ward and introduced to such other patients as may be most congenial.

Attitude and Manner of the Nurse. At times the patient comes to the hospital believing that he is the victim of a plot in which unknown enemies seek his life. He may even conclude that his hospitalization is part of this conspiracy. If, therefore, the patient seems apprehensive he should, through both word and manner, receive assurance as to the friendly nature of his new environment. The nurse should remember that the patient attaches but little value to mere verbal professions of benevolence. He is quick to note the intonations of the voice, the aspects of the face, and all those expressive movements of the body which speak more truthfully than do words. Once deceived, the patient may no longer have confidence in the nurse and may even become rebellious in his attitude toward the institution. While it may not always be wise to tell the entire truth, the patient should never be told an untruth. The nurse should scrupulously avoid a condescending attitude of smiling superiority, nor should she treat the patient like a silly child.

While every reasonable provision should be made for the physical comfort of the mental hospital patient, yet we should remember that in a great majority of cases his principal disability is mental and emotional. It is therefore of the utmost importance that the personalities and ministrations of those who care for him are characterized by a sound sympathy and impart reassurance. The nurse must be absolutely truthful, show sincerity, and create a conviction that she understands the patient's feelings.

The bedside manner of the nurse and the atmosphere she creates will exert a definite influence upon her patient, his behavior, and in many instances even upon the course of his mental disorder. An atmosphere of "comfortableness," and an attitude of friendliness and respect on the part of the nurse and of confidence on the part of the patient in her kindness and consideration, are most important elements in successful treatment. The percentage of social and indeed of psychological recoveries in a mental hospital is largely in direct proportion to the individual attention received by the patient. The psychiatrist seeks to construct a program of treatment in the light

of the needs of the patient's inner life. If the nurse has an intelligent understanding of these needs, and has some knowledge as to how they and the forces within the individual may conflict one with another and with those in the environment, she should be able to take some understanding part in the execution of the program. For the nurse to promote a rational confidence on the part of the patient in the face of an apprehension arising from a deeply seated insecurity of personality, is as much psychotherapy as if it were known under the name of some formal system. The same may be said of the encouragement of self-esteem in the self-depreciatory, or of self-reliance in the timid. The mere fact that the patient has some one to whom he may unburden himself may promote a needed serenity. The manner of the nurse may do much to convince a suspicious patient that an environment supposed to be hostile is, in fact, friendly and sympathetic. The nurse should remember that the chief end of treatment of the psychotic patient is, if possible, to make him again a socialized member of his home community; that if this is impossible, to make him a useful unit in the hospital. By re-establishing emotional bonds, the severance of which has isolated him from his fellows, the nurse may often be the socializing agent which restores the patient to social health, and may create the feeling, essential to personality integrity, that he is a member of the social group.

In another respect the nurse, appreciative of emotional and other imponderable values, may be of great value to her patients. By this is meant the opportunity which is hers to avert or mitigate many of the psychological traumas sustained by the enforced hospitalization of the psychotic patient. Taken from his home, often unceremoniously and against his wishes; thrust behind locked doors and barred windows, frequently deprived not merely of his liberty but of his own clothing and of his treasured personal trinkets; forced to associate intimately with strangers, many of whom are repulsive; and compelled to live under the highly artificial conditions of institutional life in an atmosphere that may be imagined to be hostile—the injuries to pride and self-respect under these conditions must seem to the patient to be unnumbered and insurmountable. The requests of the patient should not be passed over indifferently. They should be listened to and if within reason be granted. If this be impossible the patient should be so informed. Due regard should be had for the patient's dignity and sensibilities. Mention

may be made, for example, of the extent to which the patient's sense of modesty in bathing and dressing is often disregarded. Like any other person the mental patient has a right to privacy so far as is consistent with his safety. No small part of mental illness is the expression of loss of self-esteem. Persons suffering from it should therefore be accorded every consideration and courtesy and treated as far as possible as respected members of the community who happen to be in temporary difficulties.

Care of the Disturbed Patient. A nurse's methods of caring for disturbed and excited patients are an excellent test of her judgment and of her fitness for psychiatric nursing. In her management of disturbed patients she should not err by employing too hasty or too active measures. The psychiatric nurse will take the same objective attitude toward mutism, catalepsy, negativism, and paranoid complaints and toward excited, aggressive, disagreeable, hostile, or provocative behavior as does the general nurse toward such things as the sight of surgical operations and of blood, the cry of pain, or other unpleasant or unfortunate incidents involved in her work. She must not react with anger, irritation, annoyance, fear, or excitement. Neither will she pass judgment on the patient's behavior, but will attempt to analyze its significance and the reason for its existence.

If the consciousness of the disturbed patient is clear and he is fully in touch with his environment the nurse should calmly and frankly explain the situation, at the same time attempting to show him the futility of his unacceptable behavior and suggesting more rational conduct. Under no circumstances will she argue with him. When he is abusive, vulgar, aggressive, and noisy the nurse must be tolerant yet must manage the situation. Perhaps he has intended that his behavior should disturb the environment. With the combative patient an attitude of calm friendliness and firmness may be effective. With the tactful employment of persuasion and diversion, compulsion will seldom be necessary. In the case of the overactive patient the nurse will take advantage of his suggestibility and distractability and tactfully divert his interests and activities into constructive channels. Force should not be used in order to secure obedience to some merely arbitrary command of the nurse. In the rare instances when the employment of force is necessary in order to effect restraint or to carry out orders for treatment the nurse should never attempt to handle the patient unassisted. Not only

should she have the aid of a sufficient number of persons to avoid a struggle and possible injuries to herself or the patient, but whenever possible a physician should be present to direct the situation and share the responsibility.

Figures 10 and 11 illustrate two methods of handling an excited and resistive patient when physical interference becomes necessary. Figure 12 illustrates an undesirable and often unsuccessful method of attempting to control such a patient.

If the nurse discovers that any treatment which has been prescribed is likely to be resisted she should communicate with the physician who ordered the measure, explain the situation, and ask for instructions. It not rarely happens that the patient's adverse reaction to the treatment outweighs the results to be obtained from it. The use of unnecessarily forceful measures creates resentment on the part of the patient, increases the difficulties in his care and management, and tends to destroy that rapport between patient and nurse which is essential for the maximum usefulness of the latter. The wet pack and the continuous-flow bath are valuable sedative measures for use with disturbed patients. The nurse should not, however, lead the patient to look upon their use as punitive rather than as therapeutic measures. While restraint is perhaps permissible in the rare cases of actual violence, it should never be employed except upon the written order of a physician. Most violence is the result of injudicious management on the part of the nurse, or of insufficient capability in meeting a difficult situation. Occasions calling for restraint or seclusion of the disturbed patient will be few if the nurse, aided by sufficient assistants, provides sufficient recreation through walks or other suitable exercise.

Seclusion. In order to protect himself and others, seclusion—confinement in a room alone—of a disturbed patient may become necessary. Frequently this measure would be unnecessary if the nurse were to exercise ingenuity in redirecting the patient's activity along more constructive lines. If seclusion is employed it is usually wise to remove the patient's shoes to prevent his using them to break windows or injure personnel. If seclusion is continued during a meal hour it is well to use paper appointments for the service. All too often seclusion results in neglect of the patient. The nurse does not intentionally neglect her charge, but in his restless, destructive, untidy condition she does not find it easy or pleasant to secure temperature, pulse, and respiration regularly, to note his



FIG. 10: CROSSED-ARM METHOD OF CONTROLLING AN EXCITED PATIENT.

The nurse approaches the patient from the rear and grasps the left hand of the patient with her right hand and the right hand of the patient with her left hand, thus crossing the patient's arms in front.



FIG. 11: ARM-HOLD METHOD OF CONTROLLING AN EXCITED PATIENT.

The nurse approaches the patient from the rear and thrusts her hands beneath the elbows of the patient.

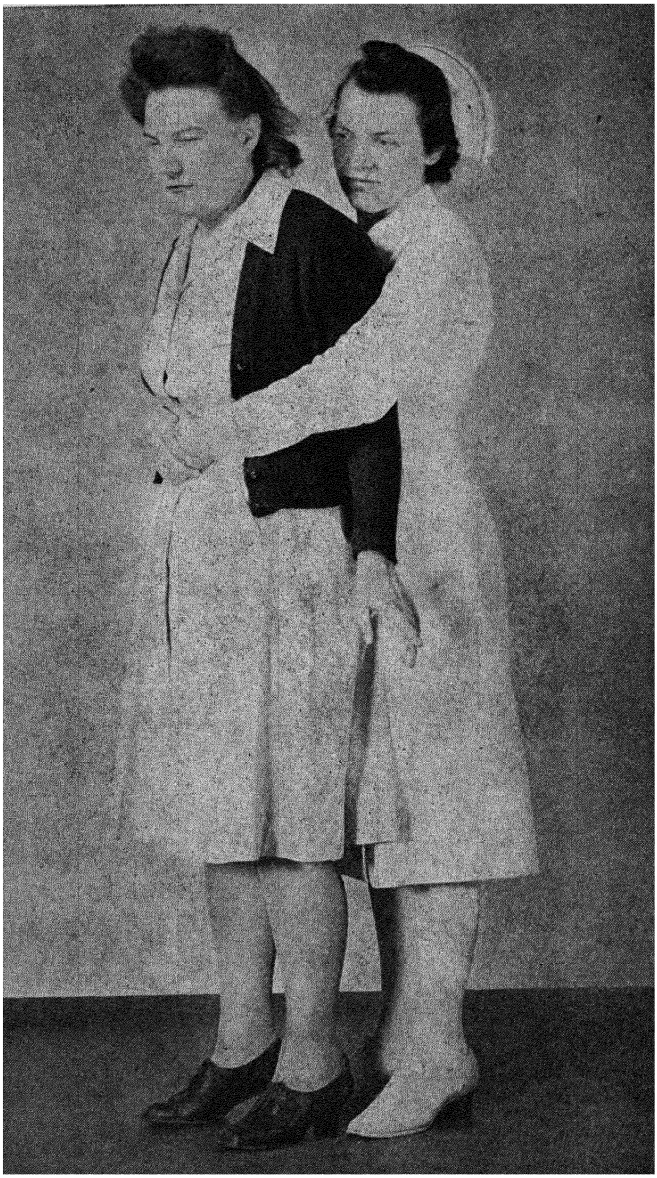


FIG. 12: INCORRECT METHOD OF CONTROLLING AN EXCITED PATIENT.

physical condition, and to administer sufficient food. The nurse may forget, too, that the patient, perhaps exhausted and often inadequately dressed because of his destructive habits, is an easy mark for the insidious development of pneumonia. Some day, perhaps, the nurse remarks to the physician that the patient must be improving since he now lies quietly in his room. Examination reveals that the patient is really hopelessly ill and is quiet merely because he is now too weak to be disturbing. Seclusion is rarely employed, but in the event of its use it should be looked upon by the nurse as a special challenge to her professional vigilance and responsibility.

Resistiveness. As unreasonable as it may superficially appear, a troublesome resistiveness springs from causes that to the patient seem good and sufficient. Sometimes it may be a protest against continued misery and discomfort. Again it may be due to fear or be the result of delusions, as in the case of a woman who stubbornly resisted efforts of the nurses to feed her and after recovery explained that her refusal of food had been due to a belief that the food offered was in reality the flesh of her father. The nurse's attitude in case of resistiveness should be one of reassurance and of obvious desire to understand and be helpful. Forcible measures in dealing with a resistive patient should be limited to those essential for providing actual physical needs.

Before leaving the subject of the disturbed patient, mention may be made of the fact that general nursing procedures must often be carried out during his overactive, destructive, or resistive state and therefore in the face of unusual difficulties. The problem of keeping on a surgical dressing, for example, may be a serious one. The patient may tear off such a dressing, pull out a drainage tube, or open an operative incision. Dressings should be applied with every device for keeping them in place. Sheet restraint may be necessary.

Suicide. The possibility that the mental patient may attempt suicide should never be forgotten. The relatives of the depressed patient should be given to understand that he must be cared for in a hospital. The life of many a depressed person has been destroyed because the members of his family were reluctant to consent to hospital care, or because they were unaware of the great frequency of suicide among the depressed. Suicide may be prompted by ideas of guilt or unworthiness, by an overwhelming sense of failure, by a feeling that life is intolerable because of constant, insufferable

persecutions, or by a feeling that the illness is a disgrace. Only nurses with long experience in care of the psychotic realize the danger of suicide and the ingenuity of the patient who contemplates self-destruction. Such a patient should never be permitted to escape the observation of the nurse for a moment. Patients have even been known to kill themselves while a nurse sat at the foot of the bed for the express purpose of preventing such a tragedy. In public institutions it is customary at night to place the beds of several suicidal patients near each other in a well lighted location where all of them may be constantly observed. A spoon is usually the only eating utensil to be permitted to a suicidal or homicidal patient. In a psychiatric hospital no patient should be permitted to leave the dining table until all knives, forks, and spoons are accounted for. Similarly a careful check must be made of scissors or other occupational therapy tools that might be used for undesirable purposes. Since in a well managed hospital it is difficult for patients to secure sharp instruments or poisonous substances, many attempt suicide by hanging. Patients may improvise a rope from garments or from any other available article that may be used for the purpose of hanging or strangling themselves. The patient will therefore not be permitted to have belt or tie. Men should never be allowed to possess or to use a razor unless specifically permitted by the physician. If circumstances permit, a depressed patient may throw himself headlong from a staircase or other height. Patients have been known to thrust an ordinary sewing needle into the heart. Cleaning, polishing, and disinfecting fluids and other housekeeping material should be locked in closets inaccessible to patients. No bottles or other glassware should be kept on the wards. In spite of apparently every precaution possible, razor blades will occasionally be found in the possession of patients. Drug and instrument cabinets must be kept constantly locked. In many mental hospitals the solution used for the hand-soak in isolation technique consists of green soap since the patient will not suffer serious harm should he drink it. If the patient is actively suicidal the word *Suicidal* should be written on his chart in red ink or a list of suicidal patients posted in the nurse's office. The nurse must know every minute of the day where such a patient is and what he is doing.

Not rarely the relatives of patients question the necessity for the precautions adopted by psychiatric hospitals to prevent suicide. Only by constant viligance, however, can the number of suicides be

reduced to a minimum. The danger of self-destruction is often not greatest in profound depression but during convalescence or in mild depression. The nurse will be particularly alert to note indirect depressive remarks or prolonged thoughtful periods with limited physical activity. Occasionally a patient will simulate improvement in order that precautions may be relaxed and he be given opportunity to accomplish his purpose.

Should suicide have been attempted by hanging, support the patient's body and at once cut the cord by which it is suspended, summon a physician, and if indicated administer artificial respiration until he arrives. If suicide has been attempted by sharp instruments, pressure or a tourniquet should be applied to check bleeding. If poison has been swallowed, produce emesis by giving the patient large amounts of warm salt solution.

Feeding. One of the important problems in the care of the mentally ill is that of feeding. Frequently the first step is to build up the patient's physical health. For a few days after admission or until there has been an opportunity to observe the patient and learn his ability to adjust to the established hospital routine, he is frequently fed from a tray. After this period of observation, and as it is found that he is physically and mentally able to do so, the patient is served his meals in the ward dining room. Here a cafeteria type of service is increasingly employed. This method of serving food has many advantages including that of making possible a greater choice of food, a reduction in waste, and the stimulating effect inherent in the necessity of selecting food. Even the disorganized schizophrenic patients soon acquire the ability to carry out successfully and in an orderly manner the somewhat complicated procedure associated with this type of service. A nurse is present at the serving counter to see that patients select a sufficient and properly balanced diet. In case any patient does not eat the nurse encourages him to take food and if necessary assists in feeding him. As the patient leaves the cafeteria he deposits his tray at the window of the dishwashing room and places his table silver in a designated receptacle. Extreme care must be taken to check the return of all silver before a patient leaves the dining room lest a knife or fork be removed for undesirable purposes. It is of great importance that the nurse insist upon the proper use of knife and fork and the observance of conventional table manners. The nurse must make patient and persistent effort to prevent the deterioration of habits, the carelessness of dress, and

the disregard of amenities which the psychotic are so prone to manifest.

A large percentage of patients on admission to a psychiatric hospital are undernourished and require special attention as to their diet. Unless remedial measures are taken many, especially during the acute phases of their psychosis, will not eat sufficient food. Many, in fact, refuse all nourishment. There are always reasons for the patient's refusal of food, although frequently the refusal is prompted by his delusions. He may believe that he is unworthy to receive food, that it contains poison, that his gastrointestinal tract is obstructed, that he has no digestive organs, etc. Some patients are so retarded or suffer from such inhibition in motor expression that they cannot spontaneously feed themselves. Others may be too active to spend time to eat, be negativistic, too preoccupied, too confused, or food may be refused in attempt to commit suicide by starvation. With constant encouragement and persuasion many patients will take sufficient food, while others must be spoon-fed. Most patients who require spoon-feeding have a strong disinclination for food. The nurse must therefore be patient and persistent. If in spite of every effort on her part the patient does not receive sufficient food or even refuses it entirely, it will be necessary that he be tube-fed. The technique of this procedure will be described in the following chapter.

Medications. Because of the tendency to impulsive acts and to suicide that not infrequently characterizes mental patients, special precautions are necessary in administering medications. When these are kept in a medicine cabinet located in the nurse's station, the door to the latter should be kept locked during the absence of the nurse. The door should also be kept locked while the nurse is engaged in pouring medications. If the following rules are observed during the serving of medications, accidents will rarely occur:

1. Never carry a tray containing several medicines about a psychiatric ward; serve each medication separately. The use of paper or enamel cups is advisable.
2. Be sure that the proper patient receives the medication; a responsible person should be on hand to identify the patient.
3. Ascertain that the patient has swallowed the medication.
4. Have ambulatory patients come to the door of the nurse's office to receive their medicines.
5. Never give a patient any medicine to be taken at a later hour.
6. Never force a patient to take medication. If he refuses:
   a. Make reasonable minor concessions, such as tasting it oneself.

b. If the refusal is due to delusions, instill doubt concerning them.
c. Report the refusal to the superior officer.
d. Make note that the patient refused medication.

7. Be careful to note any unusual reaction to the drug which is being administered.

8. In giving medication hypodermically, explain the procedure to the patient. If he is disturbed, have assistance available. Remember, the needle may break.

Insomnia. Insomnia is frequently a troublesome symptom, especially among disturbed patients. Not rarely the nurse is overly concerned as to the number of hours the patient slept, and overlooks the fact that the important matter is *why* the patient did not sleep. The causes for sleeplessness are not always obvious, hence the remedy may not be apparent. Sometimes more exercise in the open air during the day will produce relief. The practice in public institutions of serving the evening meal at an early hour may cause the patient to be hungry during the night, in which case hot malted milk or other light food may produce sleep. Restless patients often become cold because of inadequate covering and are therefore unable to sleep. In the case of disturbed patients a wet pack or a prolonged warm bath may produce sleep. Efforts should be made to make the patient's sleeping room as dark and as quiet as possible; the nurses should not engage in unnecessary conversation among themselves. Great care should be exercised in the use of drugs for the purpose of producing sleep. Their employment may lead to an undesirable habit, bodily functions may be disturbed, and the mental disease complicated by numerous symptoms. Many a patient on arrival at a mental hospital has been found to be confused and delirious because of a prolonged abuse of hypnotics. Sedatives are at times essential. Of the various drugs used for this purpose paraldehyde is the safest, is prompt in action, is inexpensive, and rarely leads to addiction. Its chief disadvantages are its unpleasant odor and taste. These will be disguised somewhat if given with cracked ice. Phenobarbital and other barbiturates are often used, but many of them are expensive and may lead to habit formation. Not rarely patients allege that they have slept little or none when such is not the case. These statements may be disregarded, or the patient assured that the insomnia is no cause for worry.

Personal Hygiene. The nurse should constantly bear in mind the frequent tendency of the mental patient to become careless in dress and personal hygiene. Some patients are too excited, others too depressed or uninterested to bother how they look or whether

they are clean. Constant care is often necessary to see that the clothing of the disorganized patient is not disarranged or removed or that shoes are unlaced. Such patients must often be taken to the toilet to prevent soiling of clothing. If gotten up once or twice during the night, bed-wetting may be prevented. Responsibility for cleanliness of person and clothing should be encouraged. Many will require constant care to assure that teeth are brushed and hands are washed. The nurse should prepare the patient's bath if a tub is to be used. In most instances the shower bath is more practicable. In every case the temperature of the water must be checked by the nurse before the bath is begun. The nurse should attend and, if necessary, assist the patient in bathing. It is well, especially in the care of the older patient, to have a rubber mat placed in front of the shower stall to prevent slipping. As the patient improves, pride in dress should be encouraged. Suitable and conventional clothing will often improve morale. For the woman patient the "beauty parlor," with the increase of personal attractiveness and the promotion of self-respect which it affords, is often an invaluable therapeutic agency. (See Fig. 9.)

Unfortunately in every mental hospital there is a considerable group of greatly disorganized patients, many of whom must remain permanently in a hospital and who, if neglected, lose both sense of self-respect and regard for the decencies of living. By painstaking effort the nurse may greatly improve the personal hygiene of these patients and in many instances establish a habit of industry that may make the patient a useful member of the hospital community. An excellent schedule for this purpose is that which was outlined by the late Mrs. Eleanor E. Slagle who rendered a most distinguished service in the promotion of wholesome habits and occupational therapy in hospitals for mental diseases:

A Habit-Training Class Schedule

(Hours to be adjusted to meet the daily program in each hospital.)

6.30 A.M.: Charge nurse and attendants on duty. Out of bed. Wash. Comb hair. Cleanse mouth, using toothbrush. Lace shoes. Empty bladder and bowels.

7 A.M.: Breakfast. Teach patients to make beds, sweep floors, and care for ward.

9–9:30 A.M.: Simple gymnastic exercises under direction of physical instructor: outdoors in summer, on porches in winter. If weather is too severe, open windows on the ward, and have exercises take place therein.

9:30–11:30 A.M.: Have patients go to toilet; glass of water. Class work; occupational therapist and attendant on duty:
Cutting out pictures.
Making scrapbook.
Spool knitting.
Knitting washrags and rugs.
Crocheting very simple filet patterns.
Crocheting rugs and face cloths.
Crocheting shoestrings.
Simple raffia work, as baskets, napkin rings, picture frames, etc.
Tearing and sewing carpet rags.
Coloring pictures with colored crayons.
Braiding carpet for rugs.
Doing simple patchwork.
Doing plain sewing and mending.

Several patients may be able to perform the same kind of work. It may be necessary to choose some particular kind of work from the list for certain patients. The thing to do is to get them interested in some form of useful employment, and gradually advance them to more complicated tasks.

11:30–11:45 A.M.: Putting up work, each patient assisting. A box or paper bag with each patient's name on it should be provided.

11:45–12 NOON: Prepare patients for dinner. Have them go to toilet, wash their hands and faces, clean their nails, and tidy hair.

12:0–12:30 P.M. Dinner.

12:30–1:15 P.M.: Scrub teeth (those able). Rest in ward.

1:15–2:30 P.M.: Toothbrush drill, consisting of the usual movements with toothbrushes in the practice of brushing teeth. Each patient should have her own toothbrush. This can be kept in box or bag.

2:30–3 P.M.: Have patients go to lavatory and drink a glass of water; empty bladder. Tidy up and go out on lawn.

3–3:30 P.M.: Physical instructor on duty. Simple gymnastic exercises on lawn. In inclement weather on porch, or open ward windows and put patients through exercises in ward.

3:30–4:30 P.M.: Folk dancing or games, tossing bean bag, catching ball, throwing rings, etc.

4:30–5 P.M.: Nurse on duty. Take patients to toilet. Rest. Make tidy for supper.

5–5:30 P.M.: Supper.

5:30–8 P.M.: Music in ward: phonograph, piano, dancing; singing if possible.

8 P.M.: Take patients to toilet. Brush teeth and hair. Retire.

11 P.M. and 2 A.M.: Toilet for bed-wetters.

Escape. Since the majority of psychiatric patients do not recognize that they are mentally ill, they see no reason for institutional confinement. Many believe they are the victims of a misunderstanding or of an injustice and therefore seek for an opportunity to escape from the hospital. With others the urge to see children or other loved members of their families or to return to home becomes so great that they avail themselves of any opportunity to leave. A few patients escape in order to secure opportunity for committing suicide. The senile or disorganized patient may wander away and suffer from exposure. Occasionally an escaped patient may, if so inclined, make sexual assaults on women or children or commit other serious offense.

It will be seen that the responsibility of the nurse for preventing escapes is a heavy one. Her keys must be fastened to her person in such a way that they cannot be removed without her knowledge. If they are lost this fact should be reported at once. All exit doors should be kept locked. After having locked a door, turn the knob to make sure the lock was turned. Be sure to identify the person who wishes to be let out and be certain that he is authorized to leave. Incidentally it may be added that the nurse should never permit anyone to enter the ward until assured that he has official permission to do so. Patients should not be permitted to loiter about an exit door, lest they attempt to force their way by persons entering or leaving the ward. Watch for keys made by patients from bed springs, spoons, or other metal articles. Groups of patients going to the cafeteria, to church, for walks, to entertainment, or to any other activity which takes them from their ward, should be counted upon leaving the building and upon their return. Occasional counts should unobviously be made during absence from the ward. A group of patients should always be accompanied by at least two employees—one in front of the group, the other at the rear. All patients should be counted and record made when the ward personnel changes shifts of duty. Many a patient, while travelling with an escort, has escaped through the ruse of indicating a desire to go to the toilet or otherwise be excused for a moment on plausible pretext. Whenever it is found that a patient has escaped, the nurse should at once report the fact to her superior officer. She should not assume the responsibility which is hers if she fails to make prompt report.

In planning group activities, the nurse should exercise care in

selecting the patients who are to be the leaders in the activity. In large institutions the same patients are often repeatedly selected for the leading roles with the result that desirable therapeutic values are lost because of the fact that competition should be encouraged in a convalescent group. In planning walking parties, regimentation should be avoided. It is usually undesirable to line up patients "in twos" for an excursion from the ward. A moderate amount of scatter may be allowed if there is an employee at the head of the group to set the pace. Patients who are known to have an urge to escape should be kept near an employee. An excursion from the ward may be the opportunity a suicidal patient has been anticipating. The nurse should therefore be observant as to moving vehicles or other hazards likely to be encountered. It is sometimes helpful to a convalescent patient to be assigned some responsibility for one who is not so far recovered.

Accidents. In spite of careful precaution, accidents in mental hospitals are distressingly frequent. The number, however, depends largely upon the skill and number of the nursing personnel. Confused, elderly patients frequently fall from bed, slip on wet floors, or are pushed down by more active patients. Many times a fall by an elderly patient results in a fractured hip. Care should be taken to help the weak to the toilet and to keep them out of the way of active patients. (See Figure 8 in Chapter XVI.) Quarrels between irritable patients should be promptly checked. Care should be exercised in the separation of any two patients who are known to be mutually antagonistic. Constructive outlets for the energy of excited patients should reduce the number of injuries caused and sustained by this group. Crib beds are often advisable for epileptics and for senile patients, and for the confused and restless. Often a patient, especially a paretic, chokes on a large bolus of food. If this occurs, lay the patient down with head lower than the body and give him a sound slap on the back. At times the food can be reached with fingers or forceps. Burns, fractures, drowning, and poisoning by drugs or chemicals are treated by the same measures as are followed in a general hospital. Accidents should be reported promptly. The oral report should be followed by a written one and in detail. The names of any witnesses, especially of employees, should be included. The patient's relatives will be notified by the physician, who should be given full information concerning the accident. Often it will be found that a

patient has been injured in some unknown manner. The nurse should then question all possible witnesses and make a most thorough investigation. If an injury, directly or indirectly, is followed by death of the patient, the doctor will wish to notify the coroner.

Prevention of Fire. Special precautions must be taken to prevent fires. The history of mental hospitals shows that there have been many fires in these institutions with a resulting loss of many lives. Patients should never be allowed to have matches in their possession and visitors should be instructed not to give matches to them. If it is believed that this rule has been violated, the suspected patient should be searched. Smoking should be permitted only under conditions designated by the physician. Tissue paper and Christmas or other decorations should not be draped or placed about light globes or electric fixtures. The nurse should know the location of fire extinguishers on the ward and be familiar with the hospital system of fire alarms. The well administered hospital will have periodic fire drills. Patients should at once be removed in an orderly manner from the building in which a fire occurs. After the building has been evacuated, each room or dormitory should be carefully reinspected for any patients who may have been overlooked.

Visitors. In a hospital for mental diseases the responsibilities of the nurse in relation to the patient's visitors are important. Before permitting the patient to be seen, the nurse should be certain that the visit is approved by the hospital officials. It is her duty to see that the patient is fully and neatly dressed in his own clothing and is well groomed as to hair, nails, and teeth. The nurse should not permit the patient to receive matches, sharp instruments, or articles which may be hazardous to other patients. She should know the contents of any package which a patient receives and takes to his ward or has in his possession on return from a temporary visit to his home. She will not permit the patient to sign papers of a business or legal nature. Visitors should be referred to the physician in charge for replies to their inquiries. If a patient becomes disturbed, the visit should be tactfully terminated. Nurses sometimes say that they have more trouble with relatives than with patients. It should be remembered that a patient's relatives are much distressed about his illness, have little knowledge concerning mental diseases, and are unacquainted with the administration of

mental hospitals and the need for its rules. While the nurse should be firm in seeing that the rules of the hospital are followed, she should show every courtesy and consideration to visitors and remember that the reputation of the hospital depends to a large extent upon the impression carried away by them.

The Nurse and the Public. Frequently the nurse in the public psychiatric hospital does not realize how important it is that the institution secure and maintain the confidence of the patient's relatives and of the public. Most people have no real understanding of mental disorders and no acquaintance either with the internal administration of institutions devoted to their treatment or with the benevolent and altruistic devotion almost universally characteristic of the officials responsible for the management of such hospitals. It is a matter of common experience that any subject concerning which widespread ignorance exists is surrounded by suspicion and prejudice. For this reason few movements having for their object the relief of human suffering and unhappiness are so poorly understood or so subject to misapprehension as is the institutional care of patients suffering from mental disorder. Many a patient fails to receive the early and intelligent care that might have brought recovery for the reason that his relatives, ignorant of the humanitarian and scientific spirit in which a majority of the public institutions for the psychotic are conducted, are reluctant to entrust the patient to their care. The nurse by her daily association with the patient and her frequent contact with his relatives, has the opportunity and privilege of demonstrating by her manner that such hospitals are benevolent and intelligent agencies for personality reconstruction and re-education. Hers is the opportunity to gain and promote the confidence of both patient and public. The physician may be an important professional agent in the situation, but the nurse is often the humanizing agent.

Means of Treatment. In the care of persons suffering from mental disorder, the nurse should remember that the objectives and therefore the means of treatment are different from those employed in physical disability. In the latter the primary objective is to re-establish normal physiological processes of the body, whereas in mental disorder the primary concern is with making it possible for the individual, within the limits of his biological capacities, to adjust happily, effectively, and with satisfaction both to himself and his social environment. The means for re-establishing mental

health must therefore include many measures other than those applicable to physical disease. The ideal treatment of mental disorder would be to afford the patient that psychotherapeutic aid and counsel which would enable him to solve his particular mental and emotional problems, as well as give him understanding and therefore control of those inner psychological forces and motivations that largely determine behavior. For the most part this is impossible, at least in the major psychoses. Instead of dealing directly with those problems of his inner life for which the patient has proven inadequate, it is necessary that any aid be indirect. Since the patient can deal more effectively with the complex problems of his personality if its physical aspects are sound and vigorous, an effort is made to remove or alleviate any disorganizing physical disease. At the same time an effort is made to promote socialized habits and a wholesome interest in reality. To this end an effort is made to provide stimulating and socializing activities which divert feelings, thoughts, and activities away from self and toward reality. For the most part the agencies employed by the psychiatric nurse in an effort to cure her patient are not drugs or surgical technique, but measures which as far as possible re-establish the interests, activities, and contacts of normal life and promote a happy, effective, and social functioning of the personality. These agencies should be regarded as medical measures and receive the same zealous and thoughtful application as do the measures of physical treatment. Not infrequently getting a patient to do things for himself is at first more troublesome than doing them for him, but to relieve him of the responsibility may prevent his developing the spontaneity and volition essential for mental health.

Recreation. Among the therapeutic agencies to be employed by the psychiatric nurse are recreational activities such as participation in games, athletic sports, calisthenics, dancing, music, and the various arts and crafts now so fully developed in occupational therapy. Idleness with its frequently resulting absorption in a world of phantasy and its regressive and deteriorating tendencies has often been one of the ills of institutional life. Recreation relieves the patient's tension, permits a utilization of his energy, substitutes beneficial pursuits for regressive activities, affords incentive for projecting thoughts and interests from self, makes the patient more conscious of his environment, affords pleasure, assists in social adjustment, and promotes the ability to co-operate. In the wards the

nurse can provide cards, checkers, chess, picture puzzles, and table tennis. Among outdoor activities may be baseball, soft ball, tennis, and badminton. Attendance at moving pictures, dances, concerts, and plays is to be encouraged. Participation in plays and pageants organized by the hospital is often attended with great benefit to the patients taking part. Other group recreations such as folk dancing are helpful.

Bibliotherapy. The value of reading should not be forgotten. Current newspapers and magazines should be available. In addition to these the hospital should have a well stocked library to which patients should have access. The nurse will be much gratified with the beneficial results that follow her efforts to encourage reading. The tastes of her patients will be found to be those of the general public. Like their friends outside the hospital many patients will prefer the most recent popular novels. Like them, too, patients will wish for books dealing with such subjects as travel, history, biography, science, art, and hobbies. Books, like those on psychology, that tend to lead to a morbid introspection, should be avoided.

Occupational Therapy. Occupational therapy represents a deliberately planned means of diverting the patient's mind from preoccupation with morbid topics and from unwholesome habits of thought. It not rarely brings out special aptitudes and abilities, the utilization of which furnish the patient with self-confidence and a pride in accomplishment and creation which promote personality rehabilitation. The usefulness and worth of the product which the patient has created enhance the patient's feeling of his own value and importance. At times, perhaps most frequently in the case of the depressed patient, the active efforts on the part of the nurse or occupational therapist show the patient that *someone* is actually interested and eager to help. The personal contacts thus established often promote helpful social relationships and even open the way for the psychotherapeutic endeavors of the psychiatrist.

The type of occupational therapy must be graded to the capacity of the particular individual, frequently beginning with very elementary forms and progressing, if possible, to work which is creative and is therefore the object of spontaneously directed interest and energy on the part of the patient. Some forms of occupational therapy which are used in general hospitals may not be advisable in mental hospitals because of danger either to the patient him-

self or to others. It should be borne in mind that in even the simplest form of occupational therapy the tools may present hazards. Careful count must therefore be made of scissors, knitting needles, crochet hooks, and even of common pins and needles.

Family Care. The mental nurse should have knowledge of the system of supervision known as family care. Not rarely after study and treatment of a patient he improves to a point where further hospital care is not essential, yet he is still unable to be a self supporting, independent member of the community. Should he have no home or no family qualified or in a position to receive him he may, in some states, be placed in another private home where he may either earn part of his maintenance or be entirely supported at the expense of the state. Patients selected for boarding out in this manner must be carefully chosen after an adequate period of hospitalization, with elimination of those unsuited for family care by reason of dangerous tendencies or temperamental unfitness. The homes in which patients are to be placed must be carefully selected and the patients adequately supervised by periodic visits of psychiatrist and nurse or social worker. Should the patient again require hospital care he may be returned at once. The purpose of family care is not merely economic and a method of increasing facilities for mental patients, but is also therapeutic. Placing the patient in this manner often serves as an intermediate step toward complete rehabilitation by providing a more natural environment of supervised home life in which convalescence may continue. The plan originated at the famous colony of Gheel, Belgium, many years ago. Here there is a small central hospital for about 100 patients which serves as a reception and distribution center for the family care system. Before World War II there were about 3,000 patients residing in private families under the supervision of the hospital physicians and nurses.

Charting.

1. Value of record. One of the most important functions of the psychiatric nurse is accurately to observe and record description of whatever is significant in the behavior of the patient. The physician may see the patient only a few minutes a day, whereas the nurse usually sees him for hours. Not rarely the patient presents a more typical picture of himself to the nurse than to the physician. Her records may therefore be of much aid to the physician in understanding the patient, determining diagnosis, and guiding treat-

ments. The nurse's record may also be of value as a legal record in case of difficulties, may be used as a teaching aid, and serves to improve the standard of care and treatment.

2. Consciousness. Is the patient well in touch with events and activities of his ward? Is he confused or bewildered? Does he appear perplexed? Does degree of consciousness fluctuate? Is he more confused at night? Does he find his bed or room without assistance.

3. Orientation. Does the patient know the day of the week, of the month, the year? Does he know where he is, and appreciate his surroundings and the nature of the institution? Does he recognize that other patients show signs of mental disorder? Does he know the names of persons about him? Does he misidentify people?

4. Emotions and mood. The nurse will observe the state of the patient's emotions, noting if he is cheerful, exhilarated, overhappy, of exuberant spirits, or if he is downhearted, depressed, or melancholy. Is he fearful, agitated, or apprehensive? Is he dull, indifferent, and apathetic? Note if his emotions are subject to sudden and marked variations. Is the patient friendly, even-tempered, cooperative, or is he excitable, rebellious, irritable, scolding, and quarrelsome?

5. Thought content and expression. Is the patient mute? If he talks does he do so spontaneously or only in reply to questions? Does he speak slowly or rapidly? Does he talk little or much? Does he stick to one subject, or does he fly from one topic to another? Does he make facetious remarks? Is his conversation tiresome because of unnecessary details? Is his speech relevant and coherent? What seems to be the trend of his thought? What is the most frequent topic of his conversation? The nurse should quote the exact expressions and statements made by the patient. Does he express ideas that may or may not be delusional? If so, what are they? What ideas does he express that are obviously delusional? Is their expression accompanied by emotion? Does he ever express threats? Does he appear suspicious? Does he seem preoccupied? What does the patient tell others about himself, his work, his illness, and his plans?

6. Hallucinations. Does the patient complain of strange or imaginary voices or state that remarks are made about him by unseen persons? Does he stop his ears, talk to himself, make sudden turning or attentive movements of his head, or look into corners

or under furniture? Does he ever gaze raptly in a direction in which nothing unusual can be noted?

7. Activity. Does the patient move slowly or more quickly than one would expect the average person would do? Is he busy, meddlesome, playful, destructive, violent, or assaultive? Does he continue on one task until it is completed, or does he change his occupation often? Is the patient's attention fleeting or secured with difficulty? Does he frequently comment on persons, objects, or activities in his environment? Does he sit or stand in one position for long periods of time without moving? Does he assume strange postures, make grimaces, or unusual movements? Is he resistive?

How does the patient usually employ his leisure time? If he reads what type of reading matter does he prefer? If he writes spontaneously, what are the principal topics of his productions? Save for the physician any productions that seem unusual either in content or in mode of expression. Preserve, too, any other samples of creative activities such as drawings or paintings.

8. Dress. Does he remove his clothing or only partly dress himself? Does he keep his clothing clean and orderly? Does he show peculiarities of dress or decorate his clothing? Does he soil his clothing with evacuations?

9. Eating. Does the patient eat voluntarily? Does he eat large or small amounts? Is it necessary to spoon-feed him? Does he refuse food altogether? If so, what reasons does he give for the refusal?

10. Miscellaneous. Does the patient sleep and about how many hours? At what time does he awake? Is sleep restless or quiet? Does he seem afraid to sleep?

Does he have convulsions or other seizures? If so, describe carefully what occurs during and after them. Is he confused before or after seizure?

Does the patient express anything which suggests thoughts of suicide? Does he attempt to harm himself? Does he ever attempt to escape from the hospital?

Does the patient masturbate? Does he manifest sexual inclinations toward others?

Method of Charting. The appearance of the patient, his manner, behavior, and conversation should be carefully described as suggested by the guides just noted. The nurse should be sure to describe what she sees and hears, not her interpretations or opinions.

She should also avoid routine or stereotyped comments or descriptions. Do not simply say that the patient is confused or excited, or has delusions or hallucinations; quote verbatim what he says. The nurse should seek to develop the ability to select significant material and to avoid recording repetitious and valueless details of conversation and behavior. Try to sketch, in a few words, a clear picture of the patient's mood, attitude, reactions, habits, chief topics of thought, the things he does, and his social adaptation to others. When a patient is transferred from one ward to another a note is entered in the chart giving a concise, clear picture of the patient's condition, together with a statement indicating any medication or treatment that has been ordered.

Convalescence. Persons who have not had extensive experience in care of mental patients usually fail to appreciate the long period of time desirable for convalescence from a mental illness. Because a nurse has not noticed obvious signs of mental illness for a period she must not conclude that a patient is well. Convalescence is often a period of doubt, loneliness, and longing, especially for those patients whose recovery is accompanied by insight into the experiences through which they have passed, or for those whose ambitions have been thwarted by their disability. Burdened by such emotions and confronted by new as well as by old problems, the task of readjustment easily becomes too great and a relapse results. The mistake should not be made of permitting an attitude of dependence to become unduly prolonged. The patient should be encouraged to resume the direction of his own affairs in so far as his ability will permit. No one more greatly appreciates being treated as a reasonable and intelligent person than does a patient convalescing from a mental illness. To many patients the return to former associations and environment is accompanied by sensitiveness and suffering. They should not, therefore, be permitted or required to assume burdens until confidence is restored.

Summary

1. Since all nursing, including medical and surgical nursing, has mental and emotional aspects a knowledge of psychiatric nursing is of value.
2. The superiority of hospital over home care is pointed out and methods of securing admission are discussed.

3. Procedures involved in the admission of the new patient and the attitude and manner of the nurse are discussed.
4. Other topics discussed are the following:
   a. Care of the disturbed patient.
   b. Seclusion.
   c. Suicide.
   d. Feeding.
   e. Insomnia.
   f. Giving of medications.
   g. Personal hygiene of patient.
   h. Habit training.
   i. Escapes.
   j. Accidents.
   k. Prevention of fire.
   l. Visitors.
   m. Recreation.
   n. Bibliotherapy.
   o. Occupational therapy.
   p. Family care.
   q. Charting.
   r. Convalescence.

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CHAPTER XXVIII

NURSING PROCEDURES AND TREATMENTS

The previous chapter was largely devoted to a discussion of the general principles of psychiatric nursing, of the problems which the psychiatric nurse frequently meets, and of the manner in which she should deal with them. In preparing the patient for any treatment the procedure should be explained to him, even though he may not appear to be aware of the nurse's effort. In the present chapter some of the special procedures used in the examination and treatment of psychiatric patients are described.

Gavage or Tube-feeding

Although in order to see if hunger will not tempt him to eat, a well nourished patient may be permitted to go without food for two or three days, yet a person already inadequately nourished should not be allowed to refuse food for more than twenty-four hours before he is forcibly fed. Gavage or tube-feeding may also be employed if the patient is too ill to eat spontaneously, for giving additional fluids to dehydrated patients, or for giving medication if the patient is unwilling or unable to take it. The tube through which the food is introduced may be passed through either the nose or the mouth. Usually the co-operation of the patient is not sufficient to make the latter route practicable. A nasal tube is therefore more frequently used. This is similar to a stomach tube, but of somewhat smaller diameter. Tube-feeding is not without danger and should never be undertaken except in the presence and under the direction of a physician. In most hospitals the rules direct that tube-feeding be given only by a doctor. Death from pneumonia or from gangrene of a lung occasionally results, due to the fact that during tube-feeding a particle of food has passed through the larynx and trachea into a bronchus.

Food for Tube-Feeding. In preparing the food for tube-feeding, substances should be included which will provide a properly bal-

anced diet of protein, fat, and carbohydrates, also salt and the necessary vitamins. A feeding may consist of 24 ounces of whole milk or malted milk, ½ ounce of butter, two eggs, and 1½ ounces of sugar. Apple sauce, thin cereals, mashed potatoes, and thin vegetable soups may be added to the feeding. One feeding a day should include 8 ounces of fruit juice or tomato juice and 1 ounce of cod liver oil. Because of its vitamin B content an ounce of brewers' yeast should be added to another feeding. Laxative or other prescribed drugs also may be added. The patient should never be fed less than twice a day while a third feeding is usually desirable. Frequently when patients are fed but twice a day the feedings are badly spaced, the interval between the morning and afternoon feedings being relatively short with the result that the succeeding interval is unduly long. A patient should receive at least 2,000 calories a day. Sometimes patients attempt to regurgitate the food given. Such patients should lie quietly on their backs for a period after having been fed. Frequently following one experience with tube-feeding, a patient will eat when he finds that preparations are again being made to feed him in this way.

Equipment for Tube-Feeding. The nurse should prepare a large tray on which she should have a quart pitcher containing the food mixture warmed to 98° F., together with the following equipment:

Enamel basin with funneled nasal tube in cracked ice.
Basin of water in which to invert funnel.
Medicine glass containing mineral oil.
Mouth gag made of tongue blade covered with gauze.
Spoon.
Gauze square.
Small pitcher of water.
Draw sheet.
Three face towels.
Gown for physician.

Method of Procedure. During the feeding the patient may lie on a bed in the dorsal position, or may sit upright in a chair (Figures 13 and 14). Usually the former position is preferred. In either case, care should be taken to see that the neck is not extended since in that position there is greatest danger that the tube may enter the larynx. If the patient is resistive two nurses should assist, each holding a forearm to prevent him from seizing the tube. The head may be held by a towel placed across the forehead. The

tube is removed from the ice, dried with a towel, and lubricated with mineral oil applied with a gauze square. It is then introduced into the nares and passed directly backward—not upward. It will frequently be found that because of a deviated septum the tube is passed more easily through one nostril than the other. Sometimes



FIG. 13: GAVAGE WITH PATIENT IN A SITTING POSITION.

The patient is draped with a sheet, and a towel surrounds her head. The nurse holds the patient while the doctor passes the tube. The nurse holds the pitcher containing the food mixture.

as the tube enters the pharynx it is forced forward and curled up in the mouth. In such a case it must be nearly withdrawn and again passed. Most tubes bear a black ring indicating the distance (18 inches) to which they must be passed before the stomach is reached. When this mark has been reached, the funnel of the tube is inverted in the basin of water. If air bubbles appear the tube is immediately removed since the bubbles indicate that the tube has entered the trachea. The funnel is then held 6 or 8 inches above the patient's head, and a few ounces of water are poured into the funnel to clear the tip of mucus. This water, without permitting the tube to become empty, is followed immediately by the

feeding. After all of the food has been given, it is well to withdraw the tube an inch or two and pour in a little water to remove any bits of food remaining near the end of the tube. The tube is then pinched to prevent dripping of any food as the end passes over the larynx. At the same time the tube is quickly with-

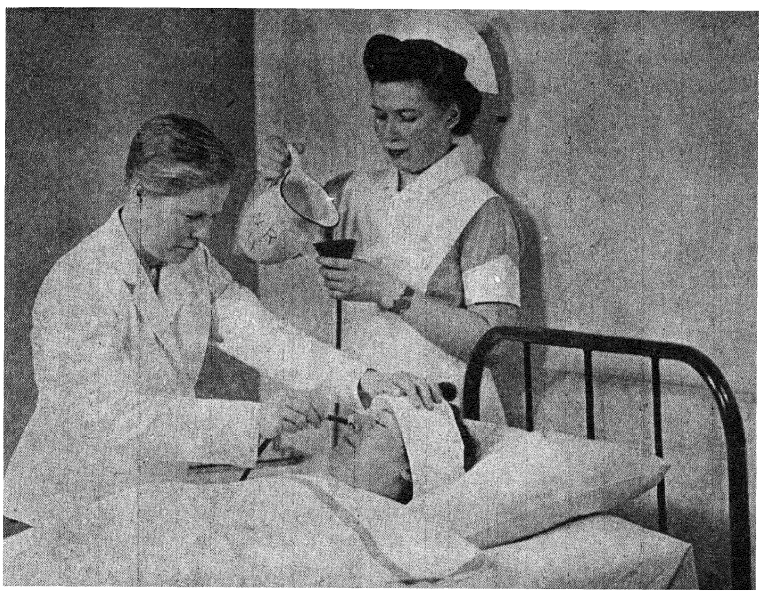


FIG. 14: GAVAGE WITH PATIENT LYING IN BED.

Note the towels draped over the chest and the head. (Equipment on the bedside table is not shown.)

drawn, surrounding it with a towel as it is removed. The patient's face is wiped and he is encouraged to remain quiet for twenty minutes, thus lessening any tendency to regurgitate.

Care of Tube. After the feeding is completed cold water should be run through the tube, which is then washed in soap and hot water, rinsed thoroughly, and boiled for three minutes in the water sterilizer. After having been held up to drain while still hot it is wrapped in a clean towel and stored for further use.

SPINAL PUNCTURE

Cerebrospinal Fluid. The cerebrospinal fluid is a clear, colorless fluid secreted within the brain. It fills the ventricles of the

brain, which is also surrounded by a thin water jacket of this fluid. It also fills the space between the spinal cord and its meningeal coverings. Frequently the physician desires to secure a specimen of cerebrospinal fluid for examination, or to relieve pressure in certain diseases. This is done by inserting a hollow needle between the lumbar vertebrae into the space occupied by this fluid just below the end of the spinal cord. The introduction of a hollow needle into this space is known as spinal or lumbar puncture. The normal pressure in the fluid varies between 80 and 150 mm. of water.

Equipment for Lumbar Puncture. A tray set up with aseptic technique should contain the following:

18-gauge, 3-inch spinal needles.
22-gauge, 3½-inch spinal needles.
One glass water manometer.
One rubber tube for attaching needle to manometer.
One pair forceps.
Three sterile towels.
Six cotton balls.
Six gauze flats.
Two mounted applicators (to apply cotton and collodion to puncture wound).
Gloves.
Three test tubes.
Two medicine glasses.

There should also be a preparation tray containing:

Two sterile test tubes each containing a cotton applicator which has been immersed in iodine.
Two sterile test tubes each containing a cotton applicator which has been immersed in alcohol.
Small bottle of collodion.
Tube of ethyl chloride.
Emesis basin.

Method of Procedure. Lumbar puncture may be performed in either the sitting or recumbent position. If the former position is used, the patient sits on the operating table, back to the operator, with feet on a chair in front of him. He clasps his hands about his knees with head down, thus arching the back and enlarging the intervertebral spaces through which the needle is to be inserted. If the puncture is to be performed with the patient lying, he is placed on his side near the edge of the table or bed. If the pressure of the spinal fluid is desired, the recumbent position is employed.

If the patient is in bed, a board should be placed between the mattress and springs to prevent the mattress from sagging in the center. If the recumbent position is employed, the patient will draw up his knees as far as possible and flex his head far downward. In either position the lumbar region is sterilized with iodine and alcohol and draped with sterile towels. The nurse will assure the patient that the operation is not the ordeal usually expected. The operator palpates the spinous processes and interspaces of the lumbar vertebrae and selects either the third or fourth lumbar interspace. He indicates the point selected which the nurse sprays with ethyl chloride (some physicians prefer to inject novocain), after having told the patient that the spray will feel cold on his back. The first 10 drops of fluid are usually discarded and then 10 cc. are collected in a sterile tube and sent to the laboratory for the following routine examinations: Wassermann test, protein content, cell count, and colloidal gold curve. Other special examinations are done as requested by physician. The site of the puncture is sealed with cotton and collodion, or covered with sterile gauze and adhesive. For twenty-four hours after the puncture the patient should lie on his back without a pillow. If headache is severe he may receive 1 cc. of pituitrin intramuscularly. Diet for the remainder of the day should usually be liquid.

Pneumoencephalography

Pneumoencephalography is a procedure in which cerebrospinal fluid is removed by lumbar puncture and replaced by air. Air, being lighter than the fluid displaced, rises and spreads over the surface of the brain and into its ventricles. Since air is of different density than the brain and the cerebrospinal fluid, any abnormalities in the contour of the brain surface and the ventricles will be demonstrated by an x-ray of the head taken when the areas formerly occupied by cerebrospinal fluid are filled with air.

Equipment for Pneumoencephalography. In addition to the equipment required for lumbar puncture, the nurse should have the following:

Two two-way adapters (sterile) for needle, manometer, and syringe.
Hypodermic syringes and needles (sterile).
One 20-cc. Luer syringe (sterile).
One ample caffeine sodium benzoate (7½ grains).
Sphygmomanometer.

Preparation of the Patient. The patient receives a cleansing enema on the evening preceding the operation and is given no food or liquids after 9 P.M. On the morning of the operation he receives no breakfast and is given enemata until the return is clear Three grains of sodium amytal are given hypodermically and repeated one hour later. Many physicians also give ½ grain of codeine hypodermically shortly before operation. In children the operation is performed under a general anesthetic.

Method of Procedure. The patient is supported in a sitting position, the spinal needle inserted, and the pressure taken. If the manometer shows a pressure of over 400 mm. of water, the operation is not continued. It cannot be performed if spinal block exists. As each 5 or 10 cc. of fluid are removed, a similar quantity of air is injected through the Luer syringe. The withdrawal and injection are continued until 80 to 100 cc. of fluid and air are interchanged. The patient is then wrapped in warm blankets, kept in a sitting position, and taken to the x-ray department in a wheel chair. During the procedure blood pressure and pulse are taken every five minutes. Should blood pressure drop markedly or the pulse become rapid and thready the patient should receive sodium benzoate hypodermically. When the patient is returned to his ward he is placed flat on his back with no pillow and the foot of the bed elevated slightly. He must not raise his head and is kept in bed for three days, receiving liquid for the first twelve hours. Headache will be relieved by an ice bag to the head and codeine by mouth.

ELECTROENCEPHALOGRAPHY

The principle of the electroencephalograph is discussed in Chapter XV. It is used not only as a means of diagnosis in suspected epilepsy, but in the localization of brain tumors and other organic lesions. The instrument consists of three parts: a receiver, an amplifier, and a recorder. The number of electrodes used with it is dependent on the number of channels with which it is provided. In a three-channel machine six electrodes are applied, three to each side of the head, or one to each frontal, parietal, and occipital region. In addition to these six a neutral electrode is placed on the vertex of the head. The hair is parted at each spot where an electrode is to be applied so as to expose as much scalp as possible. The scalp in the areas selected for the application of the electrodes

is cleaned with acetone and a bit of electroencephalographic paste is then rubbed onto these areas. A flat solder disk, 5 to 10 mm. in diameter, fused to the end of an enamel wire forms the electrode. The disks are placed firmly on the paste areas of the scalp and sealed to the scalp with collodion, which can be applied with a medicine dropper. The other ends of the wires are connected with the receiving apparatus. Electrodes may be removed with acetone.

The procedure, which is completely painless and harmless, is carried out in a room furnished merely with the machine, a couch for the patient, and a chair each for the nurse and the operator. The room should be free from interference by motors, diathermy machines, and similar electrical devices. If there is a telephone in the room it should be disconnected for the period of the treatment. The couch on which the patient lies is enclosed by a screen made of copper to eliminate chance electrical interference. All distracting elements should be excluded, and the patient must be thoroughly relaxed with eyes closed and turned away from sources of light. A "Do not disturb" sign should be placed on the outside of the door. One of the principal functions of the nurse is to reassure the patient as to the harmless nature of the examination so that he may react as normally as possible. Even such slight activities as chewing or grimacing by the patient may produce marked variations in the type of waves.

Insulin Shock Treatment

This is a form of treatment which was developed by Dr. Manfred Sakel in Vienna and since 1936 has been extensively used in the treatment of schizophrenia. The best results are secured with patients who have not been ill for more than one year. Observations over a period of several years concerning the results of this treatment show that recoveries in insulin treated cases are more numerous and more immediate than in those treated by other methods, although relapses are slightly more frequent. Most physicians prefer to secure written permission from the patient's relatives before employing this form of shock treatment. In this treatment very large doses of insulin are given with the result that the blood sugar is lowered. How hypoglycemia (hypoglycemia means low blood sugar) may produce improvement in schizophrenia has not been discovered. It is known, however, that glucose is the food from which the brain receives its nourishment and that

when the brain is deprived of this nourishment a state of unconsciousness accompanied by symptoms of shock follows. The symptoms of insulin or hypoglycemic shock are relieved by giving the patient glucose, thereby increasing his blood sugar.

Contents of the insulin tray

Sterile section:
- One 50 cc. syringe for intravenous dextrose.
- One 10 cc. syringe for intravenous dextrose.
- One insulin syringe and needles.
- Two 2 cc. hypodermic syringes.
- Three hypodermic needles.
- Six intravenous needles of assorted sizes.
- One pair of forceps.

Nonsterile section:
- Two ampules of 50 per cent intravenous glucose.
- Ampules of Unit 80 insulin.
- Two ampules each of coramine, pituitrin, caffeine and sodium benzoate, and adrenalin chloride (1–1000).
- Atropine sulphate, hypodermic tablets (1/150 grain).
- Blue litmus paper.
- Aspirating syringe.
- Bowl of ice with nasal tube.
- Karo syrup or/and oral glucose as specified by physician.
- K Y jelly.
- Mouth gag.
- Tongue forceps.
- Tongue blades.
- Tourniquet.
- Emesis basin.
- Bottle of alcohol.
- Sponges for hypodermics.
- Stethoscope and sphygmomanometer.
- Thermometer.
- Record sheets.

Preparation of the Patient. The patient to receive insulin treatment has no breakfast and is brought to the insulin ward between 7 and 8 A.M., placed in bed, and given a deep intramuscular injection of 10 to 20 units of Unit 80 insulin. Before being brought to the insulin ward the patient voids, and dentures and glasses are removed. The dose of insulin is increased daily by 5 to 10 units until a dose sufficient to produce definite symptoms of shock is reached. The shock dose varies in individuals and even from day to day in the same person, but is usually from 60 to 80 units. From 25 to 60 shocks are given.

Care during Treatment. After the insulin has been given the ward is darkened, made as quiet as possible, and the patient encouraged to rest. At first the patient is quiet and drowsy, but after two or three hours the following signs of shock begin to appear: flushing of the face, profuse perspiration, salivation, hunger, slurred speech, confusion, apprehensive restlessness (sometimes extreme and difficult to control), a panicky demand for food, followed by coma. The nurse must learn to distinguish between sleep and a real coma which may at times develop rapidly. Coma can be recognized by pinpoint pupils, which do not react to light, and by the absence of the corneal reflex. The latter may be tested by lightly touching the cornea with a cotton applicator. During the entire treatment the nurse must be most alert and observant. Symptoms are charted as they appear, and especially the exact time at which coma occurs. She will record remarks and behavior of the patient throughout the treatment, and also note the "wet" or "dry" phases. Temperature, pulse, and respiration should be recorded every fifteen minutes. Any marked variations from previous readings of these functions should be reported at once to the physician, as should respiratory difficulty, cyanosis, pallor, very low temperature, strabismus, nystagmus, fibrillary muscular twitchings, or convulsions. He should be notified immediately should the pulse rate fall below 40 or rise above 120. Because of the extreme perspiration the mattress and pillow should be protected by rubber. Salivation may be so great as to threaten drowning. Usually serious danger from this source can be prevented by turning the patient on his side or abdomen. With excited patients crib sides or canvas sides to the bed are desirable. Ankle and wrist restraints are sometimes necessary.

Uncomplicated comatose wet shock may continue for two to three hours, provided the total period of hypoglycemia does not exceed six hours. The shock is terminated by increasing the blood sugar. Many patients can be persuaded to drink a glucose solution. The nurse will therefore have at hand a mixture of glucose and syrup consisting of 50 cc. of corn syrup to which has been added 1 gm. of glucose for each unit of insulin which has been given. Sufficient water is added to make a solution suitable for gavage or for drinking. If the patient is able to drink the solution, lemon juice may be added to make it more palatable. Sodium chloride may be added to replace the body's loss of salt content through perspiration. If

the patient cannot swallow, the solution is given by a nasal feeding tube, great care being taken to make sure the tube is in the stomach and not in the trachea. This may be tested by aspirating a small amount of stomach contents and testing for acid with blue litmus paper. After having received the sugar solution by stomach the patient should wake within twenty to thirty minutes. When quick interruption of the coma is necessary, 15 to 30 cc. of 50 per cent glucose solution are given intravenously. This should bring the patient to full consciousness in one to five minutes. When this method of terminating shock is used, additional sugar should be given by mouth lest "after-shock," or recurrence of hypoglycemia, takes place. In case of difficult arousal the physician may prescribe adrenalin in doses of 1 to 2 cc. of a 1–1000 solution.

At times persistent vomiting may be a serious complication. In treating vomiting, the nurse will apply a hot water bag to the abdomen, give moderate amounts of glucose intravenously and small, repeated amounts of sugar by mouth. In after-shock a patient who has emerged from the shock after the administration of glucose and other forms of sugar relapses suddenly into unconsciousness within the next twenty-four hours. The onset of after-shock may be at night following the treatment of the previous day. The nurse may suddenly discover that the patient is cold and sweating profusely and that attempts to arouse him are unsuccessful. Treatment consists of the immediate administration of a glucose and sugar solution through a nasal tube. In another complication—prolonged coma—the coma continues in spite of the usual administration of glucose and the presence of a normal amount of blood sugar. Tube-feedings rich in carbohydrates are employed in the event of prolonged coma. Coma continuing beyond a few hours may be very dangerous.

After the conclusion of the usual treatment bedclothes and gown, damp from the excessive perspiration, are removed, and after the patient has been sponged with alcohol, are replaced by fresh linen. Hot water bottles are placed about him since his temperature is usually low. At noon the patient may receive the same meal as do other patients, but it is important that he eat freely lest delayed coma occur. About 2:30 P.M. he is served a lunch of milk and sandwiches or cake. After the lunch the patient may be allowed up and may engage in recreation or occupational therapy. At 8 P.M. he will receive a glass of orange juice and two or three

cookies. During and after the shock, great care is taken not to disturb the patient by tactless word or deed.

On at least every seventh day all treatment is omitted. The entire period of treatment is usually from six to eight weeks.

Metrazol Shock Treatment

A form of therapy much less widely used since the introduction of electric shock therapy is the production of convulsions by metrazol. Before beginning this form of treatment the physician secures written consent from the nearest responsible relative and makes a careful physical examination, including electrocardiographic examination, an x-ray of the lungs, a blood count, blood chemistry, and urinalysis. Treatments are given two or three times a week, the patient having no breakfast on treatment days. An occasional complication of metrazol treatment is the fracture, either of vertebrae or of long bones, or the production of dislocations, by the violent muscular contractions that accompany the convulsions produced by metrazol. As a means of preventing these accidents some physicians employ curare in the form of Intocostrin. This drug paralyzes the junction of nerve and muscle and thus prevents the violent muscular contractions that sometimes result in fractures and dislocations. Since curare paralyzes also the muscles of respiration, physostigmine, in the form of prostigmine, is usually used with it.

Equipment for Metrazol Shock Treatment

10 per cent sterile solution of metrazol.
10 cc. syringe with 20-gauge intravenous needles, sterile.
Ampules of coramine, adrenalin chloride (1–1000), Intocostrin, prostigmine (1–2000).
Three 2-cc. hypodermic syringes and needles, sterile.
Tourniquet.
Alcohol.
Sponges.
Mouth gag (well padded tongue blade).
Emesis basin.
Pillow for patient's back.

Method of Procedure. It is preferable that during the treatment the patient occupy a room apart from other patients so that they may not be frightened by his reactions. Since the patient is usually apprehensive the nurse will encourage and reassure him. All rings, dentures, hairpins, etc., should be removed and the cushion placed

under the thoracic spine. Metrazol must be given intravenously and the injection made quickly. The usual dose is 4 cc. of the 10 per cent solution. Within thirty seconds after the injection the patient's eyelids begin to quiver, the face becomes pale, and he appears greatly frightened. After the seizure the patient will often state that immediately following the injection he felt as if he were about to die. As the face becomes pale the patient loses consciousness and a typical convulsion occurs. Just after consciousness is lost the patient usually opens his mouth. The mouth gag is then placed between the jaws. Because of the danger of dislocation of the lower jaw, pressure by hand or by binder should be applied to the chin when the jaws open. The patient's arms will be held at his side to prevent dislocation of the shoulder. At the same time the shoulders and pelvis are held firmly but not rigidly on the bed.

If curare is also used this is administered before the metrazol. Curare is commonly in the form of a preparation known as Intocostrin, each cubic centimeter of which contains 20 mg. of curare. The dosage is usually measured in terms of 1 mg. to 1 Kg. of the patient's weight. Thus a patient weighing 150 pounds would receive approximately 70 mg. or a little over 3 cc. of Intocostrin. This is injected intravenously and slowly, one to two minutes being taken for the injection. The metrazol is given about two minutes after having completed this injection.

Following his convulsion the patient passes into a brief comalike sleep, after which he is confused and should be permitted to rest and sleep if he desires. Since during his seizure the patient is often incontinent, a change of linen may be necessary. After two hours the patient may return to his own ward and be permitted a light breakfast if desired. He should remain under constant observation for the remainder of the day. Some patients show improvement after three or four treatments. Unless improvement has taken place after twenty seizures it is not to be expected.

Electroshock Therapy

The most recent form of shock treatment is the electroshock therapy introduced in Italy in 1938 and first used in this country in 1940. The object of electroshock therapy is to produce a convulsive seizure similar to a grand mal attack. While often employed in other disorders the greatest value seems to be in cases of depression, especially in involutional melancholia. The apparatus

used is a device for regulating the strength and duration of current applied to the patient's head from the ordinary 110-volt alternating current used in lighting. The voltage to be used is controlled by a variable transformer within the apparatus and is usually from 60 to 150 volts. The duration of application can also be controlled, the usual period being from 0.2 to 0.5 second. The combined voltage and time settings constitute the "dose," which is usually from 400 to 600 milliamperes. In addition to the alternating circuit for producing the shock, there is also another for direct or galvanic current for measuring the resistance of the patient's head.

In order to determine if the physical condition of the patient is such that he can safely be subjected to the relatively few dangers that accompany this treatment, the physician not only makes the ordinary physical and laboratory examinations, but also takes an electrocardiogram, an x-ray of the lungs, and an x-ray of the spine to make sure no bone defects are present before treatment.

Equipment for Electroshock Treatment (Figure 15)

The electric apparatus, placed on a bedside table, insulated with a rubber sheet.

Bed, placed on rubber sheets, the springs being covered with a rubber sheet. Some operators prefer to use a large wooden table.

Mattress, covered with rubber sheet; bed is then properly made.

Small hair pillow for small of back.

Electrode jelly.

Hypodermic tray with stimulants as ordered.

Padded tongue depressors.

Oxygen tank and equipment for administration of oxygen.

Preparation of the Patient. The patient is given an enema on the evening preceding the treatment. On the morning of the treatment he receives no breakfast although some physicians permit a cup of black coffee. The patient should receive no sedatives within twelve hours preceding the treatment since they may abort the seizure. Before going to the treatment unit he is encouraged to void. The treatment is given about 8 or 9 o'clock shortly before which the patient is taken to the treatment room dressed in pajamas and bathrobe. The nurse removes glasses, dentures, and bridgework, and makes certain that there is no gum or other material in the patient's mouth. If the patient is a woman, all hairpins are removed. A firm pillow is placed under the small of the back. Since the patient may be incontinent during the seizure,

the bed or table should be protected and extra pajamas and bathrobe be at hand. The patient's temples are rubbed briskly with electrode jelly to diminish the local resistance and hence lower the convulsive threshold. If, as is the practice of some physicians, the patient is to be curarized, Intocostrin is given at this point. The

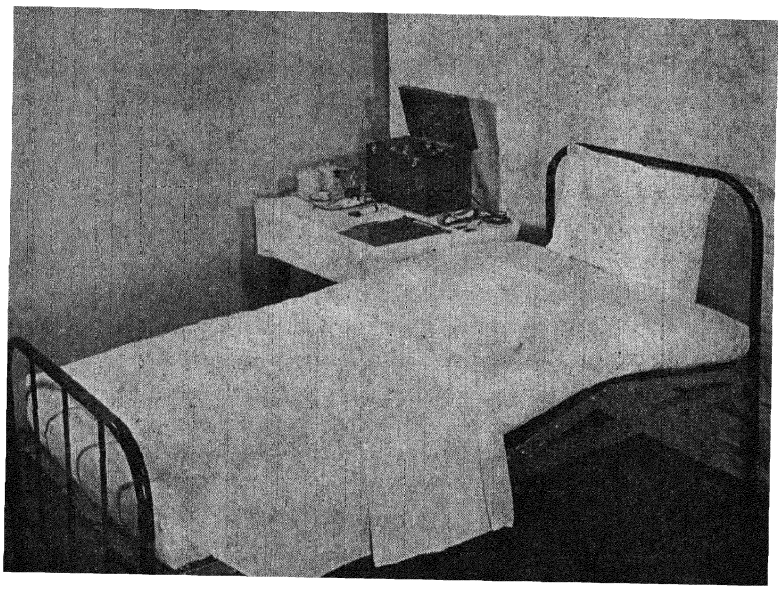


FIG. 15: ELECTROSHOCK THERAPY—BED AND EQUIPMENT.
On the left is a table with the electroshock apparatus, the emergency tray, the tube of electrode jelly, and the patient's chart.

electrodes are applied to the temples and the resistance of the patient's head is measured on the ohmmeter by means of the galvanic circuit. The resistance may vary from 100 to 1000 ohms. A resistance higher than 600 ohms means the contact is poor and that more electrode paste should be rubbed in. A nurse on each side of the patient presses gently but firmly against each shoulder with one hand and keeps the patient's arm flexed across his chest with the other hand (Figure 16). A third nurse will control the thighs. Too strong pressure on the thighs has been known to cause thrombosis of the femoral vein. A padded tongue depressor is placed between the teeth to prevent injury to the tongue and lips. The physi-

cian adjusts the machine to the desired voltage and turns on the current. The patient loses consciousness instantly. In most instances a convulsion follows immediately, although occasionally it is delayed five to thirty seconds. One of three reactions may



FIG. 16: ELECTROSHOCK THERAPY—TREATMENT.

The doctor applies the current, and one nurse holds the shoulders and another nurse holds the knees of the patient. Some physicians prefer that there be a nurse to hold each arm and shoulder, one to hold the pelvis, and one to hold each leg.

occur: (a) a blank reaction or no reaction, (b) a petit mal or abortive seizure, and (c) a grand mal or true convulsion. When either of the first two reactions occurs the "dose" is increased and the patient reshocked before consciousness returns. If a true convulsion occurs, there is a tonic spasm preceded, perhaps, by an outcry. The patient turns pale, the pupils dilate, and the eyes turn upward. The trunk, arms, legs, and hands are in half-flexed spasms for about ten seconds. Breathing stops and the patient grows cyanotic. This tonic phase is followed by a clonic one lasting from

one-half to one minute. There may be frothing at the mouth and loss of sphincter control. Muscular relaxation occurs followed by stertorous respiration, and the patient is stuporous for about five minutes. He then begins to make aimless movements and look about in a confused way. For another five minutes he may respond slowly to questions but usually with incoherent speech. At the end of this time he is usually clear but has no recollection of the treatment. If left undisturbed he may sleep for an hour or more.

During the clonic phase the nurses, in order to prevent fractures or dislocations, will resist the more violent movements of the patient. At the end of the clonic phase the padded tongue depressor is removed. The patient is rolled on his side to prevent inhalation of saliva. If he has been incontinent he should be cleaned before he regains consciousness. During his period of confusion the patient may be very restless, toss about, and shout loudly. This usually lasts for only a few seconds or few minutes, but occasionally continues for several hours in which case sedative packs are advisable.

At times the interruption of respiration is a cause for apprehension. Usually breathing begins spontaneously a few seconds after the convulsive movements subside. If breathing is delayed various maneuvers will stimulate it, e.g., turning the head from side to side or raising the chin. If clenched teeth and collapsed tongue interfere with respiration, the handle of an ordinary spoon may be used to depress the base of the tongue and bring it forward. Occasionally no respiratory efforts are made and the face presents extreme cyanosis or livid pallor. The patient should then be placed face downward and the prone (Schaefer) method of artificial respiration be begun at once.

Electroshock therapy has largely superseded metrazol treatment because of its greater ease of application, the lesser cost, the reduced danger of fracture and dislocation, and the absence of the extremely unpleasant feeling of terror and even of impending death experienced by the metrazol patient in the interval between receipt of the injection of the drug and the loss of consciousness. The patient receiving electric shock has no unpleasant memory of the experience. Often, however, electroshock treatment is accompanied by a persistent loss of memory. Patients complain that they forget more easily and may be distressed that they cannot remember such familiar things as the names of friends. This usually disappears within a few weeks after the termination of treatment.

Electroshock treatments are given three times a week. Improvement is rare before three or four treatments. If evidence of it is not manifest after twenty treatments, further ones are usually not attempted.

One of the most important functions of the nurse in this form of shock treatment is to encourage and reassure the patient, to present an optimistic attitude, and to allay his worry over his loss of memory. She should discover the nature of the patient's interests and should stimulate them, and should encourage participation in occupational therapy and recreation.

Prefrontal Lobotomy

Prefrontal lobotomy is a surgical procedure sometimes employed in chronic forms of mental disorder that have not yielded to other methods of treatment, and where there is no longer reasonable hope of spontaneous recovery. Its chief value is in cases of prolonged agitated depression, but it is sometimes used in chronic schizophrenia and serious psychoneuroses. The operation consists of making an incision into the anterior part of both frontal lobes of the brain. This incision cuts nerve fibers connecting the frontal lobes and a large group of cells located at the base of the brain and known as the optic thalamus. No one knows why this operation is sometimes followed by improvement, but it has been suggested that it cuts the link between emotion and imagination. The operation does not impair the patient's intelligence, but there is a change in his personality and he has no concern for the future. He is usually friendly and good-natured but has no ambition and is indifferent to the opinion of others. A few patients improve to a degree such that they can carry on useful work but usually only to the extent that they can be cared for at home or that their institutional behavior is improved.

Psychiatric Nursing Care Following Lobotomy. The operation is performed in a well organized surgical clinic. The duties of the psychiatric nurse do not begin therefore until after the operation. Following the operation most patients are apathetic and inactive, often in contrast to the agitated restlessness they showed before operation. Some are active, talk loudly, beat on their trays, or wander about the hall. Most patients soil themselves and must be trained to go to the toilet. If the patient goes home the nurse must make every effort to stimulate him to overcome his inertia. Unless

prompted he may, for example, consume several hours in taking his bath. Dressing and undressing are other tasks in which the nurse must admonish, urge, and perhaps assist. He will need guidance in his table manners and is apt to overeat. Occupation must be encouraged and an effort be made to get the patient to do things for himself, otherwise he will sit with hands in his lap and "watch the snails whiz by." Many patients delight in such simple pleasures as movies and the radio, and in observing activities and movements on the street. If possible, more and more responsibility should be thrust upon the patient who often, unfortunately, must continue to be treated like an overgrown child.

Fever Therapy: Induction of Fever by Malaria

Fever therapy is a term applied to all forms of purposeful production of fever for the treatment of disease. Practically the only disease which the psychiatric nurse will be called upon to assist in treating by fever therapy is general paresis. Fever may be induced by inoculating the patient with a fever-producing infection, usually malaria; by injections of a foreign protein such as typhoid vaccine; or by the use of various physical devices such as a hot humified air cabinet in which the patient is placed and his temperature elevated to the degree desired. Regardless of the type of fever to be employed, the physician first makes careful physical and laboratory examinations to determine if the patient is able to withstand repeated high rises of temperature.

Before infecting the patient with malaria the physician will carefully examine him to determine if he is physically able to withstand the stress of a long and severe infection. The malaria organism used for inoculating the patient to be treated is secured from another person already suffering from the disease. The infection may be transferred from one patient to another either by the transfusion of blood from a malarious donor to the recipient or through the bite of infected mosquitoes. The former method is the one ordinarily used, the infected blood being secured from another patient who is receiving the malaria treatment. It is necessary to be sure that the malaria organism is either of the quartan or of the benign tertian type. When the donor and recipient are in the same ward, fresh whole blood is used. The patients are placed side by side, a needle is inserted into the vein of the donor, 5 to 10 cc. of blood are drawn, the needle is changed for another sterile one, and the blood is quickly injected into a vein of the recipient before it has

time to clot. When no malaria donor is available, infected blood to which sodium citrate has been added to prevent clotting may be shipped to a distant point. In using citrated blood the vial is warmed to body temperature, shaken thoroughly, the cap sterilized with iodine and alcohol, the needle plunged through the cap, and the blood then drawn into the syringe and injected into the vein of the patient. In about one week in tertian malaria and from ten to thirty days in quartan malaria the patient begins to develop paroxysms of chills and fever. Usually the patient is allowed to have twenty paroxysms if it is believed he can withstand this amount of treatment. If a full course cannot be borne at one time, the infection is temporarily aborted by one dose of 10 grains of quinine. This will result in an afebrile period of seven to ten days.

Nursing Care of the Malarious Patient. Once the patient has been inoculated with malaria he should receive the best of attention. He should be put on a high vitamin and high caloric diet. Following the inoculation the patient's temperature should be taken three or four times daily until the appearance of chills, after which it should be taken every three hours. With the appearance of fever the patient should be confined to bed and his pulse, temperature, and general condition watched closely in order that, if necessary, the malaria may be checked and additional stimulants given. As in all infectious fevers the patient should receive abundant fluids and a liquid or semiliquid diet. During the chill he will require additional blankets and a hot water bag. As the paroxysmal fever subsides, the patient perspires excessively. After perspiration has ceased the patient is bathed and rubbed with alcohol. Because of the large amount of body chlorides lost with the excessive perspiration the physician may order sodium chloride by mouth. If the patient is robust, he may be permitted to have ten to fifteen paroxysms, but if they are not borne well they must be promptly terminated. If the malaria causes acutely dangerous symptoms, it may be checked at once by the intravenous injection of 10 grains of a 20 per cent solution of quinine dihydrochloride. Since the symptoms may indicate danger, the nurse should at once notify the physician if the patient's temperature is excessively high, if he becomes weak or pale, or if the systolic blood pressure falls below 90. If the patient's condition has permitted the desired number of paroxysms, the malaria plasmodia may be destroyed by the administration of quinine hydrochloride. The patient receives 10 grains every four hours for three days followed by 10 grains a day for four weeks.

Malaria may also be checked by atabrine (1½ grains), three times a day for five days. Patients with therapeutic malaria should be kept on screened wards.

Improvement following malaria therapy may appear within a few weeks although more frequently no improvement is noted until three to six months after termination of the malaria. Approximately 35 per cent of patients treated by this method recover or improve to a degree that they become self-supporting; 35 per cent show moderate improvement; and 30 per cent die within the first five years following inoculation. About one half of the patients treated by malaria return to the community. It is usually considered desirable to follow malaria with weekly injections of tryparsamide or bismuth until the spinal fluid becomes normal. The method by which malaria produces improvement is uncertain. The improvement is probably not because the spirochetes are killed by the fever, but in part, at least, because the defensive mechanisms of the body are strengthened.

Fever Therapy: Typhoid Vaccine Therapy

A second form of fever therapy occasionally used when a potent strain of malaria is not obtainable, if the patient is resistant to malaria, or if the institution does not have equipment or personnel trained in the use of a vapor cabinet, is inoculation with typhoid vaccine. This form of treatment is based on the fact that the introduction of a foreign protein into the body is followed by the production of fever.

Method of Procedure. The procedure often followed in typhoid vaccine therapy is as follows:

1. The first treatment consists of the intravenous injection of 1 cc. of a diluted suspension of killed typhoid bacilli (200 million bacilli per 1 cc.).
2. For accuracy of administration a tuberculin syringe is used.
3. The patient should be closely observed and symptoms and temperature be fully charted.
4. Treatments may be given every other day. Twelve to fifteen elevations above 103° F. constitute a course.
5. The dose of vaccine is gradually increased. Subsequent doses should not be more than 20 million bacilli greater than the preceding one. Later, if the patient is refractory to treatment and no untoward reactions have occurred, the dose may be increased 100 million each time.

6. If following the initial dose on any day the temperature does not rise above 103° F., the dose may be repeated at the end of two hours. Not more than two injections should be given in one day.

7. When the chill begins the patient should be covered with blankets and hot water bottles be placed outside the bottom blanket.

8. The drinking of iced physiological salt solution and of other liquids should be urged.

9. Any untoward symptoms usually resemble shock and should be treated as such. If they appear the doctor should be notified at once. Blankets and hot water bags should be removed and the patient given a tepid sponge bath.

10. Chemotherapy is continued after the cycle of treatments has been terminated, usually in the form of tryparsamide and of bismuth given for alternating periods.

Fever Therapy: Production of Fever by Physical Means

Fever-Producing Appliances. There are various methods of producing fever by physical means: hot packs, radiant heat cabinets, electric blankets, spray cabinets in which the patient is sprayed with a mist of nebulized hot water, short-wave diathermy, inductothermy, hot humified air cabinets, or a combination of the latter two methods. The hot, humid air, or vapor cabinet, often known as a hypertherm, is frequently used. The cabinet consists of an oblong box containing a rubber mattress and supported on legs at a height convenient to permit the nurse to care for the patient. The top of the cabinet is hinged on one side so that it may be lifted or opened and thus permit the patient to be easily placed on or removed from the bed. When the cover is closed the patient's entire body, with the exception of his head, is enclosed within the cabinet. On each side of the cabinet are doors which move horizontally and permit access to the patient. An electric heating unit located either at the foot of the cabinet or beneath the support of the mattress (which does not occupy the entire width of the cabinet and thus permits circulation of air on both sides of it) heats the air within the cabinet. Located, also, either at the foot of the cabinet or beneath the mattress is a pan of water which, heated by an electric unit beneath it, constantly steams. A fan, located near the heating units, keeps the warm, humified air in circulation throughout the cabinet. A thermostat maintains the air within the cabinet at the temperature desired. Some cabinets have also a humidistat to maintain the vapors at the amount desired. The vapor cabinet is usually

provided with a special rectal thermometer. This may be an electric recording instrument. Two electric fans, one on each side of the patient's head, keep cool air circulating on his face and render him more comfortable.

Condition of the Patient. Before prescribing fever therapy the physician will carefully examine the patient to determine if he will successfully withstand the stress of a somewhat exhausting form of treatment. In addition to the usual physical examination he will doubtless have an x-ray film made of the patient's lungs, take an electrocardiogram, make a complete blood count, have the urine examined, and determine the amount of sugar and of nonprotein nitrogen in the blood. An age of over 50 years, advanced vascular disease, cardiac decompensation, renal or liver insufficiency, tuberculosis, and emaciation associated with late neurosyphilis usually render fever therapy inadvisable.

Preparation of the Patient

1. After it has been decided that the patient will receive fever therapy, he will be placed on a high caloric diet. It is often helpful to give the patient a "trial treatment" in order to acquaint him with the nature of the treatment, gain his confidence, and measure his physiologic response to fever. This treatment, given on the afternoon before the first full application, may consist of about one hour of fever at a somewhat lower temperature level than that used in the regular course of treatments.

2. Evening before each treatment. The evening meal on the day preceding treatment will consist largely of carbohydrates. Before 10 P.M. the patient should receive a soapsuds enema, care being taken to assure that it is effective. After the enema he will receive 8 ounces of sweetened fruit juice. Unless ordered by the physician, the patient will receive no medication after 10 o'clock except a sedative, such as nembutal (1½ grains) or seodormid (5 grains).

3. Morning of each treatment. On treatment mornings the patient will receive no breakfast, but an hour before treatment may have coffee, without cream, and a glass of sweetened fruit juice. He may then be given 500 cc. of 5 per cent glucose in physiologic salt solution injected intravenously. When called for treatment he will receive nembutal (1½ grains), by mouth. Dressed only in a gown and robe he will be taken to the treatment room where he will be weighed and his blood pressure, pulse, and respiration taken. He will then receive 2 cc. adrenal cortex extract hypodermically.

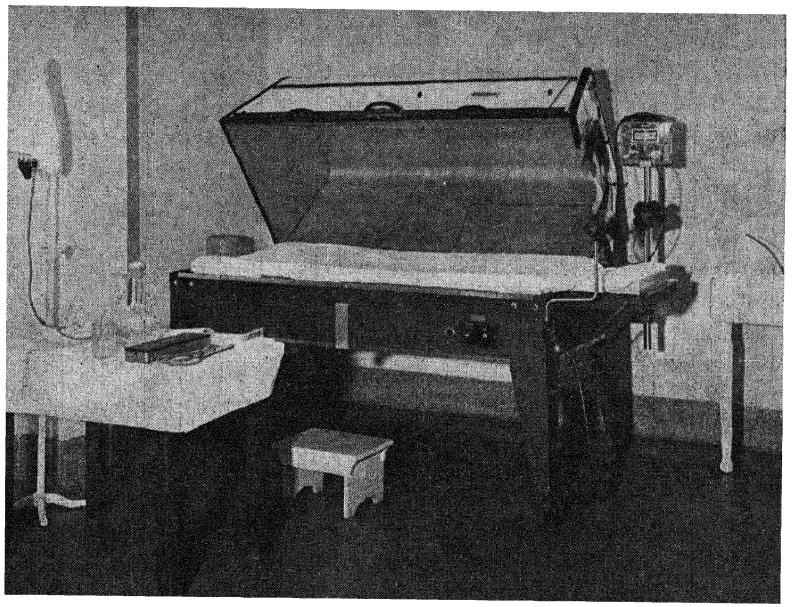


FIG. 17: VAPOR CABINET FEVER THERAPY—CABINET AND EQUIPMENT.

The cabinet is open and ready for use, with the rubber mattress covered with a cotton blanket. At the right is seen the apparatus for recording the temperature continuously. At the left is the table containing the blood pressure apparatus and solutions for emergency equipment. At the left of the vapor cabinet in the rear is an oxygen tank.

Equipment for Fever Therapy (Figure 17)

Vapor cabinet.
Two or more cotton blankets.
Blood pressure apparatus.
Oxygen tank and apparatus for oxygen administration.
Hypodermic tray with morphine sulfate or pantopan, caffein and sodium benzoate, coramine, and adrenal cortex extract.
Intravenous sets, with calcium gluconate solution and a 5 per cent solution of dextrose in physiologic salt solution, both ready for intravenous administration.
Iced physiologic salt solution for oral administration.
Ice bag and a supply of ice.
Rubbing alcohol.
Compress basin.
Chart sheets for graphic record.

Treatment Periods. The period of treatment may be divided into that of induction and that of maintenance. The induction period is that required to raise the patient's temperature to the desired height. The length of the induction period will depend upon the height of fever desired but usually occupies about one hour and forty-five minutes. The fever should not be induced too rapidly. The maintenance period is the length of time the body temperature is maintained at the desired level and will vary from three to six hours, depending largely upon the patient's physical tolerance. The cabinet will be preheated, its current having been turned on sufficiently long before the treatment so that the temperature within the cabinet will have reached 116° F. by the time it is to be used.

Method of Procedure. The cabinet mattress is padded heavily with cotton blankets. Woolen blankets promote burns and cause itching of the skin. The patient's clothing is removed, he is draped with a sheet, placed in the cabinet nude, and the drape sheet removed. In women it is well to place a towel over the breasts to prevent possible blistering of the nipples. The lid is closed and turkish towels are placed around the patient's neck to prevent the escape of heated air from the cabinet. The rectal thermometer is inserted and the temperature recorded graphically every fifteen minutes until the treatment is completed. The blood pressure is recorded at least four times during the treatment. The treatment is attended by fear, fatigue and some danger of collapse and heat stroke.

It is highly desirable that there be a good rapport between nurse and patient. It is often recommended that the nurse experience a fever treatment in order that she may secure a clear understanding of the patient's discomforts and reactions. She must gain the confidence of the patient and adapt herself to his mood. She will discuss subjects that may be of particular interest to him, select desirable radio programs, or perhaps play such phonographic records as may meet his taste. It is usually wise to explain procedures so that he will understand their purpose and co-operate with them. When the patient's temperature is rising there is often a period of restlessness, excitement, and apprehension. The nurse must reassure the patient and tell him that this is only a normal phase which will pass. Throughout the treatment the nurse will watch for extreme fatigue, cyanosis, pallor, or rapid pulse, and will recognize any signs of impending cardiac or respiratory failure, shock, or heat stroke. She will be calm at all times and be ready to act quickly and with good

judgment. She will never leave the patient during the treatment. (See Figures 18 and 19.)

The temperature of the cabinet is maintained at 116° F. until the patient's temperature reaches the desired height, which is usually 106°. The temperature within the cabinet is then gradually lowered

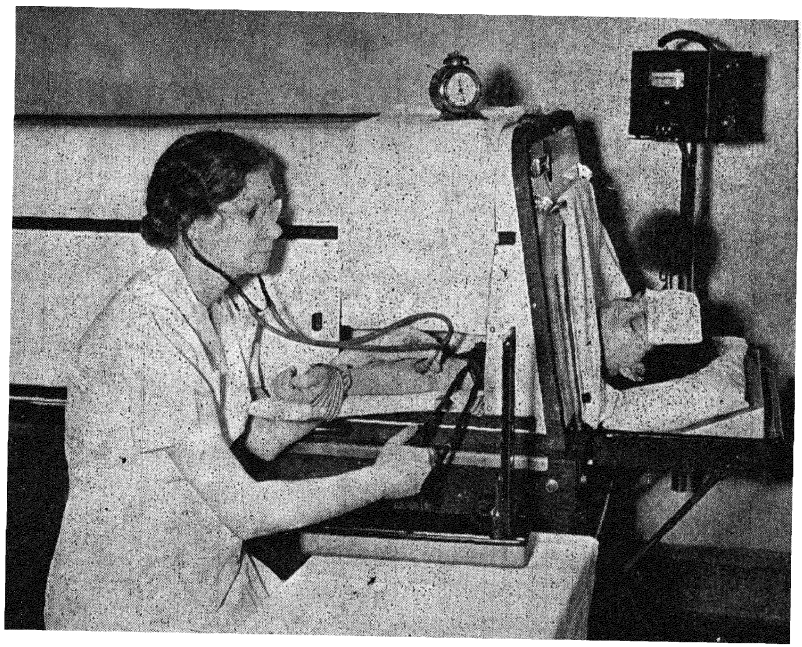


FIG. 18: VAPOR CABINET FEVER THERAPY—PROCEDURE.
The patient is in the vapor cabinet with a compress on her head, and the fans are in motion. The operator is taking the blood pressure.

and so regulated that the patient's temperature may be evenly maintained at 106°. As a rule this can be secured if the cabinet temperature is held at 108°–109° F. When the patient's temperature reaches 105° the electric fans are turned on his face and head and continued throughout the treatment. A cold compress is kept applied to the forehead. The restlessness already described usually appears as the patient's temperature approaches 103°. The assurance of the nurse that he will soon feel better may carry the patient through this stage of apprehension. If this reassurance fails, he may receive morphine sulfate (1/12 grain) hypodermically, but sedatives should not be

repeated oftener than every two or three hours. It is wise to omit sedatives whenever possible. When the patient's temperature reaches 105° F., about 6 ounces of iced physiological salt solution are given every fifteen minutes through a drinking tube. This replaces the chlorides lost in perspiration. If fluids by mouth are tolerated

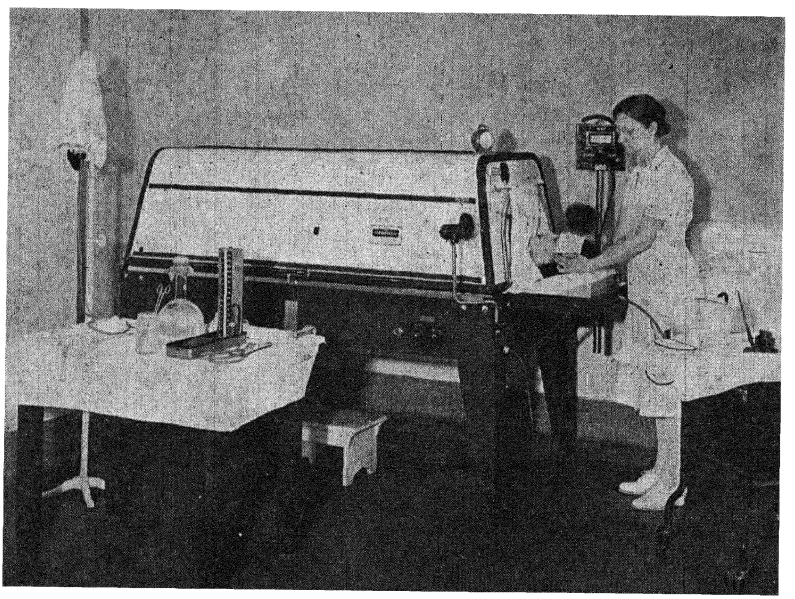


FIG. 19: VAPOR CABINET FEVER THERAPY—PROCEDURE CONTINUED.

The operator is taking temperature, pulse, and respiration. Note the pitcher and glass for giving fluids. The other apparatus is the same as in Figs. 17 and 18.

poorly or if the blood pressure drops below 90 mm. of mercury, 500–1000 cc. of 5 per cent glucose should be given in physiologic salt solution intravenously. This may be given at the elbow through the horizontal door of the cabinet. The intravenous injection of dextrose solution also is one of the best preventives of circulatory collapse. The administration of oxygen for a few minutes at intervals throughout the maintenance period gives the patient a boost. The same is true, too, of the hypodermic injection of adrenal cortex extract (1 cc. every half hour). Stiffness and numbness in the

extremities suggest impending tetany, which is best combatted by 10 cc. of calcium gluconate given intravenously. If a desired physiological equilibrium exists, the pulse and respiration become slower after the maintenance period is reached and the patient may sleep during much of that period. The patient should be moved every fifteen minutes since, if he remains in a position too long, the profuse perspiration will produce tender, erythematous areas on shoulders, buttocks, and hips. Usually oxygen inhalations and an ice bag at the base of the brain will keep a rapid pulse below 160 per minute, but if these measures fail to do so the treatment must be terminated at once. If the patient's temperature rises to 107° F. or more the nurse will notify the physician, open the sliding doors, force liquids, and apply cold cloths to the head and face. If the temperature remains high, the nurse will open the cabinet and apply tepid, wet cloths to chest, axillas, and groins. After tepid sponging a fan may be directed on the nude patient. Ice pads or ice cold sponges should not be used since by contracting the superficial blood vessels they lessen the radiation of heat. If at any time there is doubt concerning the ability of the patient to withstand further treatment, it should be terminated. If he should have convulsions or become unconscious, it must be terminated at once.

At the conclusion of the maintenance period the current is turned off, the lid of the cabinet is raised, and the fans are directed over the patient's body. He is given an alcohol rub and dry cotton blankets are placed under and over him. The blood pressure is taken every hour until the patient's temperature returns to 101° F. and every two hours thereafter until his temperature is normal. The subsidence of the patient's fever requires about one hour. After his temperature has returned to normal the patient receives a cleansing bath and is moved, by stretcher, to his usual bed. He may receive water and fruit juice but no solid food for four hours. It is well to weigh the patient again after treatment so as to secure a rough estimate of the amount of fluid lost during treatment. The patient should be encouraged to take an abundance of liquids after fever therapy since there is always a tendency toward dehydration. Following his treatment the patient should have complete bed rest for at least twelve hours but he may resume his usual activities on the following day. Treatments may safely be given every three days.

The induction of fever by air-conditioned cabinets has now largely supplanted the use of malaria or of foreign proteins.

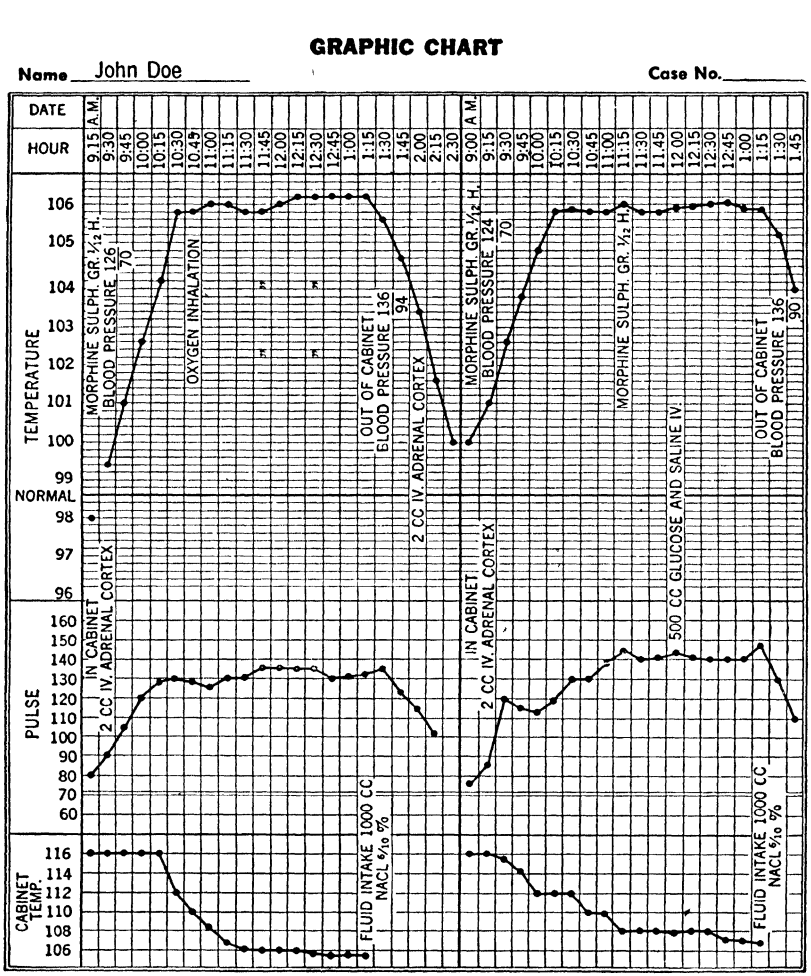


FIG. 20: VAPOR CABINET FEVER THERAPY—PATIENT'S CHART.

The graphic chart shows reactions for the same patient receiving therapy on two different days. The upper curves are the temperature of the patient, the middle curves are the pulse of the patient, and the lower curves are the temperature of the cabinet.

The reactions that occur in fever therapy, and the treatment often prescribed with it, are shown in the chart, Figure 20.

Narcotherapy

The production of a somnolent state through the administration of barbiturates and as a means of treatment in both neuroses and certain forms of psychoses is frequently used. This method is known as narcotherapy, narcosis therapy, or sometimes as narco-analysis. Two forms of narcotherapy are used: temporary or partial, and prolonged.

Temporary Narcotherapy

The temporary form of narcotherapy is used in treating hysterical amnesia, hysterical loss of voice, hysterical paralyses, acute anxiety panic states, and in the war neuroses and anxiety states caused by combat fatigue. It also is used as a means of discovering emotional factors and experiences which have contributed to the patient's mental illness. Through questioning and suggestion by the physician the patient, while in a somnolent state produced by the drug, may revive faded memories and reveal wishes and experiences which had been inhibited or repressed and which, during full consciousness, he would have been reluctant to express. With the information thus secured the physician is able to employ psychotherapy more effectively.

Equipment for Temporary Narcotherapy. This is simple and consists merely of a venipuncture tray with the usual preparation material, sterile distilled water and sodium amytal ampules, 7½ grains each.

Method of Procedure. The patient is placed in bed in a single room free from noise or confusion. He may be told that he will be given medicine that will make him somewhat sleepy, and that in this dozy state the physician will talk with him. A 7½ grain ampule of sodium amytal is diluted in 10 cc. of sterile distilled water. The antecubital fossa is prepared and the drug injected into a vein at the rate of 1 cc. per minute (checked by the second hand of a watch) until the patient begins to let fall an arm that he has been previously instructed to hold upraised, or until he experiences difficulty in counting backward from 100. The patient is also watched for flushing of the face, opening of the eyes, moistening of the lips, or body tension. At these points the injection is stopped. The dosage required will have varied but will usually be between 4 and

7½ grains. Efforts are now made to arouse the patient. Frequently he will act as if awakening from a deep sleep and will answer direct questions and readily discuss his emotional problems. If this reaction does not occur, the injection of the drug is continued slowly until the desired reaction is obtained. If the patient becomes more stuporous, the treatment has been a failure and must be discontinued. After a successful interview of twenty to sixty minutes the patient will become drowsy and will sleep for an hour unless further stimulated. Complications are not likely to occur although some physicians wish to have picrotoxin, an antidote for barbiturates, available.

If the nurse is present during the interview, she will be able to learn something of the factors that have been important in the patient's conflict and thereby secure a deeper understanding of his difficulties. When the patient becomes drowsy at the termination of the interview the doctor may desire him to rest. In other cases he may wish the patient to remain awake. If this is desired the nurse will keep him alert through participation in occupational therapy, recreation, or other interest.

Prolonged Narcotherapy

Prolonged narcotherapy is sometimes used in the treatment of manic-depressive and schizophrenic patients who are actively disturbed. The patient is kept in a deeply somnolent state for fifteen to twenty hours daily for four to twenty days. The manner in which prolonged narcotherapy produces improvement is somewhat uncertain, but it seems to suppress the psychotic manifestations, at least temporarily, and to permit normality to break through. It is the hope of the psychiatrist that, with the help of the physicians and nurses upon whom the patient, during the treatment, is thrown into dependent relationship, the temporary normality may become fixed. During the waking intervals the treatment renders the patient more accessible to psychotherapeutic efforts and seems to enable him to reveal hidden sources of conflict not usually available either to the patient or the physician.

Equipment for Prolonged Narcotherapy

A single room away from noise and confusion.

Preparation tray and, if the drug is to be administered intravenously, a venipuncture tray.

An emergency hypodermic tray with caffeine sodium benzoate, coramine, adrenalin, ephedrine sulfate, digalen in ampules, 50 per cent glucose

ampules and 1 cc. ampules each containing picrotoxin 1/20 grain, together with a mouth gag, tongue forceps, and a small catheter to use as an aspirator for the dislodgment of mucus.

Gavage tube, sphygmomanometer, and patient's chart.

Method of Procedure

1. The patient may be told that the doctor wishes him to sleep a considerable part of the day for a few days; that the physician will, however, come to talk with him occasionally each day. He is put in bed and tested for idiosyncrasy to sodium amytal by giving him several doses of 3 to 6 grains of the drug. During this test period the nurse will carefully record pulse rate and quality, respirations, blood pressure, evidence of cyanosis, or other signs of cardiovascular embarrassment.

2. While sodium amytal for prolonged narcotherapy may be given intravenously, intramuscularly, by rectum, or by indwelling nasal tube, yet the safest method is by oral administration. If sodium amytal is to be given intravenously or intramuscularly, a solution must not be used that is not clear after four or five minutes. Solutions of sodium amytal are affected by exposure to air; not more than thirty minutes should elapse between time of preparation and time of use. The maximum single dose is 15 grains, and not more than 45 grains should be given in twenty-four hours. The rate of intravenous injection of solution should never exceed 1 cc. per minute. When the oral method is used the patient is given 3 grains every three or four hours. The dose is rapidly increased every day until the fourth day where it is maintained until the tenth day after which it is halved each successive day.

3. The patient is never left alone, the room is kept darkened and quiet, and the nurse gives the patient as constant and attentive care as in postanaesthesia cases.

4. The patient is kept lying on his side to prevent the tongue from falling back or mucus from accumulating in the pharynx.

5. The pulse is taken every thirty minutes for three times after each administration of the drug, but otherwise pulse, respiration, and temperature are recorded every four hours. Take the temperature by rectum.

6. Do not wake the patient. Wait until he awakes to give food and personal care. Usually the sodium amytal is withheld for two periods during the day permitting the patient to awake sufficiently to allow feeding, attention to bowels and bladder, and routine nursing care.

7. The intake of liquids should be at least 3,000 cc. daily.
8. Watch the bladder for distention.
9. Keep accurate bedside notes including:
   a. Blood pressure.
   b. Intake and output in detail.
   c. The amount of drug given and time administered.
   d. Hours of waking and of falling asleep.
   e. All the patient says when he arouses; it should be written down verbatim.
10. Watch for the following adverse symptoms:
   a. Rise in temperature to 101° F. or above.
   b. Convulsions.
   c. Blood pressure under 90.
   d. Strangulation from mucus in throat or from swallowing tongue.
   e. Vomiting.
   f. Retention of urine.
   g. Aspiration of mucus or foreign material.
11. During the terminal phase the patient is moved to a bright, cheerful room and every effort is made to create an atmosphere of optimism and encouragement.

Continuous Flow Bath

Hydrotherapy is used in mental hospitals for various purposes but principally either for its tonic or its sedative effect. Among tonic forms are the needle spray and the Scotch douche. Sedative measures are particularly important and for this purpose the continuous flow bath (Figure 21) and the cold sheet pack are commonly used.

The tub used for the continuous bath is large, usually about 78 inches long, 33 inches wide, and 20 inches deep. It is equipped with four or more inlets and has a large outlet in order that the tub may be emptied rapidly in an emergency. The room should preferably not be too light, and it is well to have the tubs separated by movable screens. The temperature of the water should be maintained between 94° and 96° F., and there should be a continuous moderate flow. The temperature of the water is controlled by a thermostatic mixing valve, but since such an instrument is never entirely dependable, the nurse should frequently check the temperature with a bath thermometer and every five or six minutes test the temperature of the water with her hand. Extreme care must

be taken that the temperature does not go substantially below or above the figures given. The bath may be continued for long periods, and it is doubtful if much effect is obtained in less than three or four hours. If desired, there is no objection to a patient's



FIG. 21: CONTINUOUS FLOW BATHS.

(Note the pack table seen through the door in the center background.)

remaining in a continuous bath for several days without interruption. Some patients develop a cutaneous eruption after a period, but this usually responds promptly to emollients.

Equipment for Continuous Bath

Canvas hammock.
Sheet or pad for hammock.
Air pillow or ring.
Bath thermometer.
Pitcher of drinking water.
Drinking cup.
Lubricant.
Bath mat.
Basin of ice water.
Gauze for cold compresses.
Fitted canvas cover for tub (or a sheet).
Three towels.
Thermometer tray.
Ice collar.
Sheets and blankets for emergencies.
Patient's chart.

Preparation of Equipment

Arrange all small equipment on the table before the patient is brought to the tub.

Fasten the hammock to the tub. See that all straps are securely fastened to the knobs.

Place the sheet over the hammock and the pillow at the head of the tub.

Set the thermostat at 96° F. Turn on the water.

Fasten the bath thermometer in the water at the foot of the tub.

Preparation of the Patient

Encourage the patient to go to the toilet.

While the tub is filling, take the patient's pulse and temperature. Report elevations.

Assist the patient to undress, explaining the treatment to him. The patient puts on the gown.

Anoint the palms of his hands and the soles of his feet with lanolin.

Help the patient into the tub when it is about two-thirds full.

The entire body is completely immersed except the head.

Strap or hook the fitted canvas tub cover over entire tub, with only the patient's head projecting through it.

If a canvas cover is not used, cover the tub with a sheet.

Place a compress on the head; change frequently.

Lower the shades, limit conversation, and endeavor to maintain an atmosphere of peace and quiet.

Give the patient an occasional drink of water.

Record the pulse rate every fifteen minutes. If the patient is sleeping, omit pulse-taking.

If the pulse becomes rapid, or cyanosis appears, stop the treatment and report the reaction promptly.

The patient may take his meals sitting in the tub. His shoulders should be covered.

If the patient is restless or noisy, fasten an ice collar around his neck so that the back of his head rests upon it.

The patient may be removed from tub for toileting. If the bath water becomes polluted with feces, remove and cleanse the patient in the shower while the tub is being drained, cleaned, and refilled.

At the termination of the bath, shut off the water, open the drain, remove the patient, give him a shower, dry him quickly, and keep him warm with wraps.

Put the patient to bed to rest for at least an hour.

Dangers of the Continuous Bath

Heat prostration may occur if the temperature remains long at or above 98° F., or if the atmosphere is hot and humid and the ventilation poor.

Chilling may occur in patients of poor vitality if the temperature of the bath is below 92° F. and the temperature of the room below 76° F.

Scalding. This tragedy is due to lack of vigilance on the part of the nurse. Do not rely on the accuracy of a thermostat. The nurse should use a thermometer and test the water frequently by hand. Deaths have occurred as a result of scalding.

Drowning. A patient may commit suicide by drawing his head under the cover and submerging it. Be watchful.

Aftercare of Equipment

Clean the tub with brown soap and cleaning powder.

The hammock and tub cover should be laundered after each bath.

Sedative or Wet Sheet Pack

Wet sheet packs may be given for either tonic or sedative effects. The one most commonly used in mental hospitals is the cold pack, which is given for sedative effects. This pack consists of enveloping the patient first with sheets wrung out in tap water and then with dry blankets. With the application of the cold sheets the surface blood is driven into the deeper vessels and the skin is blanched and cold. In a short time circulatory reaction begins, the capillaries of the skin dilate, the blood returns to the surface vessels, and the patient experiences a feeling of extreme warmth. After a period of fifteen to twenty minutes, the pack feels pleasantly warm and the patient relaxes and may sleep. Because the movements of the patient while in the pack are extremely limited, he often regards it as a form of restraint, and because, through its sedative effect, it is frequently employed during or immediately following disturbed periods, he often thinks of the pack as a form of punishment. The purpose of the wet pack should therefore be carefully explained to the patient and an attempt be made to dispel any misconception.

Nursing Care and Precautions during the Sedative Pack. The patient's feet should be warm before he is placed in a pack. If necessary they should be soaked in hot water to warm them. If the patient will co-operate, an ice bag or compress should be placed on the forehead before beginning to wrap the cold sheets. When he is first enveloped in the cold sheets the patient may have a

feeling of breathlessness. The cold application to the head seems to prevent this. The patient should be closely observed and the color particularly noted during the first three minutes when the sedative stage should begin. If he does not begin to feel warm within three to five minutes and his skin, when the finger is placed within the blankets at the neck, feels cold, he should be removed and given a hot shower and vigorous rubdown. The application of the pack should be made quickly, quietly, and deftly and there should be sufficient assistants to make this possible. Any unusual reaction such as irregular pulse, cyanosis, or continued chilling of the body should be reported at once. Pulse and respirations should be recorded every fifteen minutes. The room should be quiet, its temperature not below 70° F., the air fresh, and all bright lights should be excluded. The pack should not be continued for more than two hours except upon order of a physician after he has carefully examined the patient.

Equipment for Sedative Pack

Bed or pack table with mattress.
Rubber sheet to protect mattress.
Three sheets.
One double wool blanket.
One single wool blanket.
Drinking water.
Compresses.
Two towels.
One wringer with sticks.
One ice cap, filled.
One basin with ice water.
One small flat pillow for head.
One foot tub containing water (50°–60° F.)
One folded sheet for knees.
Chart for recording.

Method of Procedure. Cold wet packs can be given more conveniently in a hydrotherapeutic department, but it is frequently desirable that they be applied on the ward. It is also more convenient to use a special pack table, wide, and with legs sufficiently long to permit the nurse to pack the patient without stooping, although the ordinary ward bed can be used without difficulty. Equally desirable results may be secured by any one of many techniques in applying a wet pack. Since each hospital usually has its preferred technique the equipment desired will depend upon the particular one employed. A procedure that has been found satisfactory is given in the sequence of illustrations, Figures 22 through 28, and can be described as follows:

Application of the pack:

Have the patient use the bedpan or the toilet.

Take and record the pulse.

If necessary, soak the patient's feet in warm water.

Remove the gown and drape the patient with a sheet.

Fan the bed clothes to the foot of the bed.

Place the pack materials on the bed in the following order:

1. Large rubber sheet.
2. Double wool blanket.
3. Single wool blanket.

Wet two sheets in a foot tub of cold water (50°–60° F.).

Wring out the sheets as dry as possible.

Place the sheets on the bed, the lower one lengthwise, the upper one crosswise, both fanned.

Have the patient lie in the center and far up in the bed so that the top sheet comes well under the arms.

Remove the drape sheet and have the patient raise his arms; carry the right side of the top sheet over the body to the left. Have the patient put his arms down; carry the left side of the sheet over his arms and tuck it in well.

Wrap the patient in a long sheet by taking the right side over his feet and making a crease between the legs; carry the right side of the sheet over the left side of the patient.

Be sure that no two skin surfaces are in contact and that no air pockets are permitted to form.

Take the left side of the sheet over the patient to the right, mitering at the neck and tucking under his right side.

Wrap the two dry blankets in the same manner but without making a crease between the legs.

Tuck the blankets under the feet so that no skin surface is exposed.

Be sure that the patient's hands are not under his body.

Tuck the towel between the blanket and his neck so that the blanket is not in contact with the skin.

Place a cold wet compress on his forehead; change frequently.

A soiled patient must be removed, showered, and re-enveloped.

At the termination of the pack, remove the patient quickly; avoid chilling.

Follow with a shower; if on the ward and a shower is not feasible, give the patient an alcohol rub.

The patient should rest in bed after the treatment. If this is not possible he must be fully and warmly clothed. He should not be permitted to go into the open air for two hours.

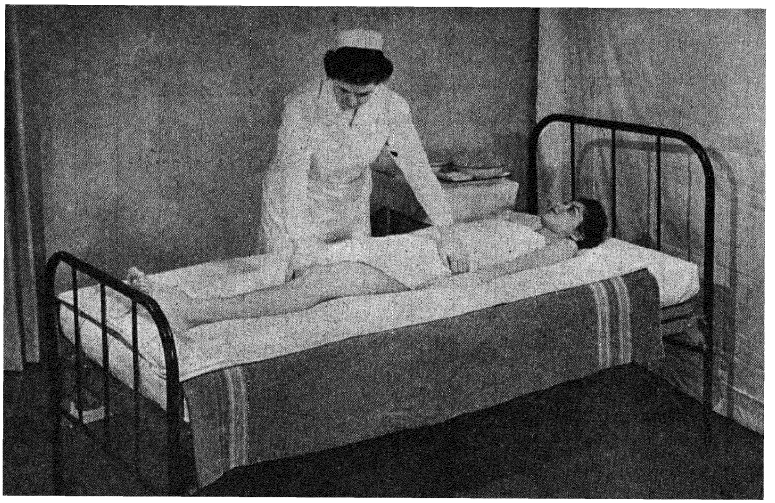


FIG. 22: COLD SHEET PACK, STEP ONE.

This is the beginning of the procedure. The two sheets are folded in place with the upper sheet passed over the body, under the arms, and between the knees of the patient. In the corner is a table with ice and towels for cold compresses, and an emesis basin.

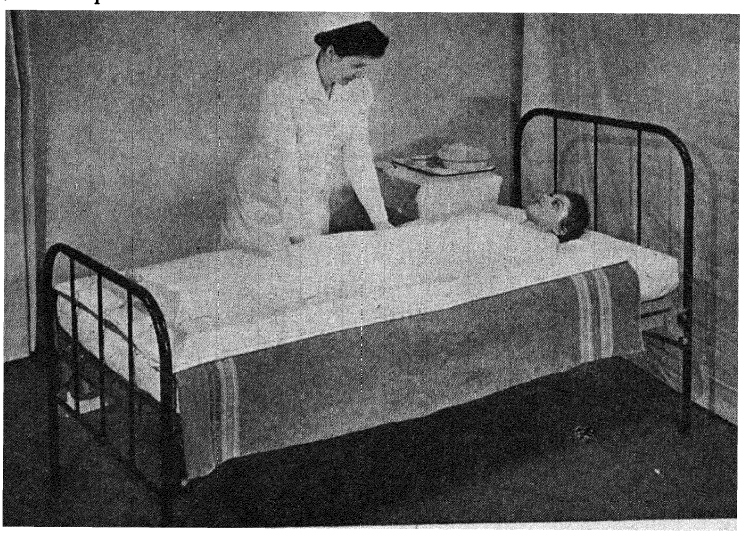


FIG. 23: COLD SHEET PACK, STEP TWO.

The second half of the upper sheet has been passed over the arms and across the patient.

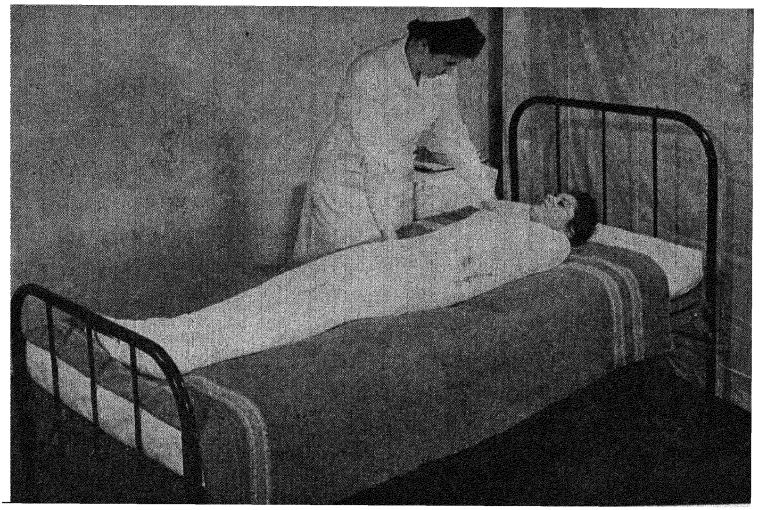


FIG. 24: COLD SHEET PACK, STEP THREE.

The second half of the lower sheet has been passed across the patient and mitred at the neck.

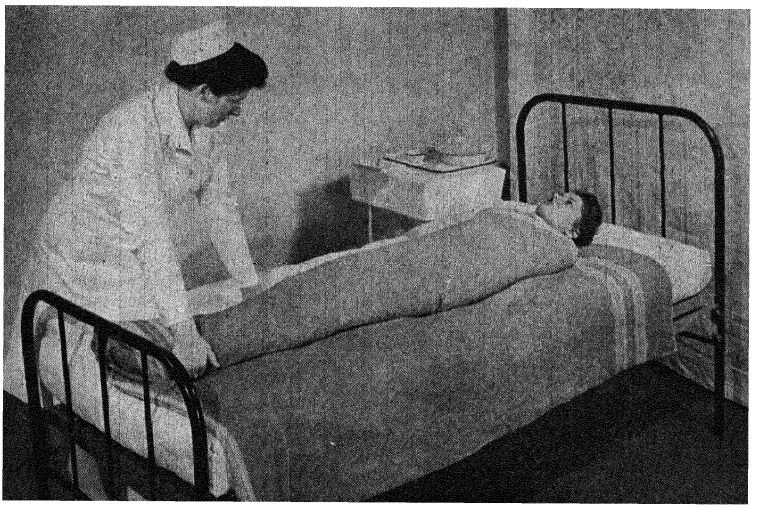


FIG. 25: COLD SHEET PACK, STEP FOUR.

The blankets have been mitred across the shoulders and folded over the feet. The first side of the blanket is folded across the feet.

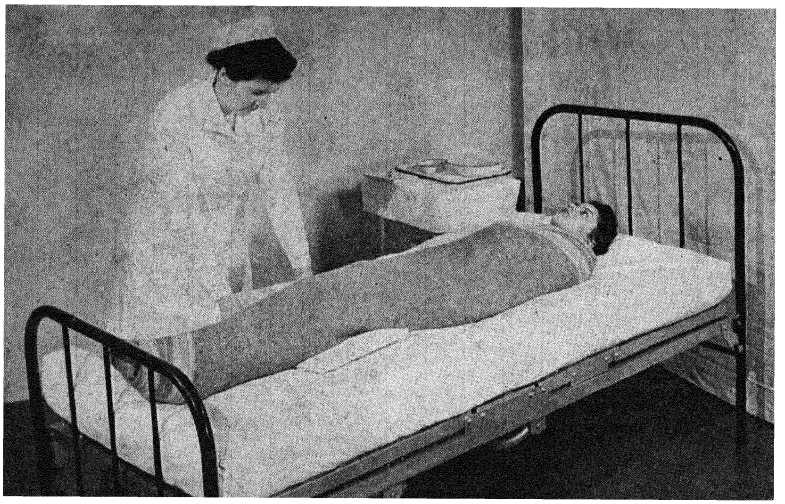


FIG. 26: COLD SHEET PACK, STEP FIVE.

The blankets are completely in place, and for greater comfort a small flat pillow or folded sheet is placed under the knees of the patient.

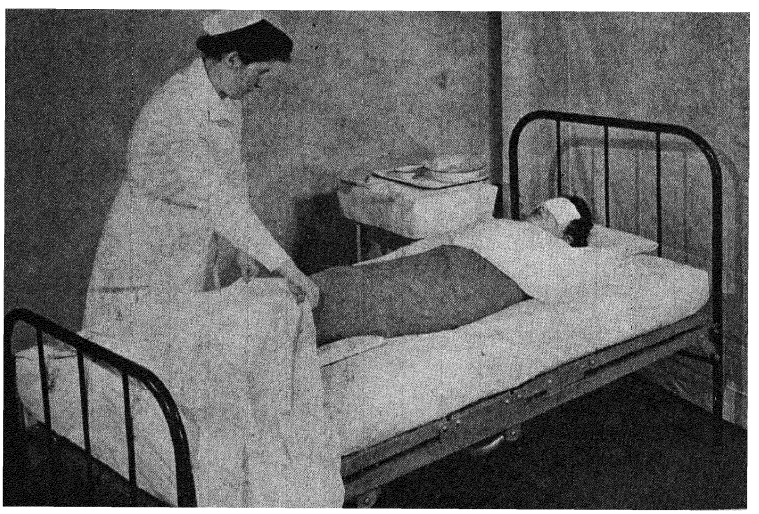


FIG. 27: COLD SHEET PACK, STEP SIX.

A towel has been folded under the chin to prevent rubbing from the blanket. A compress has been placed over the eyes and forehead. The pack is completed by drawing the spread smoothly up over the patient.

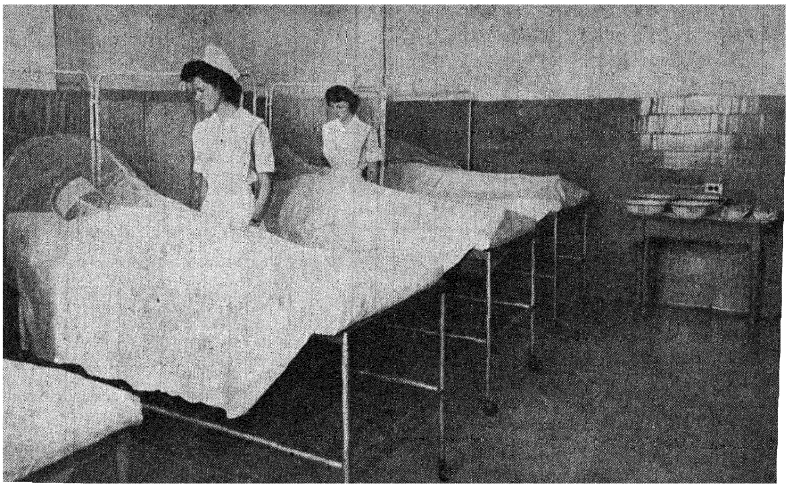


FIG. 28: COLD SHEET PACK, COMPLETED.

The patients are in completed packs. Note the fly or mosquito netting. Special pack tables are often used instead of beds.

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CHAPTER XXIX

PSYCHOANALYSIS

Two Meanings of Term. Since in her work in psychiatry the nurse will hear much discussion, both laudatory and critical, of psychoanalysis, and since it is now generally agreed that certain of its theories and their applications have extended our psychiatric knowledge, the nurse should have some acquaintance with its principles. Broadly speaking the term psychoanalysis is used in two senses: first, to indicate a system of psychology based on the assumption that there is a part of the mind of which one is not conscious; second, as a method or technic of psychotherapy.

Origin of Name. Let us first consider psychoanalysis from the standpoint of a system of psychology. In 1895 Dr. Joseph Breuer and Dr. Sigmund Freud, two Viennese physicians, published under the title *Studies in Hysteria* an account of the treatment by the former physician of a neurotic woman by means of hypnosis. As a result of their study of this woman's neurosis they concluded that the causes of her symptoms lay in her unconscious mental life. It had long been suspected that the mind contained elements not accessible to consciousness, but Freud was the first clearly to recognize that these elements might be in a state of disharmony with the rest of the mind (intrapsychic conflict). Breuer soon ceased his interest in their studies while Freud continued them and finally formulated a psychological theory to which he gave the name psychoanalysis. From time to time he modified and considerably extended his original theories.

Repression and Resistance. As Freud continued his investigations he concluded that in addition to the conscious part of the mind and that part from which by an effort of memory one can recall ideas and direct consciousness to them (Freud called the latter part the preconscious), there is a zone in which ideas are stored and experiences registered which cannot be recalled by any ordinary act of recollection. (Mention will later be made of the special method of

free association devised by Freud by which recall can sometimes be made.) As already indicated, Freud discovered that many of the ideas and motives of the unconscious are incompatible with those of consciousness. He also found that ideas in the unconscious could be and frequently are fraught with feeling. Freud conceived that these incompatible ideas, wishes, and motives are eliminated from consciousness by an unconscious mechanism which he designated as repression. This mechanism we have already studied in Chapter III. Unfortunately such repressed material may remain unassimilated in the unconscious where it continues to be a source of inner mental disharmony and may become the basis of a neurosis or even a psychosis. As Freud attempted to open up the deeper parts of his patients' minds it seemed to him that some opposing inner force prevented the patients from becoming aware of certain particularly repressed mental material. This mental force that opposed awareness of material not wanted in consciousness he spoke of as resistance. This inner resistance against full self-knowledge was one of Freud's important discoveries.

Libido and Sublimation. Since Freud regarded the fundamental biological aim of all animal organisms, including man, to be procreation and the resulting perpetuation of the species, he assigned an important psychological role to libido, the term he applied to the instinctive energy designed to ensure such perpetuation. Since in man this energy is blocked to a considerable degree in direct outlet, it is made available, according to Freud, through the mechanism he called sublimation, for activities having social, moral, and spiritual qualities.

Mental Mechanisms Described by Freud. In addition to such psychological concepts as the unconscious, mental or intrapsychic conflict, repression, sublimation, and resistance, Freud introduced various others such as the mechanism of displacement, whereby the affect or feeling that would be presented in consciousness by one idea is transferred to another idea which is more acceptable. Another Freudian mechanism is that of condensation, by which unconscious ideas fuse together to reinforce one another. Psychoanalysis assigns an important psychological role to symbolism, a symbol in its Freudian significance being a conscious idea that represents and carries the significance of another, an unconscious idea. The idea of death, for example, might be signified by the conscious

idea of sleep. In psychoanalysis the ideational content of the dream contains many symbols.

Dreams. According to psychoanalytic theory dreams are of much significance, being one of the most direct expressions of the individual's unconscious mental life. The material from the unconscious is expressed in symbolic form, both for the purpose of condensing it and for protecting the dreamer from conscious recognition of material which, if undisguised, would be disturbing. In Freud's theory of dreams one must distinguish between the *manifest content* of the dream and the *latent content.* The former is the substance of the dream as it appears to and is recalled by the dreamer. The significance of the dream, however, is not contained in the manifest but in the latent content in which the real meaning of the dream is so disguised that its recollection will not disturb or pain the dreamer. This disguise of mental material, the repression of which suffers a relaxation during sleep, is brought about by the mechanisms of displacement, condensation, symbolization, dramatization, and elaboration. The joint product of these processes is known as the *dream work,* the product of which is the manifest content of the dream. This manifest content is often an apparently absurd and confused product, yet it really represents the disguised expression of significant mental material and must be interpreted in relation to the total life situation and experience of the dreamer.

Minor Errors of Everyday Life. While we usually attach no significance to the various errors in mental functioning as they occur in everyday life, such as slips of the tongue, mistakes of the pen, mislaying of objects, or other temporary errors in mental functions which ordinarily we perform correctly, psychoanalytic psychology attributes much significance to such apparently minor lapses. Freud expressed the view that most of these happenings are really determined by mental processes of which one is at the moment unaware. According to Freud if one forgets to keep a dinner appointment, for example, there must be a motive for not wanting to remember it. The motive may be entirely unconscious but is nevertheless quite definite. Strictly speaking, the forgetting is not a defect but a purposeful act although it is performed without the individual's conscious knowledge. Many people quite unfamiliar with psychoanalytic psychology nevertheless intuitively interpret the meaning of these "slips" and even react to what they have un-

consciously perceived through the other person's self-betrayal. Many family and marriage quarrels, for example, are over apparent trifles, yet it is just these trifles which, since they betrayed underlying attitudes and tendencies, may have prompted the reaction they quite unwittingly called forth.

Freud's Use of the Word "Sex." Many of Freud's theories have provoked strong opposition. His view concerning the sexual instincts, particularly those of childhood, and his extraordinary extension of the term sexual, have frequently evoked bitter denunciation. In using the word "sexual" Freud did not at all limit the connotations of the word to genital sexuality; in fact he frequently did not imply sex in any physical sense but rather the unconscious, psychological aspects of sex, of which the genital aspect may not form any part. It is not easy for us to understand his meaning of the word, stripping it, as he did, of its usual physical implications. Perhaps if he had used the word "psychosexual" it would better have conveyed his new meaning.

Stages of Development. Using the word "sexual" as he did, Freud considered that the sexual instinct exists from birth. He regarded it as a complicated instinct that should go through an elaborate course of development from infancy to adolescence, the various components becoming gradually fused until normal adult genital sexuality is attained. Various difficulties or errors of development may occur with arrest at certain stages (fixation). Thinking of "sex" in this psychological sense, Freud maintained that in the earliest stage of its development the direction of the instinctive energy is without object although he described such early childhood habits as thumb-sucking as examples of an *auto-erotic phase* of development. At about 4 or 5 years of age the psychological interest of the instinctive energy becomes directed toward one's self. Freud called this stage or period the *narcissistic* one, after the Greek youth, Narcissus, who according to the myth fell in love with his own reflection which he saw in the water of a fountain. At about this age the individual unconsciously seeks for a love-object which he finds in himself and he therefore comes to admire his own person. This narcissistic period represents the most egotistic stage of one's existence. Normally it is given up, entrance in school with its active competition helping to divert the individual from his own egotism and forcing him to recognize his neighbors' rights. The results of this period are by no means all undesirable, however. Out

of it come a sense of one's own importance, a self-esteem, and those values of self which are essential if one is to keep his place in life.

From this stage of "loving" himself the child passes on to a stage when he appears to love those like himself—those of his own sex—a period known in psychoanalytic parlance as the *homosexual* stage. During that stage the child finds little of common interest with the opposite sex and is often inclined to avoid its members, toward whom he may adopt an air of superiority. Unless unduly prolonged or accompanied by the conditioning of unnatural sexual responses it is one of normal, healthful development, one of the desirable products of it being self-denial and co-operation. From this period the individual passes on to normal adult interests, with a directing of the love tendencies toward those of the opposite sex. This stage of full maturity is known as *heterosexual.*

Oedipus Complex. Incident to this progressive development of the child's object of love interests there arises, according to Freud, what he called the Oedipus complex, so named from the legend of King Oedipus, who, moved by forces over which he had no control, and without knowledge of his parents' identity, slew his father and married his mother. As the developmental stages in the love or, as Freud would broadly designate it, the sexual, aspects of the personality take place, the first love-objects of the child are naturally found within the family circle. Thus there arises an attitude of love on the part of the child toward the parent of the opposite sex, together with one of rivalry toward the one of its own. The child enters this phase at about the third year and in normal cases works through to a satisfactory solution by the age of 5. This complex Freud regarded as the central one in the whole unconscious. In his opinion the way the child deals with it determines more than does anything else the individual's character and temperament as well as any neurosis it may at any time develop. The theory of the Oedipus complex is often bitterly rejected by the opponents of psychoanalytic theories.

The psychoanalysts lay much stress on the complexity and early stages of development of the sexual instinct, since in their opinion most adult problems in sexuality, friction and difficulties in marriage, inadequacies in conjugal relationships, jealousy and rivalry between the sexes, and the origin of various perverse practices and attitudes can be explained only in the light of the knowledge of these stages and their development.

Theoretical Parts of the Mind: The Id. For many years Freud in his studies of the unconscious devoted special attention to the instinctive trends of mankind since they constitute the dynamic source of mental activity. Later, since man is a moral being as well as an instinctual one, he formulated a theory of the mind in which the social and ethical forces of inhibition, modification, and control are given more consideration. Freud came to conceive of the mind as being divided into three main parts. One part, because it contains the impersonal, instinctual demands and primitive urges that constitute the fount of mental energy, Freud called *das Es* or the "it," in speaking of which one generally uses the Latin word *id.* Although no part of the id possesses awareness, and much but not all of the unconscious is located in it, the two conceptions (the id and the unconscious) are not interchangeable. In addition to being the inherited reservoir of instinctual demands, the id contains all repressed ideas.

Theoretical Parts of the Mind: The Ego. The second part-mind is the *ego.* It comprises the self in ordinary language, that which gives us a sense of personality. The ego contains the conscious motives and forces of the mind and deals with reality. It condemns and rejects some of the demands made for gratification of the id impulses. This process of rejecting is the same as what we have learned to call repression.

Theoretical Parts of the Mind: The Super-ego. The third part-mind is the *super-ego,* the function of which is to watch over the relations between the ego and the id. It acts as a sort of guard warning the ego of the danger of accepting any repressed impulses rising from the id. The ego represses at the dictation of the super-ego. Most of the super-ego is unconscious, but a small part is conscious and is known as the ego-ideal. This conscious part may be regarded as what we usually know as conscience. The super-ego comes into existence in response to teaching and by identification with and influence of the parents. If the domination by the unconscious super-ego is exacting and tyrannical, there results a dread of the super-ego on the part of the ego, this dread being experienced by the ego as a sense of guilt. Conflicts between the unconscious super-ego and the conscious ego are common and may lead to cramping traits of character and to neuroses.

One must, of course, remember that this division of the mind into id, ego, and super-ego, the latter with its ego-ideal, is purely

theoretical. In speaking of these parts the psychoanalysts personify them, as it were, and endow them with particular functions. They conceive of these parts as siding with or against one another and of one part yielding to or punishing another in terms that are highly figurative. This figurative use of terms is convenient for purposes of discussion and condensed description, but the nurse should remember that the hypothetical parts are not really distinct entities.

Psychoanalysis as a Form of Therapy. We have presented in the foregoing paragraphs some of the more important theories of psychoanalysis as a system of theoretical psychology. We may now discuss briefly certain of the principles of psychoanalysis as a means of mental treatment.

As a method of therapy psychoanalysis attempts to serve as a process by which the mind is placed, as it were, under a psychic microscope by which there may be revealed to the patient not only mental material the existence of which he was quite unaware, but also material so disguised that he had not recognized its actual nature. By means of it the physician attempts to discover impulses, motives, and infantile conflicts and conditioning experiences that have distorted personality, destroyed happiness, or disturbed adjustment. Psychoanalysis finds its greatest usefulness in the psychoneuroses. It can rarely be employed during the active stages of a psychosis. Its value in the beginning of a psychosis or during convalescence is somewhat uncertain, but appears to be helpful in certain cases of schizophrenia and manic-depressive psychoses.

Procedure Employed: Free Association. The psychoanalysts believe that the most successful if not essential method of acquiring a technical knowledge of the practice of psychoanalysis is through the personal experience of being analyzed by a trained analyst. Interviews are held four to six times a week for periods extending from forty-five minutes to one hour. An analysis requires from one to two or more years. During the interview the analyst is seated a little behind the patient who reclines on a couch. The patient relaxes as much as possible, and it is essential that his attention not be diverted by sight of the analyst or by stimuli from the environment. One of the principal methods by which the analyst attempts to have the patient recall repressed ideas and desires and lost memories into the field of awareness is by means of *free association*. In the employment of this method the patient is placed under the

conditions mentioned, and he is instructed to make no effort to direct his thoughts, and to express freely whatever comes into his mind. It is believed that this spontaneous, undirected flow of associations will be closely related to material in the unconscious, particularly to wishes, strivings, and experiences that have been repressed and have important emotional or affective significance to the patient. With restraint thus removed, the associations tend to progress toward the fundamental problems of the maladjusted person and to bring them up to the surface. As repressed material approaches the surface, an opposition to awareness (resistance) occurs. These barriers of resistance may be manifested in such simple ways as sudden silence, evasions, change of voice or of facies, or in more prolonged manifestations that may bring the analysis practically to a deadlock.

The purpose of the analysis is to bring back to the patient's memory his early life history plus its reconstruction and revaluation, also for him to discover the tendencies and motives that have been of disturbing significance in his life. Much of the material in the patient's free associations is disguised in the form of symbols by which some indifferent object comes to stand in the place of or to represent material that cannot be consciously recognized lest it cause emotional distress. The patient is encouraged to discover for himself the meaning of these symbols.

Dreams. Another important method employed by psychoanalysis for rendering contents of the unconscious available for conscious scrutiny is the examination of dream material. Since dreams represent a product of the patient's thinking that lacks the direction and inhibition afforded by awareness, the material they present for examination discloses more accurately the impulses and the tendencies of the individual than does the thinking of waking hours. Early in the analysis the significance of dreams is explained to the patient. The dream may be looked upon as affording an outlet for the same mental and emotional material as is expressed in the neurotic symptom. Starting from the manifest content of the dream, free associations are employed. In connection with this manifest content there arise the same problems of symbolization and interpretation as in free association. Here, too, the patient is encouraged to discover the meaning concealed in the dream and thereby the conflicts and strivings that are dynamic in determining his reactions during his waking life.

Transference. Another important concept in psychoanalytic therapy is the mental mechanism known as transference. The term as it is employed in psychoanalysis refers to the identifications which the patient makes with the physician. The patient identifies the analyst with those who have been important to him during his lifetime, particularly his parents and siblings. His behavior and attitude toward the analyst are counterparts of those entertained toward those persons who have especially influenced him in the past and whose influence continues unconsciously to operate in his daily functioning. As the analysis progresses the analyst demonstrates to the patient the meaning of the transference and aids him in detaching the psychic energy and interest formerly attached to his symptoms to where it should be directed—to the environmental world of reality. The major portion of psychoanalysis consists of the interpretation and analysis of transferences and resistances.

If carried out by an untrained person, psychoanalysis may do much harm, but in the hands of a competent, experienced psychiatrist it doubtless offers relief to many psychoneurotics.

Summary

1. The term psychoanalysis is applied both to a system of psychology and to a form of psychotherapy. It is based on the assumption that there is a part of the mind of which one is not conscious.
2. Mental mechanisms described by Freud are discussed.
3. That part of the mind of which one is not conscious finds expression through dreams and through the minor errors of everyday life.
4. Some of Freud's theories such as his concept of sex, its stages of development, the Oedipus complex, the id, the ego, and the super-ego are discussed.
5. The principles and method of treatment by psychoanalysis are described.

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CHAPTER XXX

THE NURSE AND HER PROFESSION

How Our Personalities Are Determined. "That person alone is fit to nurse or to attend the bedside of a patient who is cool-headed and pleasant in demeanor, does not speak ill of anybody, is strong, attentive to the requirements of the sick, and strictly and indefatigably follows the instructions of the physician."

This quotation taken from the *Sushruta-Samhita* written about the fourth century B.C. indicates that from the earliest days of history special qualities of personality have been required of the nurse. Not until within recent years, however, and with the increasing knowledge of the personality and of the complex forces that determine it, have those factors and forces which especially touch the personality of the nurse received special consideration. As she has read the previous chapters in this book in which are discussed such subjects as the purpose and development of the mind, and also mental mechanisms and motives, it has doubtless occurred to the nurse that her own mind, her own personality, must be the result of the particular influences and forces which have operated upon them. She has probably recognized that in her case, no less than in that of her patient, her own personality, her own emotions, wishes, and behavior are the product of the experiences, both of the race and of herself. It is to be hoped that a study of personality forces, brought out the more sharply in the mentally ill, has given her a clearer understanding of the psychological problems common to all persons including herself. The same general personality forces and mental and emotional mechanisms operate in us all. Although we do not easily discover the operation of these forces and mechanisms in ourselves, the thoughtful nurse has probably recognized certain factors and mechanisms that are prone to arise in connection with her professional work.

Our Choice of Profession. Probably most of us believe that the choice of our particular profession was the result of considered

deliberation. Although the explanations we present to support this belief are offered in all sincerity and appear satisfactory and sufficient they are often but rationalizations. This fact need not disturb us too much; indeed in the unrecognized motive that determined our choice may perhaps be found the real source of our professional success. Since, however, the more fully we know the forces that are operating within us the more rationally we can direct them, it is better for us to recognize the motives that determined the choice of our profession inasmuch as the same forces will doubtless determine our behavior and decisions in other aspects of life.

What, then, are some of the factors which without the nurse's full awareness may have influenced her choice of nursing? Perhaps as a child the nurse was dominated to an unpleasant degree by a severe mother or nursemaid and she therefore chose a profession which seemed to offer means of exercising power over others in a way comparable to that by which power was exercised over her. Again the desire of a girl to resemble a greatly admired father might lead the daughter of a physician to follow nursing. Perhaps some previous illness left an unconscious sense of insecurity concerning health and the integrity of the organism, with the result that the student selected nursing in order that through the instruction received and the aid rendered others she might acquire the desired sense of security. Many other mechanisms operating without full awareness of their part may be the real forces in determining the choice of nursing. As already indicated, however, the profession chosen from such unrecognized motives (in this case, nursing) may provide just the desired satisfaction of personality needs and therefore lead to a satisfying and successful career.

Some Emotional Problems. In an excellent discussion of mental hygiene as touching problems with which the pupil nurse is confronted, Clara Bassett * calls attention to the high standards of physical health required for admission to schools of nursing and the continued supervision exercised throughout the training period. While thoroughly in sympathy with this attention to physical health, Miss Bassett points out that the mental aspects and the emotional experiences of the training period usually fail to receive

* Bassett, Clara: *Mental Hygiene in the Community,* New York, Macmillan Company, 1934, page 72.

similar consideration. The first several months of this period present many emotional problems and various demands for personality readjustment, a happy and successful solution of which requires wholesome mental health. In many cases there occurs the first separation from ties of home and family. It must be remembered, however, that the demands which adult life inevitably brings require that the early dependence upon parental aid and support be relinquished. Wholesome mental health requires emotional emancipation as adolescence is left behind. The sudden introduction to the sights and sufferings of physical disease as well as the necessity for discussing, experiencing, and facing subjects previously veiled by social taboo should be met objectively. An inability or unwillingness to be frank in recognizing and managing her emotional reactions to her new situation may lead to downheartedness and discontent on the part of the student nurse, with reactions expressed in the form of fatigue, headache, irritability, impairment of appetite, and even nausea and vomiting or amenorrhea. The student overwhelmed with feelings of inadequacy and of inability to meet her prospective responsibilities may become anxious and depressed. The new problems of classroom and ward may bring sensitiveness to criticism, self-consciousness, moodiness, or jealousy, or perhap feelings of inferiority. The discontent and discouragement which result may be interpreted as a sense of fatigue which the nurse may attribute to "overwork," and therefore on grounds of health and strength she may discontinue her studies. Rationalized in this manner she may, without injury to her pride, escape from a situation which she failed to meet by emotionally mature and wholesome methods. Much unhappiness and many failures could be prevented both among student nurses and other groups of students could they more clearly distinguish those ways of thinking and feeling which are inconsistent with mental health. Happiness, efficiency, and harmonious adjustment are incompatible with unwholesome habits of emotional reaction to the strains of discouragement and fatigue.

Identification and Adjustment with Others. Both to the student nurse and to the graduate who follows institutional work, the matter of a happy and harmonious adjustment with associates and superiors is exceedingly important. No matter how excellent her classroom work or her nursing technique, the nurse's professional usefulness is impaired if she fails in her personal adaptations with

others. Friction and tension are indicative of an emotional immaturity which should have been left behind as the physical and intellectual aspects of the personality developed. Various unwholesome mental mechanisms which we find it difficult to discover in ourselves may unwittingly operate and prevent that harmonious adjustment with others which is essential for personal satisfaction and professional success. It is important that the nurse seek to acquire an objective point of view as to any mental mechanisms which may be so operating in her own life as to retard or distort personality development. By the mechanism of identification, for example, the nurse may find in an associate the reflection of some person who at some time in her life was particularly loved or disliked. The same emotional attitude originally directed to such a person is now extended to the surrogate, i.e., to the person unconsciously identified with the one formerly the object of the special emotion. Similarly, the nurse may subconsciously recognize in an associate a quality, either of virtue or of defect, which characterizes her own personality and is particularly esteemed or repudiated. The associate becomes to the nurse, therefore, the reflected embodiment of the particular quality in question and is accordingly admired or disliked. Occasionally the nurse may unconsciously identify some hospital official with a particularly fond or a particularly disliked parent and her emotional attitude to the parent surrogate be accordingly determined. Such identifications and previously conditioned emotional attitudes may be important emotional forces in determining the nurse's relations to patients, associates, and hospital officials. Her supposedly unaccountable likes and dislikes may arise from unrecognized mechanisms operating in her own mental life.

Self-valuation and Adjustment. Another matter which may from the student's childhood have exerted an important influence in molding her developing personality are her feelings of self-valuation and of security. Unwholesome estimates of self or feelings of insecurity may arise in various ways, but may often be traced to childhood experiences and family attitudes. Without feelings of individual worth and of security during childhood there is danger that the growing personality may be warped and render later adjustments more difficult. Defensive and compensatory traits of character evoked as reactive protections are not uncommon and may disturb personal and professional adjustments. One nurse,

whose lack of home training and an isolated farm life had given no opportunity to develop social and cultural graces, believed, on entering a school of nursing, that she was inferior to other classmates and that she was doomed to failure. She isolated herself from the other girls, became apprehensive in the classroom when asked to demonstrate a technique, and at times burst into tears when corrected. Frequently in her contacts with other students she was arrogant, headstrong, and irritable, and in her relations with the training school administration she was belligerently aggressive and intolerant of direction or authority. When, with a little psychiatric guidance, she came to realize that her reactions arose from a sense of insecurity and inferiority and represented defenses against such feelings, she acquired confidence in her work and her attitudes and adjustments became satisfactory.

The Student and the Hospital. With the beginning of her hospital training the student finds that she must adapt to a new kind of life and behavior. This may provoke emotional tension and stimulate reactions in keeping with her personality pattern, frequently in the form of resentment, anxiety, or depression. If her life has been a sheltered one, she may be appalled by the grimness of nursing and by an absence of the romance she has always associated with it. Occasionally the student's relations to the hospital may constitute a problem in adjustment. The reasons for this are various, but many of them arise from causes of which the nurse may be but dimly or not at all aware. At times a motive contributing to the girl's choice of nursing as a profession may have been a desire to escape from the stern hand of an exacting parent and to assume for herself a position of authority. In such a case the standardized routine and discipline of the institution may be irksome. It may appear to the nurse that she is an impersonal part of an organization, is deprived of opportunity for an expression of her individuality, and is obliged to conform to a stereotyped routine not only of duty but of behavior. In her institutional relations the nurse will usually repeat the pattern she has followed in her family relations. If there she was conventional and tolerant her institutional adaptations will be easy, while a spirit of criticism, censure, or of rebellion toward parental discipline or toward established customs of the family will render adaptation to institutional requirements difficult.

At times the prescribed routine of classwork, wardwork, eating,

and sleeping, with little opportunity for participating in extra-hospital activities, may lead to homesickness, depression, rebellion, or neurotic symptoms. As a part of her own mental hygiene, therefore, the nurse should seek wholesome recreation and socializing interests.

The Nurse and Her Patient. Perhaps even more important than her relations with her associates and the institution with which she is connected are the nurse's relations to her patient. She should remember that the nurse-patient relationship is determined not only by conscious attitudes but by identification and by the other mental mechanisms already studied. She will avoid any tendency to identify herself with her patient. Such an identification may, for example, cause the nurse to be overindulgent or, on the contrary, lead her to be impatient, overly aggressive, and hypercritical. The more insight the nurse can acquire concerning her own mental life and her own personality strengths and weaknesses, the more effective a therapeutic agent will she become.

Her study of psychiatry and observation of mentally disordered patients should give the nurse a deeper understanding of her patients, of those whose incapacity is physical as well as those whose personalities are seriously disorganized. She learns the significance of aggressive behavior, of suspicion, fears, and compulsions. She should, however, be cautious in any attempt to explain to them or to others the mechanisms and motives she believes underlie the expressions of their respective mental lives. First, she may err in such an attempt since frequently the mechanisms and motives one believes have been discovered in others are really projections from one's own mental life. Again, mental mechanisms operate usually without conscious awareness in order that some psychological need may be met. The nurse should therefore carefully avoid exposing these mechanisms in a thoughtless or unkind manner.

Finally, no thoughtful nurse whose psychiatric training has revealed to her more clearly the motives and dynamics of behavior, who has watched persons struggling with problems by methods that have brought confusion instead of solution, can fail to develop to some extent those internal resources that add richness and spiritual value to living. Her observations and experiences in dealing with the disorders of personality that trouble the patient within or disturb his adjustment without, should lead to a smoother functioning in the elements of her own personality. Most nurses

who have had training in psychiatric nursing say that the greatest value that has resulted from such training is the personal benefit they have themselves derived from it. It also makes the nurse more sensitive and intuitive in the understanding of others. Her sympathy for the struggles of others is extended and her tolerance and patience toward her immediate associates is increased. Her relationships to the members of her own family become clearer and her adjustment to them is thereby facilitated. If she chooses to leave her profession for other occupation or for marriage, the specialized knowledge she has acquired concerning the personality, its problems, and the methods by which it attempts to meet them, should prove to be of great value to her in making the adjustments necessary for contentment and happiness.

Summary

1. How the patterns of personality of all of us are determined.
2. Factors that determine our choice of profession are discussed.
3. Some emotional problems of the student nurse are mentioned.
4. Mental mechanisms and factors that influence adjustments with others are discussed.
5. Attention is called to some factors that influence the nurse's attitude toward the hospital.
6. The nurse's attitude toward her patient is influenced by her own mental mechanisms.
7. Certain advantages derived from the study of psychiatric nursing are suggested.

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CHAPTER XXXI

HISTORY OF PSYCHIATRY AND OF PSYCHIATRIC NURSING

Period of Superstition. The earliest historical reference to mental disorder is to be found in the Bible. About 1451 B.C. Moses declared to the children of Israel that if they disobeyed the law which had been received from God they would be smitten with madness. That mental disease was familiar to the early Greeks is evidenced by the fact that Ulysses, in 1184 B.C., feigned dementia to escape service in the Trojan war. Although not primarily designed for the psychotic, yet the treatment which certain of them received in ancient Egypt, even though it was highly admixed with superstition, was strikingly fit. Here there came to the temples dedicated to Saturn not only the physically ill, but also the melancholics in search of relief through the beneficence of favorite gods. The various amusements and pleasurable occupations offered in the groves and gardens surrounding these temples seem to have made use of many of the principles now utilized by the modern sanitarium. Although under the leadership of Hippocrates the Greeks made a certain progress in theories concerning the nature of mental disease and made remarkable advances in hydrotherapeutic, occupational, and even psychotherapeutic treatment of mental disorders, yet with the death of Galen in 200 A.D., not only did all progress in psychiatry cease, but there followed a decline which persisted for fifteen centuries. Superstition, mysticism, belief in supernatural influences and magic again dominated the field of psychiatry. Exorcism, or the driving out of evil spirits by magic rites, degenerated into punishment by imprisonment and by various forms of torture, even to the burning alive of the patient in order to drive out or punish the demon residing within. Growing out of the belief in demoniacal possession there developed that of witchcraft. According to this superstition the devil frequently induced persons to sell their souls to him in exchange for supernatural powers. Persons

thus bewitched could make themselves invisible, fly through the air, transform themselves and others into animals, and visit misfortune upon their enemies. The Bible said: "Thou shalt not suffer a witch to live" (Exodus, XXII, 18). To seek out and destroy witches was therefore not only a social but a religious duty. Thousands of persons were accordingly burned or otherwise destroyed in Europe and not a few in America. The records of witch trials offer convincing evidence that at least a third of those accused and convicted of witchcraft were really psychotic. Many psychotic persons suffer from delusions of guilt. They believe that in some respect they have been extremely wicked, alleging, perhaps, that they have committed an "unpardonable sin." In the days of witch mania not a few such persons "confessed" they had been guilty of witchcraft and were therefore hanged or burned, perhaps, too, in their deluded state, implicating some relative or neighbor who therefore was made to suffer a similar fate.

Work of Pinel. With the close of the seventeenth century the belief in demoniacal possessions became less prevalent and the persecution of the insane on charges of witchcraft largely ceased. Their lot continued, however, to be a pitiful one. They were the victims of indifference, repression, or punishment depending on the extent to which their mental disorder became troublesome or publicly recognized. Many were thrown into houses of correction built for the confinement of criminals or misdemeanants. Where, as in England and France, institutions for the mentally ill existed conditions were, however, no less deplorable. Among the institutions in France during the eighteenth century were two in Paris—the Bicêtre for men and the Salpêtrière for women. In both of these the patients not only presented pictures of incredible neglect, but many were loaded down with chains shackled to floors and walls. They were at the mercy of cruel attendants armed with whips and with authority to use them freely. In 1792 Dr. Phillipe Pinel, who had become interested in mental disorders through the mental illness and tragic death of a friend, secured an appointment as physician to the Bicêtre and obtained permission to strike off the fetters with which many patients had been restrained. Most of these patients who had been in chains for years because of the belief that they were exceedingly dangerous proved, on release, to be perfectly harmless. By substituting a gentle and humane system of therapeutics for a barbarous one, Pinel earned for himself

the title of "liberator of the insane." Three years later he similarly released from restraint the supposedly incurable women lunatics confined in the Salpêtrière, the second largest asylum in Paris. This event inspired the most famous painting dealing with a psychiatric subject, that of Robert Fleury entitled *Pinel à la Salpêtrière.* This depicts the good physician superintending the removal of chains and fetters from the insane while a patient whose manacles have just been struck off kisses his hand in gratitude.

Work of the Friends. While Pinel was proving the fallacy of harsh treatment and opening up new paths along the lines of sympathy and humanity, William Tuke, a wealthy and influential Quaker of York, England, became greatly moved by the pathetic state of demented Friends committed to public asylums or incarcerated in English workhouses. Through his efforts funds were raised for the erection of a hospital or asylum where mentally sick Friends could obtain decent quarters, good food, humane treatment, and proper medical attention. The York Retreat, as it was called, conducted according to the principles of kindness, nonrestraint, and occupational therapy advocated by Pinel, rapidly demonstrated to the English-speaking people that these principles could be successfully employed. York Retreat has therefore come to occupy a place of great distinction in the history of the care of the mentally ill.

First American Efforts. In 1751 through the efforts of the Quakers and of Benjamin Franklin the first general hospital in America —the Pennsylvania Hospital—was established in Philadelphia. Of the first two patients received one was a "lunatick." Although in accordance with the medical practice of the day, "their scalps were shaved and blistered; they were bled to the point of syncope; purged until the alimentary canal failed to yield anything but mucus, and in the intervals they were chained by the waist or the ankle to the cell wall," it was the first time in America when a public institution received the mentally ill, not to be confined as malefactors, but to receive curative treatment as sick patients. One of its early physicians, Dr. Benjamin Rush, was the first American physician to make a serious study of mental disorder and is generally regarded as the first American psychiatrist. Later a separate department of the Hospital was constructed in another part of the city for the mental patients. This department, now located in West Philadelphia, has

for many years been one of the outstanding psychiatric hospitals in America.

The first American hospital exclusively for the mentally ill was opened by the Colony of Virginia in 1773. One would like to believe that it was free from chains and corporal punishment, but apparently this was not the case. No other state hospital was constructed for over fifty years, or until the Eastern Lunatic Asylum was opened in 1824 at Lexington, Kentucky. The organization of the second hospital in America for the special care of the mentally disabled was directly due to the influence of Tuke and the York Retreat. This was the Friends' Asylum in Frankford, now a part of Philadelphia. The constitution of this hospital, opened in 1817, stated that it "is intended to furnish, beside the requisite medical aid, such tender sympathetic attention and religious oversight as may soothe their agitated minds, and thereby, under the divine blessing, facilitate their restoration to the enjoyment of this inestimable gift."

Like the Pennsylvania Hospital the New York Hospital, opened in 1791, received mental patients as well as the physically ill almost from the date of its construction. In 1821 it opened a special branch for such patients as were mentally ill. Since it was located on Bloomingdale Road (now Broadway) it received the name Bloomingdale Asylum. This was at the present site of Columbia University. In 1893 this department was transferred to White Plains and in 1936 its name was changed to "New York Hospital —Westchester Division."

Work of Dorothea Dix. In spite of the reforms wrought through the influence of Pinel, Tuke, and Benjamin Rush, the facilities for the care of the mentally ill remained pitifully inadequate. Although there were then a few hospitals in America doing valuable work in treating mental disease, yet as late as 1840 most of the indigent psychotic were to be found in the jails and almshouses. One winter's day in 1841 a retired Boston schoolteacher, then 39 years of age, consented to conduct a Sunday school class among the women inmates of the East Cambridge jail. Arriving at the jail this teacher, Dorothea Lynde Dix, was shocked by the filth and dirt and by the evidences of neglect and brutality which she found. Particularly, however, was she shocked to find that many of these women were insane persons locked in unheated cells. Convinced

that other jails throughout Massachusetts must also contain many insane who were doubtless neglected and abused, Miss Dix determined so to arouse public opinion that suitable provisions for the mentally ill would be made. During the next two years she visited every almshouse, workhouse, and prison in the state. Based upon her observations Miss Dix in 1843 presented to the Massachusetts legislature a memorial, or a statement of the conditions she had found, accompanied by a petition for their relief. Many members of the legislature attempted to discredit Miss Dix's statements, but investigations confirmed their accuracy with the result that politicians withdrew their mercenary objections, acknowledged that the indigent insane were the wards of the state, and passed a bill providing immediate relief and additional accommodations for them. This memorial now occupies a notable place in the history of the care and treatment of mental illness.

While making her survey in Massachusetts, Miss Dix learned that equally distressing conditions existed in the overcrowded almshouses and prisons of other states where, also, as in Massachusetts, mentally ill paupers were often auctioned off to the lowest bidder for their care and were then housed in cellars, pens, and outbuildings. Determined that the reforms she had effected in her own state should also be enjoyed by the mentally sick elsewhere, Miss Dix launched on a career often described as without parallel in American annals. For nearly forty years thereafter she journeyed through America and Europe spreading the gospel of humane treatment for the mentally ill and promoting practical reforms in public provision for them. Altogether twenty states responded to her appeal, and the establishment or enlargement of at least thirty hospitals for the treatment of mental diseases in this country may be traced to her personal activities. Almost equally notable were the results of her work in Canada, the British Isles, and the Continent. Based on the report of Miss Dix as to the sad state of the mentally ill in Scotland, Queen Victoria appointed a Royal Commission to inquire into the condition of the asylums in that country. The report of this Commission's findings and recommendations revolutionized the care of the psychotic in Scotland and made its system one of the most exemplary in the world. If space permitted, much more might be written not only concerning the revolution she effected in the care of the mentally ill, but also concerning her services as superintendent of nurses during the Civil War, her com-

mission in that conflict being the first of its kind ever issued. "The most useful and distinguished woman America has yet produced," wrote one of the most widely known American psychiatrists to a group of her English friends at the time of her death in 1887.

Unsolved Problems. In spite of the remarkable pioneer work of such men as Pinel in France and of the Doctors Tuke at York Retreat, England, in abolishing chains and fetters, and of the crusading appeals of Dorothea Dix that legislatures recognize the obligations of the state to the indigent mentally ill, there still remained many problems pertaining to psychiatry and the care and treatment of the mentally disabled. There was still but little known as to the causes and nature of mental disease, practically nothing was being done in an effort to prevent it, mechanical restraint was widely employed even in the hospitals that had been established through the efforts of Miss Dix, and there had been no organized attempt to instruct or train those persons charged with the duty of daily care and of such little treatment as was undertaken.

Restraint. The name of Dr. John Conolly (1794–1867), superintendent of the Middlesex Asylum, Hanwell, England, is closely associated with the movement to abolish strait jackets, muffs, wristlets, and other forms of mechanical apparatus that interfere with the free movement of the patient. His book, *The Treatment of the Insane Without Mechanical Restraints,* established a new principle in mental hospital management. With much truth Conolly wrote: "Restraints and neglect may be considered synonymous; for restraints are merely a general substitute for the thousand attentions required by troublesome patients." Dr. Conolly's proposal excited much controversial opinion, and the battle between restraint and nonrestraint raged among hospital superintendents for many years. In 1857 Dr. Pliny Earle, one of the most famous American psychiatrists of his day, pointed out what is perhaps the greatest danger in permitting restraint: "While it is occasionally necessary to employ mechanical restraint, yet I believe that this admission is calculated to favor a tendency to its excessive use." Progress against the use of restraint has been constant, but even yet not a few institutions merely deal with the consequences of violent and destructive behavior instead of seeking for its causes and attempting to check them at their root.

The state hospitals have constantly increased in number and, keeping step with the advances of psychiatric and general medicine,

have steadily improved in the technique of their treatment since Miss Dix gave remarkable impetus to their establishment. Because of the nature of mental disease, much of their attention must necessarily be directed to patients requiring prolonged care and attention. Since the beginning of the present century two other types of mental institutions have developed: one is represented by the psychopathic hospital or the psychopathic ward in a general hospital; the other is represented by what is usually described as a psychiatric institute.

Psychopathic Hospitals. The psychopathic ward or the psychopathic hospital is usually located in large towns and cities. It provides first care, examination, and observation for persons suffering or believed to be suffering from mental disorder, pending commitment to a state or similar mental hospital. It administers short, intensive treatment in incipient and acute cases. It often serves as a clearing house which sorts out those persons whose mental and personality difficulties are not of such kind or degree as to render them socially inadequate from those whose disorder requires commitment to a mental hospital. The first psychopathic ward in a general hospital in America was "Pavilion F," established at the Albany Hospital in 1902. Since then, psychopathic wards or hospitals have been established in connection with general hospitals in many large cities. One of the best known of such institutions is the Boston Psychopathic Hospital, opened in 1912 under the directorship of Dr. E. E. Southard. This hospital also fulfils many of the functions of a psychiatric institute since it is an active teaching and research center. Another institution that not only fulfilled the functions of a psychopathic hospital but also those of a teaching and research center was the State Psychopathic Hospital at the University of Michigan opened in 1906 under the direction of Dr. Albert M. Barrett. Among other noteworthy psychopathic hospitals in the United States connected with medical colleges of universities are the Colorado Psychopathic Hospital at Denver, the Iowa State Psychopathic Hospital at Iowa City, and the Langley Porter Clinic at the University of California.

Psychiatric Institutes. The second type of mental hospital, the psychiatric institute, does not provide first care or observation or serve as a clearing house, but is primarily a center for teaching and for clinical and pathological research in nervous and mental disorders. The most widely known hospital of this type is the

Henry Phipps Psychiatric Clinic of the Johns Hopkins Hospital, Baltimore, opened in 1913. This was developed under the plans of Dr. Adolf Meyer who served as its director for nearly thirty years. It is recognized as one of the great centers of psychiatric research and education, not only of this country but of the world. Many women distinguished in nursing education have been connected with this Clinic. Among them have been Miss Effie J. Taylor, who organized and directed its nursing service and was subsequently Dean of the Yale University School of Nursing, and Miss Harriet Bailey, who long occupied various official positions in nursing education in New York.

Another notable psychiatric institute is the New York State Psychiatric Institute and Hospital, opened in 1929 under Dr. George H. Kirby as an affiliated unit of the Columbia-Presbyterian Hospital Medical Center, the largest medical center in the world. Constructed and operated by the State of New York, it serves both as a research institute and as a teaching unit for Columbia University.

Contribution by Kraepelin. The history of psychiatry shows that progress in efforts to formulate a working classification of mental disease has been exceedingly slow. The Greek physician, Hippocrates (born 460 B.C.), often spoken of as the Father of Medicine, divided mental illness into two main groups: mania and melancholia. For hundreds of years little progress was made, with the result that as recently as 1892 Dr. Hack Tuke, a descendant of the famous William Tuke of York Retreat, wrote: "The wit of man has rarely been more exercised than in the attempt to classify the morbid phenomena covering the term insanity. The result has been disappointing." A little later, however, Dr. Emil Kraepelin (1856–1926), a German psychiatrist who was unusually skilful in observing and describing symptoms, formulated a classification based both on the symptoms which mental patients manifested and on the whole course of a disease, even when the course of the disease is characterized by changes in symptoms during the course of its development. Kraepelin noted the alternation of the symptoms mania and melancholia frequently occurring in the same patient and concluded that they were but phases of the same disease, which he called manic-depressive insanity. By noting common similarities in the character and duration of their symptoms Kraepelin gathered together several groups of mental diseases, su-

perficially unrelated, into a single group which he called dementia praecox. Later Eugen Bleuler (1857–1939), a Swiss psychiatrist, substituted the term schizophrenia (meaning split or disorganized mind) for dementia praecox. By recognizing the relations between apparently unrelated symptoms and by his ability to present systematized descriptions of psychotic behavior, Kraepelin created a certain order out of what had previously been largely a mass of chaotic, unsystematized facts and observations. This descriptive type of psychiatry with its orderly classifications was a distinct step in advance, but it did not assist the psychiatrist in discovering the problems which perturb the patient, nor did it show why in his attempts to deal with them the patient behaved in the maladjusted way which we speak of as psychotic.

Contribution by Freud. While Kraepelin was engaged in clarifying the descriptions of mental disorders which he believed were as much definite disease entities as hyperthyroidism, cancer, or other physical pathology, a Viennese psychiatrist, Sigmund Freud (1856–1939), was engaged in formulating a new theory which he maintained explained many phenomena in the mental life both of the normal and the psychotic person. To this psychological theory, to a method of exploring the mind which he discovered, and to a technique of mental treatment which he developed, Freud gave the designation psychoanalysis. As indicated in Chapter XXXI, one of the most important assumptions of psychoanalysis is that a large part of man's mental processes goes on beyond his awareness and that these processes play an important part in determining behavior, particularly that observed in the psychoses and psychoneuroses. Driven from Vienna in 1938 during the persecutions of his race, Freud sought refuge in London where until his death in September, 1939, he continued his studies of the human mind.

Contribution by Adolf Meyer. Among American psychiatrists Dr. Adolf Meyer, formerly professor of psychiatry at Johns Hopkins University and director of the Henry Phipps Psychiatric Clinic, has greatly extended and at the same time clarified and simplified the conceptions of mental disease. He emphasizes that the thinking, feeling, and doing reactions of human beings are reactions of the whole individual personality. He points out that while the personality has anatomic, physiologic, neurologic, and psychological aspects, yet its expressions and reactions at any time, whether con-

sidered normal or abnormal, represent the result of the interplay and interrelations of these aspects. Any behavior, any isolated reaction of an individual is, then, a reaction of the total personality, of an inseparable unity of physical and mental. The study or science of the personality, whether normal or abnormal, and of its expressions, functions, and activities Meyer designates as psychobiology. Psychobiology may be looked upon as the study of the development, structure, and functions of personality, just as biology is the study of the development, structure, and functions of organisms. The concept of a psychobiology, a term introduced by Meyer, is one of his most important contributions.

Born in Zürich, Switzerland, in 1866, Meyer came to America in 1892. Through his progressive yet sound and conservative views he has greatly influenced the development of psychiatry. Professor Meyer has long been acknowledged to be the foremost teacher of his subject in the English-speaking language. His former students now hold many chairs of psychiatry in this country and abroad.

Extent of the Problem. Until comparatively recent years the attention of general medicine was focussed upon the curing or alleviation of disease that already existed, while but relatively little effort was directed toward the prevention of disease. While greater knowledge concerning the treatment of disease has contributed to the expectancy of life, yet it is largely through scientific advances in the prevention of disease that the expectancy of life for the newborn child has been extended twenty years since 1900. Not until 1909 with the founding of what is now spoken of as the mental hygiene movement, was there any serious thought given to the prevention of mental disease. How great is the necessity for exerting every possible effort to prevent mental disability will be apparent when the weight of its burden is realized. On January 1, 1941, the patients on the books of mental hospitals in the United States numbered 532,999. It is estimated that there were 200,000 more not under hospital care. New admissions to mental hospitals average 106,000 annually. Since the discharges and deaths average 86,000, the average annual increase of patients in the mental institutions in the country is approximately 20,000. The annual expenditures for hospital care of the mentally affected in all the states amount to over $200,000,000, while the economic loss from mental disease is estimated at over $1,100,000,000 annually. Finally, students of the problem of expectancy of mental disease report that

1,000,000 of the boys and girls now in the public schools may be expected to spend some portion of their lives in an institution for mental disease.

Beers and Mental Hygiene. Any survey, even brief, of the history of American psychiatry must include mention of the rise of the movement both to lighten the burden noted in the previous paragraph and to conserve mental health. The stimulus for lightening this burden and for promoting mental health, the impulse for what has now become known as the mental hygiene movement, came not from a psychiatrist but from a patient. In 1900, a young businessman, Clifford Beers, a graduate of Yale University, suffered a mental breakdown so complete that he spent three years in mental hospitals. Following his recovery Mr. Beers, remembering the neglect and even abuse which existed in the hospitals to which he had been confined, determined to correct such conditions if he could. To this end he wrote and published an account of his experiences in the form of an autobiography, *A Mind That Found Itself.* This vivid and convincing record published in 1908 has now become a classic. Taking advantage of the strong surge of sympathy for the mentally disabled aroused by the publication of his book, Mr. Beers, aided by William James, professor of psychology at Harvard University, by Dr. Adolf Meyer of Johns Hopkins, and by Dr. William H. Welch, professor of pathology at the same university, organized and launched a movement for the enlightenment of the public concerning mental disabilities and the promotion of mental health. To this movement Dr. Meyer gave as a name the title—long forgotten—of a book published in 1873 by Dr. Isaac Ray, superintendent of Butler Hospital—*Mental Hygiene.* The mental hygiene movement has come to bear the same relation to psychiatry that the public health movement bears to medicine in general. While a movement for the conservation of mental health, for the prevention of nervous and mental disorders, for a raising of the standards of care for those suffering from these disorders, and for the dissemination of reliable information on these subjects would have arisen before the present time, yet a great impetus to these aims was given them by the foundation in 1909 of the National Committee for Mental Hygiene. The organization of this important agency in the promotion of mental health and of better care for the mentally disabled was largely due to the influence of Mr.

Beers and to the moving appeal of his autobiography. His death occurred in 1943.

Child Guidance Clinics. The mental hygiene movement has led to the development of many activities in addition to the betterment of institutional facilities for the mentally ill. Among them is the establishment of child guidance clinics or psychiatric clinics designed to diagnose and treat the behavior and personality problems of childhood. These problems are manifested by disorders of behavior, such as tantrums or stealing, by nervousness, inattention, or shyness, or because of school difficulties, such as poor work, retardation, and indifference. The clinics treat these problems by treating not only the child whose problems are expressed in this way, but by treating also the family, school, recreational, and other factors and persons which contribute to the child's problem, and whose disorder the problem may reflect. Such clinics require the special training possessed by the psychiatrist, the psychologist, and the psychiatric social worker trained in the analysis of social situations and the social treatment of emotional and behavior problems. The first clinics of this nature were established to deal with youthful delinquents brought before the juvenile courts. An early and notable one was established in Chicago in 1909 by Dr. William Healy, later the director of the Judge Baker Guidance Center now serving the Boston Juvenile Court. Between six and seven hundred child guidance clinics have been established in this country during the past twenty years, and some 50,000 children are seen each year. In addition to the activities of the independent child guidance clinics, much work of a similar nature is carried on in connection with the school.

Mental Hygiene in Colleges. Another development of the mental hygiene movement is that of psychiatric counseling for college students. College, with the attendant first separation from the home, possible social unhappiness, scholastic problems, perhaps disturbed family relationships, financial difficulties, and the frequent sex problems of adolescence, often brings emotional crises that express themselves in the form of scholastic failure, disturbed social behavior, obstinate physical symptomatology, anxiety states, and other personality maladjustments. Psychiatric discussion and therapy for the problems of college students have therefore become one of the valuable developments of the mental hygiene movement.

Psychiatry in Other Fields. Psychiatry, through the greater understanding of the personality which it makes possible, assists the court in making punishment fit the individual rather than the crime and is often used in prison to aid in planning methods calculated to help and reform the inmates rather than merely to punish them. In several instances business and industrial concerns have come to employ a psychiatrist in order that through the relief of emotional problems troubling the individual employee, his efficiency may be increased and less time be lost from work through physical symptoms determined by emotional factors. The psychiatrist will understand the psychological origin of the jealousies, resentments, misunderstandings, dominations, and petty tyrannies which arise among workmen and between workmen and supervisors, and will often be able to smooth them out.

Psychiatric Nursing Education. The mental hygiene movement with its objective of preventing mental disease is not only one of the most recent, but also one of the most desirable developments in the history of psychiatry. While by improving personality adjustments it has undoubtedly promoted the happiness and efficiency of many lives, yet the care and treatment of the psychotic will long remain one of the great tasks of nursing. Organized instruction designed to develop skilled workers trained in the care of the mentally ill is, as in the case of general nursing, a comparatively recent undertaking. In the great general reform in the care of the insane initiated by Pinel and Tuke are to be found the origins and conditions out of which came the special reform of nursing. In Prussia, England, and America there was early recognition of the need of persons of intelligence and character who could be interested in the nursing of the insane. In all these countries there were many attempts throughout the first half of the nineteenth century to establish a system of training of such nurses, but little was accomplished beyond improving the individual excellence of the ordinary attendant. In spite of this comparative failure of the effort to devise methods of systematic training for those engaged in the care of the mentally disabled, no such effort was attempted in the general hospitals until the teaching of Florence Nightingale and the organization of the first training school at St. Thomas', London, in 1860. Although the leadership in nursing reform then passed over to the general hospitals, many believe it was inspired in part by the example of the work among the insane which was

well known when in 1849, Miss Nightingale visited Pastor Theodor Fliedner's asylum with its nursing sisterhood at Kaiserswerth, Prussia. In 1854, the very year when Florence Nightingale went to the Crimea, Dr. Browne, superintendent of the Crichton Institution, Dumfries, Scotland, made the first attempt to educate the attendants on the insane by a course of thirty lectures.

In 1880, two years after Linda Richards had at the Boston City Hospital established the first training school for nurses in America, the first step toward organized instruction in psychiatric nursing in this country was taken at the McLean Hospital, Waverly, Massachusetts (then located at Somerville). In 1882 the work of organizing the school was completed and Miss Mary F. Palmer was appointed superintendent of nurses. A graduate of this school, Miss Sara E. Parsons, contributed greatly to the development of psychiatric nursing, not only organizing the training schools at two of the leading mental hospitals, Butler Hospital, Providence, Rhode Island, and Sheppard and Enoch Pratt Hospital, Towson, Maryland, but several others also. In 1883 a school was organized at the Buffalo (New York) State Hospital, the first to be established in any state hospital for mental diseases.

The conception of mental illness is still befogged in the public mind by a sense of stigma and disgrace, born of the same ignorance and superstition described earlier in this chapter. The traditional attitude toward the mentally ill was a barrier to an understanding of the opportunities for acquiring experience and skill in nursing. It is little wonder, therefore, that the schools of nursing in mental hospitals were looked upon for many years by the earlier organized schools in general hospitals as inferior and insufficient for a good nursing education. The latter, enjoying the sunlight of greater public interest and stronger professional backing, grew more luxuriantly. The schools attached to the mental hospitals, deprived of this light and warmth from public interest and professional encouragement, developed more slowly but did not cease to grow and have become deeply rooted in many hospital organizations. The keen and unique observation of Dr. Edward Cowles, former superintendent of McLean Hospital and founder of the first school of nursing in a mental hospital, has been verified by thousands of other physicians: "The primary and most general requisite in the nurse is perfection in her *personal relations with the patient,* and this is best attained in mental nursing."

Prompted by the success of Dr. Cowles in organizing a school of nursing in a mental hospital, many other mental institutions in an effort to improve the nursing care of their patients established training schools. Their students spent a year in a general hospital having an affiliate relation with their home school in order that they might supplement their experience and instruction in other branches of nursing. For various reasons, including the fact that such a nursing education was not well rounded, the undergraduate nursing schools conducted by mental hospitals have been largely discontinued and their nursing educational activities confined to affiliate and postgraduate instruction in psychiatric nursing. The constantly increasing recognition of the intimate relationship between the physical and mental aspects of personality has caused nursing educators to realize that the nurse should be trained in mental as well as physical nursing. There has therefore been an increasing demand that the undergraduate nurse should pursue an affiliate course of instruction in a hospital for mental diseases—a demand that the educational facilities of the mental hospitals have not yet been able fully to meet. World War II with its many psychiatric casualties and the recognition that they should receive prompt and skilful psychiatric nursing has greatly increased the call for psychiatrically trained nurses. It is now realized, as never before, that nursing education is incomplete unless it includes instruction in psychiatric nursing also. Its objectives are well stated in *A Curriculum Guide for Schools of Nursing*, as prepared by the National League for Nursing Education:

1. To develop an appreciation of the interdependence of physical, intellectual and emotional factors characterizing an integrated personality.
2. To develop a basic understanding of the etiology, symptomatology, course, and treatment of the more common types of psychiatric disorders.
3. To acquire a basic understanding of the principles and methods in the psychiatric aspects of nursing.
4. To better appreciate social problems associated with mental illness and the community facilities for dealing with these problems.
5. To appreciate the nurse's responsibility in furthering a positive mental health program in the community.

During the twelve years since they were written, the words of Miss Annie W. Goodrich, distinguished leader of nursing education, have become progressively appreciated:

I know of no developments in nursing education and nursing practice of greater significance than those in the field of mental hygiene and

psychiatry. So greatly has the movement influenced nursing that it is reasonable to predict that in the immediate future every student will be required to include as of basic importance in her professional preparation a course in mental diseases through which she may acquire the knowledge essential for the mental, not less than the physical aspects of every case.*

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GLOSSARY

abulia: Inability to make decisions or to exercise will-power.

affect: Feeling-tone.

affectivity: The prevailing character or tone of one's feeling-life.

agoraphobia: Morbid fear or dread of open places.

alienist: A specialist in the legal aspect of mental disorders.

ambivalence: The simultaneous existence of contradictory and contrasting emotions, e.g., love and hate toward the same person.

ament: An extremely feebleminded person; a very low-grade idiot.

amentia: Literally, "without mind"; feeblemindedness.

amnesia: Impairment or loss of memory.

anamnesis: Previous history of an illness.

anxiety: An emotional state characterized by apprehensiveness, uncertainty, and fear.

apathy: A pathological indifference.

aphasia: Partial or complete loss of the power of expressing one's self in words or of understanding the meaning of words.

aphonia: An inability to produce vocal sounds.

apoplexy: A sudden cerebral hemorrhage or thrombosis usually causing loss of consciousness and muscular control.

apraxia: Loss of ability to manipulate and use common objects or to perform skilled movements in the absence of any actual paralysis.

aprosexia: Inability to maintain fixed attention.

Argyll Robertson pupil: A pupil that contracts on convergence but not with light.

associations: The succession or linking of ideas.

astereognosis: An inability to recognize the form of objects by the sense of touch.

ataxia: A disturbance in the coordination of voluntary movements.

autistic thinking: Thinking dominated by unconscious trends and uncorrected by reality.

automatism: Performance of more or less complicated action without guidance of consciousness.

autonomous depression: An emotional depression arising from factors not recognized by the patient.

Binet-Simon tests: A series of tests for measuring the degree of intelligence.

blocking: The cutting off of an association due to mental conflict.

catalepsy: A condition in which a patient shows a sustained immobility.

catatonia: A state of profound mental automatism or absence of voluntary activity, together with a tendency to immobility and negativism.

catatonic stupor: A mental state associated with catatonia and a stupor-like inaccessibility.

cerea flexibilitas (waxy flexibility): A condition in which the extremities show a waxlike rigidity and continue to remain in the position in which they have been placed.

choked disk: A swelling of the disklike eminence formed by the nerve fibers of the retina as they collect just before emerging from the eyeball to form the optic nerve. It is usually due to brain tumor.

chorea: A disorder of nerve centers at the base of the brain resulting in irregular, jerky, involuntary movements.

choreiform: Characterized by irregular, jerky movements like those occurring in chorea.

circumstantiality: Extreme digressiveness in flow of speech.

clonic: The stage of a convulsion during which the muscles alternately contract and relax.

clouding of consciousness: A mental state in which clear-mindedness is impaired and orientation partially lost.

coma: A state of unconsciousness so profound that the patient cannot be aroused.

comatose: An adjective employed to indicate that one is in a state of coma.

combat fatigue: A state of extreme fatigue, apprehension, and mental tension resulting from the stress of battle conditions.

compensation: A mental mechanism in which one covers up or disguises an undesirable trait by calling into play and developing a desirable trait, usually of a contrasting nature.

complex: A group of repressed emotionally invested ideas possessing unconscious activities.

compulsion: Performance of an act in response to an irresistible urge, though contrary to conscious inclination.

conation: The striving aspect of the personality.

condensation: The representation in a dream of several unconscious wishes or objects by a single dream-image or thought. It is a psychoanalytic term.

conditioned reflex: A reflex or response which was originally initiated by a certain stimulus, but is now produced through a second stimulus which was formerly associated with the first.

confabulation: Fabrications invented to fill in gaps in memory.

conflict: A painful emotional state resulting from a tension between opposed and contradictory wishes.

confusion: A state of mind characterized by lack of clear thinking and often by disturbed perception.

constitution: The sum of the bodily and mental qualities that have been received by heredity.

conversion: The transformation of repressed conflict or affect into a physical manifestation, as a hysterical paralysis.

cyclothymic: Characterized by contrasting mood-swings of depression and of exuberance of spirits.

delirium: A mental state characterized by more or less clouding of consciousness, dreamlike and incoherent thinking, illusions, hallucinations and restlessness or stupor.

delusion: A false belief unshakable in the face of reason.

dementia: A lasting impairment of intellectual capacities.

dementia paralytica: General paresis, or general paralysis of the insane.

depersonalization: Loss of the sense of one's self, of one's body, or of the reality of others.

depression: A persistent feeling of sadness often accompanied by feelings of hopelessness, inadequacy, and unworthiness.

deterioration: An impairment of the emotional and higher mental aspects of the personality.

disorientation: Impairment or loss of ability to recognize and locate one's self in respect to time, place, or other persons.

displacement: Transference of affect from one idea to another.

dissociation: A mental mechanism whereby certain aspects or activities of the personality escape from control of the individual.

distractibility: A tendency for the attention to be easily drawn away from its focus by external (distracting) stimuli.

drive: An innate prompting toward a particular type of behavior.

dynamic: Pertaining to the causes or effects of mental activities, with emphasis on their motivation.

dynamic psychology: An explanation of behavior and other mental phenomena as a succession of causes and effects, with emphasis on instinctive drives and motives.

dysarthria: An impairment of speech or articulation due to disease of the nerve cells or fibers supplying muscles of speech.

echolalia: The reiteration of what the patient hears spoken.

echopraxia: The automatic repetition of the acts of another person.

ego: The conscious self; that part of the personality which through the senses brings one into conscious relation with his environment.

Ego-ideal: Name given by Freud to the conscious part of the superego; in general it corresponds to what is understood by "conscience."

elaboration: A mental mechanism occurring in dreams in which the content of the dream becomes a coherent whole.

elation: An emotional disturbance marked by intense pleasure and a feeling of buoyancy.

emotion: A mental state involving a distinctive feeling-tone.

encephalitis: Inflammation of the brain.

episode: A transitory phase in a disorder.

euphoria: A mental state characterized by unfounded feelings of well-being, optimism, and bodily health or strength.

exaltation: Intense elation.

extraversion: A type of personality characterized by the directing of one's psychic energy to objects and affairs outside one's self.

extravert: One whose personality type is characterized by extraversion.

feeblemindedness: Defective development of the mind.

feeling-tone: State of one's emotional feelings.

flight of ideas: A rapid succession of superficially related ideas.

free associations: Ideas which are allowed to arise spontaneously without conscious restraint or selective criticism. The analyst seeks to bring up such associations and their contents during the process of psychoanalysis.

fugue: A period of nonremembered activity during which the patient disappears from an accustomed abode.

general paresis: A disease of the brain caused by syphilis and resulting in various mental and physical symptoms.

grand mal: A major epileptic attack with convulsive movements, unconsciousness, and amnesia.

hallucination: An imaginary perception.

hebephrenia: A form of dementia praecox characterized by silliness, mannerisms, and deterioration of personality.

hebetude: Mental dullness.

hemianopsia: Blindness of one-half of each eye.

hemiplegia: Paralysis of one side of the body.

heterosexual: Characterized by sexual attraction for or toward persons of the opposite sex.

homosexual: Characterized by sexual attraction for or toward persons of the same sex.

Huntington's chorea: A hereditary disease of the nervous system characterized by jerking choreic movements.

hypermnesia: An exaggerated degree of retentiveness of memory.

hypnosis: An artificially induced state usually resembling sleep and characterized by an increased suggestibility as a result of which certain sensory, motor, and memory abnormalities may be brought about.

hypochondria: A morbid conviction of physical disease in the absence of evidence for it.

hypomania: A mild form of manic excitement.

hysteria: A form of psychoneurosis producing various symptoms, many of which simulate physical disease.

id: Name given by Freud to that unconscious part of the personality which contains the primitive, instinctual impulses and urges.

identification: A mental mechanism whereby an emotional tie with another person is so established that one behaves as if he were the person with whom he has this tie.

idiot: One whose feeblemindedness is of the most extreme type (intelligence quotient below 25).

illusion: A falsely interpreted perception.

imbecile: A person who manifests a medium grade of feeblemindedness. The maximum possible development is to a mental age of from three to seven years and to an intelligence quotient of 26 to 50.

imperception: A failure of a stimulus of the special senses to produce awareness or conscious experience.

incoherence: An absence of an orderly flow of ideas.

inhibition: A checking or preventing of the expression of impulses or desires.

innate: Inborn.

insight: Self-judgment.

instinct: An innate tendency to react in a definite adaptive manner.

integration: A harmonious blending and adjustment of components so that a stable unity is obtained.

intelligence quotient, I. Q.: The ratio of an individual's intelligence, as determined by some mental measure, to normal or average intelligence for his age.

introjection: An absorption of the environment or the personality of others into one's own self, thus producing identification of one's self with other persons or objects; essentially the converse of projection.

introversion: A type of personality characterized by a directing of mental energy toward one's self and one's own experiences.

introvert: One whose personality type is characterized by introversion.

involution: The period when the activity of the endocrine and of the sex glands and of the physiological functions in general begin to decline, generally from 50 years of age onward.

Korsakoff's psychosis: A mental disorder usually associated with excessive alcoholism, characterized by multiple neuritis, memory loss, and confabulation. Named after Sergei Korsakoff, a Russian neurologist.

libido: The original meaning is sex energy or desire. Psychiatrically the word is used to indicate the sum of the vital force or energy that motivates life adjustments.

malingerer: One who pretends illness.

manic-depressive: A term applied to a mental disorder characterized by alternating exaltation and depression.

mannerism: A rapidly performed, semiautomatic grimace or gesture often seen in dementia praecox.

melancholia: Characterizing a temperament given to depression.

mental hygiene: The investigation and furtherance of measures that tend to preserve mental health, promote wholesome, well adjusted personalities and prevent mental disorder.

mental mechanisms: Mental devices employed to meet the emotional needs and purposes of the personality.

moron: An individual of the highest grade of feeblemindedness, i.e., of the grade most nearly approaching normal mental development and having an intelligence quotient of between 50 and 70.

mutism: A condition of being mute or without speech.

narcissism: A psychoanalytical term applied to an assumed early stage of psychosexual development in which the self is the love object.

narcolepsy: A sudden, uncontrollable desire for sleep manifested at intervals.

negativism: A strong resistance to suggestions coming from others.

neologism: A newly constructed or coined word.

neurasthenia: A form of psychoneurosis characterized by a feeling of muscular and mental fatigability, by irritability, and by diminished power of concentration.

neurone: Nerve cell.

neurosis: A word often used with slightly different meanings; the term may be considered as practically synonymous with psychoneurosis.

nystagmus: An involuntary, back-and-forth twitching movement of the eyeballs.

obsession: A pathologically persistent and irresistible idea, emotion, or urge.

oedipus complex: A concept held in psychoanalysis to the effect that the son desires to displace his father and possess his mother.

orientation: Ability to recognize and locate one's self in respect to time, place, and other persons.

overdetermined or *overvalued idea:* An idea with which so much emotional feeling is connected that it tends to dominate thought.

panic: A sudden, overpowering feeling of terror.

paramnesia: A distortion or falsification of memory.

paranoia: A psychosis characterized by fixed and systematized delusions.

paranoid: Resembling paranoia.

Parkinson syndrome: A characteristic group of associated symptoms resulting from disease of certain nerve cells at the base of the brain.

passive: Characterized by inactivity; submissive.

perception: Awareness or conscious experience of external objects as obtained through the special senses.

personality: The blended organization of all the knowing, feeling, striving, and physical characteristics of an individual; the general pattern of behavior that results from the organization of these components.

personal unconscious: That part of the unconscious which is contributed by the experience of the individual.

petit mal: A minor form of epilepsy characterized by momentary suspense of consciousness.

phantasy: Daydreaming, imagination, fancy.

phobia: An exaggerated and pathological dread of some object or situation.

preconscious: Ideas of which one is not aware at a given moment but which may be recalled.

preoccupation: A state of being engrossed or lost in thought.

presbyophrenia: A form of senile psychosis characterized by a tendency to confabulation.

projection: A mental mechanism whereby repressed mental processes are ascribed to the external world and so not recognized as being of personal origin.

pseudologia fantastica: An abnormal tendency to make false statements without apparent reason.

psychasthenia: A form of psychoneurosis characterized by obsessions, phobias, or compulsive tics.

psyche: The mental life.

psychic: Pertaining to the mind.

psychic trauma: An emotional shock.

psychoanalysis: A system of psychology developed by Sigmund Freud. It attributes abnormal behavior to repressions in the unconscious, for the investigation of which Freud developed an elaborate technique known as psychoanalysis.

psychobiology: The study of the personality according to the methods and principles of biology.

psychogenic: Caused by mental conflicts or other psychological factors.

psychometrics: The practice of mental testing, i.e., of determining the degree of mental development.

psychomotor: Pertaining to the motor activities initiated as a result of volitional and other mental activities.

psychoneuroses: A group of mental disorders less pronounced than the psychoses. They have no demonstrable organic pathology and do not result in distortion of reality or impairment of intellect.

psychopath: An abnormally unstable individual whose personality is poorly integrated, i.e., is not harmoniously developed and blended.

psychopathology: The science which investigates and seeks to trace and understand the mental factors, influences, mechanisms, and phenomena occurring in mental disorder.

psychosis: A major form of mental disorder resulting in considerable disturbance of personality.

psychotherapy: Treatment by psychological methods such as persuasion, suggestion, hypnosis, and psychoanalysis.

psychotic: Pertaining to a psychosis; a term often used to signify that a person is suffering from a major mental disorder.

ptosis: A drooping of the upper lid.

racial unconscious: That part of the unconscious which derives from ancestral experience.

rationalization: A mental mechanism whereby ostensible reasons are, without being apparent to the rationalizer, devised to justify behavior actually based on other motives.

reaction-formation: A character trait, usually the exact reverse of the original trait, developed to keep in check and conceal repressed tendencies.

reactive depression: An emotional depression produced by an incident or experience that might naturally tend to produce sadness.

reference, idea of: A misinterpretation whereby it is believed that the activities of others have a personal reference to one's self.

regression: A tendency for some part of the personality to revert

to some form or channel of expression which belongs to an earlier phase of development.

repression: A mental mechanism by which ideas which would be painful to consciousness are forced into the unconscious.

resistance: Opposition to a conscious awareness or recognition of particular material contained in the unconscious.

retardation: A slowing up of the flow of ideas.

schizoid: Characterized by a shut-in, unsocial type of personality given to phantasy and with more or less inadequate emotional life.

schizophrenia: Nearly synonymous with dementia praecox. A mental disorder characterized in general by hallucinations, phantastic delusions, and a disorganized emotional life with relative intellectual preservation.

sensorium: An inclusive term for all the special senses.

siblings: Children of the same parents.

situation psychosis: A psychosis arising from the individual's inability to cope with a difficult situation or experience.

somatic: Pertaining to the body.

somnambulism: Sleepwalking.

spasticity: A tendency to an involuntary and unnatural contraction.

status epilepticus: A state characterized by rapidly recurring epileptic convulsions.

stereotypy: A prolonged, monotonous repetition of words, movements, or attitudes.

strabismus: Squint.

stream of thought: The progression or continuity of thought.

stupor: A mental state characterized by nonresponsiveness and by real or apparent partial unconsciousness.

subjective: Pertaining to or derived from one's own self, feelings, or mind, as contrasted with external objects, qualities, and forces.

sublimation: The unconscious process of transforming the energy of repressed tendencies and directing them to socially useful goals.

super-ego: Name given by Freud to the repressing and inner critical aspect of the personality.

suggestion: The process of influencing another person by verbal or other means.

suggestibility: A susceptibility to suggestion.

suppression: A tendency to dismiss from consciousness the unwanted memory of thoughts, desires, or experiences.

symbolization: A mental mechanism whereby ideas are represented in forms so figurative that the real meaning is not apparent.

syndrome: A group of associated symptoms.

syntonic: Characterizing a type of temperament which is appropriate and adequately responsive emotionally.

temperament: The general nature of one's feeling-tone.

tension: A feeling of strain or intensity.

tonic: The stage of a convulsion during which the muscles are in a sustained contraction.

train of thought: The flow or sequence of ideas.

transference: The emotional attitude which the patient develops toward the physician during psychoanalysis.

trauma: A wound or injury.

trend: (a) Propensity for thought content to center around a special topic. (b) Inclination toward particular behavior.

tropism: The most elementary type of behavior manifested by living organisms.

unconscious, the: That part of the mind not accessible to conscious awareness.

virus: The poison of an infectious disease.

volition: The act of determining a course of action and of initiating it.

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