Psychological support based on positive suggestions in the treatment of a critically ill ICU patient – A case report

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Abstract: This case report describes the way psychological support based on positive suggestions (PSBPS) was added to the traditional somatic treatment of an acute pancreatitis 36-year-old male patient. Psychological support based on positive suggestions (PSBPS) is a new adjunct therapeutic tool focused on applying suggestive techniques in medical settings. The suggestive techniques usually applied with critically ill patients are based on a number of pre-prepared scripts like future orientation, reframing, positivity, supporting autonomy, etc., and other, very unique and personalized interventions, which are exemplified with verbatim quotations. We describe the way several problems during treatment of intensive care unit (ICU) patients were solved using suggestive methods: uncooperativeness, difficulties of weaning, building up enteral nutrition, supporting recovery motivation, and so on, which permanently facilitated the patient's medical state: the elimination of gastrointestinal bleeding, recovery of the skin on the abdomen, etc. Medical effects follow-up data at 10 months show that the patient recovered and soon returned to his original work following discharge.

Keywords: therapeutic suggestions, PSBPS (psychological support based on positive suggestion), critically ill, intensive care unit, pancreatitis

Introduction

Suggestions are messages which have involuntary effects on the recipient. Suggestions could be verbal or nonverbal and intentional or unintended. In this paper, we would like to evaluate the prospects of consciously used positive suggestions in medical settings as a new adjunct therapeutic tool. Psychological support based on positive suggestions (PSBPS) is a method developed by Varga et al. [1], which is specifically focused on applying suggestive techniques in medical settings. It is based on a number of pre-prepared scripts representing some basic principles of suggestive communication, like future orientation, reframing, positivity, supporting autonomy, etc., and other very unique and personalized interventions as well, such as using our knowledge of the patient: family, hobbies, beloved activities, etc.

The general description of this method is available in an earlier issue of this journal [2]. The aim of this paper is to provide detailed descriptions of the techniques applied and raise the attention of the very basic psychological needs of an intensive care unit (ICU) patient, that are usually not addressed in a conventional ICU treatment [3].

Case Presentation

At the end of November, 2012, the intensive care unit asked for psychological support for a 36-year-old male patient. Let us call him Daniel. At that point, the situation was quite complex (see *Table I* for summary); the patient had already been in the ICU for 3 months. He was transferred to the ICU with acute pancreatitis in August, 2012, as it progrediated and sepsis developed. He had to have five abdominal operations. Due to his chronic pain, he required opiates in high dose over a long period of time. In November, a liver failure

Table I | Main events in the intensive care treatment of Daniel (born 1976)

20.08.2012	Abdominal pain, vomiting (the onset of symptoms)
21.08.2012	Hospital admission (start of hospitalization, Hospital "A")
27.08.2012	Transfer to Hospital "B"
02.09.2012–29.09.2012 and 01.10.2012–28.01.2013	SE AITK (Department of Anaesthesia and Intensive Care, Semmelweis University) – been treated at the 2nd Department of Surgery for 2 days in between
04.09.2012	CT guided drainage (pseudocyst)
08.09.2012	Thorcic tap (1st) of left sided hydrothorax
21.09.2012	Operation (1st) – laparotomy
22.09.2012	Thoracic tap (2nd) of left sided hydrothorax
01.10.2012	Thiracic tap (3rd) of left hydrothorax and chest drain insertion for PTX
09.10.2012	Repeated laparotomy due to the septic shock
19.10.2012	Operation (2nd) laparotomy
22.10.2012	Operation (3rd): intra-abdominal bleeding causing shock Duodenal perforation – jejunal feeding
First days of November 2012	Developing liver failure, extrahepatic cholestasis, and acalculotic cholecistitis
06.11.2012	ERCP – unsuccessful
09.11.2012	Operation (4th), laparotomy, transhepatic drainage Liver biopsy: toxic origin, hepato-protective treatment Plasmaferesis for hyperbilirubinaemia (2×)
17.11.2012	Diarrhoea due to *C. difficile* infection
23.11.2012	First visit by psychologist (start of PSBPS)
24.11.2012	PR bleeding (responded to the correction of coagulation status)
04.12.2012	Extubation
09.12.2012	Initiation of oral feeding (removal of naso-jejunal feeding tube)
17.12.2012	Diarrhoea, fever Repeated fevers, change of antibiotics Abdominal and pelvis contrast CT; Ga scintigraphy SPECT: focus in the retroperitoneal and subhepatic regions; Control U/S: subhepatic region is clear Recurrent abdominal pains Oral substitution of pancreatic enzymes
11.01.2013	Finishing parenteral nutrition
28.01.2013	Discharge (end of hospitalization)

developed; this, fortunately, was successfully treated. He was ventilated due to pneumonia. Before the first contact with psychological support, he had been sedated, and when the dose of sedatives decreased, he became agitated and uncooperative.

At the beginning, all the background information about the patient was that he was working as a driver at a private company. On the positive side, we can mention the family care: the patient was visited each day, and his colleagues and boss were also very supportive.

Investigations

According to a review of research in the topic, positive suggestive techniques are widely and efficiently started to be used in several fields of somatic medicine (e.g., intensive care unit, radiological procedures, surgeries, somatization disorders, etc.) for more than 4 decades [4].

In the study of Szilágyi et al. [5], intensive care unit patient's regular treatment was extended with PSBPS. The study revealed that patients in the intervention

group (with PSBSP) required 2.5 days shorter mechanical ventilation and the length of stay in the ICU was reduced by 4 days compared to the control group (regularly treated patients).

Good effects are reported in postoperative outcomes in patients treated by positive suggestions as well. Patients were discharged, on average, 1.6 days earlier from hospital after a bariatric surgery [6], patients experienced less nausea and vomiting, incidence of headache and muscle discomfort is decreased [7], less pain and fatigue were reported, and patients had better subjective well-being [8], etc. For a recent overview on effectiveness of suggestions in medical settings, see Ref. [4].

Building upon previous findings on the topic, in this case report, the effects of our method were shown by the patient's physical and psychological improvement.

Psychological support based on positive suggestions (PSBPS) was added to the traditional somatic treatment at day 82 until day 148 when he could leave the hospital. The senior and the second author visited him in turns, providing detailed information about the visits to each other (altogether 70 pages of e-mail correspondence). Because of this very close cooperation, we do not specify in this case report which intervention belongs to which psychologist. The therapeutic suggestions were delivered on the patient's bedside, in a normal tone of voice, including those days when he was sedated (as the suggestive methods during general anaesthesia provide support for the possibility that a person even in this state could perceive and semantically process verbal communication) [9–14]. The application of PSBPS does not require any special condition (silence, dim light, etc.), so to an observer, it could appear as a normal conversation. During this process, the usual care is ongoing (nurses and doctors are doing their care; events, noises, etc. of the department are there, and so on). Sometimes, these activities are commented on by the psychologist along with positive suggestions.

Treatment

First phase: Building rapport, cooperation, and finding a common aim

When the patient was contacted first, he was sedated; nevertheless, following a relatively long "just observing him" period, he was told all the basic suggestions regarding ICU stay and treatment. He was told that this was a secure place for him; the machines and healthcare professionals are all working for his benefit.

Our role was formulated as *"we will join the team by supporting you to mobilize your inner possibilities to add them to the outside ones, the medications, machines, and healthcare professionals".*

As he was not in a condition to express agreement, he was told: *"We will clarify the details of our cooperation when you are awake again."* This element functioned as **future orientation**, supporting his **autonomy**, and positive messages ensuring him about his future coming health state.

During the following psychological contact, **rapport building** continued, stressing the importance of cooperation, formulating his role as one member of the team (not the passive recipient of the treatment).

He was encouraged to have a nice rest, simple relaxation techniques were also taught to him, and a simple communication (1 blink means yes; 2 blinks, no) was built so that he can remain relaxed while in contact with us. He was reinforced that he can reach this physical and mental relaxation on his own, whenever he prefers to be in this state (this way providing **sense of control**).

Regarding "favourite place," that is usually offered to be created for the patients in their imagination replacing the not-so-comfortable reality of ICU, the patient became sorrowful; tears in his eyes showed that, at the moment, it was more painful than positive to imagine a place *"where you'd prefer to be instead of the hospital".*

Gastrointestinal bleeding added to his medical records: melaena and haematemesis. In order to solve these problems, the patient was invited to imagine that his *"stomach's inner surface gradually becomes intact, and a nice healthy layer is created".* He was provided with several possibilities (e.g., imagine a magic lamp or an everyday scenario, like painting a room) and encouraged to use his imagination creatively to reach the desired aim.

According to our observation, some of the doctors and nurses were pessimistic, and even clear negative suggestions (in words and facial expressions) also reached the patient. So we told him that *"only the beneficial and helpful influences and signal reach you from the outside"* [15]. He was given the suggestions on the importance and use of ventilation (see the details on this [1]).

The patient was also told that he can strengthen his immune system by imagining the *"soldiers that can concentrate on the enemies, as this is a safe and secure place for you, here your body does not have to fight against the usual everyday challenges".*

His agitation and lack of cooperation when he was released from sedation were absolutely missing when we continuously commented what was happening: *"Now you got the medication to regain your full consciousness... You will gradually feel oriented. You will notice that you are here in the hospital which is the best and most secure place for you now… You already move your legs… and now your hands… You start to open your eyes… You feel that tube in your mouth; this is connected to the machine that helps you to breathe until you will be strong enough to breathe on your own again."*

As the patient had an mp3 player, we used the general positive suggestion text that we had used earlier in a study [16]. We also asked the family to bring photos of everyday, outside family events: soon the wall was decorated with the photos and drawings of Daniel's children. His lungs became cleaner, lab results were also better, and less purulent detritus left the abdomen.

So the first phase of suggestive treatment could be closed: in about a week, we had a cooperative patient, in rapport with both of the psychologists, and the medical parameters also reflected gradual improvement – though the patient was still far from being well. Daniel was reinforced regarding the upcoming improvements: *"Soon you will be able to report what you notice as positive change. The machines and tubes, catheters, drains will gradually disappear as you are getting better."*

Second phase: Successful weaning

The patient could be successfully weaned off, and sedation was not needed anymore. So we could enjoy a real active communication with the patient: we greeted each other with shaking hands.

As the patient had no memory regarding the past 3 months, everything had to be summarized for him: the abdominal operations, the mechanical ventilation, the daily interventions, etc. We have been working on all of the possible questions he might have, and he could even reach some not-so-pleasant memories: e.g., before an operation having fear of death and being in a very closed body posture, shrinking with terror. Following the extubation, we supported Daniel in the difficult phase of cleaning the lungs.

We could search for positive feelings and favourite activities: almost everything was connected to his family and being with the children whom he desperately missed. Daniel told us that his hobby was fishing, and he liked his work and colleagues very much.

It turned out that he is very much interested in the medical results: for instance, when the X-ray was made, he asked about the quality. When the doctor listened to his lungs: the patient was interested to know what she heard.

Soon it turned out that one of the neighbours of the patient had just recently died of pneumonia, "being my age and also having two small children" – Daniel formulated his concern. We had to work actively against this **negative model effect** reflecting the many differences between him and the neighbour. We also agreed with the doctors that they will always stress the **positive** results of his lungs. Instead of saying: "the pneumonia is over," he'd stress: *"the lung is nice and clean… healthy."* We asked the doctors to explain all the signs of improvement to the patient, as he was very much interested in the "objective" signs of his recovery.

The patient was very active in doing the physical exercises and chest physiotherapy.

The actual weakness, a natural consequence of being passive for 3 months, was **reframed** as: *"how economical and flexible our body is… as soon as we do not use our muscles, they gradually decrease just to grow and get strong again as soon as we need them."*

"Purpose" of recovery

The patient wanted very much to go home to see his children. The fact that it was just not possible yet was formulated to him as *"Now this place is the secure place for you, here all those things are available that provide safety for you: the machines, the professionals, the continuous monitoring, etc."*

As Christmas was coming, the patient's attention was raised; it was suggested to him that the strong feeling of being homesick reflects an inner energy that can be used for the purpose of recovery: *"The more homesick you feel, the more energy you can use for your benefit; for instance, you can support your immune system with it."*

The head of the department organized a "surprise" meeting with the children though: when Daniel was already accustomed to going out to the corridor of the hospital, the doctors asked Daniel's wife to bring the children to the corridor, as they are not allowed to enter the ICU, so that they waited for their father to see him after nearly 100 days.

Naturally, Daniel wanted so much to go home for Christmas, but we could not promise him this at all. So he was given the advice to "let go" of this wish. This formulation put him in a control position: it is up to him when and how the wish is let go. Apart from **regaining control** – instead of being a passive sufferer of not-being-allowed-to-go-home, this was also good because if he just keeps thinking about this, and wishing so much the improbable, he could waste not only energy, but the time can also be spent with more helpful activities. As an example, several **imaginative** scenarios were recommended, e.g., the possibility to *"go fishing"* was raised, or *"driving around the country on the well-known roads, or… visit home, enter the flat… feeling a bit strange after so much time away…"*

It was explained to him that, according to recent neuroimaging studies, the brain activity, when we imagine something, is very close to the brain activity during actual perception: *"so when you imagine to go home, it is really very close for your brain to the actual visit"* [17–19]. Christmas passed calmly. He was not allowed to leave the hospital, but the children and the family came to visit him.

Next phase: Regaining strength and building up enteral nutrition difficulties

The patient became strong enough to start eating normally. At that phase, we had to face a new difficulty. He could not eat anything: he had no appetite and vomited everything, although he understood the importance of eating.

This phase started with the announcement made by the nurse that he is allowed to drink and eat cookies. Daniel carefully started sipping at his tea. More than 100 days had passed since he last drank or ate anything *per os;* therefore, we suggested to him to feel natural about his fear and strangeness of drinking and eating. But on the other hand, it could be interesting to re-experience the speciality of these automatic phenomena. He nodded.

While he was sipping, it was suggested to him that these drops were going to continue their way to their right location in the digestive system. The rest, which is not needed anymore, is going to leave his body in the natural way.

Since he experienced the ability of drinking again as a turning point, he seemed to be calmed down and relaxed.

Once, Daniel was asked: "What is your interpretation? Why did you become ill?" – "Because I liked eating," he replied. "And now you do not like… eating… so that you will not be ill again" – our interpretation was formulated tentatively. And we got the simplest reason behind his eating difficulties: if one gets so seriously ill because of eating, who would dare to eat again?

By speaking openly about this, it became evident for him that not eating is not the best "tactic" in the long run. We elaborated a successive way of reaching normal balanced diet again: starting with the types of meals that he likes the most and more easily can have (soups, liquids, foods made by his wife), and only later turning to the other (e.g., dry) types of foods.

While discussing all these, it turned out that he still had extreme fear of eating, as that is supposedly behind his original illness. This time, the rational explanations, *"But it is obvious that you must eat… one cannot run long without eating…"* did not seem to help. Daniel was formally paralysed with fear.

At this point, a **manual technique** was introduced: gentle lines were drawn at the back of his hand, toward his fingertips, connecting these types of suggestions to each line: *"your unnecessary fears and worries are coming together (along these lines) and drop here (pointing to his fingertips)."* As these suggestions were repeated connected to new and new lines and drops. At the end, he was taught how he can touch his fingertips by his thumb whenever he wants to get rid of any unwanted worry.

We agreed with the doctors of the night shift to discuss eating in the same way with Daniel, explaining with him the medical aspects of his operations and the current state. It turned out for instance that Daniel thought that his stomach also was operated on, but actually this was not the case.

Daniel started to eat on his own, with extremely small portions at one setting, and this continued; in the succeeding days, he continuously ate more soups, sandwiches, and yoghurt, with good appetite. He was encouraged to concentrate on the pleasure of eating as well. On a scale from 0 to 10, Daniel scored 4–5 in the "joy" of eating. *"Please keep the highest numbers, 9 and 10, to really special occasions, so it is enough to go up to 7 or 8 in the usual daily ones",* the **paradoxical suggestion** was applied.

The patient still trembled from time to time. It was clarified that it had no organic reasons: this is a vegetative sign of extreme fear. But it was not clear yet why.

Fear of relapse

Once when he was relaxed, it was reflected to him that there is no visible trembling at all. He said that there is always something in the background, the fear of relapse, because even though he was doing the chest physiotherapy last time as well, his lungs got inflammation, he is uncertain about his state, could never be sure about the recovery, cannot be calm about it, and he expressed extreme fear about the relapse and the chance of him being put to sleep again.

He, obviously, was always fearful when he got diarrhea, considering it as a sign of relapse. Receiving the lab findings indicating the type of infection behind diarrhea, we could reassure Daniel: *"So good that we already know what was the reason behind it… and now by the help of medication even the remaining will stop soon."*

But these changes would not happen immediately; therefore, patience was needed. We suggested to him the **metaphor** that his digestive system is like an engine: without being used, it gets rusty, and to get back to its proper functioning, has to be cleaned first: *"Your body needs a cleaning (diarrhea) first as well and after all the nutriments could build it up again like lubrication the engine…"* After all, it could work as new again.

So, finally, we got to the subject of the fear and could talk about it. We summarized all the things which were different from the last time. When he got pneumonia, the surgery had just been done (the immune system was weak and vulnerable), medical aids were needed, and he was less energetic, could not move so well, and could not drink and eat alone, things which he can do much better now. In the end, we found the present situation much different from the last time which could be illuminated as a great sign and good conditions of recovery.

At the second week of our visits, the first meeting with his wife took place. That meeting made us completely sure about her innate and positive support. She was calm and totally confident about Daniel's recovery. She was even talking to him in terms of positive suggestive communication. She was **"pacing and leading"** the first steps in drinking and eating; she supported the first sips like this: *"It has been a while since you last drank anything... you haven't drunk, but it is a good sign of your recovery, now you can taste different flavours in your mouth…"* which was so well formulated that it was easy to verify it.

Daniel was excited and he was trembling, but his wife could calm him down with giving massage to his feet and telling him the following: *"Everything is going to be all right... you have done a great job so far, you've gone through so many troubles… but you should still keep on for a while"* – again an excellent suggestion from a nonprofessional.

One day, we took into consideration many things which occurred because of Daniel's illness. We illuminated those aspects which gave him chance to realize how much he is appreciated by his colleagues and boss: they supported him and his family financially during these months. He could also be sure of the solidarity of his family and friends, since they shifted each other at their home to help out his wife with the household and children. So these kinds of hard times helped him to realize that he might be a man who deserved all help and support which he got from his surroundings.

A couple of days before Christmas, a conversation took place in an absolute relaxed atmosphere, calmly considering the most serious question: the possibility of dying (in general) but his will to live. A bit later, when one of the patients died next to Daniel's bed, we could discuss it again: *"Yes, ICU is a place where many patients die: especially the old ones with complex illnesses"* – we soften the negative **model effect**, as Daniel was young and (at this stage) had only one remaining symptom.

Self-suggestions and future orientation were also applied. His favourite activities, like fishing, could be discussed in detail. Connected to the fresh snow that actually covered the city, we could recall the snowy winter days of his home village. The warm feelings of all these nice memories could be seen on his face.

We summarized all the achievements in his recovery: clean lungs, recovered skin on his abdomen, and good and powerful movements on his own. Daniel was also taught how to give **self-suggestion** to himself: short, positive statements that he can repeat daily.

Several positive changes happened: he was without pain-killers for days and started to talk to a family acquaintance who had had the same type of operations and finally recovered. He could find a **positive model.**

Next stage: Fighting with the time-bomb

Daniel's doctors used the metaphors of fighting: "His body contains a time bomb… at any time, there could come anything that blasts leaving such ruin and damage behind." Surprisingly, the doctors started to speak about an earlier patient also suffering from acute pancreatitis who also recovered but, at the end, died of a heart attack. As these remarks affected us very negatively, we could conclude that these serve as serious negative suggestion for Daniel as well.

The next problem to fight with was the abscess. As soon as Daniel was off antibiotics, his fever ran up and lab data also reflected an inflammatory process in his body. Various technologies (ultrasound [US], magnetic resonance [MR], computed tomography [CT]) were used to locate these abscesses.

Background discussions about these abscesses were not really promising: as he already had several abdominal operations, it was impossible to open his belly again: "Either he will die of bleeding or the faeces will empty into his abdomen" – doctors told, sometimes in front of Daniel.

It was uncertain if a specialist could perform a CT-guided punction of abscesses, and the traditional operation was not a choice. We suggested to Daniel, again, to use his **imagination** to make the abscesses disappear.

"You know that our immune defences are mainly in our intestines (he nodded). *You can eat well, so they get munitions* (he nodded). *Your defecation is also all right* (he nods), *so your inner part is working well. Now your whole body has nothing else to do but dissolve these abscesses. Just find them in your body and send enough defensive soldiers to eliminate them."*

We also encouraged him to imagine the *current* situation (in body feelings, colours or any other way) and the *desired* situation and just let his unconscious lead his body from the actual situation to the desired one. He nodded. He asked some factual data about the abscesses to help him to imagine it: what they look like, what they contain, etc.

There came the long days of waiting for new results and/or for the radiologist who could perform the punction for emptying the abscesses. Unfortunately, we heard again and again: "this can kill him in 2 days".

Parallel to this, eating difficulties returned. Although the patient could manage to eat, it was not enjoyable for him at all; he did not long for the taste of the food. At this point, we realized the misunderstanding: he did not know that eating meat and everything else was medically allowed to him in moderate doses. After the surprise, the doctors' standpoint was detailed to him about the importance of balanced nourishment to him to dissolve the vitamins in his body.

When asked about his daily routines in the hospital, Daniel mentioned that he listened to a book of Albert

Wass. This line "took us" home to Transylvania, to the old winter times when he used to go to the nice white snow together with his brothers: he mentioned these memories with shining eyes, apparently reliving these early events.

We went on how hungry a child could be following playing all daylong outside. Finally, we discussed the tradition of pig slaughter in the country, mentioning in detail the good dishes one can have at these family occasions. Daniel could be involved without any difficulty of these scenarios all connected to eating.

We continued talking about his family, and he showed further photos which were not posted on the wall: summer holiday by the sea. It was hard to recognize Daniel: he looked much younger, stronger, and masculine. After comparing that man to this one, he was faced with all the experiences and new skills he possess now and the long way he took to get back from a critical illness. We referred to new goals and destinations as **future orientation**, for example, travelling to the sea again. His older daughter started to have regular swimming lessons which we used here as a metaphor: he has to make a fresh start to be able to swim without water wings. We agreed on this.

We noticed several signs showing that Daniel is really paying attention to the signals of his body: for example, he immediately "sensed" when his "fever" run up to 37.5.

We commented this as a very helpful skill, so even a slight rise in body temperature immediately reminds his body that his immune defence system (his defensive soldiers) has to be mobilized to start/to launch the healing process in his body. Fortunately, during the days of waiting for the results regarding the abscesses, he started to feel a change in his abdomen: the earlier "strange" feeling started to dissolve.

Comparing his way of cooperation to other "difficult" patients, we could conclude that this illness taught him a lot, including being much more patient than before. This was regarded as a further sign of post-traumatic growth [20].

Closing phase: Active and optimistic involvement

During the final meeting, we summarized the whole time of illness and recovery. "There were difficult moments, when the thread almost tore…" he starts.

He identified 2 examples of these especially difficult times: when he became yellow in October (referring to liver coma) and had pneumonia. When Daniel was asked, how he represents the whole process, he mentions: "As a wonder…" Especially (we add), that he could turn back not only once but twice from the "almost dying" level.

We also clarified that, as he was sedated for a long time, he could not use his volitional will to recover *"that also proves that you are meant to live"* — we gave the **future-oriented positive suggestion.**

Still, we daily overheard statements from the doctors: "If the content of an abscess gets into the abdomen, he can die even in a few hours' time". It was not easy to be optimistic and share our optimism with Daniel.

Our daily correspondence about the events in the hospital helped a lot to ventilate our negative experiences. And as it became more evident that there is no possibility to surgically clean the abscesses, our psychological approach (in combination with antibiotics) became the only realistic solution. So we went on suggesting to him the possibility that he *"can win on his own, and clean these unwanted abscesses from his body"*.

We made him realize how much stronger he was already than some weeks before: *"You can breathe on your own. You can eat. This way you support your immune system. You regularly go out for walks in the snowy winter. You meet people from the street. This way being in contact with the pathogens of everyday life… And consider how many more healthy cells and tissues are in your belly now than those small abscesses. This is a clear force of numbers. Your body would do this cleaning anyway. As you think it over, just help this process with your conscious control"* – we end up the **yes set** with a **positive double bind:** either unconsciously or with volitional control he will win anyway.

"… as you think about it a bit, the healthy order will appear in your stomach due to your inner resources… you can tame those abscesses, you can talk to them, or any other way you can reach the aim that they will disappear, go away, as you could do the same all along the way of becoming healthier and healthier."

"Yes," Daniel replies proudly. "I was also told that my lung is absolutely clear."

We also stressed his **active role** in his recovery. As opposed to the majority of patients who just want to be cured (passively), he took a really big part in the process. Once asked to estimate his "ratio", Daniel estimated around 50%.

When he became so highly cooperative, he referred to the earlier times of his agitation, kicking, and problematic behaviour with some uneasiness. We calmed him by saying that, at that stage, it was absolutely normal, as he really was in an extremely difficult physical and mental state, but, as that is over, *"we can meet the real Daniel"*.

Outcome and Follow-up

After several days of waiting, the radiologist arrived but could not locate a big enough abscess. There was no target to clean.

So Daniel was again without antibiotics – and there came no fever and his laboratory data also proved that there is no inflammation in his body.

Daniel, naturally, was very relieved and proud of himself. He **repeatedly** suggested to himself that he can clean the abscesses. We reinforced his role in the process and encouraged him to use **positive self-suggestions** later as well. The well-known suggestion of Cue was also recommended for later use: *"Every day in every way I am getting better and better"* [21].

When the discharge from ICU became a reality, Daniel and his wife asked for help in family matters (e.g., how to handle the problematic behaviour of their children). We recommended them to speak honestly with the children, as they sense anyway that it was a close-to-death illness, and obviously it is very difficult to understand for a small child. We recommended to explain to the children that *"it was a serious illness, and your father is even stronger than we thought before as he could recover"*.

Daniel's wife was supported when she expressed her concern regarding Daniel being home "without the possibility of daily laboratory tests and life-support machines". Here it was enough to refer to Daniels's special skills to follow the inner processes in his body, he will monitor everything properly. Around discharge the positive outcomes of the illness and recovery were listed together with the wife. For example the strong support from the family, the strength of their marriage, the love between the children and Daniel, the helpful behaviour of colleagues, and, especially, the activation of inner strength of Daniel. "All this might not be so evident without this illness", we concluded.

Daniel was asked to contact us twice per year (around Easter and Christmas). At this stage, it was, again, a **future-oriented positive suggestion** and a real need for getting follow-up information. He was also offered (free) possibility to talk about the whole time of illness and recovery process in case he feels the need for this. He agreed that his case can be a source of reference for teaching professionals and for written reports.

After two months, Daniel informed us via telephone call that he is well, healthy, and strong. All the lab results are negative. He gained weight (13 kg) and is working in a part time position in his workplace. "I am all right, physically, mentally", he says. The 10-month follow-up also showed maintained physical and psychological well-being.

Discussion

We do not know what would have happened to Daniel without psychological support based on positive suggestions (PSBPS), as there is no control patient/condition for comparison. Just like other critically ill patients' case histories where PSBPS has been introduced his also shows a clear improvement from the day this intervention was added to the traditional medical treatment.

Learning Points

What makes his case special is that the state of the patient was really critical at the beginning of PSBPS, so we also had difficulties in finding what to base our optimism on, to be able to share it with the patient. The clear and exceptionally strong negative suggestions and the pessimistic statements affected us as well.

So we had nothing else left to do but to follow the usual principles of providing PSBPS: future orientation, positivity, reframing, providing sense of control, etc. In Daniel's case, the "pure" information proved also to be very important, as he was more reality focused than many of our other patients.

Daniel's case shows how detrimental negative suggestions, especially from high prestigious medical professionals, could be [22]. It is also important that all those emotional and psychological conditions (sensitive unconscious state, various types of extreme fears, false beliefs) should be handled during an intensive care, and more active involvement of patients possibilities included into the treatment (understanding signs of the body, influencing various functions by imaginative and self-suggestive techniques).

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