My observations suggest that in treating hysterical patients by the annihilation treatment of Bini and Milligan we are taking the risk of producing a new symptom which it may be difficult to remove. I therefore regard it as contraindicated in such cases. Considering the frequency of hysterical features in all neurotic conditions, the scope of this method in the treatment of psychoneurotics seems very limited. Possibly intensive E.C.T. has a place in certain chronic schizophrenic states, but my experience with it in that type of patient is too small to allow me to express an opinion.

Indications for Shock Therapy.

By E. C. Dax, B.Sc., M.B.,
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It is time the term "shock therapy" was dropped. Its meaning is not clear, we constantly attempt to avoid shock to our patients, it is not always therapy and the term does not do us much good in the eyes of our colleagues or the public.

The various forms of treatment usually referred to in this way will be considered in turn. The attitude towards convulsions has had to change. The effect of insulin comas has been attributed to the convulsions which may occur, but precautions are now taken to avoid the fits. Electrical convulsion therapy is just as effective when the muscular contractions are eliminated with curare; convulsions are avoided in prolonged narcosis though the results have been attributed to an induced epileptic state. We have shown that section of the lower portions of the frontal lobes in leucotomy operations is in many cases more effective than the upper incisions, though by this means the subsequent convulsions are practically eliminated.

There is much to be said for examining the role of consciousness in the effects of these treatments and the part played by the diencephalon in psychiatric disturbances. Too great an importance has been paid to the motor rather than to the receptor side in association with its affective relations, and we have, I believe, much to learn from the study of the effects of the various physical treatments approached from this angle. The epileptic manifestations may be simply the end products of a more fundamental diencephalic disturbance from which the therapeutic effects are obtained.

In retrospect it may well be shown that the so-called shock therapies have passed their day and that we are beginning to embark upon a new era of applied pharmacology which is growing with added understanding from the advancement of these empirical treatments. It is, however, still unpredictable as to whether the use of drugs exerting their actions on one or other portion of the nervous system will be as effective as other means of stimulating the brain centres to the production of biochemical changes within the body.

Arising from such considerations as these the distinctions between electrical convulsive therapy and leptazol (metrazol, cardiazol) become of interest. We have generally used leptazol in preference to electrical convulsive therapy

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in feeding difficulties, stupor, in depressions associated with marked delusions, and in cases with much psychomotor activity, as in mania and certain varieties of schizophrenia. The distinction between leptazol and E.C.T. was supposed to be one of fear, but this has been disproved, whilst the period of delay between the injection and fit, which also has been held responsible, can be practically eliminated by using a higher dosage of leptazol than is usual. There are certain other differences; for instance, that with leptazol there are less memory defects, tuberculous lesions are more easily reactivated, there are some differences in the variety and strength of the fit, and that in consequence more fractures occur, whilst various sedatives have different actions on the form of the induced fits or their threshold.

In general there is now a fair agreement in the use of the physical forms of treatment. E.C.T. relieves the symptom of depression in most varieties of illness, though its most striking effect is probably seen in the cases of involutional depression where the prognosis has been completely changed; for instance, it has been said that approximately twice as many of these patients now recover in about a quarter of the previous time. In the simple schizophrenics with apathy, most people, I think, prefer at least to start treatment with a longish course of convulsion therapy. It is of interest that all these conditions, for which E.C.T. is usually given, react well to the orbital incisions of selective leucotomy. Convulsion therapy is also widely used in states of psychomotor activity either in mania or catatonia excitement. Some would prefer to use leptazol in these cases; others, multiple electrically induced convulsions. In catatonic excitement convulsion therapy can usefully be combined with insulin comas. In the agitated depressions there is much to be said for giving electrical convulsions in the waking hours of a preliminary prolonged narcosis, and a similar procedure is often useful in those patients who become restless and noisy in their waking hours. Multiple electrically induced convulsions have also been reported to be of use in breaking up neurotic reactions resistant to other forms of treatment, although the confusion and memory loss may be severe.

Insulin coma treatment is still the method of initial choice in most cases of schizophrenia, but few hospitals have the facilities for using this therapy on any but the earlier cases, and in any case convulsion therapy may be preferred in such instances. In this country insulin comas often seem to be used with convulsion therapy in catatonia and preceded by E.C.T. in simple schizophrenia. There have been some advances in recent years in the additional means of approach used in conjunction with the comas. The comas are but a part of a course of treatment, which involves attention to every portion of the patient's life during the period of treatment. In this light the psychological approach, individually, in groups or through the arts, now appears to fill a more important place than was previously the case.

There has been no reliable evidence to suggest that the subjection of the early schizophrenic in the out-patient department to either E.C.T. or electronarcosis has anything to recommend it over insulin coma therapy. It would still appear that a case needing insulin should be fully treated, but that the results of such treatment are possibly to accelerate the discharge of patients

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with illnesses from which in any case they might eventually attain a remission. However, the degree of recovery seems to be better than before insulin was used. I think there is a point here which has constantly to be kept in mind. As more is known to the public about psychiatric illness and its treatment and further out-patient clinics are opened, patients seek admission earlier than before, and in many cases we may see schizophrenic reactions associated with adolescent instability. A proportion of these were successfully dealt with by general practitioners in the past and perhaps a fair allowance should be made for this factor in our assessment of the patients and the results of treatment.

We gave up using electronarcosis some months ago after a fairly extensive trial, without success, in cases which had failed to improve after being adequately treated with deep insulin and convulsion therapy. I have not used acetylcholine; triazol and ammonium chloride have been given up, although I am inclined to believe that a further trial of ammonium chloride might be warranted. Lastly we still use prolonged narcosis with sodium amytal and paraldehyde by the mouth. We have treated twelve or thirteen hundred cases, mostly for periods of three weeks, by this means, and still feel that it is of the greatest use in cases of psychomotor hyperactivity, those who are non-co-operative in treatment and some with neurotic reactions, and that it lays a satisfactory foundation for the other forms of treatment and thereby enhances their usefulness.

A Note on the Indications for Shock Therapy.

By T. P. Rees, M.D., M.R.C.P.,

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Our present state of knowledge concerning the changes brought about by shock therapy is such that the application of these forms of treatment is still largely empirical. This is due to the fact that we are not aware of the mode of action of these different modes of treatment and also because the classification of the various forms of mental disorders is still very unsatisfactory. This is particularly true when we are dealing with that heterogeneous group of mental illnesses lumped together as schizophrenia. Many cases of so-called schizophrenia will recover without and even in spite of shock therapy, and I very much doubt whether the concept schizophrenia has done anything to help us in choosing our cases. A diagnosis to have any value should give us (*a*) a clinical picture of the patient, (*b*) an indication of the course of the illness which would be helpful in giving a prognosis, and (*c*) some guidance as to the appropriate treatment for a particular patient. Most clinical psychiatrists will agree that the diagnostic label schizophrenia fails us in all these respects. I read with great interest in the booklet of the International Congress Dr. Meduna's article in which he divides schizophrenia into two groups (*a*) endogenous schizophrenia, and (*b*) symptomatic schizophrenia. He points out that shock therapy is of value only in cases of symptomatic schizophrenia, which is more or less identical with the confusional insanity and the exhaustion psychoses of the English Board of Control classification of mental diseases. He goes

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