**Dr. Emil Kraepelin:**

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**III.Agitated States.**

**B. Mania** (pages 241-261)

The fundamental manifestation of this disease picture, compiled under the name mania, constitutes an abnormal facilitation in the thought processes and the transformation of central feelings of pleasure into actions. Whereas in active melancholia, the dominant pathological moment could be found in the powerful all-consuming affects, which by their influence brought about only imaginings with depressive content and were violently vented by means of compulsive motor reactions, here the perception of outer and inner impulses is so facilitated that even a mild intensification of the latter suffices immediately – admittedly only momentarily – to attract attention. Disposition fluctuates rapidly and unexpectedly from one extreme to another, but tends to be predominantly buoyant and exalted. External excitement is often not so much the expression of violent, compelling affects, as it is the result of easy and prompt transformation of every impulse into an actual action, of the loss of central inhibitions, whereas a healthy person mostly suppresses such impulses as they arise.

According to the intensity of the symptoms, various degrees of manic disorders can be determined, which however overlap without any defined borders, but nevertheless offer significant characteristics relative to symptoms and prognosis.

The mildest forms of mania were summarized by Mendel (Mendel: *Die Manie, eine Monographie,* 1881) under the term hypomania. The disorder often proceeds within limits, which makes it very difficult for the layperson to identify. The perception of outer impressions and the process of imaginings is facilitated, the interests of the patient expanding in the most varied directions making him seem much more alert, perceptive and capable than before. It is the ease with which distant similarities are apprehendedwhich often impresses the listener. The patient is capable of witty phrases and insights, puns and surprising comparisons, which however, on closer inspection are mostly less valid comparisons, and, similarly, of feats of fantasy based on such heightened gifts of observation and combination.

Within their environment gifted patients thus occasionally, in these forms of mania, seem to bein a state of genial euphoriaand increased intellectual ability, until their thoughts lose coherence due to the increased elation, and even skeptics have to admit to the pathological nature of the observed changes. Invariably, even in the mildest forms of the disorder, the lack of inner coherence of thoughts, the inability to follow a consistent series of concepts, theinability to calmly, logically work through and order given ideas, the volatility of interests, the abrupt and unexpected jumps from one thing to another, are all exceedingly characteristic. Nevertheless, patients often know, with great effort, how to temporarily obliterate these phenomena and for a time to gain mastery over their aimless mental processes. In unguarded moments and especially in their writings, it will, however, mostly be possible to determine these symptoms.

Often, as a result of the volatility with which external impressions are conceived by the patient, illusions of all kindsdevelop, particularlyof faces, less frequently hallucinations may also come about. Vague similarities lead to mistaken identity; the objects within his environment sometimes have faces, pull faces, move, etc. The delusions which sometimes become apparent are based on these distortions of perception and on the ease with which every imagination gains power over the content of the patient’s thoughts, without meeting with any critical rectification. The patient may think that he is in a very noble house, surrounded by distinguished personalities, that he is destined for an honor, etc. Nevertheless, very often he has a suspicious mistrust within himself about these ideas, which hinders him from uttering these unequivocally and coming to terms with them. Often the presence of these ideas only becomes known once the patient talks about them after recovery.

The fundamental disposition of the patient is mostly buoyant. Admittedly this phenomenon is not established in the process of the illness from the outset; rather it is only the lability, the facilitated change of disposition that is characteristic for mania. The perception of ease with which all psychological processes take place, the falling away of inhibitions, are all a source of perpetual feelings of pleasure, which result in an especially exalted disposition. Do we not see, in the first stage of drunkenness, a rapid sequence of perceptions and acts of will, which are also usually related to feelings of pleasure! An important confirmation of this view comes from the reaction that the patient has toward outer influences, such as those which obstruct his actions. Any dissent, or anyone disallowing his wishes and so forth, will cause a significant increase in irritability in his disposition. Even minor events bring about severe, but quickly passing, affectsof anger.

The self-image of the patient usually presents asgrandiose. For him there are no difficulties and obstacles; everything he tackles has to have a successful outcome. Part of the malaise is a lack of insight into the illness: He feels so healthy and capable, as never before in his life, and disregards every suspicion of a psychological disturbance with laughter or indignation. Every new impression is construed optimistically in the light of the reigning feeling of pleasure, and in this manner serves to increasingly strengthen the self-satisfaction of the patient. The outer world appears to him in the ‘rosiest light’; the most foolish undertakings and ideas are taken up by him with completely uncritical enthusiasm. He sees everyone as a friend, meets such excellent people; there is money lying in the streets, fortune smiles upon him, and all the lesser and greater deprivations of existence, which had previously embittered his life, shrink and disappear when faced with the feelings of youthful strength and flexibility which invigorate him.

In the field of behavior, manic exaltation is expressed in increased activity. The patient has an urge to go beyond himself, to have lively interaction with his environment, to play a role. He thus starts to go out a lot, to visit taverns, societies, places of entertainment, to travel, to write many long letters, to take care of all possible matters and relationships, which previously lay far from his mind. He enters into many relationships, builds castles of air and throws himself, with quickly changing enthusiasm, from one undertaking to another, without ever completing anything. In this vein, on the spur of the moment, he may undertake a long, unplanned journey, collect all manner of useless things, make meaningless purchases and barters, because every new object excites his desire, to such an extent that his pathological desire to own some or other longed for object, occasionally leads to theft and fraud. This interest mostly wanes as rapidly as it arose; so that, in the next moment, the thing which had to be acquired by any means is then discarded, given away, or squandered without any further thought.

The outer behavior of the patient, to begin with, becomes conspicuous due to his inflated self-esteem and obsessiveness, then the restlessness and unsteadiness. Very lively and exalted expressive movementsare combined with theatrical, stilted gestures. Clothing is conspicuous, perhaps dandyish, but at the same time careless and slovenly. Handwriting has large pretentious features, many exclamation and question marks, much underlining, and in addition, many blotches and a certain cursoriness in the outer form. The patient leads conversationswherever he goes, pushes himself forward at every opportunity, wants everyone to notice him; he often talks about himself, often in the third person, to give himself a certain esteem, he postures, strongly exaggerates his accomplishments and achievements to his notable acquaintances, without sticking closely to the truth. He often unashamedly lets himself go, offends decency and custom, tells obscene jokes in the company of ladies, behaves with cordial familiarity towards strangers and people of a higher social standing, becomes best friends and enters a state of familiarbrotherhood with anyone that comes along, and gets into frequent conflict with his environment and public order, because he follows his momentary whims and inspirations, leading to all kinds of willful, imprudent and improper actions. Soon the patient, who may have been disciplined and respectable previously, in his dynamicmania begins to give himself over to all kinds of excesses, gets drunk, plays pointless games, remains out all night, hangs around brothels and dubious locales, smokes and uses snuff excessively, eating strong spices and so forth. In women, the exaltation is often expressed in lively sexual desires thatare especiallynoticeable ina conspicuous way of dressing, in shameless behavior, suggestive intimacies, in the tendency to attend balls, to be coquettish, to get involved in love affairs and to read risqué novels. Often these conspicuous changes in character are not initially seen by society as pathological, instead they are viewed as lapses in morality, and vain attempts may be made to correct them by means of friendly discussion and social measures. The patient himself is not particularly affected by this; he seems to know how to adequately justify all his singularities and new habits: he would like to enjoy his life and needs to let go a bit, and so forth. In some cases, this elatedmania remains as described. As a rule, however, the disease picture develops in intensity. Accompanying the increase of receptivity, ever more abundant information streams through the portals of the patient’s senses, so that the individual perceptions alternate in an accelerated colorful sequence. Ultimately, every item that is observed by the sweeping eye, every sound penetrating the ear, demands his attention, so that he is entirely incapable of, systematically and in context, following an event in the outer world according to one particular ‘point of view’. All perceptions, however, due to the volatility and ease with which interest is distracted, remain unclearly and superficially apprehended, as they come about through the play of coincidence rather than selective observation.

It is entirely the same in the case of the sequence of ideas. Here too, every memory image that arises is associated with an element of pretension in the consciousness of the patient, which supplants what went before and is supplanted in turn by what follows. This abnormal facilitation of apperception, which makes the act of choosing from given impressions and imaginings impossible, and which meekly surrenders the patient’s content of consciousness to the arbitrary influences of the environment and the play of associations, ultimately allows the most distant and superficial similarities to be enough to determine associative connections between completely heterogeneous elements. As a result of such often uncontrollable, convoluted mental leaps, which often come about due to simple word associations, rhymes and suchlike, the facilitated process of conceptualization eventually loses all inherent cohesion; in other words, the symptom of disorientated flight of ideas develops.

The capacity for any kind of intellectual processing of received impressions, for the execution of independent logical thought, is suspended. The most illogical ideas are readily accepted by the patient, the most crude contradictions remain unnoticed in all facilitated considerations, because, in the meantime, new images again and again interrupt and lead the sequence of thoughts in this and that direction, ‘from the hundredth to the thousandth’. Just as easily as individual external and inner impressions have entered consciousness, so they are forgotten. The patient often no longer knows what he said or did previously, evenafter only a few minutes; he forgets what he had wanted to say, that he was about to wash himself, dress himself or eat, but only because the manifold new images and intentions that have arisen within him have obliterated the previous ones.

An almost consistent phenomenon in the course of intensive manic exaltation is the appearance of hallucinations, mostly having the character of centrifugal distortions. They are fantastical, change frequently, the content of the imagination being related to the false perception of disparate sense areas: colorful moving scenes, nodding laughing figures, angels, large armies, music, loud voices, mostly pleasant, and only more rarely with annoying content etc. Cases where hallucinationsappear at the outset in huge quantities and continuously dominate the situation have been summarized under the description ‘hallucinatory mania’.

Hallucinations often connect to delusional ideas. Mostly the content of these is more expansive; the patient claims to be emperor, king, Christ, the mother of God or immortal, etc. These delusions are however always just passing phenomena; they are not processed internally, nor taken into the consciousness of the personality, but should instead be seen as notions which have only gained an element of intensity as a result of the general feeling of increased capability, and due to the facilitated lack of critical ability, which for the time being remains uncorrected.

Disposition ismostly expansive in character, it is however definitely not consistently so, unlike melancholic conditions; instead there is almost always a rapid and frequent change of affects, in which the feelings of pleasure however mostly gain the upper hand, and which thus tend to give the disease picture its peculiar coloring. In the middle of paroxysms of the most exuberant exaltation, a sudden, unexpected sad resentment will make its fleeting appearance, accompanied by vehement crying and wailing, which will disappear as rapidly as it came about, giving way to the previous state. Or there may be intermittent, lively outbreaks of furious petulance along with the tendency to aggressive acts directed toward the environment, which sometimes dominate the disease picture to such an extent that a category of ‘angry raving mania’ (mania furiosa) has been established. These experiences certainly confirm the view that mania is not a particular affect, but that it is specifically characterized by the ease and speed with which the most varied affects develop and again disappear. Without a doubt the rapid changes of theseis frequentlydetermined by external causes, such as how the patient is treated in his context, arbitrary conceptions, delusions, hallucinations and occasionally also the contrast between these factors.

Corresponding to the increased liveliness of the affects, the motor exaltation also gains in exceptional intensity. The patient is dominated by a reckless urge to move, which often does not allow him to rest either in the day or at night. Almost without a break his ideas come rapidly and he perorates incoherently, grimaces, laughs, then cries, then is angry again, or sings in between. Hejeers, whistles, claps hands, jumps and dances around in the room. He cleans and wipes the floor, the walls, the windows, even with his own feces or urine, he bangs and drums on the door, undresses and rips his clothing into thin strips so that he can knot the pieces a hundred times over and drape it fantastically. In the same way, other reachable objects are also taken apart to be reassembled in new ways, as determined by the active imagination of the patient at a given moment. All kinds of useless items, such as stones, pieces of wood, shards of glass, nails, dry leaves, scraps of paper are collected eagerly and hoarded, so that they can be used to scratch on walls, furniture, windows or cover them with painting or writing. By using chewed bread all kinds of sculptural artworks of dubious value are made. Always inventive, always busy he carries out such plans, greatly admiring his own ability. Often due to the lack of other materials, his own secretions and excrement serve as mediums.

Sexual arousal is vented by means of disgraceful speech and in shameless masturbation. In the case of the female gender, also in the loosening of hair, salving with saliva, frequent spitting out, ranting with obscene expressions, and particularly a tendency to sexual suspicion of the guards.

Patients afflicted with mania are not particularly dangerous to their environment, although due to their constant loud restlessness and their tendency to willful, boisterous, often very coarse jests, they are frequently very annoying. Bouts of angry agitation, which may be brought on by unsuitable, irritating treatment, or due to uncontrollable antipathies, delusions etc., may result in violent assaults with blind destructiveness, in which case the patient may become extremely dangerous.

In the most extreme degrees of manic agitation, consciousness is very considerably clouded. The perception of the outer world is completely disorientated, altered in a dream-like way by numerous fantastical hallucinations, and the process of perceptions is precipitous, incoherent and disjointed, the content is vague, unclear and blurred. This is accompanied by an intensive drive-like urge to move. The movements themselves lose the character of psychologically motivated actions and appear simply as aimless and futile symptoms of the intense central state of agitation, which in particularly severe cases can also sometimes be observed in the elements of ‘nervous’ irritability and paralysis, spasms in the muscles of the face and extremities, disturbance of speech, and so forth. The patient rolls on the floor, slides along, kicks with his feet, claps his hands, rhythmically hits the ground, bores his head into his pillow, snorts and blows, and so forth. Speech is extremely impaired; the patient strings together incoherent, unintelligible syllables into a meaningless sequence, or utters only inarticulate groaning shouts. These most severe, prognostically unfavorable forms of mania have also been described as ‘mania gravis’. There is however no complete consensus regarding this description.

Sleep is very significantly disturbed in cases of mania. Even in its mildest forms the patients often spend their nights occupied in various excesses or projects, go to bed very late and then get up again at daybreak to go for long walks, write letters and suchlike. In cases where the agitation is of a greater intensity, there is usually complete insomnia, with only one or very few hours of interrupted sleep, which state continues sometimes for weeks and even months. Appetite is increased, sometimes significantly, but the constant restlessness often prevents the patients from taking in regular nourishment. Nutrition tends to decline in severe cases, body weight showing a regular decrease, but which admittedly usually is not significant. In the case of mania gravis, weight drops rapidly, the skin becomes pale, cool and dry, fat disappears very swiftly, and the facial features sink. Temperature is normal or above normal, especially in the case of continuous muscular activity, the pulse somewhat faster. Mendel found a notable decrease of phosphoric acid content in the urine.

Often there is increased hyperesthesia, which in severe cases can be so extreme, that if suddenly touched, the patients abruptly recoil and in the case of strong external stimuli get into a veritable paroxysm of broad reactive movements. On the other hand, the central susceptibility is significantly reduced due to the severe disruption of attention. The patient does not significantly experience either unpleasant impressions or compassion, and he feels no concern about them as he effectively has no time to. This is similar to the soldier who does not feel the pain of his wound during battle, and it is the same as when we are able to forget everything around us, even our physical needs, when our interest is captured intensively. This explains the manic patient’s notable lack of sensitivity toward heat and cold, hunger and thirst, pain and injury. They jump around naked in a cold room, or sit for hours in the burning sun; they forget to eat or drink in their incessant preoccupation with a deliriousflight of ideas; they oftenruthlessly tear bandages from their wounds and mistreat unsound parts of their body – broken limbs and suchlike – withoutany sign of discomfort.

This central lack of sensitivity is also connected to the complete lack of muscular fatigue. Despite the fact thatagitation of extreme intensity sometimes, with only minor interruptions, lasts for weeks, even for many months, the patient does not become weary and drawn; the use of the muscles shows no sense of decline, partly because the feeling of central facilitation of all actions does not allow fatigue to reach apperception. Due to this factor and also due to the recklessness with which the patients use their limbs, there is the untrue though widespread belief that these patients possess exceptional physical strength. A simulation of this condition always fails after a short time because it is impossible to overcome the lame feeling of fatigue purely by strength of will. Furthermore, in the case of increased irritability in the patient, even the mildest impulse suffices to trigger extensive movements, whereas a healthy person would require a greater effort of will to attain the same effect.

Mania is a relatively common psychological form of illness; it seems that it accounts for about 1/6th to 1/7th of all admissions in mental asylums. It appears most frequently between the ages of 20 and 25; the most important causes of the psychosis are probably exhaustion, the puerperium, lively affects, excesses and general neuroses (hysteria). As a rule, the outbreak of manic agitation is preceded by a melancholic prodromal stage, which can have a short or long duration, even of a few months. The patients are gloomy, disgruntled, utter all kinds of depressive ideas, complain about digestive disturbances, sleeplessness, pressure in the head and so forth. In the case of hypomania and the rapidly developing hallucinatory forms, this initial stage may be completely absent. The change in the level of agitation usually occurs very quickly. The patient seems to be healing, feels free and unburdened, is enterprising, until the increased garrulousness, restlessness and exaltation suddenly reveal the true nature of the situation. The subsequentprogression then varies considerably. Hypomania relatively rarely remains in a mild form; as a rule, manic agitation escalates rapidly into the typically stormy disease picture with disorientated rapidity of ideas accompanied by the lively urge to movement. The psychosis can remain at these rapidly reached heights for a number of months without any significant change. However, there may be improvement and worsening without any particular regularity. Even in the worst cases of the illness, with severe clouding of consciousness, calmness may return temporarily, but such a remission does not justify prognostic conclusions.

The abatement of the disease picture is often accomplished relatively suddenly in cases which proceeded very acutely. The patients simply wake up one morning after having slept calmly and quietly the night before and regain health without any incidents; however, they frequently retain a mild manic agitation with a great tendency to infrequent, short relapses, outbursts of anger, etc. In most cases, however, and indeed in all chronic cases, convalescence occurs with the slow abatement of the symptoms accompanied by various exacerbations and remissions. Sometimes during this period, the manic agitation takes on a form that has a peculiar foolish, feeble-minded character with childish garrulousness and silly behavior. This condition, which is usually described as ‘moria’, can however over time still lead to complete recovery.

Usually there is a long or short period of exhaustion when the agitation abates, particularly in severe cases and persistent forms of mania. The patient is depressed, quiet, gives single-syllable, hesitant answers, utters concern about his future, is sensitive to all strong external influences. His psychological functions, the process of connecting ideas, is slowed down and difficult; even with mild exertion he gets tired; his previous flexibility and activity has completely disappeared. In very severe cases, this may result in dementia acuta. However, these phenomena gradually disappear. As physical strength increases, after some weeks or months the old abilities and resilience return. Memory of the illness is generally clearer in cases where consciousness was less clouded. With hypomania, the patients remember most details very accurately, whereas they tended to remember the time of disorientated rapidity of ideas only vaguely and summarily.

The duration of mania is on average a period of 5-7 months, and seldom stretches over a year. On the other hand, there are single cases where it seems that the illness may proceed very quickly, over a matter of minutes or at the most in hours, a condition which has been summarized under the designation ‘mania transitoria’. Such sudden agitation, which intrudes into a healthy life quite unexpectedly, and then disappears just as quickly, most probably has an epileptic foundation and can thus be categorized among the fugue states described above. However, taking this circumstance into account, there are still a small number of cases where there seems to be a different cause – mostly those cases of angry agitation accompanied by aimless thrashing and fury, to the point of exhaustion, and sometimes also exhibiting individual symptoms of brain irritation. The influence of alcohol (or pathological smoking) especially, or severe effects (iracundiamorbosa) on neuropathic people seems to enhance the development of this condition, the cause of which probably most likely can be traced back to intensive functional irritation by means of fluxionary hyperemia, or perhaps also to toxic influences. The attacks, as a rule, are followed by sleep for a number of hours, from which the patient awakes with a headache, vertigo, fatigue, but also with a clear consciousness, devoid of any definite memory of what had happened. It remains questionablewhether or notthis peculiar disease picture should be included in the disorder spectrum of mania, or in other words, whether the general facilitation of the thought processes and the conversion of central agitation into motion, with which we have become acquainted as the essential criteria for the form of illness described above, is present here.

The prognosis of mania is generally very favorable; about 4/5ths of cases recover; the most favorable is hypomania. In cases of a longer duration of the illness and a higher number of relapses, the chances for healing decrease. The dangers which threaten the patients are, for a start, ‘defective healing’ and the transition to incurable debilities, and then the possibility of death as a result of exhaustion, or from severe somatic complications. In predisposed individuals, the danger mentioned first seems to immediately become apparent. In such cases, there is often not a complete recovery after the disappearance of the severe disease. Instead there remains a lasting increase of lability in the equilibrium of the disposition (increased irritability, mild changeability), sometimes even a slight weakness of intelligence. In other cases, the patient is not able to critically correct the delusions of grandeur and distortions of perception which arose during agitated mania; they become permanent ingredients of the content of his consciousness. At the same time, there are more frequent agitated states, brought about spontaneously or due to external influences, a disease picture which could perhaps be described as ‘chronic mania’, but which decidedly belongs to the disorder spectrum of dementia. When observed over a long time one sees that the patient, especially in the agitated forms of this disorder, passes over to speaking complete nonsense. The deeper affects of the agitated phases are completely lost, but the lack of cohesion and disorientation of the sequence of thoughts continues, as well as grimacing which is residual of the previous urge to movement, untilfinally there is a complete disintegration of psychological life and the last trace of inner activity wanes.

Mania does not often result in death (only in about 3-5% of cases). Death can come about as a result of various intermediate illnesses, as a result of simple exhaustion, injury and fat embolisms of the lung caused by prolonged crushing injuries, or suppuration of the subcutaneous tissue. A particularly pernicious form of illness, which in most cases results in death, is the so-called ‘delirium acutum’, a disease which is believed to be connected to particular changes in brain anatomy. Without a doubt a whole number of different conditions have been thrown together under this heading, as delirium acutum may also appear in very different illnesses (e.g. dementia paralytica, delirium tremens and severe melancholia). In the violent progression of mania gravis, the symptoms of exhaustion become more apparent. Consciousness becomes clouded to the point of stupor; the lively states of delirium become mumbling, the motor agitation decreases to floccillation, fumbling and tugging at blankets. Body temperature fluctuates irregularly between 38° and 39°, and sometimes rises to 41°; the pulse is small, faint and frequent; sometimes there is protein in the urine. Reflex agitation decreases, various signs of paralysis, dilation of the pupils, tremors and uncertainty in movement, collapse of the body, etc. set in, until eventually, due to a gradual weakening of the heart, the patient most often dies. When this severe disease picture has not been caused by accompanying somatic disorders, the main reasons for the occurrence must be sought in the diminishment of individual resilience, either of the organs of the central nervous system in general, or perhaps ofthe neurovascular system in particular. The circumstances indicate that weakening influences, distant dreams, alcoholism, inherited strains, and female gender are all very decisive predisposing factors. The pathological anatomy of mania has until now not been able to demonstrate any confirmed and constant findings. The many reports about hyperemia of the brain and its membranes should not be given much weight due to the established fact of erroneous findings, which are based on the assessment of the congealed blood found in the corpse. Nevertheless, in cases of delirium acutumespecially, the skull content is said to often display very strong hyperemic conditionsand furthermore, the appearance of venous congestion and its consequences: edemic swelling and migration of white and even red blood cells into the perivascular and peri-ganglionic lymph regions. However, these findings are not consistent and their pathogenic relationship to the psychological symptoms have not been demonstrated. The theory of mania is thus, for the time being in any case, wholly without somatic foundation and we have to be content to accept functional disorders in the progression of the psychological processes. A true resolution regarding the relations of these disorders can perhaps only be achieved through experimental analysis.

The diagnosis of mania usually does not present any particular problems. The most important factor is to differentiate them, in relation to prognosis and therapy, from the agitated states of paralytics and epileptics. In this regard, it is particularly the long duration of precursors, the exorbitant, feeble-minded character of the delusions of grandeur and other signs of psychological debility, the mostly older age of patients, as well as the presenceof symptoms of paralysis, that have to be taken into account. In the case of epileptic psychosis, on the other hand, diagnosis is achieved by means of the contingent evidence of seizures, the rapid appearance and disappearance of the disorder, and lastly by the deep clouding of consciousness, particularly with fearful affects. Melancholic states of agitation can also be eliminated by observing the underlying affect and the lack of all-around ease and speed of the combinations; finally, organic brain diseases (such as meningitis), febrile delirium and intoxications are in part evidenced from the clinical history, and in part from the accompanying physical symptoms. Sometimes in such a case the diagnosis fluctuates for a time.

The goals in the treatment of conditions of mania are especiallyto avoid external irritants, but also to reduce psychological agitation. As soon as the patient tends toward bursts of rage and excesses, or enterprises which endanger his financial position, his transfer to an institution is urgently required. In the milder forms, the calm of the institute is already conducive to the abatement of symptoms; for severe cases, isolationis to be considered as a powerful and promptly effective means for calming the patient, which serves the double objective of avoiding outer irritants and the protection of his environment from acts of violence. Mechanical constraints on the other hand are a powerful irritant which result in a steady increase in agitation. Isolation, nevertheless, may also not be implemented for too long. Where it is at all possible, it is highly recommended that manic patients be allowed, at least for a few hours daily, under special supervision, but separated from their fellow patients, to hold forth without hindrance in an empty section or in a garden. Weeks or even months in continued isolation without a break is absolutely to be avoided. For the reduction of increased irritability, long baths are especially recommended, where it is appropriate to spray the head with cold water or apply ice compresses. Often simple bed rest achieves significant calming, especially in the case of patients who are very weak or who lack blood (in the case of extreme restlessness, beds with high padded sides or a low bed with mattresses covering the floor are recommended). In the case of established brain anemia and the threat of collapse, stimulants may be used, such as alcohol (grog, wine, mulled wine, champagne), also camphor, musk or ether. The latter however only has very fleeting results. Concurrent heart weakness indicates careful administration of digitalis. Broom-potassium is recommended in cases of sexual excitement. For continued high degrees of sleeplessness, occasional doses of chloral often have a positive effect; hyoscyamine also often serves exceptionally well. Only in very isolated cases, with the occurrence of brain irritability (cramps, miosis, trismus, neck rigidity, and suchlike), bloodletting as a measure is appropriate, as was implemented extensively in earlier times, and namely in the form of leeches on the mastoid processes. General bloodletting is absolutely to be avoided. In the case of significantly increased reflex irritability, small doses of morphine in the form of injections, administered frequently throughout the day, are recommended. The most important factor is of course the provision of sufficient nutrition and of hygienic needs. At the height of agitation, the disorientation prevents the patient from eating plentiful meals. It is nevertheless possible with patience and the repeated offering of food, and by waiting for a favorable moment, to always achieve this goal. The provision of adequate liquids should also especially be ensured. Sufficient heating of the rooms is important due to the patients’ tendency to undress. Lack of cleanliness can only be prevented by good supervision, which on the one hand should allow the patient to satisfy his needs, but on the other hand every soiling should immediately be cleaned. Neglect of these rules easily leads, in the case of longer periods of isolation, to the highly deplorable habit of smearing, which is difficult to eradicate. Preventing states of exhaustion follows from the rules already discussed above. During convalescence,it is important to provide a suitable activity, which serves as a distraction from the still prevalent psychological agitation, such as conversation to stimulate awakening interests of a healthy kind. Avoiding excesses and moody emotions is especially important here, as these factors represent the most frequent cause of relapse.

The psychological treatment of the manicpatient requires above all that any irritants are avoided as much as possible, as these lead to severe outbreaks of anger and unruliness. An attitude of calm friendliness, only approaching more painful subjects when the patient is in a good frame of mind and careful maneuvering of the patient, are all factors which ease interaction significantly, and make the patient, who in unskilled hands is very dangerous and violent, manageable and good-natured. During convalescence, it is often very difficult to prevent the early release of a patient who feels well, but is still agitated, especially if the relatives have no clear insight in the pathological condition. If the home situation is favorable then a release can be considered at this point, more so than in the case of suicidal melancholics; otherwise one has to hope that the undeterred postponement of this event can be approved on behalf of the patient to occur only after complete recovery.