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.,

Warlingham Park Hospital.

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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further and shows that there are biochemical differences which can be administered between the two groups. I feel this observation, if confirmed by other workers, will prove invaluable in enabling us to prescribe the appropriate treatment.

In my own hospital I find that the best results in shock therapy are to be obtained by giving E.C.T. in the affective disorders of the psychotic type, particularly in involutional melancholia, including the late involutional melancholias occurring between the ages of 65 and 80 which are often erroneously diagnosed as senile dementia. Favourable results from E.C.T. may also be obtained in—

(*a*) Catatonic type of schizophrenia.
(*b*) Epileptic instability, including epileptic furor.
(*c*) Unmanageable behaviour in chronic psychotics.
(*d*) Reactive depression, particularly in elderly people.
(*e*) Paraphrenia, particularly where there is a marked affective component.
(*f*) Psychoneurotic depression, if inaccessible to psychotherapeutic approaches, but on the whole the psychoneurotics do not respond well to E.C.T.

Insulin therapy is of value in the psychoses of the non-affective type :

(*a*) Schizophrenia, particularly hebephrenia and paranoid schizophrenia, and in the catatonic type combined with E.C.T.
(*b*) Schizoid depressive states and paraphrenia.
(*c*) Schizoid personalities. In our experience very young schizophrenics do not respond well to insulin treatment.

Leucotomy should not be used until other methods of treatment have failed. It is successful in schizophrenia (but is of no value in the hebephrenic type), paraphrenic, manic depressive psychoses and chronic psychoneurotics, particularly obsessional neurotics, where psychotherapy has proved unsuccessful.

I agree with Dr. Mayer-Gross in deploring Sakel's attitude. I think that E.C.T. has a place in the treatment of neurotics in mental hospitals. They are of a rather different type from the neurotics one sees in out-patient departments, and E.C.T. has the effect of making them more co-operative and thus facilitates other forms of treatment. I have used E.C.T. in epilepsy, and found it most useful in cases of epileptic furor. It also has a definite use as a symptomatic treatment ; there are many chronic patients who are more settled and better controlled if given occasional E.C.T.

As for schizophrenia I think that the term has little meaning ; it often signifies no more than that the patient is mad ; it carries no clinical picture, no prognosis, and no clear indication for treatment. It must be recognized that many schizophrenics are incurable by any means so far known. Meduna believes that these were the true endogenous cases ; there were also symptomatic forms and in his biochemical studies he had discovered differences in sugar metabolism between the two forms.

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