Psychotherapy Guidebook

Elavil Sleep Therapy

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e-Book 2016 International Psychotherapy Institute

From *The Psychotherapy Guidebook* edited by Richie Herink and Paul R. Herink

Table of Contents

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DEFINITION

Elavil Sleep Therapy is a method of treatment for certain non psychotic reactions in which amitriptyline (Elavil) and a phenothiazine (Sparine) are utilized to maintain almost continuous sleep or dozing for a period of three days.

HISTORY

There is historical precedent for this method. Noizet in 1854 wrote of the beneficial effect of sleep lasting three days, and Liebault when it lasts a "considerable time." Janet reported the relief of hysterical paraplegia with four days of hypnotic sleep. These methods seem to coincide with this technique more than those of a Swiss physician, Wetterstrand, who formulated a hypnotic sleep system lasting a three-week period or more.

The method of sleep therapy is to be differentiated from the rest approach, which was formulated by an American, Samuel J. Jackson, and developed and applied by S. Weir Mitchell in 1875. This rest approach utilized

rest, massage, and super feedings and became quite popular and fashionable in America. Its use spread to Britain and France and was applied and theorized there at the turn of the century.

Controversy occurred with these rest-sleep methods. Cabot thought that mental disturbances were caused by emotions and not overwork. Morton Prince thought that these methods would foster the neuroses. Dubois pointed out the difference in those conditions of stress reactions and those of the severe pathologic state.

Janet seemed to be aware of all of these things and was not so simple as to think that prolonged sleep would cure every thing. But he clung to the sensibility of the rest-sleep approach: 'The patient has been exhausted by undue activity. Very well, then, let us prescribe rest. Let us, as far as possible, suppress every form of activity. The subject is not rich enough to bear the cost of the life he is leading. We need not trouble to enquire which items in his expenditure are excessive and ruinous; it will suffice if w~ simply prohibit every kind of expenditure, for then we shall be quite certain that the patient will have to economise his energies. " (Williams and Webb, 1966).

TECHNIQUE

Following a history taking physical examination, and diagnosis, the patient and the family are told that sleep therapy will be utilized in order to

ameliorate the symptomatology. They are told this is symptomatic therapy and is analogous to methods utilized for "combat fatigue" during war (Black, 1970). They are given a description of the procedure and told that this is an initial approach rather than a specific treatment for a specific disease. _

The patient is told that his responsibility will be to sleep, doze, relax, dream, daydream, to get up only with aid, eat what he wishes, and drink abundant fluids. He is warned about dry mouth, postural hypotension, loss of accommodation, and constipation. He is told that no problems will be discussed for the next three days but will be taken up thereafter. He is separated from all responsibility and decision-making. For example, if a patient is worried about the children's care or finances, he is told this is the spouse's or family's problem, and it is not discussed further.

Visiting privileges are based solely upon the anticipated effect upon the patient.

When allowed, it is kept to a minimum with an appropriate, cooperative, supportive, knowledgeable person. Visits should be brief (fifteen to twenty minutes) and occur at mealtimes when the patient is awake (noon or 5:30 P. M.).

The amount of drugs utilized varies, dependent upon weight, previous use of drugs and/or alcohol, and age. In general, the following is ordered:

1. Elavil 25 mg 1M q6h

2. Elavil25 mg p.o. q6h (0-10-25 mg may be ordered)

3. Sparine 100 mg p.o. q6h (50-75-150 mg may be ordered)

4. Valium 10 mg IM/PO p.r.n.

5. The patient is allowed to get up only with aid

6. Blood pressure and pulse q6h (prior to medication)

7. Colace ii h.s.

Sometimes Dalmane (15- 30 mg) or Quaalude (150- 300 mg) can be substituted for Valium. About 50 to 100 mg of Thorazine or Mellaril can be substituted for Sparine.

The nursing care is extremely important. Medication must be varied in order to maintain sleep without excessive hypotension. Blood pressure is taken prior to medication and rechecked as indicated. The nurse needs to control firmly and consistently the program relating to visitation. The most important aspect of nursing relates to the nurse's attitude; a nurse who is comfortable emotionally with this treatment approach is an absolute necessity.

Post-sleep phase. On the fourth day, this regime is discontinued. PO

medication is started as is appropriate. Commonly, Elavil (10-25 mg t.i.d. and 75- 100 h.s.) and Valium (2-5 mg t.i.d.) or Tranxene (SD 22.5 mg) at 8:00 A.M. is utilized. Dalmane (15-30 mg h.s.) can be utilized as a sedative if needed. Mellaril (25- 100 mg h.s.) can be used when indicated. The type medication depends on the target symptoms and basic personality type.

Rehabilitation is carried out on a gradual basis. On the fourth day the patient is up in the room in bedclothes. Meals are served to him in his room. A midmorning rest, a one hour nap following lunch, a half hour rest about 4:30 P.M., and bed by 9:00 or 10:00 is ordered. This is continued for the next few days and decreased as appropriate.

On the fifth day the patient is up and around the unit, usually dressed, and has meals in the dining room. About the sixth day occupational therapy and/or physical therapy is begun as is indicated. Trial visits outside the hospital, with or without home visits, can be ordered as appropriate.

During this post-sleep period, exploratory interviews, conjoint interviews, psychological testing, and further laboratory procedures, as needed, are carried out. It is during this time that a genetic and dynamic diagnosis can be added to the clinical diagnosis and further treatment plans formulated. This may vary from any of the psychotherapeutic techniques, chemotherapy, marital counseling, or combinations thereof.

The total time involved is usually one to two weeks when dealing with an acute stress reaction with a good home situation, and perhaps ten to twenty days with more neurotic symptoms and/or difficult home situations. Appropriate out-patient follow-up is recommended.

APPLICATIONS

This technique is utilized for those reactions usually classified as a stress reaction, one of the neuroses, or one of the psychosomatic disorders. It is contraindicated in the psychoses or more severe borderline states. It is of greatest use in crisis intervention, whether the symptoms are primarily those of anxiety, agitation, tension, depression, obsessions, or are psychosomatic. The depression that responds the best is that classified as reactive in type. This method is utilized as a beginning rather than as a definitive ‘‘treatment” or “cure.” What follows varies as to the individual patient at that particular time.

The following problems sometime occur:

1. Allergic type reactions to Elavil, in particular, may occur with agitation and hyperactivity. Sometimes a delirium type acute brain syndrome may develop (“central anticholinergic syndrome”). Elavil must be decreased significantly or discontinued. Valium and Thorazine are good substitutes for the Elavil-Sparine combination.

2. Overt passive-agressiveness — whether in hysterical, passive-agressive, or emotionally unstable personalities — leads to a poor result. This patient resists being "put to sleep." When this occurs, the method is discontinued and the patient is told why. Often the patient then will ask for a repeat of the method which will then be effective.

3. In severe borderline patients, a psychosis may be precipitated, either schizophrenic or manic in type. (For this reason, an anti-psychotic drug is always used.) In a suspected borderline type, the amount of Elavil is reduced and the phenothiazine is increased (Thorazine or Mellaril is used).

4. Some people are threatened by dreams. They may erroneously think that we are going to analyze dreams, or that dreaming is bad or a weakness. They are encouraged to dream.