When I was in training, I used often to feel that a dirty, ill-kept woman could not be in a clean bed, with her body wholesomely cared for, if only for a few weeks, and ever sink back as far again, as she had been before entering the hospital, and now I am sure of it. These friends were, for four weeks at least, absolutely under my care. I scrubbed and fresh-aired them to my heart's content—a rare chance for me. We had breakfast at 7 A.M., of good simple food, with plenty of milk and cream. Then all patients who could, swept and mopped their rooms, and by 10 all soiled linen was in the tub of formalin solution. All dishes to be returned to the kitchen were in a pail of formalin solution, from which they were taken out wet. Dinner was at 12, supper at 5.30. Baths began at 7, and at 9.30 P.M. all were in bed. For the rest of the time the patients were kept out of doors as much as possible when the sun was warm, and they were sheltered from the wind. For the most part they were fairly content and cheerful, and some were loath to leave.

The results of systematic living in those under-fed, ill-cared-for children and the dissipated men and women were wonderful to watch. After one week of the simple life, the children were like drooping flowers suddenly revived by gentle showers and warm sun. That result alone more than repaid me.

There is much I have not told, perhaps the very things you would like to know. However, I will stop here by simply saying that my faith is strengthened that soap, water, and fresh air are not only wonderful purifying agents, physically, but are as wonderful purifying agents, morally, to a degree beyond my understanding.

EMERGENCY CARE OF THE MENTALLY DISORDERED *

By SMITH ELY JELLIFFE, M.D.

EMERGENCY care in surgical practice, meaning usually "first aid to the injured," is something very definite, whereas in the subject about to be discussed it may mean a number of different things, from sprinkling a patient from a water-cooler to calling up the police department.

We have to consider the care of a mental case at the home, in the street on transportation to a hospital, in the hospital wards proper, and furthermore one has to take into consideration the emergency care of

---

* Notes of lecture delivered before the nurses of the Neurological Institute of New York, October, 1910.

the numerous accidents that occur to the mentally disordered, and of other accidents that bring on attacks of acute mental disturbance. Thus the subject of this lecture becomes fairly well spread out, and offers considerable opportunity for discussion.

We are to speak, in the first place, more particularly of the care of the violent, the destructive and the impulsive. These terms, it must be remembered, are descriptive solely of conduct, and have nothing to do with what the doctor would call a diagnosis. In nearly all of the mental disorders which fall within the scope of the alienist to treat, violent, destructive or impulsive acts are liable to occur, and although these acts may be so performed as to offer some clue to the observer concerning the type of disease under treatment, it must not be inferred that there is any one mental disease in which such acts occur and not in others.

Furthermore, in discussing the care of such patients let it be firmly held in mind that, inasmuch as such types of conduct may occur in various mental disorders, any uniform method of handling them is bound to invite discomfiture, for the wild excitement of a patient suffering from what the alienists would designate as the manic phase of a manic depressive psychosis requires quite a different mode of approach from the patients whose excitement is due to the disease general paresis, and which, to the untrained observer is quite similar to that of the excitement of the former.

Secondly, we should not lose sight of the fact that violent and destructive states are rarely continuing. The lurid picture of wild excitement with which literature abounds is rarely met with in real practice, and with proper modes of treatment need continue, when present, only under certain limited conditions.

Thus the first question that should be brought to your attention, even should you imagine that you are to deal with patients who do not know what they are doing, is that of your mode of approach on your first introduction to your patient.

Before going further into the question of violent and destructive actions, let me say a word in explanation of what we understand by pathological excitements, and what significance they may have from the standpoint of the physician working with mental cases.

You can all readily understand that the contrasting states of excitement and of depression must have always stood out in the picture of the mentally sick. You may not know that these two states formed the basis of the classifications of mental diseases for the earliest Greek physicians, and that even to-day for the laity mania is synonymous with excitement, and melancholia with depression. With the advances

made, however, by physicians who have studied the workings of the mind, it has become apparent that a number of different diseases of the brain machine can give rise to excitements and the same is true for the depressions, and I wish by the use of a figure to illustrate just this point, and to show you into what different divisions the excitements may be divided, and then we can study some of the physical and mental signs by which they may be recognized. Naturally, in order to look after such varying excitements, some knowledge of their cause is necessary.

Let us imagine two circles—the inner one representing the great mass of miscellaneous pathological excitements; in the days of Hippocrates they would all have been called *paranoias*, or *amentias*, or *phrenitis*, and perhaps some other names. Some of the first conditions which gave rise to these excitements that were recognized by these early physicians were those due to the acute diseases, such as pneumonia, typhoid fever, malaria and the like, and for many years the word *phrenitis* was applied to these excited maniacal states that accompanied the fevers. This was the first recognition that these excitements might not all be of the same kind. It was probably also soon recognized that strong drink gave rise to a mania, and *delirium tremens* was well known in the early days. Thus a group of toxic excitements was split off from the others, and the big group of the manias was still further limited. This process of sorting took place gradually and finally we find the group of excitements split up into a number of groups. The deliria of fevers, or infectious psychoses, the toxic and exhaustion psychoses or deliria, the excited mental states due to meningeal diseases, the excitements due to organic disease like tumor, foreign bodies, cerebrospinal syphilis, epilepsies, and multiple sclerosis. When, in the middle of the last century general paresis was clearly recognized, this cut off a large section from the maniacs, and then they were further reduced by the growing knowledge of dementia præcox excited states, of hysteria, etc., until finally there remains only one true mania—the mania of manic depressive insanity.

It has taken thousands of years to reach this point, and it is not improbable that the circle will be still further divided and subdivided into different groups which are all quite unlike with the exception of the one common factor of excitement. Unfortunately the day has not yet arrived in psychiatry when the tendency to name a disease according to one striking symptom has been overcome, but it is slowly arriving. I bring this matter up because in your work in controlling these excited patients you will soon learn to distinguish the earmarks of these differing psychoses and not fall into the faulty habit of regarding all violent acts as similar.

It is frequently said that the best policemen on the force are those who have gained their experience of how to handle people as attendants in those hospitals that treat mental illnesses. This simply means that the same principles apply to the handling of the healthy and of the diseased. Whereas one finds differences in degree, there are few differences in kind, and if for so-called normal people the first impression is of value, it is of even greater importance in the first impressions in the mind of an individual who is more apt to react immediately to his first impression than is the more balanced mind and controlled healthy individual.

First impressions then are to be carefully considered. You as a nurse have to be of help and assistance—that is your key-note. You are a friend, not a hireling and a paid stranger. You are not to wait to be asked to do things, but should anticipate the desire and do the needed thing with neatness, despatch and resolution. Remember that practically all excited patients, unless working with their own deliria or in confusion, are keenly alive to what is going on, and that injudicious talking may only serve to excite suspicion ever ready to feed on mental pabulum. In the beginning of your work, be a worker, and remain a sphinx. When through your head and hands you have made yourself needed, then you may be able to afford to talk, but above all do not be gushingly sympathetic in word or in action. I shall return to this attitude of treatment in speaking definitely of certain cases with which you may have to deal.

Be eternally vigilant. The emergency is to be met with at every turn, and is to be anticipated. By this I refer to the actual conduct of the patient, which may result primarily from his mental disorder, as well as the accidents and emergencies that may arise, dependent or independent of the disease. Mischievousness, maliciousness, downright destructiveness are found in the manic, the paretic, the dementia præcox case; accidental choking may result in the deteriorated, the stupid, the senile, the confused; delusions of persecution may lead to acts of extreme violence, while delusions of unworthiness, of sinfulness frequently lead to attempts at self-destruction. Convulsive seizures in epileptics, in paretics may occasion severe accidents. Thus a great variety of acts, violent, destructive and impulsive, must be constantly guarded against.

In endeavoring to follow out one's work in as efficient a manner as possible, and yet to be on the alert for the accidents and emergencies just referred to, it is important that the external evidences of an over-watchful, over-suspicious attitude be suppressed. Vigilance should be there constantly, but masked; the removal of objects likely to suggest weapons of violence must be done unostentatiously and yet effectively;

the nurse should arrange the furniture in a room so that the minimum opportunity for accident or confusion be afforded. It is in the sphere of avoiding accidents that the greatest efficiency is attained. Slippery rugs, polished floors, protruding rockers of rocking chairs, useless jim-cracks, hot water radiators, toilet chains, steam pipes, machinery, steps, hangings, all of the usual surroundings should be carefully scrutinized in advance as to possible complicating factors for the particular case in hand, and one's mind already made up as to the proper method of meeting an emergency.

Much useless contention or irritation that leads to violence is avoided by the watchful nurse, and attempts at impulsive acts, particularly suicide, can be aborted. Constant and thorough watchfulness is imperative and will meet with its reward. It goes without saying that a nurse who loses her head should not attempt to work with those suffering from mental disorder, for the accidents and emergencies that come up do so at most inopportune moments and under conditions which are usually most trying. Quick sizing up of the situation and prompt action, preferably not too prompt if one is apt to be rattled, are required. Further situations call for inaction, and the skilful nurse learns how to refrain from action, and thus avoids unpleasant issues that otherwise would result in conflicts and even violence.

Violent, destructive and impulsive acts, as I have already pointed out, are not the attributes of any particular kind of mental illness, but rather may be found in a number of quite different kinds of mental disorders. As a rule, patients when suffering from a mental disorder, in the course of which they show such motor manifestations, are best treated in a special hospital, and in private work one is rarely called upon to care for such cases. Only in the beginning of the psychosis, previous to transfer to a hospital, will the private nurse be called upon to observe and care for such forms of disordered conduct.

Violence as a symptom, a motor manifestation of loss of control or excessive irritation of the motor symptoms, presents a number of gradations and a variety of forms. Hence in the beginning permit me to call attention to the fact that the note on the history chart "Patient is violent and destructive" in reality means very little to some one else who has not seen the acts themselves performed. This permits me at this time to call to your attention a point of primary importance, concerning which I shall have occasion to refer again and again. I mean the method of recording your facts concerning these motor manifestations. I say facts advisedly, for unfortunately nurses, and even physicians, get in the bad habit of recording judg-

ments and inferences rather than facts. So instead of recording "patient is violent and destructive," write just what the patient did. "Patient sprang from bed, went to window, banged with great violence upon window with hand several times, paced backward and forward in the room, stumbling over the objects in the room, muttering meanwhile 'Take them away; they are after me; the red things, they squirm,' then beat the air with his arms," etc. From such observations the character, maybe the cause, of the patient's activities can be judged by the physician. This is important, for excitement takes different forms in different mental disturbances, and much can be learned of the fundamental psychosis from accurate descriptions of the motor manifestations. Thus the violence of a post-epileptic furor is very different from that of the delirium tremens violence, or that of the excited manic, and yet again from that of the hysteric and the paretic. From the description cited one can easily draw the inference, yes, almost come to a positive conclusion that the patient had delirium tremens; the motor restlessness, the violence of trying to escape something, the presence of hallucinations of sight, all point to some form of toxic delirium.

Such deliria may result from a variety of intoxications. Infections and exhaustion also give rise to practically the same types of deliria, so they may be discussed under one head as the toxic, infectious and exhaustion deliria. These excitements are apt to be quite violent, but may vary from slight agitation to the wildest forms of furibund violence, coupled with destructive and homicidal possibilities in the event of a struggle. In the milder grades the patients are oriented both as to time and place, but in the severe grades this lack of orientation is very manifest. Although one may talk with such patients, and hold their attention for a time, they usually soon wander off and commence to work with their own ideas. Loss of knowledge of one's surroundings with no loss of ability to express one's self, or no failure to understand what is being said is a very striking characteristic in these deliria. From the patient's attitude of looking about, under the bed, at you, suddenly over his shoulder, working with his hands meanwhile, it may be in the motion of driving a horse, or running a sewing machine, or laying bricks, etc., one can see at once that he is in what is termed an occupation delirium—he is doing his daily occupation over again in a dazed dreamy excitable way, and is seeing objects about him at which he strikes, or spits, or dodges, or kicks, or at which he throws some missile. There is anxiety, or even fear, in his emotional attitude. This is the typical mild or severe delirium of the toxic, infectious or exhaustion case. It is present in chronic alcoholism, delirium tremens; in the delirium of infection after

childbirth, in the exhaustion delirium of excessive lactation, in anæmia, in a post-pneumonia or post-typhoid case. In times of war and stress soldiers frequently suffer from this type of delirium and the ancient descriptions of the old-time furious lunatics are largely drawn from such cases.

In the milder cases, by falling in with the mood of the patient—by taking the supposedly-finished bit of hypothetical garment, by diverting the attention as the excitement wanes, one can keep such patients in bed and prevent their hopping in and out and walking around, whereas an offer made to restrain them would result in most violent and vehement protest and maybe lead up to an assault. In the more severe grades of such deliria the same character traces are present, but the patients cannot be diverted, and require for the most part physical or chemical restraint to which I shall refer later.

(To be continued)

HIGH CALORIC FEEDINGS FOR TYPHOID PATIENTS *

BY MARION ROTTMAN
Bellevue Hospital, New York City

WITHIN the past five years experiments have been made to prove that withholding food from a patient with a temperature is a fallacy. Heat is produced when any material combines with oxygen. Then food is to the body what fuel is to an engine, and when food is withheld the reserve supply of nourishment stored in the body oxidizes. The reserve supply consists of the carbohydrates stored in the liver and muscles as glycogen and the fatty deposits under the skin. When the first reserve, that stored in the liver and muscles, is exhausted the fat is consumed and eventually the protein-holding tissues. Of course during this process the body loses in weight and when, after an ordinary run of fever, the patient begins to convalesce, his convalescence must extend over the period of repair to those tissues consumed.

The principal food elements which, when taken into the body, yield heat and energy and repair tissue, are carbohydrates, proteins and fats. Carbohydrates yield a large amount of heat and energy and comprise

---

* Read before the Bellevue Alumnae Association, December 18, 1911.