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Management of "Bad Trips" in an Evolving Drug Scene

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"Bad trips" arise out of an increasingly complex drug scene. Rational therapy must consider completely, social, psychological and physiological factors. Complexity results from the development of new drugs, indiscriminate ingestion, contamination, and adulteration. Drug-induced psychological changes occasionally lead to fatal behavior. Bad trips from anticholinergic compounds may be seriously worsened by phenothiazine treatment. Protection of the patient from dangerous behavior is fundamental to treatment. A clear history is invaluable but should be augmented by physical and mental examinations. Treatment begins with establishment of verbal contact without the use of tranquilizers, if possible. Reassurance and reality defining are often sufficient. With severe ego disruption, medication in combination with verbal interaction may be required. Administration of phenothiazines or sedatives helps to reestablish the observing ego with rapid dissolution of perceptual distortion and reestablishment of the premorbid ego functioning in most cases. Optimal treatment includes a follow-up visit.

Psychedelic drugs produce perceptual and cognitive distortions which, in the majority of instances, are experienced by an individual as strange but tolerable, if not pleasant or even exhilarating. Although the exact reasons for a person's feeling threatened by these changes are unknown, periodically, the necessary mix of factors occurs, and a state of anxiety varying from mild apprehension to panic evolves. The crisis created in an individual when he perceives himself in a threatening situation following psychedelic drug usage is commonly known as a "bad trip." It arises out of an extremely complex drug scene, making effective management an increasingly difficult problem. Attempts at therapeutic intervention should take into account such complicating factors as the increase in the number of drugs available, impulsive use of unknown compounds, adulteration and contamination of drugs, and the lethal potential of psychedelic agents.

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Complications of the Drug Scene

The rising incidence of psychedelic drug usage is paralleled by the evolution of new drugs. The ever-increasing list of "mind expansion" drugs now includes lysergic acid diethylamide (LSD) ("acid"), peyote, mescaline ("cactus"), psilocybine ("magic mushroom"), marihuana ("pot"), 2, 5-dimethoxy-4-methyl-amphetamine (STP), dimethyltryptamine (DMT), methylenedioxyamphetamine (MDA), N, N-dimethylthyptamine (DMA), trimethoxyamphetamine (TMA), methoxymethylene + dioxyamphetamine (MMDA), thiocarbanidin (THC), the amphetamines ("speed"), phenylcyclidine (Serny) [PCP], and various solvents.[1] Recently, reports have appeared describing the use of cough syrup, cold tablets, sleeping pills, heart stimulants, nasal inhalants, insecticide aerosols, asthma remedies, throat disks, and aerosol refrigerants to create the mind-expanding kick (*Medical World News* 9:24-26, 1968). The rapid expansion of this psychedelic pharmacopoeia is accounted for by several factors: (1) the ease with which derivative compounds can be synthesized, (2) the availability of numerous proprietary agents containing potential psychedelics, such as atropine, scopolamine, and various solvents, (3) the desire of an increasing number of people for the psychedelic experience, (4) the prevalence of naturally occurring psychedelic agents, such as mescaline, belladonna, and marihuana, and (5) the large profit that can be realized through the sale of these drugs.

The growing number of psychedelic agents results in changing drug fads as the popularity of one drug gives way to more recent arrivals on the drug scene. The medical director of the Haight-Ashbury Clinic has recently commented on this evolution in psychedelic drug usage.

For better or for worse, San Francisco was the "acid" capital of the world for a long time, and now it has become the "speed" capital of the world.[2]

The tendency of drug users to ingest indiscriminately adds further complexity to an already complicated drug problem and creates a significant danger. Research in the hippie community shows that almost one half of the persons interviewed had taken unknown drugs. At a San Jose, Calif, rock festival, 4,000 unidentified pills were taken! In addition, mixing of various drugs is common, resulting in combinations such as LSD and methamphetamine hydrochloride (Methedrine) and marihuana "cut" with a variety of substances including amphetamines, heroins, mescaline, cocaine, and opium. Contamination of marihuana with tincture of camphor containing 2.2 gm of opium per ounce has been reported in California.[3]

The mixing of cheap psychoactive agents with more expensive psychedelic drugs can greatly increase profits and thus has become common practice. Unfortunately, such adulteration can create serious treatment problems. For example, the central anticholinergics, particularly the belladonna alkaloids, are frequently used for "spiking," thus making treatment of bad trips with phenothiazines potentially hazardous. The anticholinergic effects of these alkaloids are enhanced by the addition of a phenothiazine, and this combination may lead to coma and cardiorespiratory failure. The undesirable consequences resulting from the interaction between anticholinergic agents and phenothiazines have been adequately demonstrated in clinical studies. Patients receiving an anticholinergic agent treated with a representative phenothiazine showed marked central nervous system (CNS) depression.[4]

The psychedelic drugs have established their lethal potential. Although deaths have been reported following the ingestion of STP (probably adulterated with belladonna alkaloids)[5] as a result of cardiovascular and respiratory effects,[6] death from the physiological effects of these drugs is rare. The psychological changes and their behavioral manifestations represent a greater threat to life. Feelings of omnipotence or panic, with an associated increase in irrational risk-taking have led to deaths resulting from such things as leaping from high places with the intention of flying, or standing in front of oncoming vehicles in an attempt to push them back. Heavy usage of methamphetamine has been associated with an increase in paranoia and violent behavior.[7]

Evaluation of the "Bad Tripper"

Protection of the individual from dangerous behavior either to himself or others should be a fundamental concern in treating the bad trip. For this reason, the patient should not be left unattended while he is awaiting medical attention. An attempt should be made to provide a quiet place, away from unnecessary stimulation, since the patient is already overwhelmed by external and internal input. His main task is to reassemble and control this input overload, and extraneous data can only aggravate the situation. After initial safety is established, treatment of the bad trip should include an attempt to clarify the situation. Frequently, bad trippers are brought in by friends who have already unsuccessfully attempted to alleviate the condition. Usually some knowledge of what has happened can be elicited from them. Most importantly, the physician should try to determine what drug was taken, the amount involved, and the approximate time the patient took the drug. Knowledge of the amount of drug and when it was taken will determine to some degree the course of the trip and may give the treating physician a rough idea of the amount of intervention that will be required, assuming he possesses a certain familiarity with the dosage, range, and duration of the common psychedelic agents. This area has been thoroughly covered in a recent review.[8] The experience of other drug-taking participants should be determined. This information may allow the examiner to determine whether he is dealing with an effect that is primarily the result of the unusual susceptibility of one person. Any attempts to treat the bad trip prior to the patient's being brought for help should be explored, particularly in terms of medication that might have been administered. Accompanying friends often cannot give reliable information, either because of the drug effects they are experiencing, or because they simply do not know what has happened. A clear history is the exception—not the rule. Fear concerning the possible legal implications of drug ingestion may block history taking. Emphasizing the confidentiality of this information may be helpful. A history of the patient, obtained in order to facilitate medical treatment, comes under the rule of privileged communication and should not be shared with authorities.

Sometimes bad trippers are brought in alone by the police without any history. In such situations, a physical examination may yield some clues as to what drug was taken. Because of the ever-increasing problem of drug contamination, even a straightforward history which identifies the drugs should be substantiated, if possible, by physical findings.

The hallucinogens, such as LSD and mescaline, generally produce dilated pupils and reflex hyperactivity. Accompanying anxiety may mimic moderate sympathomimetic signs such as mild increase in pulse rate and blood pressure, sweaty palms, and tremor.[9] Anticholinergic agents produce somewhat similar physical findings which usually cannot be distinguished from those of

other psychedelic agents. Excessive dryness of the mouth and absence of sweating, however, may be useful clues in establishing that an anticholinergic drug was involved. Amphetamines such as speed produce marked sympathomimetic effects such as rapid pulse rate, moderately elevated blood pressure, and excessive sweating, as well as increased motor activity. Miosis is a symptom of opiate usage. Marihuana causes dilatation of conjunctival blood vessels, creating a reddened appearance similar to that seen in conjunctivitis. There is no dilatation of pupils[10] (Table).

Physical Findings

Agent	Effects
Hallucinogens (LSD, mescaline)	Dilated pupils Reflex hyperactivity Anxiety symptoms
Anticholinergics	Dilated pupils (with cycloplegia) Reflex hyperactivity Anxiety symptoms Dry mouth Absence of sweating
Amphetamines	Rapid pulse Increase in blood pressure Increased sweating Increased motor activity (variable)
Opiates	Miosis
Marihuana	Dilation of conjunctival blood vessels Rapid pulse No pupillary dilation

A wide variation of mental states ranging in severity from mild apprehension to severe panic may be seen in persons undergoing bad trips. With high doses, a picture, best described as a toxic acute brain syndrome with disorientation and clouded consciousness, is present. Perceptual changes, such as illusions and hallucinations, are usually present and can be terrifying. A person may feel that he is going to "lose control" or "never come back." Severe feelings of depersonalization or even total loss of one's sense of identity may appear. Gross distortions of body image may be present such as the sensation that one's "brain is melting." But these same sensations that are experienced by one individual as extremely frightening and threatening may be experienced by another as mystical or beautiful.

An important indicator of the severity of psychological disruption is the amount of observing ego present. The degree to which an individual is able to "get outside" this experience, seeing it as apart from himself and the result of taking a drug, can be of important prognostic significance. The individual who develops the awareness that what he is experiencing is drug-induced and time-limited generally reintegrates successfully at the end of the experience. The absence of observing ego, however, indicates severe disruption; if it fails to reappear as treatment proceeds, the possibility of functional psychosis triggered by the drug experience should be considered.

Treatment of the "Bad Tripper"

Establishment of verbal contact with the minimum use of tranquilizers should be a fundamental rule in the management of "bad trips." In cases of apprehension or even panic where contact with reality is maintained as evidenced by the presence of observing ego, reassurance and repetitive defining of reality often prove to be adequate treatment. In defining reality, the physician should emphasize statements which attribute the distortions and frightening feelings of the experience to the drug. It is often useful to get the individual to put into words the experience he is having. Patients who are able to grasp and verbalize these experiences may thus be able to bring them under control rather than feel overwhelmed by them. One therapist found it helpful to pick up simple concrete objects such as a book and say to the patient, "This is a book; feel the book." Simple repetitive concrete statements about person and place are useful. The temporary nature of what the patient is experiencing should be repeatedly emphasized. For a panicked "bad tripper," it can be very reassuring to be repeatedly told his name, that he is in a hospital bed, and in such and such a city. Concrete labeling helps the patient reassemble his reality, allowing him to firmly establish that he is indeed a real person experiencing a drug-induced "bad trip" that is time-limited.

While a person "comes down," he experiences a phasic "in and out" alternation of mental clarity and confusion. This should be expected and predicted by the therapist. Reassurance should include making explicit this waxing and waning of awareness. Caution should cause the physician to make certain that a patient who evidently has come down is truly "all the way down," not just in a temporary or transient clear spell.

The verbal "talkdown" with continuing reassurance and reality-defining is usually effective when given an adequate period of time. The treating physician, however, may not have sufficient time or staff. In these instances, medication should be used, and in the majority of cases will result in rapid dissolution of perceptual distortion and reestablishment of premorbid ego functioning. If medication is used, initially, it should be administered in a dose related to the size of the individual, not to the extent of the toxic effects. Subsequent doses, however, will depend to some degree on severity of symptoms and response to initial medication. Most experience has been with chlorpromazine. A 70-kg (154.3-lb) person could be given a first dose of 50 mg of chlorpromazine (instrumuscularly) (100 mg of chlorpromazine should be given initially if the oral route of administration is used). The intramuscular route is preferable for its rapid onset of action and because bad trips are frequently accompanied by gastrointestinal disturbances such as nausea and vomiting. If, after 45 minutes, no symptom improvement has occurred and blood pressure has been adequately maintained, the initial dose can be repeated. This treatment can be continued every 45 minutes until a favorable response is achieved, but usually after the second dose, oral medication can be substituted. The physician should exercise caution in administering repeated injections of phenothiazines.

Orthostatic hypotensive episodes can occur. If this happens, the medication should be discontinued and the patient placed in a reclining position. Levarterenol may be given, but is usually not indicated.

The main contraindications for phenothiazine medication are previous allergic reactions to phenothiazines, the presence of significant hypotension, and the suggestion of an anticholinergic drug etiology.

Treatment of the bad trip should include caution concerning the possible development of excessive anticholinergic effects. A large dose of a centrally acting anticholinergic agent such as scopalamine (commonly found in proprietary sleeping medication) or the combination of a centrally acting anticholinergic compound and phenothiazine may result in an "anticholinergic crisis." This medical emergency can be effectively handled with quick reversal of symptoms by the oral or intramuscular administration of 2 to 4 mg physostigmine salicylate. Since physostigmine has a short duration of action, the patient must be closely observed for recurrence of symptoms. Additional doses in one to two hours may be necessary. This treatment regimen must be undertaken with considerable caution, however, so as to avoid over-treatment and a resultant cholinergic crisis.[11] Although extensive experience with chlorpromazine supports its efficacy, it should be used only when support and reassurance are ineffective or time is a primary consideration, such as might be the case in a busy city-county hospital emergency room.

Clinical experience has suggested to the authors that the therapeutic affect of the phenothiazines in the treatment of bad trips may not be related to their antipsychotic properties, but rather to their sedative qualities. This observation has led to the use of such sedating drugs as paraldehyde, diazepam, and the short-acting barbiturates, thus avoiding the possible complication of anticholinergic potentiation. Results of initial clinical trials have been promising.

Most patients with adverse drug reactions respond favorably to supportive psychotherapy with or without medication to the extent that hospitalization is not needed. If the perceptual distortions have subsided and the patient feels comfortable in returning home, this is a reasonable disposition. The patient should be with a responsible person for the next 24 hours. Thus, if he lives alone, he should only be released if he is able to stay with a friend or relative.

Certain exceptions to this disposition should be considered. Prolonged use of speed often results in severe depression with increased suicidal risk when the person is "brought down." Hospitalization may be required. In addition, complicating medical problems such as abscesses and hepatitis are present in some patients treated for adverse drug reactions, particularly where the intravenous route has been used. Patients should be carefully screened for medical problems and hospitalized if indicated. Overnight hospitalization is advisable in those cases where observing ego fails to return or contact with reality is tenuous so that the individual does not appear in control of his thoughts or impulses. If these deficits persist beyond 24 hours, the diagnosis of functional psychosis is strongly suggested. It is good practice to avoid the use of phenothiazines as a sleeping medication when the patient is hospitalized overnight. They may mask a psychosis and falsely reassure the physician that the individual is reintegrated the following morning.

Once the acute reaction is over, the physician may be tempted to investigate the reasons for drug use. He should be cautious about this, however. Patients just recovering from a bad trip are unlikely to be able to discuss more general issues such as continued drug use or underlying emotional problems at this time. Decisions about future use of drugs are likely to be in reaction to the bad trip rather than based on rational thought and therefore easily reversible. The physician should confine his treatment to the immediate situation that prompted the request for medical help. He should encourage the patient to return for a follow-up, and at that time, when the patient is far more likely to be receptive and open, a discussion of drug use and possible underlying emotional problems could be started. Questions about drugs and the possible need for continued counseling can be explored. If there are no signs of continuing ego disruption and the person feels no need for counseling, further follow-up is not indicated.

Nonproprietary and Trade Names of Drug

Chlorpromazine—*Thorazine hydrochloride.*

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