INSULIN COMA TREATMENT

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The Doctor-Patient Relationship

When a stuporous patient responds only slightly or not at all to insulin, Dr. Sakel advises physical and psychic stimulation. The patient is poked in his ribs or abdomen and challenged to defend himself. Blankets are stripped off his bed and he is ordered to sit up or get out of bed and go to the dining room to eat. When the patient is slow, he is encouraged to be faster. However, this is done in a good-natured fashion, so that the patient gets the impression that the physician has only the patient's welfare at heart. . . .

The writer is convinced that during the hypoglycemic treatment an emotional relationship, which is essentially a transference, develops between most of the patients and the physicians. The physician may not be aware of it but the patient surely feels it. This transference develops frequently even in patients who prior to treatment were extremely disagreeable and refused to talk to the physician or to shake hands with him. . . . Such expressions as, "Doctor, I have a whole world of confidence in you. . . . I believe in you. . . . You are my only doctor. . . . You are a very kind doctor. . . . I will do anything you say. . . . You saved my life. . . ," are a daily occurrence. On numerous occasions, while the patient is in hypoglycemia or after he is taken out and awakes, he will grab the physician's hand and kiss it or demand to be kissed. Many more instances could be cited. . . .

The injection of insulin makes the patient sick both physically and mentally. Food is taken away from the patient, his life is threatened and he becomes a helpless and dependent baby. The patient recollects that when he was a helpless child, his mother used to take care of him. She gave him food, watched over him and was solicitous that nothing wrong should happen to him. Further, he recollects that when he was disobedient, his mother punished him but at the same time she was good to him and took care of him. He received love and security from her but he had to obey and give something to his mother in return, such as good behavior, obedience, cleanliness, et cetera. A similar situation is created during the hypoglycemic treatment. The patient is mentally sick, his behavior is irrational; this "displeases" the physician and, therefore, the patient is treated with injections of insulin which make him quite sick. In this extremely miserable condition he seeks help from anyone who can give it. Who can give help to a sick person, if not the physician who is constantly on the ward, near the patient, and watches over him as over a sick child? He is again in need of a solicitous, tender, loving mother. The physician, whether he realizes it or not, is at present the person who assumes that attitude toward the patient which patient's mother did when he was a helpless child. The patient in his present condition bestows the love which he once had for his mother, upon the physician. This is nothing else but a mother transference.

MARCUS SCHATNER, M.D. Some observations in the treatment of dementia praecox with hypoglycemia: part 2, psychological implications. *Psychiat. Quart.*, 12(1):22-26, 1938.

What It's Like

One patient said, "I dreamed I was on a roller coaster and the place where the roller coaster was, was in Hell."

HAMLIN A. STARKS, M.D. Subjective experiences in patients incident to insulin and metrazol therapy. *Psychiat. Quart.*, 12(4):699, 1938.

Nailed to the Cross

Another schizophrenic asked us, "Why do you kill me every day?" One of our paranoid female patients compared the physician forcing her into [insulin] coma with someone pulling the wings off a fly. This patient had formerly expected to be killed by her husband, and to avoid that had cut her wrist. The treatment, especially the going into unconsciousness, was experienced as the realization of her persecutory ideas. Another patient told us she was nailed to the cross like Jesus as soon as she lost consciousness.

LUCIE JESSNER, M.D., Ph.D., and V. GERARD RYAN, M.D. *Shock Treatment in Psychiatry.* New York: Grune & Stratton, 1941, p. 42.

Forced Insulin Coma Treatment

When patients are actively resistive, force is used, but not without explanation; and when such patients begin to improve, further necessary explanation is given. As a rule, comas are not produced for at least a week. This is to give to the patient an opportunity to accustom himself to the entirely new routine, and to afford better opportunity for him to get to know the therapist and the nurses who attend him. He is prevented from seeing all at once the actions and treatment of those patients further along in their therapy. This can be managed by placing him in a single room, or by terminating the hypoglycemia a little earlier, if he is in a dormitory. Thus, as much as possible, he is saved the trauma of sudden introduction to the sight of patients in different stages of coma—a sight which is not very pleasant to an unaccustomed eye.

ALEXANDER GRALNICK, M.D. Psychotherapeutic and interpersonal aspects of insulin treatment. *Psychiat. Quart.*, 18(1): 187, 1944.

In the Name of Adjustment

What counts alone with most shock therapists is the "adjustment" their fearful apparatus and its brain-searing explosion produce. In effect, there is little difference between the white-coated psychiatrist shock specialist and his primitive forebear, the mud-daubed witch doctor, who also treated diseases of the mind by scaring out, shaking out, routing out, and exorcising by dire agony and inhuman ordeal the demons or devils—today disguised by scientific-sounding names—which they believed caused patients to behave in such deplorable, tactless, or irritating ways. In the name of this adjustment, and in order to bring about the desired quiet and submissiveness, the patient is put through a crucifixion of such torment as one would wish to spare the lowliest animal.

ROBERT LINDNER, Ph.D. *Prescription for Rebellion.* New York: Grove Press, 1952, p. 52.

Rapport with Schizophrenics

It has been recognized that one of the striking characteristics of the schizophrenic patient is his inability to form interpersonal relationships. Both transference and countertransference are often appallingly lacking in the treatment of schizophrenics, and long before the shock treatment era it had been obvious how difficult it is to establish a warm emotional rapport with many schizophrenics. This lack of empathy has even been used as a diagnostic sign in schizophrenia. In insulin treatment it is often the first indication that the patient's isolation is mellowing when he shows an urge for love from his doctor, and thus begins to form an attachment in which the physician can also more readily reciprocate.

LOTHAR B. KALINOWSKY, M.D. Problems of psychotherapy and transference in shock treatments and psychosurgery. *Psychosomatic Med.*, 18:400 (Sept.-Oct.), 1956.

Lying to Survive

Every morning I grew slightly hotter, thirstier, and more uncomfortable during treatment. I would experience sudden palpitations. And then it happened. My mind started breaking up, crumbling up, crumbling like a stale cake. Thus was insanity. I clung to each nurse who came to take my pulse, but couldn't speak. All control went, with such callous stealth, one fought every inch. Then, nothing.

The coming round was equally prolonged. I believe it took about half-an-hour. One seemed to be struggling for one's life. Again and again some monstrous power pushed one under just as one clawed feebly at the speck of light. Gigantic nightmares attacked one like savage beasts. For endless minutes one was hurtled round at breakneck speed. On a glaring platform, the round-shaped exit flashing past, always just out of reach. Slowly, painfully, the whirling circle eased to a gentle rocking motion and turned into the light shade above my bed. I lay trying to focus it. There was no sensation in my body, no power of movement. I felt alive within my own corpse. . . .

Insulin does not improve with use. One traverses the same pattern of grotesque emotions every time. The first coherent thought on return is how many that leaves to go, although one cannot believe it has to be gone through again. The idea is plain fantastic. The minute the injection goes home, one thinks . . . nothing can stop it happening now. The sight of us submissively making up our beds, getting into them and waiting meekly, filled me with impotent rage and bitterness. The thing outraged all decency. It was a travesty of the human soul. . . .

The daily fear of shock treatment, which at first had been a dazed, flat sort of fear, became sharper and more accentuated each time. Just when it seemed impossible to face another dose, I caught a cold and was reprieved. There were only five doses to complete thirty comas. Two days' freedom, and the thought of returning was torturous. The next day was one of judgment. We were all to pass before a committee. This was everyone's big chance, and we all busied ourselves working out what we would say. The Rebel had none of this gnawing and nibbling thinking to do. She said exactly what she thought. I decided to be very politic—hardly original of course. There was a shrewd, peaceable North Countryman who'd say behind his pipe: "Ah just tells 'em what they want to hear." Why, I thought, should psychiatrists be immune from psychology? All men succumb to flattery. So when my turn came, I was gay and witty, I made jokes against myself, denied all my notions . . . told the watchful quartet how clever they were, and exalted shock treatment to the skies. . . . The lame doctor looked quite pink and proud when he informed me of the verdict later on. I was off shock.

MARY CECIL (England). Through the looking glass (*Encounter*, 1956). In Bert Kaplan, ed., *The Inner World of Mental Illness*. New York: Harper & Row, 1964, pp. 222-226.

The Classical Sakel Shock Treatment

[In this paper] I hope to explain why, although the *Sakel Borderline (subcoma) Insulin Treatment* and the *Classical Sakel Shock Treatment* have been at the disposal of the medical profession for more than a quarter of a century, thousands of sufferers from psychiatric illnesses have not been given the chance to benefit by them. There is, it is true, no explanation sufficiently substantiated by experiment of why the Borderline Insulin Treatment and the Classical Shock Treatment are effective, but the favorable results obtained over a period of 28 years of *constant experience with all kinds of psychiatric problems have established their value beyond any possibility of doubt* [Sakel's emphasis].

MANFRED J. SAKEL, M.D. Sakel shock treatment. In Arthur M. Sackler et al., eds., *The Great Physiodynamic Therapies in Psychiatry: An Historical Perspective*. New York: Hoeber-Harper, 1956, pp. 13-14.

A Controlled Brain Lesion

One must keep in mind that the objective of ICT is the destruction of brain cells, in other words the production of a controlled brain lesion.

O. H. ARNOLD, M.D. (Austria). Results and efficacy of insulin shock therapy (1958). In Max Rinkel and Harold E. Himwich, eds., *Insulin Treatment in Psychiatry*. New York: Philosophical Library, 1959, p. 215.

I think what Dr. Arnold means when we think of the insulin shock treatment, has to be done by the destruction of cells; cells that are sick, and new cells which are potentially sick, have to be destroyed. Otherwise relapses will come. That means that one of the most important things is to see that really every cell which is affected is really destroyed.

HANS HOFF, M.D. (Austria). In Rinkel and Himwich, *Insulin Treatment*, p. 222.

Combined Insulin-Convulsive Therapy

Combined insulin and convulsive therapy has been used quite extensively and has become so much a routine in insulin units that a clear evaluation of insulin coma treatment alone has hardly ever been made since convulsive therapy became available. Both Metrazol and electrically induced convulsions are used, mostly when the patient is in deep hypoglycemic coma and shortly before he is awakened. Originally, convulsions were induced to achieve faster suppression of unpleasant schizophrenic symptoms. The slow clinical effect of insulin treatment suggested additional convulsive treatments, which later became a routine in many, though not all, insulin centers.

LOTHAR B. KALINOWSKY, M.D. Insulin coma treatment. In Alfred M. Freedman and Harold I. Kaplan, eds., *Comprehensive Textbook of Psychiatry*. Baltimore: Williams & Wilkins, 1967, p. 1288.