THE TECHNIQUE OF PSYCHOTHERAPY

HANDLING EMERGENCIES IN PSYCHOTHERAPY

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Handling Emergencies in Psychotherapy

Although emergencies are not common in the practice of the average therapist, preparation for their proper management, should any occur, makes good sense, since mishandling can be destructive to the patient and ruinous to one's reputation, apart from the medico-legal complications that can ensue. Not only will the therapist have to palliate the patient's turmoil, but will also have to cope with the concerns of the patient's family, as well as the anxieties within oneself. To retain objectivity and composure in the face of ominous happenings will tax the resources of the most stable therapist. Responsibility should therefore be shared with a skilled consultant psychiatrist, especially if the therapist is a non-medical person.

Crucial decisions are essential in emergencies. Knowing when to pacify, when to confront, when to enjoin, when to direct, when to order, when to notify relatives or friends, when to hospitalize, when to prescribe medications, how to evaluate existing stress situations, how to appraise useful support systems, how to gauge available ego strengths, how to bring the patient to an awareness of factors that keep the crisis alive, when to involve the family in the treatment plan, and the solution to other troublesome points requires expertise in crisis intervention practiced in the medium of an empathic relationship.

Among such possible emergencies are suicidal attempts; psychotic attacks; excitement, overactivity, and antisocial behavior; panic states; acute alcoholic intoxication; acute barbiturate poisoning; hallucinogenic and other intoxications; severe psychosomatic symptoms; and intercurrent incurable somatic illness.

SUICIDAL ATTEMPTS

Suicide ranks among the 10 most common causes of death among adults and among the three most common causes among adolescents. Statistics underestimate its true incidence due to flaws in reporting. Most (90 percent) of suicidal attempts are unsuccessful. This is because they are ill conceived and reflect the ambivalence of the perpetrator. Usually they constitute a gesture that communicates a plea for life. About 70 percent of successful suicides are among adults, most occurring in the syndrome of major depression and in alcoholics experiencing periodic depressed states. A disproportionate number of suicides are found among professional persons such as lawyers, physicians, dentists, and military men. The therapist should be alerted to a number of warning signs.

1. Symptoms of severe depression especially in males over the age of 55, social isolation, recent divorce or widowhood, unemployment, alcohol or drug abuse, and physical illness of a chronic or painful nature are predisposing factors.

2. At any age those who have made serious suicidal attempts, or where there is a history of suicide or of affective disorder in the family,

these should be considered danger signals.

3. Dysthymia (reactive depression) resulting from broken or unhappy love affairs, disharmony in marriage, serious fights with parents among the young, bereavements in the elderly, and severe physical ailments may initiate a suicidal attempt. Likewise, personality problems of a psychopathic or hysterical nature with poor impulse control and peaks of violence and aggression may register themselves in suicidal gestures or in suicidal equivalents like reckless driving and dangerous sports.

4. Most likely to commit successful suicide are severe depressions during early stages of treatment when retardation and indecisiveness are replaced by a slight release of energy. Here prescribed psychotropic drugs and hypnotics may be massively incorporated.

Even in well-conducted psychotherapy vague suicidal threats may be expressed by some patients to the effect that they would be better off dead but they are too cowardly to try suicide. Where such statements lack the tone of conviction, it is best for the therapist not to subject the patient to concentrated interrogation around the matter of suicide. The therapist's expressed concern may frighten the patient badly resulting in loss of self-confidence. It may be found that the patient is trying to prove something or to hurt someone with a suicidal threat. Actually, an individual is responsible for his or her own actions, and cannot be watched 24 hours per day to prevent executing a threat if this is what is urgently wanted. The family of the patient may also be helped to resist being blackmailed

by suicidal threats.

The following signs, symptoms, and situations, however, do point to a potential suicidal risk in a patient:

1. Loss of appetite, severe weight loss, insomnia, listlessness, apathy, persistent expressions of discouragement and hopelessness, loss of sexual desire, extreme constipation, hypochondriac ideas, continuous weeping, and general motor retardation which are present at the start or appear in the course of therapy.

2. Irrespective of diagnosis, any patient who has made a suicidal attempt in the past, or who has a history of severe depression, or who is taking antihypertensive and other medications and drugs that are having a depressive effect.

3. A patient who, during therapy, insistently threatens suicide.

4. Dreams of death, mutilation, and funerals.

Where during treatment, the patient talks *openly and seriously* about a desire to "end it all," it is important not to change the topic or to reassure the patient unduly. Rather, a frank talk about the reasons why the patient feels that suicide is the best recourse gives the patient an opportunity to investigate hidden feelings. This will enable the therapist to determine whether the threat is real, whether it is casually made as a dramatic gesture, whether it is a hostile stab at the therapist, or whether it constitutes an appeal for reassurance. Under no circumstances should

the therapist minimize the importance of the threat, cajole the patient, or administer a verbal attack. Arguing with the patient is generally useless. Where the threat seems ominous, the therapist might make helpful statements to the effect that suicide *seems* to be a way out of difficulty, but it actually accomplishes nothing; that there may be other solutions than suicide that are not now apparent; and that suicide is a final act that cannot be undone and that it could always be resorted to later on if the patient so wishes. The attitudes conveyed to the patient in such statements are respect for one's right to self-determination and a reminder that one is not giving oneself an opportunity to explore more constructive actions. Talking frankly about suicide often serves to rob it of its awesome or appealing quality. Where suicide seems imminent in spite of anything the therapist can do or where an abortive attempt is actually made, there is no alternative than to advise responsible relatives to get the patient hospitalized immediately in a closed ward of a psychiatric hospital.

Suicide prevention centers do exist in the larger cities, and they have been used by depressed individuals and their families in crises. How effective these centers are in preventing suicide has not been evaluated adequately. Their impact may be minimal because individuals intent on suicide do not generally call in. Suicide centers do, however, serve a purpose if no more than to act as a referral source.

Hysterical Personalities

Suicidal attempts in hysterical personalities are common and consist of histrionic gestures calculated to impress, frighten, or force persons with whom the patient is in contact to yield attention and favors. Such attempts are incited by motives for display rather then by genuine desires to take one's life. Dramatic performances of an ingenious nature are indulged, during which there is a superficial slashing of the wrists, or feigned unconsciousness with stertorous breathing while placing an empty bottle of sleeping pills alongside the bed, or the gulping of tincture of iodine, or the impetuous opening of gas jets. Feverish demonstrations of suffering and martyrdom continue after the patient is restrained or "revived," until convinced of having emphasized protests sufficiently. The danger of these pseudo-suicidal maneuvers is that the patient's judgment may not be too good during dramatic overacting and one may accidentally go too far and commit suicide even though this was not the original intent.

In treating hysterical cases with suicidal threatenings, we must demonstrate to the patient that we are neither intimidated by nor angry at the actions of the patient. Interpretation of the purpose of the patient's frenzied behavior should be made in terms of the broader neurotic patterns.

Psychopathic Personality

Of a related but more serious nature are the suicidal attempts of the

psychopathic personality. During episodes of excitement, violence, deep remorse, excessive drinking, or temporary psychotic outbreaks, the psychopaths may slash the wrists or take an overdose of sleeping pills. The desire for self-punishment and death are genuine, though temporary. When their attempt has been aborted and they have been hospitalized, such patients recover rapidly, evidence no further suicidal impulses, and express great remorse at their folly. Yet, a short time later, under propitious circumstances, the attempt will be repeated, with further contrition and promises of abstention. Interpretation of the episode is essential, but it usually fails to act as a deterrent to the patient's actions. When the suicidal episodes are motivated by disturbed interpersonal relationships, as, for instance, a broken love affair or rejection by a love object, the continued exploration of the patient's feelings and patterns is indicated. In addition, the therapist may have to increase the frequency of visits and insist on being telephoned when the patient is tempted to indulge in suicide.

Where the patient persists in this impulsive suicidal behavior, after seeming to have acquired insight into operative patterns, the therapist may have no other alternative than to tell the patient that treatments will have to be discontinued. It may be suggested that the patient may perhaps want to start treatment with another therapist. This may give enough of a jolt to the patient to ensure insistence on the therapists continuing, based on the promise that all further suicidal attempts will be abandoned. Whether or not the therapist concedes to the patient's wishes to continue treatment will depend on how the therapist feels

about the patient. Unfortunately, with some psychopaths the threat of discontinuance of therapy may be the only force that can control their explosive conduct. Even here the effect may be temporary.

Schizophrenia

In some types of schizophrenia suicide is a grave possibility. It is most common in acute, excited catatonic states, particularly those associated with panic. Hallucinations may drive certain patients to mutilate or kill themselves. Fear of homosexual attack or of being persecuted may also force some paranoidal individuals to suicide. The methods of self-destruction employed in schizophrenia may be bizarre, including such mutilations as disembowelment and genital amputation.

The handling of the suicidally inclined schizophrenic patient is organized around administering ample sedation, communicating with the family so that they may assume some responsibility, and arranging for transportation and admission to a mental hospital. Electric convulsive therapy is often indicated. Chlorpromazine (Thorazine), thioridazine (Mellaril), perphenazine (Trilafon), or haloperidol (Haldol) in ample dosage (see the section on somatic therapy in Chapter 56) are indicated.

Pathologic Depressions

Depressed episodes may occur in people due to loss of security, status, or a love object; however, the depression is rarely of such depth as to inspire a desire to take one's life. Where the depressed state is extreme, suicide is always a possibility. Among the most vulnerable pathologic depressive conditions are major depression, bipolar depression, depressions in alcoholics, involutional depression, senile depression, and depressions in organic brain disease.

To manage a patient with a pathologic depression, certain palliative measures are helpful. The handling of diet with the inclusion of stimulating and appetizing foods and the prescription of tonics and vitamins may be indicated in anorexia. In mild depression, a stimulant like Ritalin may be useful temporarily to activate the patient during the day, while sedation may be required at night for insomnia. Here small amounts of a mild hypnotic like chloral hydrate (Noctec) may be prescribed to prevent the patient from accumulating a lethal quantity. In more severe depressions, the patient's family or a reliable friend should be contacted and acquainted with the potential dangers. Where the patient remains at home while in a deep depression, a trustworthy adult person should be in constant attendance. The patient should not be permitted to lock oneself into a room, including the bathroom. Sleeping pills, tranquilizers, poisonous drugs, razor blades, rope, and sharp knives and instruments should be removed. Window guards are necessary if there is a chance that the patient may destroy oneself by leaping through a window. Hospitalization on a closed ward with constant supervision by efficient nurses or attendants may be essential. The treatment of

choice is electroconvulsive therapy, which may prove to be a lifesaving measure. Antidepressants are second best where the patient refuses ECT, but the patient must be watched carefully since the early "lift" from the medication may give enough energy to try suicide. Psychotherapy during severe depression is generally confined to supportive measures, as insight approaches tend to stir up too much anxiety.

Fear and guilt feelings are common in the therapist who will usually be in a dilemma about hospitalization. It is urgent that a non-medical therapist secure a consultation with a psychiatrist to share responsibility, to prescribe ECT or proper medications, or to arrange for hospitalization should the patient need it and is willing to consider it. Although a desperate patient can terminate life in spite of any safeguards, there is a lesser chance in a hospital setting, particularly when ECT is immediately started. Usually there is little problem in decision making when the patient has made an unsuccessful attempt. Here relatives and neighbors rush the patient to an emergency hospital service, or the police are brought into the picture and arrange for admission and perhaps for transport of the patient.

Difficulties in decision are greater in the event a patient has mildly threatened to take his or her life, but makes no active gesture to do so, and has no history of past suicidal attempts. Under these circumstances the therapist may have to utilize the greatest interviewing skills (Murray, 1972). The patient may be told that the ultimate responsibility for one's life is one's own. "You probably

won't believe this, but you *will* get over this depression and will feel better. Right now it is natural for you to imagine your suffering will continue indefinitely. It will not." Here it is assumed that the patient is started on a regime of antidepressant drugs (e.g. Tofranil, Elavil, Sinequan) in adequate dosage (see the section on somatic therapy in Chapter 56). In the great majority of patients a frank empathic talk will tide them over the crisis.

It is often important to see the patient frequently and to telephone between sessions to maintain as close a tie as possible.

Miscellaneous Suicidal Conditions

Sometimes a therapist is consulted by the parents or friends of a child or adolescent who has made a suicidal attempt. Examination may fail to reveal hysteria, depression, or schizophrenia, especially when the child is non-communicative to the point of mutism. It is possible here that the child is internalizing destructive feelings. Young drug abusers are particularly vulnerable. Because the youth is non-motivated for therapy and resents having been taken to a psychiatrist, it may be difficult to treat the patient. By following the rules outlined in Chapter 32. Dealing with Inadequate Motivation, and by indicating to the patient that he or she seems to be angry at someone, it may be possible to establish rapport.

A 14-year-old girl, for example, who had made a suicidal attempt by

swallowing 50 aspirin tablets was brought in for a consultation. Refusing to talk except in monosyllables, it was difficult to carry on an interview. The therapist finally remarked, “You must have been awfully angry at someone to have done this to yourself,” The patient blanched, then brought her hands to her face and started compulsive sobbing, which went on for 15 minutes. Intermittent were outbursts in the form of protestations of how “bad” she was for feeling the way she did about her mother. Ventilation of her resentment produced immediate emotional relief and established sufficient contact with the therapist to start psychotherapy.

Should a suicidal attempt have been made, the immediate injuries will have to be treated and artificial respiration instituted if necessary. If concentrated oxygen is available, it should be given. In asphyxiation with gas or from fumes of an automobile 50 cc of 50 percent glucose, injected intravenously, may help prevent cerebral edema. Intramuscular adrenaline (epinephrine), 0.5 to 1.0 cc of 1:1000 concentration, may also be administered.

If suicide was attempted with poisons or drugs, identification of these will permit selection of the proper antidote. Patients who are not unconscious and who have not taken corrosives or petroleum products may be induced to vomit by tickling the pharynx with a finger or spoon, and by giving them a glass of water containing 1 tablespoonful of salt or 1 teaspoonful of powdered mustard or soap suds. This should be repeated several times if necessary and followed by a gastric

lavage with 1 quart of water containing 1 tablespoonful of (a) “universal antidote,” or (b) 2 parts burnt toasts to 1 part strong tea and 1 part milk of magnesia, or (c) table salt. Next, a neutralization of the specific poison with the antidote is attempted and demulcents (flour, starch, gelatin in a paste, or 12 beaten eggs mixed with milk) are given. Finally, the poisons remaining in the intestinal tract are removed by administering magnesium sulfate (Epsom salts: 30 g in a glass of water). Suicidal attempts with barbiturates are handled by inducing emesis, administering “universal antidote,” and preventing shock with measures to be described in a later part of this chapter, under Acute Barbiturate Poisoning.

The Telephone Threat

Where a patient telephones the therapist and states that he or she is about to take a lethal dose of medication (or engage in another kind of suicidal act) the therapist should try to keep communication going especially around any incident that has inspired the impulse to die. The patient’s name should be repeated to firm up the sense of identity and some constructive action may be suggested as well as a reminder that the therapist wants to help as much as possible, and that others care for the patient and want to help. If the patient has already taken the lethal pills or opened a gas jet the address should be obtained while the patient is kept talking on the telephone. Another person should be dispatched (perhaps by a note written by the therapist during an interval when the patient is talking) to call the police, trace the call if the patient refuses to say where he or she is, and

immediately send an ambulance to escort the patient to an emergency room.

PSYCHOTIC ATTACKS

In the course of psychotherapy anxiety may be released that is beyond the endurance of certain patients. A psychotic episode occurring during treatment may be the product of too early or too avid an attack on resistances and defenses in a patient with fragile ego strength. It may be the consequence of a transference neurosis that gets out of control. A good psychotherapist is capable of gauging the ego strength of the patient and of introducing supportive measures should signs of shattering appear. Nevertheless, even good psychotherapists may be unable to control the outbreak of psychosis in vulnerable patients. The quality of the working relationship is a crucial factor. Some therapists are capable of operating sensitively and empathetically with potentially psychotic and even overtly psychotic patients. Other therapists, particularly those who are unable to manage their countertransference, may be unable to work with infantile dependent personality disorders, with borderline, or with psychotic patients. They may have to transfer patients who show tendencies toward psychotic outbursts once the treatment process is under way.

Symptoms that lead one to suspect beginning ego disintegration during psychotherapy are feelings of unreality, depersonalization, excessive daydreaming, ideas of reference, paranoidal ideas, bizarre somatic sensations,

motor excitement, uncontrollable sexual and hostile impulses, propensity for perversions, heightened interest in toilet activities, compulsive talking, fears of castration, and fleeting hallucinations and delusions. These symptoms may appear individually or in combination. For a while the patient may maintain a good grasp on reality, recognizing the unusual or irrational nature of his or her ideas, impulses, and acts. Later on, distortions of reality may occur in the form of fixed delusions and hallucinations, perhaps accompanied by panic reactions, suicidal tendencies, and violent aggression. The first step is to identify any immediate stress factor that is upsetting the patient. Is it in the current life situation? If so, the patient should be helped to resolve the problem or to extricate satisfactorily from it. Is it a consequence of what is happening in therapy? Transference reactions are extremely common, and in a patient with weak ego strength this may pitch protective defenses overboard. Such reactions in stronger patients may be concealed and evidence of them manifested only in acting-out or in dreams. Getting the patient to talk about feelings in regard to the therapist, with proper clarification and interpretation, may restore the patient's equilibrium. It may be necessary to increase the patient's visits during a period of emotional turmoil.

Second, if the precipitating factor cannot be identified, an attempt should be made to get the patient to speculate as to some cause for the trouble. The preferred explanation may then be used as a focus around which interviewing is organized to explore the patient's suppositions or to discover more cogent etiologic factors.

Third, where the support offered through psychotherapy does not restore the patient to an equilibrium in a short time, a neuroleptic drug, like Thorazine (chlorpromazine), Haldol (haloperidol), Stelazine (trifluoperazine), or Permitil (fluphenazine), in proper dosage may be prescribed. Too frequently, inadequate doses of medication are used. A non-medical therapist will have to bring a psychiatrist who knows drug therapy into the picture.

Should a psychotic attack take place it may be handled within the therapeutic situation by a therapist who has a warm feeling for the patient, who is not disturbed by the existing symptoms, and who is capable of modifying the approach so as to bring about the restoration of repressive barriers. The fact that a psychosis has precipitated is usually indicative of something having gone amiss in the therapeutic relationship. If one can admit to oneself the possibility of errors in handling and if one is able to restore the patient's feelings of trust and confidence, such a therapist may be capable of bringing the retreat from reality to a halt. In line with this objective it is best to discontinue probing for conflictual areas and to keep the content of the interview focused on current reality problems. The relationship with the therapist should be kept on as positive a level as possible, the therapist assuming a helpful active role. Under no circumstances should the therapist express alarm at or condemnation toward any of the patient's misconceptions. Listening attentively to the patient's productions, the therapist counters with reality, suggesting that perhaps things seem to be as they are because the patient has been so upset. If disturbing transference is at the basis of

the patient's turmoil, measures to lessen transference, described in Chapters 42 and 46 may be invoked. Should the patient require more support, the frequency of interviews may be increased.

Where these practices fail to bring relief to the patient, it is likely that the therapeutic relationship has deteriorated and the patient may have to be referred to another therapist. The referral can be upsetting to the patient, and he or she is apt to consider it a further manifestation of rejection or an indication of failure. The therapist may explain that the patient's specific problem will probably be helped more by another therapist with a slightly different approach. If the patient is incapable of thinking rationally and if the difficulties are potentially dangerous to oneself and others, a reliable family member should be asked to assume some responsibility in the matter of referral. Should the patient object to the therapist's making contact with the family, the therapist may, if the situation is sufficiently dangerous, have to communicate with the family irrespective of the patient's wishes.

Where self-injury, suicide, homicide, violent aggression, ruinous spending, criminality, or other disasters are possible, hospitalization may be mandatory. If the therapist is a non-medical person, a consulting psychiatrist should be called in. Discussion may convince the patient to enter an institution voluntarily. Hospitalization will, however, have to be accomplished against the wishes of the patient where one is dangerous to oneself or others and sees no need for

confinement. In the event that one is actively resistant and must be hospitalized, intravenous sodium Amytal to the point of deep sleep will permit transport to an institution without the need for physical restraint. A physician should be in attendance in the ambulance that transports the patient in order to handle such emergencies as respiratory paralysis.

The therapist will have to arrange the details of hospital admission in cooperation with the patient's family and, in addition, may have to explain the reasons for hospitalization to them in a reassuring way. In doing this, the therapist may experience some guilt and anxiety, as if accountable for the patient's collapse. It is important, however, not to castigate oneself for what has happened nor to confess to failure; rather, the family may be informed that the patient's personality structure has been unable to stand inner tensions and that the patient has temporarily broken down. A period of hospitalization is necessary to restore equilibrium.

The specific treatment rendered in the hospital will depend on the severity and type of psychosis. In acute excitement or depression with exhaustion it will be necessary to sedate the patient adequately, to correct dehydration by injecting fluids and salts parenterally, and to administer electroconvulsive therapy or intensive drug therapy, whichever is indicated. In milder excitements or depressions sedatives and hospitalization alone may suffice to restore the patient's stability. It is important that the person assigned to look after the patient

avoid arguing with or "psychoanalyzing" the patient, no matter what the provocation, since this will upset the patient even more.

Postoperative reactions after extensive surgery are not uncommon and probably occur in persons who have been maintaining a tenuous emotional homeostasis. For example, a considerable number of cases of psychosis have been reported following open heart surgery. Even in less major procedures, a temporary massive outbreak of pathology (brief reactive psychoses) may occur in unstable personalities. One sees this in some patients receiving hemodialysis for chronic kidney failure. The clinical picture in postoperative reactions will vary, syndromes may resemble organic brain upsets (confusion, disorientation, memory loss), acute schizophrenia (delusions, hallucinations), or affective disorders (depression, agitation, mania).

EXCITEMENT, OVERACTIVITY, AND ANTISOCIAL BEHAVIOR

States of excitement and overactivity developing during psychotherapy are signs of acting-out or manifestations of ego shattering.

During acting-out the patient may engage in destructive, antisocial, or unusual sexual behavior. In attempting to understand acting-out, one's first suspicion is that the patient is protecting the self from awareness of transference by projecting it away from the therapist. Hostile or aggressive outbursts, delinquency, criminality, marked promiscuity, and perverse sexuality are often

products of hostile and sexual impulses toward the therapist that the patient is unable to acknowledge. It is natural to react emotionally when a patient becomes antagnostic toward the therapist. Counteraggression, even though verbal, will only stir the patient up more. Recognizing one's own fear of violence, as well as the pot of anger one may be trying to control that always seeks some kind of release is vital. One should try to get the patient to verbalize anger and outrage without being judgmental and without trying to justify untenable conditions against which the patient is rebelling. If the patient's reaction is an aspect of negative transference, this may be interpreted, but the patient should not be made to feel guilty for his or her behavior. If the patient is responding to some outside stimulus, one should ask oneself: "How would I feel if I were in the patient's situation?" Since the other side of violence is fear, one should try to find out what frightens or upsets the patient and try to act empathic, supportive and reassuring. A simple statement such as "I don't blame you for being upset," may do much to quiet the patient. By acting composed, the therapist may be able to calm the patient. If fear is shown, this may engender more fear and violence in the patient.

MANAGING DANGEROUS PATIENTS

When a patient is being treated who makes a substantial threat against an identifiable third person, the therapist should first assess the degree of dangerousness and possibilities of acting-out as indicated by past history and present lack of impulse control. Then if violence is felt to be possible, a course of

action to protect potential victims should be evolved. Documenting one's decisions in the case record is important. It may be that hospitalization, medication, and intensified psychotherapeutic interventions will eliminate the possibility of actualizing the threat. Non-medical therapists should seek the help of a psychiatrist where a dangerous situation impends. In some cases, confidentiality will have to violated and the intended victim notified. A considerable literature has accumulated around the California Tarasoff case (Appelbaum, 1985; Beck, 1982; Monahan, 1981; Dix 1981; Stone, 1976) that initiated the ferment about dangerousness in patients.

The best way to resolve acting-out is to explore the patient's feelings and attitudes toward the intended victim, to determine which of these are rooted in realities and which are irrational carryovers from the past, and to see if concealed transference is at the basis of the patient's aggression. As long as the patient is unaware of and cannot verbalize proclivities toward the therapist, the patient will continue to "blow off steam" outside of therapy. Skillful use of the interviewing process that brings out verbalizations related to the transference may put a halt to the patient's destructive patterns.

Sometimes it is difficult or impossible to get the patient to analyze transference and in this way to terminate acting-out. The therapist here may attempt to deal with this obstruction by (1) stimulating transference, through devices already described, in order to make its manifestations so obvious that the

patient cannot help but talk about his or her feelings, or (2) controlling acting-out by increasing visits to as many as daily sessions and by the assumption of a prohibitive, authoritative role. If these measures fail to help the situation, therapy will have to be terminated with transfer to another therapist.

Excitement and antisocial behavior that occur as a result of ego shattering may be dealt with after identifying the cause of the present difficulty. A struggling patient may have to be restrained and 5 mg of Haldol injected into the nearest available muscle. Rapid neuroleptization may be essential (Schwarcz, 1982). Supportive techniques are generally indicated, and the patient may have to be put on a regimen of Haldol (2-5 mg), Thorazine (25-100 mg), or Valium (10 mg), repeated at intervals until adequate sedation occurs. If the decline continues, the therapist had best transfer the patient to another therapist, since the therapist is probably unable to control the situation. Where a dangerous psychotic condition develops, the patient's family will have to be apprised of it, for hospitalization will in all likelihood be necessary. Where violent rages or excitement continue, an organic cause such as temporal lobe lesions including epilepsy should be ruled out. It is not usual that a dangerously disturbed or assaultive patient will have to be handled in one's office, but if this is unavoidable common sense dictates that the therapist should be reasonably protected. This means that where a patient is potentially dangerous to oneself or to others, he or she should be sent to a hospital or place where adequate treatment can be given and protection is available if necessary. In emergency units in general hospitals, sufficient personnel should be

available to restrain the patient, (at best four accessory persons are needed, one for each limb should restraint be essential) The attitude of the therapist is a most important factor, an easygoing, calm manner being reassuring for a patient. Since most violence is a consequence of fear, a quiet, secure atmosphere surrounding the consulting room is desirable. Angry threats directed at a disturbed patient merely aggravate the fear and create further violence. More can be accomplished with calming demeanor than with drugs, which, of course, also should be administered where necessary. Once communication is established with the patient and the patient has confidence that he or she will not be hurt, psychotherapy may be possible under the usual office conditions.

INTENSE ANXIETY ATTACKS

Severe anxiety sometimes breaks out in the course of psychotherapy. It may become so overwhelming that the patient feels helpless in its grip. One's coping resources have seemingly come to an end, and one can no longer crush the fear of imminent disintegration. Demands on the therapist then may become insistent, and the patient will bid for protection and comfort.

The handling of intense anxiety reactions will require much fortitude on the part of the therapist. By assuming a calm, reassuring manner, the therapist provides the patient with the best medium in which to achieve stability. Accordingly, the therapist will have to tolerate the emotions of the patient,

conveying a feeling of warmth, understanding, and protectiveness while respecting the patient's latent strengths that have been smothered by the turmoil. Upbraiding the patient for exhibiting foolish fears and attempting to argue away anxiety serve to stimulate rather than to reduce tension.

The best means of handling acute anxiety is to permit the patient to verbalize freely in an empathic atmosphere. Helping the patient to arrive at an understanding of the source of the anxiety, whether it be environmentally oriented or rooted in unconscious conflict, transference, resistance, or the too abrupt removal of existing defenses, promises the quickest possibility of relief. The triad of emotional catharsis, insight, and reassurance operates together to permit of a reconstitution of defenses against anxiety.

Where anxiety is intense, it is usually impossible to work with the patient on an insight level. Here, supportive measures will be necessary to restore the habitual defenses. If the patient is living under intolerable environmental circumstances, a change of environment may be indicated to lessen harsh pressures on him. In the event that anxiety has followed intensive mental probing, a holiday from exploration may be necessary, with a focusing on casual or seemingly inconsequential topics. A patient who has spent many sleepless nights tossing about restlessly or, once asleep, has awakened periodically with frightening dreams may benefit from a benzodiazepine like Valium (5 or 10 mg) orally. In highly disturbed patients 10 mg of Valium intramuscularly or

intravenously may be given. The use of sedatives during the day is to be minimized, if possible, to forestall the sedative habit. If anxiety continues, the frequency of sessions may be increased and the patient may be assured that he or she can reach the therapist at any time in the event of a real emergency. Referral to an experienced psychiatrist skilled in the somatic therapies may be necessary.

Excessive anxiety in psychoneurotic patients is best handled psychotherapeutically, increasing the frequency of sessions if necessary. Where this fails to bring relief, several sessions devoted to "narcosuggestion." that is, reassurance and suggestion under intravenous Pentothal or Amytal (see Narcotherapy, Chapter 56), may be tried. Oral Librium (25 mg, 3 to 4 times daily) or Valium (10 mg, 3 to 4 times a day) may restore the individual's composure, following which the drugs are diminished, then discontinued. Where anxiety is out of control and constitutes an emergency, 50 to 100 mg of intravenous Librium, repeated in 4 to 6 hours if necessary and followed by oral Librium, may be helpful. Some patients respond better to barbiturates than to tranquilizers. In acute anxiety pentobarbital (Nembutal) ¾ to 1½ gr, or secobarbital (Seconal) ¾ to 1½ gr may dissipate symptoms in about 30 minutes. Some patients prefer to take ¼ to ½ gr of phenobarbital sodium every 3 or 4 hours. Barbiturate administration is to be halted as soon as possible because of the danger of habituation.

In borderline or psychotic patients it is wise to institute drug treatments immediately. Haldol, Thorazine, or Mellaril in adequate dosage (see Table 56-3)

may bring anxiety to a halt.

These measures will rarely fail to control severe anxiety in borderline or psychoneurotic patients. In the rare case where they fail, and especially where a transference neurosis is present and cannot be resolved, the patient may have to be referred to another therapist or a short period of hospitalization may be required.

PANIC STATES

The treatment of panic states is more difficult than the management of anxiety. Here the patient is victimized by a wild, unreasoning fear that plunges one into disorganized thinking and behavior or drives one to the point of immobilization. Suicide is always a grave possibility. Admission to an emergency unit in a hospital may be essential, the therapist giving the admission doctor pertinent information about the patient.

Where a patient in panic is seen for the first time, the therapist will be somewhat in a dilemma. The initial step in the management of a panic state with a strange patient is attempting to promote calm by quiet, empathic listening in a quiet atmosphere. Thereafter prescribed a tricyclic antidepressant or MAO inhibitor may be all that the therapist may want to do at the moment. Reassuring the belligerent individual that one is belligerent because one is frightened may have a dramatic effect. Often lit-tie more will be needed than to display interested

attention and to express sympathy at appropriate times. Sorting out the problem in this way will give the therapist clues about appropriate therapeutic steps to take, whether medication or hospitalization necessary (emergency units unfortunately do not usually have a secluded place where quiet interviewing can take place). Where the patient is out of contact with reality, is suicidal, or is aggressively excited, however, he or she will require rapid sedation or tranquilization and probably hospitalization.

Diagnosis is important. The patient may be psychotic as a result of a functional ailment like schizophrenia. Or the patient may be manifesting a toxic psychosis as a result of taking too many drugs or because of a physical ailment. Giving the patient more medication in the latter instances will merely compound the injury. Information about the patient from relatives or friends is highly desirable, even indispensable, in ruling out drug intoxication or physical ailments, such as cardiovascular illness, diabetes, etc., that may be responsible for delirium.

If drug intoxication is ruled out, drug therapy is the treatment of choice for schizophrenic or manic excitements. Rapid tranquilization is indicated to reduce social consequences of morbidity. Not everybody agrees with this, however. In young schizophrenics who are having a first attack there are some who believe that they should be allowed spontaneously in a protected environment to reach a baseline. Thus, Mosher and Feinsilver (1973) state, “We believe that the inner voyage of the schizophrenic person, which is induced by environmental crisis, has

great potential for natural healing and growth, and we therefore do not attempt to abort, rechannel, or quell it before it has run a natural course." Whether one heeds this advice or not will depend on the existing social support systems on which the patient will depend. A congenial hospital regimen with empathic nurses and attendants is helpful. On the other hand, and particularly in older patients or those who have had a previous minimum absence from work and their families, it may be vital to avoid prolonged disability and unemployment which can operate as stress factors after the schizophrenic episode is over.

Restoration to a non-psychotic state is possible within a few hours employing powerful neuroleptic drugs that act on the limbic system and influence the psychotic thinking process. The drug often chosen is haloperidol (Haldol) given intramuscularly. The first dose is 5 mg, then 2-5 mg every 30 minutes until the patient is sedated; the blood pressure should be monitored to avoid hypotension. The objective is to get the maximum therapeutic impact with a minimum of side effects (dystonia, akithesia, and other Parkinsonian symptoms). If the patient falls asleep after the first 5 mg injection, he or she is probably suffering from a toxic psychosis like drug intoxication (e.g., alcoholism), and Haldol is stopped.

Some therapists still prefer chlorpromazine (Thorazine) which is given intramuscularly in 25 to 75 mg dosage according to the size of the patient and degree of disturbance. If the systolic blood pressure standing is below 95, the

Thorazine is discontinued; the patient's head is lowered and the feet elevated. If the blood pressure is maintained satisfactorily, the drug is given every hour until control of the excitement is achieved. The dosage is either increased or decreased depending on how the patient responded to the previous dose. The intramuscular medication is discontinued should the patient fall asleep or quiet down sufficiently. The choice of being subsequently seen on an outpatient basis or immediately hospitalized will depend upon whether the patient is dangerous to oneself or others, the attitude of the family, hospital resources in the community, and the patient's cooperativeness.

What dosage of drug orally for ensuing 24-hour periods will be required can be estimated by multiplying the intramuscular dosage of Thorazine that it has taken to tranquilize the patient by 2⅔ (Ketal, 1975). With Haldol one may give the same dose orally as was given intramuscularly. If the patient is too sedated, this can be reduced. Patients should be seen daily or every other day to make sure that they do not slip back.

Drowsiness and hypotension with Haldol are less than with Thorazine. Extra-pyramidal side effects are more common, however. Where such side effects occur with Haldol or other antipsychotic drugs, 1 to 2 mg of Cogentin by mouth (or intravenously if emergent) or 50 mg of Benadryl by mouth or intravenously may be given. Continuance of the drug for several days is indicated. Reassurance of the patient and the family are important. To avert the pyramidal symptoms,

some therapists give Cogentin prophylactically, but others do not recommend this.

Where intramuscular injection is not possible or urgent, oral medications are used. Here 10 to 20 mg of Haldol may be given in liquid concentrate form for the first day; if no response, this is raised to 40 mg the second day and 60 mg the third day until an effect is achieved. Or Thorazine in liquid concentrate form of 50 to 150 mg dose may be given and regulated according to response.

Intravenous sodium Amytal (up to 15 gr) will put the patient into narcosis. If panic continues following this, the patient may require hospitalization on a closed ward. Electroconvulsive treatments will also often interrupt the excitement. As many as 2 ECTs daily may be needed for a few days, followed by one treatment daily, until equilibrium is established. Where delirium and confusion appear in elderly patients or those with respiratory and cardiovascular disorders, Thorazine may be given for restlessness and paraldehyde or chloral hydrate for insomnia. Should epileptic seizures develop and continue (status epilepticus), intravenous sodium Amytal, phenobarbital sodium parenteral, or diphenyl hydantoin (Dilantin) may be administered.

In hospital settings “sleep therapy” is occasionally instituted, especially in psychotic patients, where panic cannot be arrested through other means (Azima, 1958). Here sleep, which lasts 20 to 24 hours a day, is induced by giving the patient a combination of 100 mg (1.5 gr) Seconal, 100 mg Nembutal, 100 mg

sodium Amytal, and 50 mg of Thorazine. The patient is aroused three times daily, and the dosage of medication is regulated according to the degree of wakefulness. Good nursing care is urgent; indeed, without it sleep therapy is hazardous. During the waking period the pulse rate, blood pressure, temperature, and respiration are recorded; the patient is gotten out of bed, washed, and fed. Daily 2000 cc of fluid and at least 1500 calories in food are supplied, while vitamins are administered parenterally. A half-hour prior to meals 5 units of insulin are injected to stimulate the appetite. Milk of magnesia is supplied every other day if necessary, and a colonic irrigation is given should a bowel movement not occur in 2 days. Catherization is performed if the patient does not urinate for 12 hours. The bed position of the patient must be changed every 2 hours, and should the patient's breathing become shallow, oxygen and carbon dioxide are administered. Sometimes ECT is instituted with sleep therapy, either daily during the first waking period or three times weekly. In this way a deep regression is induced. The average treatment duration is 15 to 20 days. Rehabilitative therapy must follow the sleep-treatment episode.

In manic reactions, after the acute psychotic disturbance is brought under control, lithium therapy may be started. Where panic has occurred as a result of battle conditions or civil catastrophes, a withdrawal from the stressful situation for a few days may be necessary. This should not be prolonged to avoid chronicity in cases where the patient will have to function in an unstable atmosphere.

Once the panic state has subsided psychotherapy is essential to forestall further attacks.

TOXIC DRUG PSYCHOSES

Mixed drug intoxications are common and may constitute important emergencies. It is difficult, if not impossible, to determine what substances the patient has imbibed since even he or she may not know their true nature, purchased as they have been from dubious sources. Knowledge of the local drug scene may be of some help, at least in screening out certain possibilities. The kinds of drugs utilized vary in different parts of the country. They include amphetamine, barbiturates, meprobamate, alcohol, phencyclidine, THC, nonbarbiturate hypnotics (like Doriden, Quaalude), marijuana, morning glory seeds, nutmeg, LSD, mescaline, codeine, DMT, STP, MDA, psylocybin, and a variety of mescaline and amphetamine combination compounds.

In many cases adequate therapy can be administered only in a hospital, which unfortunately may not provide the quiet, relaxed atmosphere that excited patients need. Gastric lavage is limited to instances where the drug was recently taken. After a number of hours it is relatively useless. Hemodialysis is valuable for certain drugs and not for others. In all cases maintenance of an airway, of respiration, and of the cardiovascular apparatus is fundamental.

If the nature of the drug that has been taken is known, for example, from the

blood or urine analysis, it may be possible to prescribe certain antagonistic medicinal agents. Thus, if amphetamine is the culprit, Thorazine or other neuroleptic or antipsychotic drugs can be given. If the patient has taken STP or LSD, antidotes may block some sympathomimetic effects without influencing the hallucinogenic aspects. As yet there is no totally effective antagonist for these hallucinogens. Indeed, Thorazine is contraindicated in STP toxicity because of the hypotensive and convulsive potentiating effect, which can be dangerous. Mildly excited patients may respond to a mild tranquilizer like Valium given parenterally.

Global nystagmus is a frequent symptom in drug psychosis and may serve as a valuable diagnostic indicator. Disorientation, confusion, and hallucinations are common, of course. Because, in the average toxic patient, the kinds of drugs that the patient has been taking are difficult to diagnose, it is best to err on the side of caution in administering antipsychotic drugs. Some of the effects of the substances the individual has been taking, like THC (the pure extract of marijuana), may be reinforced by antipsychotics. After reassuring the patient that recovery will soon occur, he or she may be given 10 to 20 mg of Valium intramuscularly. If there is no improvement in the patient after a few hours and no anticholinergic symptoms, such as a lowering of blood pressure and rapid pulse, a major antipsychotic, such as 5 mg of Haldol or 4 mg of Navane or Trilafon, may be given. These drugs have a marked antipsychotic effect without too great sedation. Where an opiate drug is suspected, an airway is introduced, the heart monitored, fluids introduced intravenously with 50 cc of 50 percent dextrose, 2 mg of naloxone (Narcan) and

100 mg thiamine.

Handling the "Bad Trip"

Individuals experimenting with hallucinogenic drugs, including marijuana and amphetamines, may occasionally experience a frightening journey away from reality and need emergency intervention. In the street vernacular such an experience is referred to as a “bad trip.” Hallucinations may be vivid, and there may be an inability to communicate. Such reactions may be inspired by an overdose of drug or may be the consequence of something frightening that the patient perceives or imagines in the environment or even may occur with small dosage in schizophrenic patients. The atmosphere in which the “bad tripper” is treated is important. It should be as quiet as possible. Sending the person to an emergency hospital unit may induce more panic. The therapist or person managing the patient should be reassuring and gentle and never question the patient about the experience, for this may tend to stir the patient up. One should be asked to concentrate one’s attention on something in reality, like an object in the room, in order to shift the focus from one’s inner life. Rarely are physical restraints or drugs necessary, except when the patient becomes violent. Valium (10 mg intramuscularly, repeated if necessary) is helpful in the latter instance.

The treatment of severe amphetamine psychosis is similar to that of schizophrenic psychosis, namely, prescribing Thorazine or Haldol

intramuscularly. In the case of LSD, psylocybin, or marijuana intake with a psychotic-like response, the therapist should stay with the patient while reassuring that the reactions are temporary and will pass in a few hours. Valium (5-10 mg) or Librium (25-50 mg), or a short-acting barbiturate, may be helpful. Where not successful and panic increases, Thorazine intramuscularly may be utilized with all of the precautions outlined under the section on Panic States. Great caution must rule the use of phenothiazines because of the danger of lowering the blood pressure too much, especially where phencyclidine (PCP) has been ingested. In the event of overdose of sleeping medications containing scopalamine, Thorazine should be avoided. Valium may be utilized as may physostigmine (2-4 mg).

The most frightening consequence of a toxic drug absorption is a status epilepticus, a constant series of seizures without the patient regaining consciousness in between. Here one must establish an adequate airway, particularly being sure that the patient's tongue does not block respiration. Diazepam (Valium) 5 to 10 mg intravenously followed by 200-400 mg of phenobarbital intravenously, or reinjecting Valium alone every 10 to 15 minutes for up to one hour (maximum of 40 mg per hour for adults). Phenobarbital (100-200 mg intramuscularly) is also commonly utilized after a single seizure to prevent status epilepticus. It may be given intravenously (200-400) very slowly. A respirator should be available in the event respiration stops. Phenobarbital may thereafter be given intramuscularly (100-200 mg) every 2 to 6 hours up to 1 g of

the drug in 24 hours. The next day the patient may be started on Dilantin (200 mg intramuscularly).

Acute Alcoholic Intoxication

Pathological intoxication sometimes presents itself as a psychiatric emergency. The reactions range from stupor or coma to excited, destructive, combative, homicidal, or suicidal behavior. Comatose states are best treated in a hospital where a neurological study may be made to rule out other causes of unconsciousness, such as apoplexy, brain concussion, status epilepticus, cerebral embolism or tumor, subdural hematoma, toxic delirium, uremic or diabetic coma, and carbon-monoxide or morphine poisoning. Where alcoholic intoxication exists, a hospital with a 24-hour laboratory service permits of the testing of blood sugar and carbon-dioxide levels required for the administration of insulin and dextrose. Nursing care is important. The patient must be turned from side to side regularly and the head lowered to prevent aspiration pneumonia. The pulse, respiration, and blood pressure are recorded every half hour. Oxygen is given by tent or nasal catheter where respiration is depressed. Intravenous sodium chloride should be injected in amounts of 250 cc every 3 or 4 hours.

Where the patient is conscious and gag reflexes are present, a gastric lavage may be provided, external heat applied, and strong coffee administered by mouth or rectum. Intramuscular caffeine and sodium benzoate (0.5-1.0 g) may be

dispensed every hour until the patient is alert. Intravenous dextrose solution (100 cc of 50 percent dextrose) may be introduced and repeated, if necessary, every hour, and 10 to 20 units of insulin may be provided, repeated in 12 hours. Thiamine hydrochloride (100 mg) intravenously is also a useful medicament.

Excited reactions, including acute alcoholic intoxication, alcoholic hallucinosis, and delirium tremens are treated by intramuscular injection of Haldol (5 mg), or Navane or Trilafon (4 mg), or Thorazine (25-50 mg) repeated if necessary. Many psychiatrists use Librium intramuscularly or intravenously (50-100 mg) or Valium (10-20 mg) repeated, if necessary, in 2 to 4 hours, for alcoholic agitation and impending or active delirium tremens or hallucinosis. Dextrose (100 cc of a 25 percent solution), thiamine hydrochloride (100 mg), and 20 units of insulin are given routinely. Morphine and rapid acting hypnotics (Nembutal, Seconal) are contraindicated; however, sodium Amytal (0.5-1.0 g) is sometimes administered intravenously (1 cc per minute) to quiet a violently disturbed patient. Ample fluids should be given intravenously to combat acidosis and dehydration (approximately 3000 cc daily, containing magnesium and potassium minerals). Other drugs include thiamine hydrochloride (20-50 mg), intramuscularly, and nicotinamide (niacinamide, 100 mg), intravenously, substituted in several days by oral thiamine hydrochloride; vitamin C (100 mg), caffeine and sodium benzoate (0.5 g every 4 to 6 hours for 4 to 6 doses) for stimulation, saline laxatives to promote proper elimination, and Compazine (10 mg intramuscularly) for uncontrollable nausea and vomiting. Milk and eggnog

may be offered the patient; if not tolerated, 10 percent dextrose and sodium chloride solution intravenously may be required. The need to protect the patient from convulsions is urgent in delirium tremens and here anticonvulsant therapy (e.g., diphenylhydantoin) may be necessary.

Acute Barbiturate Poisoning

The popularity of barbiturates as sedatives has resulted in a relatively large incidence of barbiturate poisoning. Patients who have developed a sedative habit may accidentally take an overdose of barbiturates, or the drugs may be purposefully incorporated with suicidal intent. Sometimes the patient, having swallowed a lethal dose, will telephone the therapist informing of his or her act. At other times relatives or friends will chance on the patient before respiratory paralysis has set in.

The usual therapy consists of immediate hospitalization, if possible, and the institution of the following measures:

1. Establishing an airway, such as with an endotracheal tube with suction of secretions.

2. Administration of oxygen, or artificial respiration if necessary, using a mechanical resuscitator.

3. Early gastric lavage carefully administered.

4. Fluids given parenterally (5 percent glucose); in extreme hypotension, plasma injected intravenously.

5. Stimulants—vasopressors like Neosynephrine (2-3 mg) if blood pressure is low or L-norepinephrine (4 mg/L of 5 percent glucose solution).

6. Turning the patient hourly with head slightly lower than feet. (Trendelenburg position)

7. Catherization of the bladder if necessary.

8. Prophylactic antibiotics.

9. Hemodialysis with an artificial kidney, if available, or peritoneal dialysis.

10. Digitalis for heart failure.

11. Avoidance of analeptics.

Clemmesen (1963) has described the treatment of poisoning from barbiturates in Denmark, where the incidence of attempted suicide has always been relatively high. A special intoxication center helps control the clinical condition day and night. The pulse, respiration, temperature, blood pressure, and hemoglobin are monitored every 2 or 4 hours; each day the barbiturate acid content of the blood is determined, as is plasma chloride and bicarbonate, blood urea, and serum protein. The gastric contents are *not* aspirated unless the drug

was taken within the past 4 or 5 hours, and the pharyngeal and laryngeal reflexes are present. Gastric lavage is avoided. The Trendelenburg position is maintained during the first few days to prevent aspiration of gastric contents. Patients are moved to a different position in bed every 2 hours. There is intensive slapping of the chest and suction of secretion from the air passages. Procaine penicillin (2 million units x 2) are injected each day as a prophylactic against infections. Fluids of 2-3 L are given parenterally. Shock, if present, is managed by blood transfusion and perhaps by drugs such as norepinephrine. Complications, such as pulmonary edema, pneumonia, and atalectasis are treated. Stimulation with analeptics is avoided. In the absence of pronounced hypotension, pulmonary edema, and reduced renal function, after the clinical condition is under control, osmotic diuresis and alkalinization by infusions of urea and electrolyte solutions reduce the duration of coma two to four times. Of 92 patients with severe barbiturate poisoning, 85 recovered with this treatment approach.

Poisoning from overdose of nonbarbiturates or tranquilizers like the benzodiazepines, may be managed in essentially the same way, although these drugs are somewhat safer than barbiturates. Amphetamine and pressor amines are contraindicated, although norepinephrine may be given. Should inordinate restlessness or tonic and clonic convulsions follow excessive phenothiazine intake, careful administration of sodium Amytal may be helpful, recognizing the potentiation possibility. Cogentin or Artane may also be valuable.

SEVERE PSYCHOSOMATIC SYMPTOMS

There are a number of psychosomatic symptoms for which the patient initially seeks treatment, or that develop suddenly in therapy, that may be regarded as emergencies. Most of these are hysterical conversion or dissociative reactions, such as blindness, seizures, fugues, vomiting, aphonia, amnesia, paralysis, astasia-abasia, violent contractures, and anorexia nervosa. The patient may be so disabled by the symptom that he or she will be unable to cooperate with any attempted psychotherapeutic endeavor. Immediate removal of the symptom may thus be indicated. Such removal need not block the later use of more ambitious therapeutic measures. In the course of symptom removal, efforts may be made to show the patient that the symptoms are rooted in deeper personality problems, the correction of which will necessitate exploration of conflictual sources.

Hypnosis is an ideal adjunctive technique to expedite the emergency relief of hysterical symptoms. Once symptom removal has been decided upon, it is necessary to determine whether to attempt the removal at one session or whether to extend therapy over a period of several weeks. The severity of the symptom, its duration, the nature of the patient's personality, and the aptitude for hypnosis have to be considered. The approach is an individual one, and suggestions must be so framed that they will conform with the patient's personality, the type of symptom, and its symbolic significance. It is essential to adapt one's language to

the patient's intelligence and education. Many failures in symptom removal are due to the fact that what the hypnotist is trying to convey is not clearly understood by the patient.

If hypnotic removal of the symptom at one session is decided upon, sufficient time must be set aside to devote oneself exclusively to the problem. As many as 2 to 3 hours may be necessary. A new patient may be encouraged to discuss past history and symptoms in order for the therapist to determine the patient's reaction to the illness as well as to gain clues to the patient's attitudes, motivations, and personality structure. Accenting of the patient's protestations of how uncomfortable he or she is, the therapist may emphasize that there is no reason why, if the patient has the motivation, the symptom cannot be overcome.

An optimistic attitude is important because many patients are terrified by their illness and have convinced themselves of the impossibility of cure. However, a cure should not be promised. The patient may be told that hypnosis has helped other people recover and that it can help him or her, too, if one will allow oneself to be helped.

The patient may be informed that it is necessary to test individual responses to suggestion; there is no need to concentrate too hard on what is said because, even though attention wanders, suggestions will get to the subconscious mind and produce desired reactions. An urge to rid oneself of suffering stimulates the desire

to relax and follow suggestions. No indication is given the patient at this time that the symptom will be removed in its entirety, since the symptom may have hidden values and resistance may occur if the patient suspects that its immediate loss is at hand.

Hypnosis is then induced, and confidence in the ability to follow suggestions is built up by conducting the patient through light, medium, and, finally, if possible, deep trance states. Where the patient has a symptom that consists of loss of a physical function, it may be expedient to suggest that the therapist does not want the patient now to use the part. This is done in order to associate malfunction with the hypnotist's command instead of with a personal paralysis.

The next step in treatment is to get the patient, if so desired, to discuss under hypnosis reactions to the illness and what is happening in the immediate life situation.

In some patients active participation is encouraged. A reasonable explanation is given for the suggestions that will be made. The patient may even be encouraged to veto suggestions should there be any suspicion that they are against one's best interests or if there is no real desire to follow them. Active participation is encouraged in patients with relatively good ego strength who shy away from too authoritarian an approach.

Symptom removal by suggestion is far more effective where it is

demonstrated to the patient that one has not lost control over one's functions, and hence is not the helpless victim of symptoms that cannot be altered or removed. This is achieved by showing the patient, while in a trance, that it is possible to create on command such symptoms as paralysis, spasticity, and anesthesia. Once the patient responds to these suggestions the important influence that the mind had over the body is stressed. Then a symptom identical with the patient's chief complaint is suggested in some other part of the body. Should the patient respond successfully, a partial removal of the symptom in the original site is attempted. For example, where there is a paralyzed arm, the suggestion is made that the fingers will move ever so little. Then paralysis of the other arm, which has been artificially produced, is increased in intensity, while a strong suggestion is made that the patient will find that function is restored to the ailing part. In the case of a paralyzed arm it is suggested that the hand will move, then the arm, and, finally, that the paralysis will disappear altogether.

The fact that symptoms can be produced and removed so readily on suggestion may influence the patient to accept the fact that one is not powerless and that one can exercise control over the body.

In order to protect the patient, should the symptom have a defensive function, some residual symptom that is less disabling than the original complaint can be suggested. It is hoped that the residual symptom will take over the defensive function. For instance, in the case of a paralyzed arm, paralysis of the

little finger may be induced, and a suggestion may be given the patient that the finger paralysis will have the same meaning as the arm paralysis and that the finger paralysis will remain until the patient understands fully the reasons for the original paralysis and no longer needs the paralysis. In the event of an extensive anesthesia, numbness of a limited area may be suggested as a substitute.

Posthypnotic suggestions are next given the patient to the effect that the restored functions will continue in the waking state, except for the induced residual symptom. An activity may then be suggested that brings into use the ailing part; the patient finally being awakened in the midst of this action.

These suggestions are repeated at subsequent visits, and, if desired, the patient is taught the technique of self-hypnosis so that suggestive influences may continue through one's own efforts.

Although removal of the patient's symptom at one sitting may be possible and desirable in certain acute disabling hysterial conditions, it is usually best to extend therapy over a longer period. Suggestions are carried out very much better where the patient is convinced that one has been hypnotized and that hypnosis can have a potent influence on one's functions. It may, therefore, be advisable to delay giving therapeutic suggestions until the patient achieves as deep a trance as possible and gains confidence in the ability to experience the phenomena suggested. The employment of therapeutic suggestions at a time when the patient

lacks confidence in his or her ability to comply, and where faith in the therapist is not sufficient may end in failure and add discouragement and anxiety to the patient's other troubles.

A deep trance seems to increase therapeutic effectiveness in most patients. Where only a light trance is possible, the patient may not be able to get to a point where he or she becomes assured of the capacity to control the symptom.

All suggestions must be as specific as possible and should be repeated several times. The therapist should build, as completely as possible, a word picture of what the patient is supposed to feel or to do.

The lighter the trance, the less emphatic should the suggestions be. In extremely superficial hypnotic states the patient may be instructed that there is no need to concentrate too closely on the suggestions of the therapist, but rather to fixate attention on a restful train of thought. This technique is based on the idea that the patient's resistances can be circumvented. A logical explanation may be presented of why suggestions will work, along such lines as that the mind is capable of absorbing and utilizing suggestions even though some resistance is present.

If the patient is in a medium or deep trance, suggestions should be framed as simply as possible. The patient, especially when in deep hypnosis, should repeat the suggestions to be followed. Otherwise the therapist will not know whether the

commands have been understood. Somnambules, may be instructed to carry out instructions even though they do not remember that these were formulated by the therapist. It is also a good idea in somnambulistic patients to give them a posthypnotic suggestion to the effect that they will be unresponsive to hypnotic induction by any person except the therapist. This will prevent the patient from being victimized by an amateur hypnotist who may very well undo therapeutic benefits.

If facts important in the understanding of the patient's condition are uncovered in hypnosis, these may or may not be brought to the patient's attention, depending upon their significance and upon the ability of the patient to tolerate their implications. It is best to make interpretations as superficial as possible, utilizing knowledge one has gained in working with the patient to guide him or her into activities of a creative nature that do not stir up too much conflict.

Termination of hypnosis by having the patient sleep for a few minutes before interruption is advantageous. The patient is instructed to continue to sleep for a designated number of minutes, following which he or she may awaken. The period of sleep may range from 2 to 15 minutes. Where the patient is able to dream on suggestion, this period may profitably be utilized to induce dreams either of a spontaneous sort or of a nature relevant to the particular trends elicited during the trance.

There is no set rule as to how much time to devote to hypnosis during each session. Except for the initial induction period, the trance need not exceed one-half hour. Ample time should be allowed to take up with the patient problems both before and after hypnosis. Reaction to the trance may also be discussed. Prejudice against symptom removal continues in force. On the whole, it is unjustified. Needless to say, more extensive psychotherapeutic measures will be necessary to insure lasting relief.

INTERCURRENT INCURABLE SOMATIC ILLNESS

The incidence of an intercurrent incurable physical illness constitutes an emergency in some patients. Development of certain conditions, such as multiple sclerosis, brain tumor, Hodgkin's disease, cancer, cerebral hemorrhage or thrombosis, or a coronary attack, will make it necessary for the therapist to take stock of the reality situation and perhaps to revise therapeutic goals. Essential also is a dealing with the emotional impact of the intercurrent illness on the individual. Insight therapy may have to be halted, and supportive approaches implemented.

Where the person is suffering from a nonfatal illness and where there is a possibility of a residual disability, as in coronary disease, apoplexy, tuberculosis, and various neurologic disorders, an effort must be made to get the patient to accept the illness. A desensitization technique may be utilized, encouraging the

patient to discuss the illness and to ventilate fears concerning it. The need to recognize that this illness does not make one different from others, that all people have problems, some of which are more serious than one's own, that it is not disgraceful to be sick, may be repeatedly emphasized.

Persuasive talks may be given the patient to the effect that the most important thing in the achievement of health is to admit and to accept the limitations imposed on one by one's illness. This need not cause the patient to retire in defeat. One will still be able to gain sufficient recognition and success if one operates within the framework of the handicap. It is most important for self-respect that one continue to utilize remaining capacities and aptitudes, expanding them in a realistic and reasonable way. Many people suffering from a physical handicap have been able to compensate for a disability in one area by becoming proficient in another.

In patients who tend to regard their disability as justifying a completely passive attitude toward life, an effort must be made to stimulate activity and productiveness. The dangers of passivity and dependency, in terms of what these do to self-respect, are stressed. The person is encouraged to become as self-assertive and independent as the handicap will allow.

Where it is important for the patient to relax and to give up competitive efforts, persuasive or cognitive therapy may be combined with a reassuring,

guidance approach aimed at externalizing interests along lines that will be engaging, but not too stimulating. The cultivation of a different philosophy toward life, directed at enjoying leisure and looking with disdain on fierce ambitious striving, will often help the patient to accept this new role.

Tension may be alleviated by Librium, and Valium; nausea, by Compazine; severe pain in dying patients, by regular administration of narcotics such as heroin. Intractable and unbearable pain that does not respond to the usual analgesics and to hypnosis may require psychosurgery (lobotomy). The practice of permitting a terminal patient to die with dignity (passive euthanasia) without being burdened with useless and desperate artificial means and heroic measures is becoming more and more accepted (Fletcher MI, 1974; Jaretzki, 1975). Interesting also is the publication called *A Living Will* (Euthanasia Education Council, 1974). Antidepressant drugs are often valuable for reducing pain as well as depression.

In progressive, incurable, and fatal ailments there may be a temptation to stop therapy on the basis that nothing more can be done for the patient. Actually, the patient may need the therapist more than before the ailment had developed. Where the patient has no knowledge of the seriousness of the condition, as, for instance, inoperable cancer, the decision of whether or not to reveal fully the calamity is a grave one that will influence the degree of suffering in the remaining days of one's life. In many cases it is unwise to burden one with the full

seriousness of the condition. Statements may be made to the effect that a condition exists that the physician has classified as one that will get worse before it gets better. There is an obligation, of course, not to withhold facts from the patient, but honesty can be tempered with optimistic uncertainty. Many persons cling to a straw extended to them by an authority and maintain a positive attitude to the end. This is especially important in an illness such as AIDS where the degree of suffering may be influenced by the hopeful outlook that a cure may eventually be discovered through research.

In other patients it is sometimes practical to inform them, particularly if they already more than suspect it, that they have a progressive ailment. They may be assured that everything will be done to reduce pain and suffering and to keep up their good health as much as possible. Persuasive suggestions to face the remaining months with calmness and courage may be very reassuring. The patient may be told that while one's life span is limited, one may extend and enjoy it by the proper mental attitude. A guidance approach helps reduce the disturbing effect of environmental factors and permits the patient to divert interests toward outlets of a distracting nature. Where the patient is so disposed, he or she may be encouraged to cultivate religious interests in which one may find much solace.

The patient's time may be so arranged so as not to sit in utter desolation waiting for death. One may also be taught the technique of self-hypnosis to induce relaxation, diminish tension, reduce pain, and promote a better mental outlook.

Mendell (1965) states that patients respond to his statement: “You are not alone. The struggle is not over. You don’t have to worry that what can be done is not being done. 1 am with you and aware of what you are undergoing. I am with the forces that are to help you, and if anything develops, I will bring it to you immediately.” An attitude should be inculcated in the patient that one has fulfilled one’s task well and that it is now time to let oneself relax. Such an attitude may permit of the peaceful, even happy, acceptance of the end of life. Actually, few dying patients do not appreciate the imminence of death, even though their psychological defenses tend to deny it. The therapist may keep emphasizing that the patient, through courage, is doing much for his or her family. What the patient needs is someone to understand and to help mobilize existing resources, to listen closely with respect and not pity, to display a compassionate matter-of-factness, and above all to help him overcome the fear of isolation. The greatest problem in working with the dying patient is the therapist’s own feeling of helplessness, guilt, and fear of death.

The work of Cicely Saunders, Director of St. Christopher’s Hospice (Liegner, 1975) is evidence that for dying patients a great deal can be done toward making their last days comfortable, painless, and free from anxiety. Administration of medications (“polypharmacy”) to render the patient symptom-free has been routine at St. Christopher’s. Diamorphine (heroin) every 4 hours orally, Thorazine and its derivatives, and other medications that are indicated for special conditions, such as dexamethasone for brain metastases and increased intracranial pressure,

may be given during the day and night. The physical atmosphere should be clean, cheerful, and comfortable. The members of the staff must be supportive and participate in working through the stress of separation anxiety. Discussion about incurability and dying are not avoided, and the fact is accented "that death is a continuum of life and is not to be feared." Under these conditions the patients may respond to the passing of another patient with little dread or fear.

If the patient who knows that he or she is dying can be shown that the acceptance of death is a positive achievement rather than resignation to nothingness, much will have been accomplished in making the remaining days more tolerable. Understanding the patient's anxiety, guilt feelings, and depression through empathic listening may be extremely reassuring. Helping members of the patient's family to deal with their hostility and despair may also be an essential part of the therapist's task. Cautioning them on the futile search for expensive and nonexistent cures may, incidentally, be in order. At all times the focus is on relieving the patient's physical pain and distress, on making one comfortable in one's home, and on assuaging mental turmoil. If this is done, peace will usually follow. A good relationship with the patient's family during the last days will help them to an acceptance of the reality of death and lessen the pain of bereavement.

Where death has occurred, the therapist may be called on to render help to the bereaved. Different members of the family will respond with their distinctive reactions to the incident. The detached and presumably adjusted member may

actually need more support than the one who is ostensibly upset and manifestly grief stricken. Since members are bound to respond to the emotional tone of those around them, the manner and mode of communication of the therapist will influence the healing process. Cooperativeness, understanding, sympathetic listening, and an expressed desire to help can inspire friendship and trust in the therapist. As Beachy (1967) has pointed out, it is unwise to whitewash the facts of suffering and death or to try to evade the evolving emotional reactions, however unreasonable they may seem. A completely open, factual manner that is not falsely oversolicitous is best, and where needed, the continued care and attention of a clergyman or other supportive person may be advisable. The value of therapy with groups of terminally ill patients makes this modality one that should be considered in selected cases (Yalom & Greaves, 1977).

Readings on this subject may be found in Aldrich (1963), Cassem (1974), Christ (1961), G.W. Davidson (1975), Eissler (1955), Feifel (1959), J. Fletcher (1972), GAP Symposium (1965), Gerson & Bassuk (1980), Kennedy (1960), Krupp & Kligfeld (1961), Kubler-Ross (1969), Langer (1957), Makadon et al. (1984), Morgenthau (1961), Pack (1961), Reeves (1973), P.S. Rhoads (1965), Rund & Hutzler (1983), Saul (1959), A. Schwartz (1961), Standard & Nathan (J955), Tagge et al. (1974), Wahl (1960), A.F.C. Wallace (1956), Weisman (1985), Worcester (1935), Worden (1982), and Zilboorg (1943).