

The Implications of Psychedelic Drug Research for Integration and Sealing Over as Recovery Styles from Acute Psychosis

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INTRODUCTION

A recent paper by Levy, McGlashan and Carpenter (1975) presents excellent descriptions and theoretical explanations of integration and sealing-over as recovery styles from acute psychosis. Their observations and conclusions can be supported, extended, and somewhat integrated, by data emerging from research on the use of psychedelic drugs such as LSD as adjuncts to psychotherapy.

Earlier research with LSD resulted in a great deal of controversy about the appropriate nomenclature to be used with compounds of this type. The term "psychotomimetic" was suggested, since it seemed that frequently the experiences triggered by such compounds mimicked in some substantial way the mental processes and experiences accompanying psychotic episodes. It was hoped that by administering such drugs to normal volunteers, and to sophisticated professionals in the psychiatric and psychological professions, important new insights with regard to the mechanisms underlying psychotic processes would emerge. Although this hope has been fulfilled to some extent, the insights produced have not been as easily implemented as it had been expected they might. General similarities and differences between psychedelic drug-induced states and psychotic states have been delineated by Mogar (1968).

Other names were suggested to describe the category of drugs that included LSD, psilocybin,

mescaline, and similar compounds. The term "psychedelic," meaning "mind-manifesting," has become the most commonly accepted term in use today. Although research based on a psychotomimetic model has virtually ceased, there has been some continuation of research into the potential therapeutic utilization of these compounds. It is within this context of therapeutic application that the term "psychedelic" is most commonly used, and it is from this area of research that a number of important insights pertaining to the question of integration vs. sealing-over as recovery styles have emerged.

Levy, McGlashan and Carpenter (1975) conceptualized a continuum of styles of response from acute psychosis. This continuum ranges from integration to sealing-over. They give the following description of sealing-over:

Sealing-over describes a process by which psychotic experiences and symptoms are isolated from non-psychotic mental events and then made unavailable by both conscious suppression and repression. Impenetrance to influence is both its intrapsychic and intra-personal characteristic. Individuals who successfully seal-over are disinclined to discuss the thoughts and feelings they experienced while actively psychotic, often appear to lack awareness of the details of their psychotic episode, and fail to place their psychotic experiences into personal context. Such individ-

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uals see their psychosis as an encapsulated, circumscribed event which is alien to, and distinct from, that part of their mental life they experience as evolving in a continuous causally related manner. They rarely treat their psychotic experience as a source of new information about themselves and seek to return to their premorbid opinions and behavior – often with remarkable success. (p. 310)

At the other end of the continuum, Levy, McGlashan and Carpenter (1975) describe integration in the following manner:

Integration describes a process by which a continuity is recognized between thoughts and feelings experienced during psychosis and prepsychotic and postpsychotic mental life. Individuals who make integrative recoveries struggle with the conflicts evident in their psychotic ideas, feel responsible for them, and attempt to use their psychoses as sources of new information about themselves, with the goal of modifying premorbid opinions and behavior. (p. 311)

SEALING-OVER AND INTEGRATION AS SEEN IN RESPONSE TO PSYCHEDELICS

Both integration and sealing-over have frequently been observed as responses to the experiences engendered by a psychedelic drug. Sealing-over of a response to a psychedelic drug is most often seen in persons who ingest these compounds for recreational or social purposes. Although the response to the agent in this situation frequently is the one sought, there are also occasions when the opposite occurs. In street parlance, these occasions are described as "bad trips." They usually entail severe panic, anxiety, depression, or unresolvable conflict that has emerged into consciousness during the period of drug action. Persons finding themselves plunged unexpectedly into such experiences not only manifest a sealing-over strategy after the drug reaction has subsided (analogous to the sealing-over recovery style from an acute psychosis), but can actually be seen to be employing such a strategy during the experience itself. Persons who have had such experiences have reported repeatedly reminding themselves that they had taken a drug whose effects could be expected to abate within a few hours, or else attempting to divert their attention from the experience and trying to concentrate on some external distraction. In one case, it was described as sitting for eight hours and repeating the word "Om" over and over until the drug effects had subsided. Savage (1955) has noted that this strategy is a

relatively effective one for experimental subjects as well. The sealing-over strategy that frequently occurs after such a drug experience is very directly analogous to that described by Levy, McGlashan and Carpenter (1975). It involves an encapsulation of the experience and isolation from the rest of one's life, and whatever emotional impact that may have occurred during the drug experience itself is dismissed as a bizarre drug effect. Frequently it is assumed that the drug itself was impure or improperly labelled, thereby giving further explanation of the experience that occurred and greater distance from the person's own psyche. Weil (1972) has described in detail the ways in which such psychological maneuvers take place.

When integration is applicable as a description of the process whereby a person deals with the experiences engendered by a psychedelic drug, the outcome is usually much different. Such events can be dramatically positive in their impact on the individual's functioning and are the basis for the use of such compounds as adjuncts to psychotherapy. It is interesting to note that the term "integration" itself has come to be used to refer to the portion of psychedelic drug-assisted psychotherapy that follows the drug session itself. It is significant that Levy, McGlashan and Carpenter (1975) describe a very marked degree of rapport with the therapist as being a reflection that the patient has been coping with his psychotic experience in an integrating fashion. They say:

To a large degree, the use of integration as a descriptive term for a particular individual's recovery reflects aspects of the patient's relatedness to the observer. There is a degree of interpersonal involvement, therapeutic engagement, and empathic interchange which readily distinguished these patients from those who seal-over. (p. 311)

The use of a psychedelic agent allows one to establish such therapeutic rapport before the drug experience, thereby maximizing the probability that integration will occur. In the case of a spontaneous psychotic episode, the interpersonal rapport is merely a correlate of an integrative outcome, which in a psychedelic drug-assisted psychotherapy situation is presumed to be causative. This is not meant to imply that the therapist and patient who engage in a course of psychedelic drug-assisted psychotherapy do not greatly deepen their relationship as a result of the experiences that emerge during the drug sessions, since this is also true, but rather that a preestablished baseline of substantial rapport greatly facilitates the positive outcome that is sought.

Some of the theoretical aspects of the concepts of sealing-over apply to treatment failures of psychedelic drug-assisted psychotherapy, as well as to the experiences that sometimes occur when such drugs are taken on a casual basis and without therapeutic intent. Although every attempt has been made before a psychedelic drug is given to a patient in therapy to engender in the patient a receptive attitude toward the experience and a deep rapport with the therapist, it nevertheless is sometimes the case that the experience itself is in some way too overwhelming and is subsequently repressed or consciously suppressed. Consequently, there is the requirement for a great deal of clinical judgment in determining the initial selection of candidates for psychedelic drug-assisted psychotherapy, and in deciding when sufficient therapeutic rapport has been established to allow for maximum probability of a positive outcome from a drug-assisted therapy session.

When a patient or casual drug user employs a sealing-over strategy to deal with psychedelic drug induced experience, it is highly probable that he or she will be one of those who subsequently report a "flashback" (Grof 1973). Just as the acute psychotic episode may bring into overt expression certain conflicts that previously were outside of awareness, the psychedelic drug experience may bring into consciousness certain conflicts of which the patient was previously unaware. Although the intent and emphasis is to bring about the integration or resolution of these conflicts, failures do occur. When no therapeutic intent was present before the ingestion of such a drug, the probability of resolution and integration is especially low. In these cases, the conflict seems no closer to consciousness than it was before the experience, and hence is more likely to manifest itself in the ongoing life experience of the individual. In a manner analogous to the example given by Levy, McGlashan and Carpenter (1975) the conflicts may "remain intact, albeit in a transformed state of partial resolution . . ."

INTEGRATION OF STRUCTURAL/ECONOMIC METAPSYCHOLOGICAL CONCEPTS OF PSYCHOSIS WITH DYNAMIC CONCEPTS OF PSYCHOSIS

The theory and techniques of psychedelic drug-assisted psychotherapy incorporate both metapsychological and dynamic views of the psychotic process. Since this theory and these techniques have been discussed elsewhere (Grof 1975), they will merely be summarized here. First, it is presumed that the probability of the occurrence of significant psychotherapeutic progress is extremely low in the absence of a meaningful interpersonal relationship. Trust and rapport

are therefore established in the therapeutic relationship before any drug is administered. Shortly before a psychedelic is to be introduced into the ongoing therapy, a co-therapist, of sex opposite to that of the primary therapist, is introduced to the patient and allowed to establish basic rapport as well. On the day when the drug is administered both the therapist and co-therapist are present during the course of the drug action. The patient usually spends most of the time reclining on a sofa, wearing eyeshades and listening to stereophonic music through headphones. He or she is encouraged to surrender to the experience that ensues, giving up all attempts to control or direct it. The therapist and co-therapist provide interpersonal support for the experiential journey undertaken by the patient, both verbally, by encouraging the patient to confront any frightening or painful material that may emerge, and non-verbally, by taking the patient's hand or holding the patient. The patient is encouraged to refrain from talking about his or her experiences during most of the period of drug action, although from time to time the therapist and co-therapist will remove the eyeshades and ask if there is anything that the patient particularly wishes to share with them. Sometimes the patient is also invited, usually near the end of the drug reaction, to examine various objects, such as family photographs which may have personal significance, or objects which may have more universal significance, such as beautiful flowers, seashells, and the like. In the therapy session following the drug-assisted session attempts are made to understand and to integrate into the patient's daily functioning the experiences and insights gained during the drug-assisted session.

From the standpoint of libido economy, the procedures of psychedelic drug-assisted psychotherapy can be seen as involving considerable "withdrawal of libidinal cathexes from external objects . . ." (Levy, McGlashan & Carpenter 1975). However, this withdrawal is not the result of a conflict between ego and reality, but is directed by the therapist as an integral part of the therapeutic process. This externally-structured withdrawal does indeed lead to what may be described as a "hypercathexis of the self . . ." (Levy, McGlashan & Carpenter 1975), and this may or may not produce symptoms of megalomania, narcissism, and hypochondriasis. The patient is actively encouraged to surrender his or her ego's ability "to cathect its own boundaries . . ." (Levy, McGlashan & Carpenter 1975) and to permit the deneutralization of sexual, aggressive, or any other form of energy that may be found to exist in the patient's psyche.

Part of the theory and practice of psychedelic

drug-assisted psychotherapy can also be seen to be rooted in a more structural approach to the formation of psychotic symptomatology. In such an approach intrapsychic conflict is considered to be a possible source of anxiety that would in turn be great enough to produce overt psychotic symptoms in an acute phase, and "less pathologic defenses to the point of recovery of the capacity to experience relatively unmodified sadness and anxiety" during recovery (Semrad, Grinspoon & Feinberg 1973). However, in the course of psychedelic drug-assisted treatment, especially during a drug-assisted session, the patient would be encouraged to experience directly and immediately whatever anxiety, sadness, or other emotion which might present itself, rather than moving along a continuum of defenses going from immature to mature as described by Semrad, Grinspoon and Feinberg (1973).

Although structural and economic components are clearly present in the psychedelic model, a dynamic conceptualization of defenses is also included, implying that defenses may provide both frustration and gratification, within the immediate interpersonal environment, of certain drives or wishes. It is partially for this reason that the treatment team contains both a male and a female member during a drug-assisted session. Such an arrangement allows maximum opportunity for the projection and exaggeration of defensive styles and distortions, in a context in which preestablished therapeutic rapport provides the necessary safety, and a psychedelic drug provides the "undifferentiated activation" (Grof 1975) of unconscious material, for the direct experiencing of, and resulting resolution of, intrapsychic conflicts. One of the rather unique dynamic mechanisms that is often present in psychedelic drug-assisted psychotherapy has to do with the concept of dedifferentiation as an individual. Such a breaking down of boundaries between self and objects, while usually seen as an indication of significant psychotic decompensation, can also be seen as providing a primitive and intense gratification for both the patient and therapist. Searles (1959) has discussed the need for the therapist to be aware of the fact that he or she must give up such gratification as the patient progresses in therapy, in addition to the psychotherapeutic impact on the therapist of this and other aspects of the therapeutic alliance (Searles 1975).

Dedifferentiation is a relatively frequent occurrence during the course of psychedelic treatment, and is usually regarded as being potentially very therapeutically productive. Patients sometimes feel themselves to have merged with objects or persons in the immediate environment. Such merging with the persons in the

environment (the therapist and co-therapist) may be catalyzed by a touch or embrace, a meeting of the eyes, or, without any such observable contact having occurred, may simply be reported after the fact to have been experienced by the patient. Such an experience can obviously be of great significance for a person who is very alienated from other humans in general. However, it appears that, in accord with Searles (1975), it meets a very primitive and strong need in all of us. If such is the case, then the opportunity to have such an experience in a complete and intense form may act to meet that need and satiate it, at least temporarily. By doing so the experience would presumably be beneficial to almost anyone, and might even remove the need for continued dedifferentiation on the part of a psychotic person. Perhaps the opportunity for controlled experiences of dedifferentiation, such as might occur in certain religious practices, a day's retreat in nature, making love, and other situations (including experiences with psychedelic drugs), could even be considered a psychological prophylactic, preventing the occurrence of a less controlled or psychotic dedifferentiation.

An example of therapeutic dedifferentiation is given by a young woman who was treated with psychedelic (LSD) drug-assisted psychotherapy for the depression and anxiety she was experiencing secondary to learning that she had terminal cancer. During the course of the LSD session the eyeshades were briefly removed, she looked deeply into her therapist's eyes, and suddenly embraced him. Later she reported that what she experienced during that embrace had a very profound impact on her, that she felt it impossible to discern whether he was comforting her or vice versa, and that for a few moments she was unable to differentiate herself from him. She subsequently showed a marked reduction in anxiety and depression up to, and including, the time of her death.

IMPLICATIONS FOR THE TREATMENT OF SCHIZOPHRENICS

Levy, McGlashan and Carpenter (1975) postulate that, with regard to recovery from acute psychosis, "the integrative mode may provide opportunities for personal growth which would be lost if the psychosis were sealed-over." This observation is congruent with the belief held by many that exposure to psychedelic drug-assisted psychotherapy can offer unique opportunities for personal growth. In fact it has been noted (Unger 1976) that of all the psychometrics that have been used in attempts to measure the impact of such psychotherapy, the Personal Orientation Inventory, a

test designed to measure self-actualization (Shostrom 1975), seems to be one of the most sensitive.

It is interesting to note that a number of investigators have become intrigued with the possibility of allowing an integrative resolution to a psychotic episode to occur by withholding psychotropic medication and encouraging the individual to experience completely what is occurring within his/her own psyche. Examples of this approach are found in Mosher and Menn (1975), Perry (1974a, 1974b), and Lang (1967).

Each of these investigators regards the psychotic episode as in some way a potentially healing or therapeutic experience that can be best utilized if it is fully experienced. Interestingly enough, some data that have emerged from these studies seem to provide support for such a contention (Mosher & Menn 1975). However, Perry has recently indicated (1974b) that there seems to be some problem in this approach with regard to the motivation of individuals to go through the experience. Although Perry has outlined an elaborate and intriguing model of the general form a psychotic experience can be expected to take if it is allowed to unfold to its theoretically optimal therapeutic conclusion (1962, 1974a), nevertheless it seems to be the case that fewer and fewer individuals wish to allow this process to take place. Apparently there is a greater interest in many of the acute young psychotics seen in Perry's facility in sealing-over the episode rather than integrating it.

One of the points made by Levy, McGlashan and Carpenter (1975) is that sealing-over may be the recovery style of choice for some patients. These authors postulate that an attempt at an integrative recovery runs the risk of bringing into conscious awareness conflicts that may subsequently mobilize anxiety and depression and lead to relapse. The implication is that certain conflicts simply cannot be confronted and resolved by certain persons. However, data from psychedelic drug-assisted psychotherapy research does not confirm such a theory. When employed within the context of a supportive and therapeutic interpersonal setting, there seems to be almost no conflict that this treatment cannot help bring to resolution. The success in helping terminal cancer patients confront their own deaths (Richards et al. 1972) provides a relatively dramatic example of this.

The material emerging into consciousness during a psychotic episode might be compared to dream material; its emergence is spontaneous and beyond the control of the subject, the content is often symbolic and representative of intrapsychic conflict, and the seeds of therapeutic change are presumed to be contained within

it. In this regard Zinberg's observation may be noted that the mechanisms of a psychedelic drug response are "more susceptible to synthesis" than those of a dream state (1976).

A patient who attempts an integrative recovery from an acute psychotic episode, and subsequently relapses, seems to be manifesting the same mechanism that is seen when a person takes a psychedelic drug without adequate preparation and therapeutic support, and subsequently experiences flashbacks. In both cases some conflictual material has presumably been brought into consciousness, but not adequately integrated. The fact that the patient has relapses, or the person who takes a psychedelic has a flashback, does not necessarily imply that complete resolution and integration of conflictual material was impossible for either of them; it may only mean that the circumstances were not appropriate or adequate to allow such resolution and integration to occur. Levy, McGlashan and Carpenter (1975) note that patients who achieve an integrative recovery from an acute psychotic episode show "a degree of interpersonal involvement, therapeutic engagement, and empathic interchange which readily distinguish these patients from those who seal-over." In a like manner, the probability that a flashback will occur following exposure to a psychedelic drug seems to be inversely proportional to the quality of the interpersonal environment in which the drug was initially taken. It is obvious that one rarely has the opportunity to establish rapport before the onset of an acute psychotic episode, but one does have such an opportunity before the administration of a psychedelic drug. Current knowledge of the action of these drugs dictates that taking advantage of this opportunity is actually on the order of an ethical mandate.

Continuous interpersonal contact and support during the entire period of drug action have come to be viewed as important aspects of standard procedure in the conduct of psychedelic drug-assisted psychotherapy. The emphasis is not on active therapeutic intervention in most cases, but merely attentive presence and availability to guide, support, and share experiences as needed. A similar approach has been suggested by Savage (1956) as being appropriate for the patient experiencing an acute psychotic reaction. Mosher (1972) has implemented this suggestion to a substantial extent, with promising results.

Another suggestion made by Savage, though somewhat indirectly, has also been implemented by Mosher, though perhaps unintentionally. Savage noted that LSD "allows the investigator to develop a certain feel or empathy" (1955). Although the use of the word

"investigator" seems to direct the suggestion toward researchers, one can hardly overlook the implication that such "feel or empathy" might also be valuable to the clinician. Mosher, Reifman and Menn (1973) have recruited nonprofessional staff members to work with acutely psychotic patients who are not given medication and are encouraged to regard their psychotic state as a unique opportunity for personal growth that should be experienced fully. These nonprofessional staff members are told that "their therapeutic role is analogous to that of the LSD-trip guide." They are selected on the basis of their presumed "ability to tune into the psychotic person's 'space,' and to provide a constantly reassuring presence, without being intrusive or demanding or 'laying their trip' on the psychotic person." A post hoc analysis of personal histories of the persons who came to be selected for these staff positions indicated that they had experimented with psychedelic drugs, but had not developed patterns of abuse. Such a background is congruent with the kind of background that most practitioners of psychedelic drug-assisted psychotherapy would prescribe for persons entering into the latter field of endeavor. Ideally one should be able to experience a psychedelic within a therapeutic framework before attempting to use it in the conduct of psychotherapy, in a manner similar to the way an analyst would participate in a training analysis as part of his or her professional preparation. What emerges from all this is the implication that some experience with psychedelics and/or other methods of altering consciousness might be valuable background experience for anyone intending to attempt to conduct psychotherapy with schizophrenics. Psychedelics represent one of the safest and more reliable means available for inducing profoundly altered states of consciousness, and might therefore be recommended for providing such experiences for would-be therapists.

Perry (1974a) has noted that acute psychotic episodes usually have within them a subjective continuity and meaningfulness of experience, that can be discerned by the observer who is trained and alert. A similar point has been made by Grof (1975) with regard to the experiences that are manifested within a given LSD session, as well as across repeated LSD sessions within a given individual. Although superficially the content may appear to be random samplings of a chaotic stream of consciousness, predictability and meaning may be elicited through attending to the experience without an overly-constricted theoretical orientation that would preclude the attribution of significance to certain types of experience, while at the same time maintaining a sensitivity to the fact that certain material may be

represented in a symbolic fashion and require interpretation before its significance can be appreciated and integrated. It therefore would behoove the therapist working with acutely psychotic patients to cultivate the kind of theoretical open-mindedness and sensitivity to symbology that would permit him or her to grasp and empathically share with the patient the kinds of existential and interpersonal meaning that are potentially available through a psychotic experience. Once again, these are precisely the kinds of traits that one would expect to find in a therapist who is effective in the conduct of psychedelic psychotherapy.

Levy, McGlashan and Carpenter (1975) make the point that certain types of individuals may do better making an integrative recovery to a psychotic episode, while others may find a sealing-over strategy to be optimal for them. McGlashan, Levy and Carpenter (1975) suggest that certain types of therapists may even be more successful in promoting one or the other type of recovery. While it is almost certainly the case that patients can be categorized in terms of their tendency to adopt either an integrative or a sealing-over strategy, and that therapists differ in the extent to which they would foster and support one or the other strategy, there is some evidence to indicate that an integrative recovery offers a better long-term prognosis. Levy, McGlashan and Carpenter (1975) point out that, for the patient who has sealed-over, "the conflicts involved in the psychosis remain intact, albeit in a transformed state of partial resolution, allowing the individual enough freedom from anxiety to approximate prepsychotic levels of functioning." This situation is analogous to the person who attempts to resist, and subsequently to deny, the experiences engendered by a psychedelic drug. By doing so, he or she is more likely to experience flashbacks after the drug experience that are based on material which was activated but not integrated during the drug experience. In a similar manner, it is probable that future research will demonstrate that those who seal-over a psychotic episode are more likely to experience relapses.

The ongoing integration and maintenance of therapeutic gain achieved in psychedelic drug-assisted psychotherapy requires some kind of continuity to treatment beyond a brief and intensive intervention. This seems to be the case at least for alcoholics treated with a psychedelic approach in a state hospital, and it has been suggested that an ongoing group that meets once or twice each month might be able to meet this need (Rhead et al. 1977). Presumably individuals who are relatively psychologically sophisticated and have some inherent curiosity about their own mental

processes would need less of this kind of external support, but would nevertheless be expected to benefit from it. Schizophrenics who have made an integrative recovery might also benefit from such an aftercare structure, by offering each other support and encouragement in their continuing attempts to fully integrate the insights made available during their psychotic episodes. An organization such as Schizophrenics Anonymous might be ideal to provide such an opportunity, except that in the case of this particular organization, the theoretical orientation that predominates would not be expected to foster positive attitudes toward integrative strategies. The members of this group view psychotic symptomatology as the result of a biochemical imbalance that can be corrected by megavitamin therapy, a view that corresponds to the tendency of those who seal-over a psychotic episode to deny personal relevance for their experiences.

It appears that psychedelic drug-assisted psychotherapy might hold some promise for the treatment of schizophrenics. Although previous research has produced some intriguing findings (Savage 1955; Grof 1975), there is a great need for more systematic and extensive investigations. Possible applications would include both chronic and acute patients. In the latter case, the intervention with a psychedelic would be seen as an adjunct to the psychological processes that are already present in the acute episode. It would provide the opportunity to catalyze those processes at a point in time deemed to be therapeutically auspicious, in the presence of a therapist with whom some significant therapeutic rapport had been established. The goal would be the facilitation of an integrative recovery.

In the case of the chronic schizophrenic the task at hand seems somewhat greater. Nevertheless, LSD has been shown to be capable of producing a rather dramatic modification of the behavior of such patients (Cholden, Kurland & Savage 1955). One might conceptualize these patients as having achieved a stabilized partial recovery based on sealing-over. Psychedelic drug-assisted psychotherapy might be able to "break the seal" in such a case, and then at least provide the patient with the option to attempt an integrative recovery.

The question of appropriate settings, both physical and theoretical, for the treatment of schizophrenics with psychedelics is rather open. Mosher (1972) emphasizes the need for a non-institutional setting that vigorously suppresses the development of hierarchical roles or theoretical models in allowing acutely psychotic patients to come to a satisfactory resolution with a minimum of psychotropic medication. On the other hand, Carpenter, McGlashan and Strauss (1977) claim similarly promising

results when medication is minimized in a clearly hierarchical institutional setting that openly espouses a medical model and psychoanalytically oriented therapy. Finally, Abruzzi (1975) reports the relatively successful treatment of over 2,000 cases of acute psychosis with almost no medication on an outpatient basis, using an approach that emphasizes the therapist's empathic sharing of the psychotic experience and the integration into everyday living of the insights to be gained therefrom.

It seems highly likely that future research will continue to refine the diagnostic criteria for schizophrenia and to delineate subtypes that will show differential responsiveness to different treatment approaches (Carpenter 1976). Studies of the application of psychedelic drug-assisted psychotherapy to such populations may not only reveal an effective treatment modality, but may simultaneously contribute to nosological advancement in the field.

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