during the period of observation. The mean increase in the seventh hour after glycine was about 4·0 mgm./100 c.c., but the actual increase in a particular case appeared to depend entirely on diuresis and the urea excreted. Blood-sugar decreased about 10-15 mgm. per 100 c.c. after glycine ingestion, but tended to approach the fasting level in the course of six to seven hours. The non-glucose-reducing substances were not significantly altered. The non-protein nitrogen fraction (non-urea and amino-N) of the blood was increased after glycine administration. Nitrogen elimination was much increased also and the excess urea-N excretion during six hours of the post-glycine period amounted to 0·23 of the nitrogen given as glycine. The total nitrogen of the urine (less the amino- and urea-N fractions) was increased after glycine, and this was due either to increased elimination or to increased production in the tissues, or to both. Sulphate excretion was maintained at a higher level than was found for controls during the postabsorptive period. It appeared that the sulphate excretion provided a more reliable index of specific dynamic action than the nitrogen excretion during the period of observation in the experiments dealt with here. The examination of schizophrenics after glycine ingestion did not reveal any striking deviation as to their blood and urine chemistry from those in normal subjects. The character of the mean blood amino-N and urine amino-N curves suggested delay in the absorption of the ingested material as compared with normal. Blood nitrogen and urine nitrogen estimations were not significantly different in schizophrenics from the normals. Approximately the excess urea-N excretion after glycine amounted to 0·21 of the nitrogen ingested as glycine. Sulphate excretion on the whole was less for schizophrenics than for the normals, and this could be due to decreased specific dynamic action in these psychotics or to a diminished absorption rate of the ingested material. Blood urea values in schizophrenics and in normal controls after the giving of 15 gm. urea in 100 c.c. were suggestive of delayed absorption, since the rise in blood urea was slower in the former. Conclusions based on blood urea values after glycine without consideration of the urea excretion are not justifiable. The attempt to demonstrate variations in the specific dynamic action of foodstuffs or glycine by ingestion methods in psychotics is also unjustifiable, in view of the variations in the processes of absorption which have been demonstrated in both normal and psychotic subjects.

C. S. R.

PROGNOSIS AND TREATMENT

[40] Prognosis in manic-depressive psychoses.—Reginald R. Steen.
Psychiatric Quarterly, 1933, 7, 419.

From a study of 493 cases it is concluded that an individual would be most likely to recover from his manic-depressive attack if he had a normal previous
personality, a clear heredity, no previous attacks, or a previous attack between his 20th and 30th birthdays, and an abrupt onset of a typical manic or depressive reaction with no delusions or hallucinations. The average duration of the writer's recoveries was 1.51 years.

C. S. R.


While we may learn a great deal about narcissism by applying the technique of ordinary analysis, we fail to help the narcissist. Some new method must be evolved. The attitude toward the mental disease is one of 'watchful waiting,' and yet a fairly large number of cases, for all practical purposes, recover. In each individual case it seems as though some combination of fortuitous circumstances has had influence. The inference is that the therapy of 'watchful waiting' allows the ego to take its own time in gradually adapting itself to the outer world. The value of the fortuitous circumstances mentioned apparently consists in their providing to the weak ego the love and support it requires, and in their granting it the extended opportunity for slowly making ready for the changes which the instincts and reality impose. The purpose of a psychoanalytic technique would be to make such an outcome less the result of chance, more the product of enlightened effort. It may be that the relationship of analyst and patient will never assume the conditions of an ordinary transference-analysis; but through a modified technique the ego is given the chance to resume its interrupted growth at a speed of its own choosing. It can be made possible to discharge emotions without at once facing the retributions of the real world. It should be a relationship where the analyst goes with the patient rather than the reverse. Thus is promised the possibility of overcoming that primary mountain of resistance which has hitherto defeated most attempts to analyse the narcissist.

The early stages of treatment may conform largely with the pleasure-principle, but eventually as the transference becomes stronger there must be slowly offered an influence towards accepting the reality-principle. The ultimate aim of therapy would be to bring together narcissistic libido and object-libido into a united release upon real activities. It must be held that it is possible to strengthen the ego. All that is asked of the patient is that he talk about himself. The problem becomes one of allowing the analyst to be recognized as not completely attached to the patient's ego but requiring some projection of libido in order to gain narcissistic satisfactions. Once a narcissistic transference is established the procedure is very similar to that followed in the analysis of the transference neuroses. The danger may be that too much may be expected of the narcissistic patient.

C. S. R.

Five patients resided continuously for two and a half months in an oxygen chamber at a concentration of approximately 50 per cent. oxygen. During this time they received treatments of carbon dioxide and oxygen daily. After each carbon dioxide inhalation attempts were made to establish communicability with the patients. Two of the five gained a state of remission and the clinical history of these had indicated a favourable prognosis. A second group of five patients were treated similarly except that no communicability attempts were made. None of these showed improvement. A third group of five resided in the oxygen dormitory without carbon dioxide treatment and without communicability attempts. None of these showed any improvement. A fourth group of five, living under normal atmospheric conditions, were given daily inhalations of carbon dioxide and oxygen. Here one showed clinical improvement but did not gain a remission.

The blood chemical studies showed no effect of long-continued oxygen inhalation on the urea nitrogen, uric acid or blood sugar content of venous blood. Basal metabolic determinations varied so much that no consistent conclusions could be drawn. Under various psychological tests no consistent improvement was observed in the patients who did not gain a remission. From observations made, it does not appear that oxygen and carbon dioxide treatment of catatonic dementia praecox patients is to be advocated as a general therapeutic procedure.

C. S. R.
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