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A NOTE ON THE TREATMENT OF LSD PSYCHOSIS: A CASE REPORT

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Although the psychiatric literature (Frosch, 1965, Ungerleider, 1966) reports psychotic episodes following injection of LSD, to my knowledge there have been no discussions of treatment of such cases. The almost universally accepted treatment for such cases is chlorpromazine or another phenothiazine tranquilizer. Within the "psychedelic movement," and among physicians and other professionals who have had personal experience with LSD, there is a growing concensus that the tranquilizers, although they may "bring the patient down," do not allow him to work with the material that has been released or uncovered (Leary, 1964, Smith, 1968). This latter position of course dovetails with certain approaches to endogenous schizophrenia, such as that of Laing (1967) in which the goal also is to allow the patient to live and work through what might ultimately be a salutary experience.

The following case is illuminating and interesting because both approaches were used simultaneously, with rather surprising results. It illustrates the theoretical feasibility but practical difficulty of the second approach (of allowing the psychotic to go on his "trip") and the necessity of considering the whole ecological framework in which this kind of work is done. The case also raises again, in acute form, the whole question of mental hospital policy: Are we in fact trying to help people master bewildering internal fears and confusions, or are we involved in protecting ourselves from the discomforting behaviors of those we call 'mad'?

Case History

The patient was admitted to a State Hospital in an acute psychotic episode induced or triggered by LSD. He was 22 years old, middle-class, and had been living the life of a "hippie" for approximately one year. For a while he had travelled around the country, living in various semi-communal apartments, working occasionally as a folk-singer in coffee houses, or with rock bands. He had attended college. He had first taken LSD at a rural commune 3-4 months prior to entering the hospital, and again three or four times while living in the Haight-Ashbury district in an apartment with six other people, one of whom was a friend of the author. Apparently his behavior over a period of two months became progressively more and more disturbing to his friends. The disturbance was not physical; he was never violent, he ate and slept regularly, but communication and contact deteriorated progressively. He seemed to be in a state of worsening anxiety and confusion, and would not participate in his friends' artistic or other activities. He was considered a burden and was brought to the hospital for professional assistance. He agreed to come since he knew my name, but it is not clear whether he anticipated "treatment."

His appearance on arrival was somewhat uncared for—"hippie" shirt and beads, hair almost touching his shoulders. He held his hands in front of him clasped in such a way that the fingers were pulling against each other sideways. His eyes were darting around anxiously, his mouth smiling or laughing rather frequently in a fearful, excited manner. He would talk in a rather low voice, much of which was inaudible. His whole face twitched and jerked so that his glasses moved up and down on his nose, and, from time to time, his eyes would roll inward, to the nose, but not synchronously.

To my questions about his state of mind or feeling he would merely giggle or twitch, and he responded similarly to his friends' questions of whether he would like to stay in the

hospital. Another patient, who was in the drug program, explained the admission procedures, but the only responses were apparently inconsequential remarks, some of which were inaudible. To my question, "what do you want to do?" he replied "take acid with Ralph Metzner." Another staff member questioned him but elicited no direct responses. When this staff member then turned to the patient's friends and asked: "How long has he not been communicating?," there was an immediate response from the patient who exclaimed almost indignantly "communicating!" But further contact was lost immediately.

Later I walked with the patient and his friends to the coffee shop. Most of the time he was babbling incoherently, and looking around, leaning his head back, laughing, rolling his eyes. At one point he suddenly placed his hands flat on the table, looked straight at us and said in a normal voice, "It's coming in so fast I can't function at that speed." Contact was made, and then he would "go off" again immediately. One had the impression of someone on a high-speed rollercoaster who every now and again can land on earth, swiftly make a statement to bystanders and is swept off again by uncontrollable energies.

The admitting physician was unable to persuade him to sign voluntary admission papers. He did not refuse; he just wasn't there. He was talking about Buddha, evolution, cosmic energy, etc. One of his friends tried to persuade him to sign the papers by pointing out: "If you sign, you can split anytime you want to." The response was, "I've got to figure out the difference between splitting and fusion." On the recommendation of the physician he was finally put on a 72-hour hold by the sheriff's office, pending a court hearing. He was put through the routine questioning procedure —name, age, etc.—for the third time that day. Again, inconsequential answers except to: "what state were you born in?," the response came lightning-fast: "state of innocence."

That evening and the next morning he refused food and medication, but was otherwise quiet and peaceful. The next day I asked him if he wanted to try sensory deprivation and he agreed. Getting to the room on the next floor took a long time since he would stop from time to time and stare for several minutes at, say, a doorknob, a passing person, trees outside of the window, etc. He was also talking incoherently, twitching his face, and rolling his eyes in the manner previously described. Finally he lay down in the room, which is completely light-proof and contains only a mattress on the floor. An intercom was connected so that I could listen to him in the next room. He babbled on for a couple of minutes, then fell silent. He was completely silent and motionless (the intercom picks up turns on the bed) for about two hours. I assumed he had fallen asleep and went into the room to wake him up. However, his eyes were wide open, staring straight up. I had to ask him several times to get up and come back to the ward before he responded. He said, "I've been schizophrenisized." And as we were going down the hall: "the question is whether to stay catatonic or not," to which I replied, "stay catatonic if you like it." Later on that day and the following days he would spend several hours in the bathroom standing perfectly still, with his hands clasped in front of his chest.

It was my impression that the dark (and more or less silent) room enabled him to control somewhat the overwhelming flood of information-stimulation that was pouring in. According to his later statements it also appeared that he was confusing inner and outer, i.e., was unable to tell what were his thoughts and what were those of others. By eliminating external input, the task of sorting was made easier. He was definitely calmer and almost "in touch" when he emerged from the room. The later "catatonic posturing" could be seen as an attempt to similarly slow down the flood of input. At one point I asked him why he was standing like that. He replied, "It seemed the appropriate thing to do after sensory deprivation." The clasping of the hands he explained as attempting to prevent the two halves of the body from splitting. The facial twitching and rolling of the eyes disappeared completely after this first session. He explained the eye movement as "going into the next room." This explanation is very reminiscent of Wilhelm Reich's analysis of a schizophrenic girl (1949) who used an upward turning of the eyes to "go off."

The next sensory deprivation session was

terminated after about two hours by a nurse returning him to the ward for lunch. As the patient emerged he said, "I always did want to be an astronaut." The calm induced by the sessions in the dark room usually did not survive the return to the ward, where the stimulation caused by interaction with the other patients and staff would send the patient back on his "trip."

During the next two weeks two more sensory deprivation sessions were run, and I talked with the patient almost daily on the ward. The sensory deprivation room was unlocked and the sessions were of course voluntary and could be terminated by the patient, which he never did. In fact, several times he asked for more sessions. Staff reports of this time indicate that he was generally quiet and cooperative. Some of the technicians commented that he would respond appropriately at times when he felt like it, and not at others. Although he talked from time to time of his desire to leave, he would not take the necessary steps to be considered for discharge.

About two weeks after admission he was caught, early in the morning, walking off the hospital grounds. He was then transferred to a locked ward with mostly elderly chronic schizophrenics. The physician on this ward described him as "classical catatonic schizophrenic with flexibilitas cerea (waxy flexibility)."

The physician decided that ECT was indicated, although when I objected that it would interfere with my treatment, it was deferred. The stated reason for ECT was "that acute psychoses tend to develop chronic patterns if not interrupted early in their course, and there is ample evidence that ECT is the treatment of choice, especially since the patient has been uncooperative in taking oral medications." Privately, the resident told me that the patient "was taking too long to come down from his trip."

While on the locked unit I was able to persuade him to sign voluntary admission papers which cleared the way for voluntary self-discharge. He was transferred back to the open ward. He irritated the staff there by refusing to take medication, by visiting other wards and refusing to return, and by "fraternizing with female patients." It was also alleged that he and two other patients smoked marihuana on the grounds, though this was not proven. Other "psychotic behavior" manifested included "lying on the floor, banging his head against the wall, spitting in the drinking fountain." He also talked threateningly to other patients.

These behaviors were considered sufficient reason for giving ECT after all. During the period of days that these behaviors were observed by the ward staff, my talks with the patient continued, and he was in excellent contact. I pointed out to him the likely consequences of his aggressive behavior and he appeared to understand this. One of the physicians also described him as having "exquisitely acute contact." In other words, his state fluctuated wildly from day to day, and even hour to hour, from total catatonic withdrawal to sharp, immediate awareness. My efforts at this time were directed at getting him to "center," to balance these wild swings. His ability to "snap out of" his catatonic postures, when his interests were aroused, indicated to me that the postures were still semi-voluntary attempts to achieve inner calm by outer immobility. Some of his talk was about Zen, which advocates a still posture as a means of quieting the mind.

After the first ECT further treatments were discontinued because the patient's attorney intervened, stating she was obtaining a writ to prevent these treatments.

His behavior on the ward began to take on more religious overtones. On two or three occasions he was found praying in a kneeling position. He also started complaining about the food and telling other patients and staff they should stop smoking. When I pointed out to him that, although I agreed smoking was hazardous, he should work on his own problem and not interfere with others, he replied "but they're all me." On that very same day I had to ironically take note of a newspaper statement by a Stanford University Nobel prize-winning chemist that smoking was not only hazardous to the smoker but also to others close enough to breathe the smoke.

A few days later another incident occurred which led to the resumption of ECT's. At 7 in the morning the patient was kneeling in the hallway, apparently praying. When one of the

technicians asked him what he was doing, he replied, "watch your language, soul and spirit." Then he rose up on his knees, spread his arms, and made strange noises, and then fell back on the floor. It was clear the technicians and some of the other patients were scared, although no one was actually hurt or hit. Three ECT's were given over three consecutive days.

Following this series of treatments there was a marked change in the patient's behavior. He "came down" from his trip. He was able to talk coherently with staff and other patients. He was uniformly regarded as being more "in contact." However, to me he complained that he felt worse. He stated that he felt confused, that he no longer remembered things, that the ECT's were harming him and that he felt irritable and anxious. Whereas before he had felt free and had been able to "see" things, and "see through" people. When I pointed out that he was so out of contact before that he did not perceive how he was frightening and threatening other patients and staff, he seemed genuinely surprised.

During the next few days he improved consistently in outward behavior, though continuing to maintain that he was very dissatisfied and unhappy. A week later he was discharged.

DISCUSSION

It was my impression that the ECT had effectively interrupted his psychotic episode. It apparently put him back into the neurotic condition in which he had been before his "trip" began. In that sense ECT arrested further regression. How permanent this arrest was is impossible to tell.

Whether or not one regards this change as beneficial or therapeutic would depend on one's attitude about psychosis. The textbook rationale for administering ECT was to prevent the psychosis from "consolidating" into a chronic state. The convulsions are thought to "shake up" the beginning paranoid structures.

On an alternative view of psychosis, such as that proposed by Bateson and Laing, the psychotic regression is a necessary phase of a total process, which is a circular journey backward in time which certain persons have to undergo in order to move forward again. The ultimate meanings of "madness" would be to allow all structures to disintegrate and to trust the innate regenerative programs of the psyche to reconstruct from the beginning.

Whether or not one accepts such a model for psychoses in general, it certainly seems applicable to the special kind of episode induced or triggered by LSD or psychedelic drugs. The main difference from endogenous psychosis seems to be in a certain "insight" the patient has, a knowledge that he is on a trip, with a beginning and, most importantly, an end. There is a drive to understand, to figure it out. And there is an acceptance, even enjoyment, of "weird" or unusual perceptual or cognitive phenomena. There is awareness that the loosened perceptual structures involve at times, perception of others' thoughts and feelings. The reduced ability to "test reality," to discriminate and check or verify one's observations, interferes with interpersonal communication but is often not recognized or deemed unimportant. Often such a person will say, in effect, "how can you expect me to wash the floor, or carry my tray, when I'm figuring out how God created matter?"

We have then a choice between two diametrically opposed approaches. The ECT definitely curtails the trip in a relatively short time; it brings the person back from psychosis into neurosis. It is cheaper to the hospital and to the taxpayer.

The chief objection to it is that, because of its disruptive effect on memory and identity structures, it does not allow the patient to work through and integrate the material that has been released. The patient *felt* worse and stated his intention to have psychedelics again as soon as possible, to continue the interrupted journey. Assuming psychosis is again the result, there might be expense to hospital and taxpayer. The bring-down is not permanent.

The sensory deprivation sessions were used here, not as a primary therapeutic tool, but as an adjunct to the "talking-down" approach that I basically employed. In terms of time spent, the sessions occupied perhaps one-quarter of the total, the remaining three-quarters being spent in continuing attempts to develop interpersonal closeness and communication. I would question whether the approach would have worked at all, had not a certain relation-

ship and trust already existed which enabled the patient to accept the experimental use of the sensory deprivation room.

The use of sensory deprivations and allied supportive measures, on the other hand, reduces stimulus flooding and provides opportunity for more adequate coding and sorting of information by the overloaded circuits. Gradually, a psychic center could be re-established, enabling the person to piece together again the fragmented elements of his universe. We would expect such a process to take longer, perhaps a period of months, but to be more permanent and psychologically satisfying to the patient. Being based on genuine insight and psychic integration we would expect a better adjustment. Full exploration of this approach requires staff who can tolerate episodes of bizarre behavior which can be seen as extreme forms of non-verbal communication.

The sensory deprivation room was used minimally here, and one case is insufficient to assess adequately the relative validity of the two approaches, but the results certainly warrant further research and discussion.

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