3. **absence of indications of consistent self-identity,** which seems to be linked to the lack of affectional relationship and consistency, with anger at closeness. This vacillating behaviour is associated with a confused view of the self—"as if I were watching myself playing a role"—and the frequent assumption of complementarity (*i.e.*, the passive awaiting of cues from others, with relationships based on mimicry or imitation of others).
4. **depression**—not the guilt-laden, self-accusatory, remorseful type; but loneliness, as the subject realizes his predicament of being unable to commit himself in a world of transacting individuals.

The four subgroups of the syndrome are set out hereunder:

Group I.: The Psychotic Border. These patients are characterized by:

1. inappropriate and non-adaptive behaviours;
2. deficient sense of self-identity and sense of reality;
3. negative behaviours and anger towards other human beings;
4. depression.

Group II.: The Core Borderline Syndrome, characterized by:

1. vacillating involvement with others;
2. overt or acted-out expressions of anger;
3. depression;
4. absence of indications of consistent self-identity.

Group III.: The Adaptive, Affectless, Defended, "As If" Persons, characterized by:

1. adaptive and appropriate behaviour;
2. complementary relationships ("as if");
3. little affect or spontaneity in response to situations;
4. defences of withdrawal and intellectualization.

Group IV.: The Border with Neuroses, characterized by:

1. childlike depression (anaclitic);
2. anxiety;
3. generally close resemblance to neurotic, narcissistic characters.

The authors carried out a follow-up study, involving 86 *per cent* of the original group. In the period of follow-up (1 to 3.5 years), only 2 patients, both from Group I, became schizophrenic. Despite therapy in hospital orientated towards improving social aptitudes of the patients, they remained for the most part socially isolated. Most returned to school and employment and maintained their roles successfully. Thirteen patients had to be rehospitalized.

While the criteria for selection must have some influence on the ultimate findings, it is clear that this is a valuable piece of work which has shed, and will continue to shed, a good deal of light in this obscure area. It is to be hoped that other workers will apply the same energy and perhaps similar techniques to clarifying other obscure areas of psychiatry, and indeed some areas where we complacently feel in our current ignorance that little obscurity exists.

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EDITORIAL ANNOTATIONS

THE CURRENT STATUS OF THE HALLUCINOGENIC DRUGS

During the past decade, the use of these drugs has fostered one of the major medical and social crises of our age, and the time would now seem opportune for a sober appraisal of their appropriate place in current psychiatric practice.

To date, the Australian and New Zealand College of Psychiatrists has not committed itself to any formal expression of opinion or policy in this regard, though the Royal Australasian College of Physicians two years ago waged quite a vigorous publicity campaign, warning against the non-medical or even the injudicious medical use of these drugs. This culminated in a formal statement "The Hallucinogenic Drugs — Their Use and Abuse" (Royal Australasian College of Physicians, 1968).

Historically, the use of hallucinogenic drugs is not new to man. Plants and fungi known to the Aztecs and to various Indian and Mexican tribes in pre-Columbian days were widely used as part of religious ritual and ceremony. In fact, the use of peyote among North American Indians has had a long and stormy history dating back nearly 500 years, and recently it has been accorded sacramental status in the North American Indian Church.

It was not, however, till World War II that these drugs attracted attention other than in botanical and anthropological circles. Then, in 1943, Hofmann accidentally stumbled across the weird hallucinogenic properties of an ergotamine derivative which he had identified as lysergic acid diethylamide five years previously. Little notice was taken of his discovery however for another decade, and it was not

until the 1950's that the subject became one of clinical interest and research. L.S.D. was not used in Australia prior to 1960 save for occasional pioneering trials, especially by Whitaker in Melbourne (Whitaker, 1964). After 1960 however its fame became widespread, both in medical and lay circles, and it became the most glamorous and controversial drug of the decade.

Many doctors, and not only psychiatrists, were attracted to its use, hoping for dramatic cures and magical effects. By and large, they were disappointed as regards cures, though the effects were often dramatic enough. The mid 1960's witnessed an odd reversal of use from the professional to the amateur. Many doctors and very many psychiatrists gradually gave up using L.S.D. (and its weaker cousins psilocybin and psilocin), finding it disappointing clinically and often dangerous and unpredictable in its effects on the patients' emotions and on their life adjustments. On the other hand, more and more lay people were lured into L.S.D. experiences, being attracted by its *mystique* and by the aura of mystery and magic that surrounded its use and abuse.

The mood of the times proved ripe for its abuse. Western society has not yet regained its stability and balance since the global upheaval of World War II. Indeed, since that time the minds of men have been almost constantly besieged with major anxieties on a scale unknown in human history. As a result of the "communications explosion", there is very little of importance, or of even potential danger, that is not brought home on the television screen to nearly every family, at least in the western world, so that children from their earliest years are subjected to the strain of conflicts, whether international, national or social, and of experiencing the effects of such conflicts on their parents. Furthermore, we live in a world in which there are very few countries which are not at least potential seats of conflict and crisis.

Perhaps more importantly, we have reached a stage of social, religious and intellectual evolution where there are few remaining absolutes or sources of traditional stability and permanency. Little is now sacred; virtually nothing unchallenged and unchanged. Psychologically, this situation is charged with great possibilities for growth and development. It can be likened to the great critical periods, biological and historical, when crisis precedes resurgence. This is witnessed time and again in the ontology, phylogeny and social history of man. But it is a period of instability for all that, and a time when the less secure and more unstable members of our society are thrown, as it were, to the periphery of the social orbit.

It is hardly surprising, then, to find amongst these fringe dwellers many who are attracted to the lure of brave new worlds, whether these be attained politically or pharmacologically. Many feel no root or tie with the old order and see no meaning in its continuance. Either it must die or change or they must. And if they cannot die literally, they are only too relieved to opt out chemically and to create a new world for themselves, even if it be based on chemically-induced fantasy.

This is broadly the basis of the rise of the Hippie cult, which has mushroomed in the United States and throughout the west, and even in parts of the communist world, during the past decade. This new subculture was founded by those who rejected the prevailing social and cultural mores, and sought to found a new type of semicommunal existence based on their concept of love and the pursuit of pleasure, an existence in which, ideally, hate, competition, authority and discipline have no place. They have found that the hallucinogenic drugs have extraordinary power to liberate the imagination, and to provide an almost indescribable wealth of sensory stimulation, and also to provide *entrée* to a sort of mystical dream world in which finite barriers cease to exist, and there is a sense of infinite omnipotence. Having once experienced this Utopia, they have no wish to return to this dull world of sordid care and responsibility, and they seek either to escape by taking as many "trips" as possible, or else to refashion and recreate their lives with all the colour and *décor* of psychedelic art. They have been powerfully encouraged by the eloquence and example of such academic dropouts as Leary and Alpert.

This has been the social experience through which we have lived in the past decade. It was estimated that in the United States in 1965 approximately 4 million Americans took L.S.D., one in eight at least once a month. Perhaps as many as 70 *per cent* of all users were high school and college students, including dropouts (Schiller *et al.*, 1966).

In western countries, psychiatrists have been slow to react or to mobilize their collective opinion — perhaps because of their desire to observe longitudinally before pronouncing prematurely.

Governments, on the other hand, have felt obliged to react more quickly — especially when they have felt that the existing social order is threatened, or when "flower power" has talked of tincturing water reservoirs with "the acid".

In 1967, the various state governments in Australia enacted legislation to control and regulate the manufacture, sale, and use of the hallucinogenic drugs, dimethyltryptamine, lysergic acid diethylamide, mescaline, psilocybin and psilocin. Of these, the two of most important concern are L.S.D. and psilocybin, and these are the only two which are now supplied (through the state Departments of Health) for appropriate use by approved psychiatrists in approved clinical settings.

It is obviously difficult to obtain precise or definite information, let alone valid statistical data, as to the effect of this legislation on the non-medical use of these drugs. The impression gained, at least in Victoria, is that the result has been generally successful.

There seems to be a definite and significant falling off in the illicit use of these drugs — and with it a perceptible and increasing swing towards the use of

marijuana, together with an increase of pressure at all levels for some mitigation of the laws relating to the latter drug. This is another wide question on which our College will doubtless be called on to pronounce at some time, but it is rather too complex to tackle in this editorial.

The decline in the usage of hallucinogens has been apparent also amongst psychiatrists authorised to use them. Those who still use these drugs seem to be favouring psilocybin rather than L.S.D. except in the most difficult cases, presumably because its use is less traumatic (for both patient and therapist), less demanding, especially as regards time and emotional involvement, and safer, especially as regards potential chromosome damage.

The Victorian Branch of the A.N.Z.C.P. recently appointed a subcommittee to investigate and report on the current use of these drugs, and this report is being considered at present. The writer is greatly indebted to Dr L. H. Whitaker for the following information which has been compiled from a *questionnaire* sent out to gather information for the report (Whitaker, 1970). The information applies only to the state of Victoria, which is apparently the main "hallucinogenic state" in the Commonwealth.

In Victoria, 19 psychiatrists hold warrants to use the drugs, of whom 18 are in private practice. Of these 19, 11 have replied to the *questionnaire*. Their experience with the drug ranged from 2 to 15 years (mean 8), and the number of patients treated varied from 1,000 to 6. Some 4,000 patients were treated in all, the average number of treatments per patient being 4.2. The estimated proportion of good to poor results, overall, ranged from 80:20 to 10:90 (the estimated average being in the order of 60:40, and the most common range from 40:60 to 60:40.

Good results were mostly reported in cases of anxiety neurosis, hysteria, mixed neurosis, character disorders, psychosexual disorders, and alcoholics and drug dependent personalities.

Varied reports were submitted relating to obsessional neurosis, and poor results were noted mainly for psychopathy, latent or current functional psychoses, and for patients with infantile hysteric ego, poor ego strength, and low intelligence. Specific mention is not made of the age groups but it is the writer's belief that the second, third and fourth decades of life are most suitable, successful therapy being progressively less likely after the middle of the fifth decade.

Most observers noted the following temporary reactions: panic, confusion, paranoid reactions lasting for up to 24 hours, depression for up to several days (often requiring active antidepressant treatment), occasional suicidal tendencies, aggressive acting out, and disturbance of marital or interpersonal relationships. Most of these reactions were regarded as reasonably manageable.

There were surprisingly few long-lasting adverse reactions. Two psychiatrists reported an increased number (not specified) of marital breakups. Three reported a total of 8 suicides occurring some months after treatment and possibly related to it. Two reported aggressive behaviour on a continuing scale. One psychiatrist reported frequent troublesome recurrences of hallucinatory episodes, and three reported a total of 10 recurrent hallucinatory episodes (3 troublesome), in their combined 2,700 patients.

As regards addiction and dependence, 7 psychiatrists found none in 2,340 cases. Four others noted 4 definite cases of dependence (not addiction) amongst 1,300 patients. In fact, several psychiatrists commented that it was more difficult to motivate patients to continue rather than to discontinue therapy, though the patient population included a large number of drug dependent persons and alcoholics.

There was considerable difference amongst psychiatrists, both as regards the type of psychotherapy employed during and between sessions, and also as regards the choice of patients for such treatment. These differences admittedly constitute a considerable difficulty in the overall evaluation of the efficacy of this treatment, for some cases successfully treated by Psychiatrist A would have been regarded as curable by other means by Psychiatrist B. Most psychiatrists tended to use the drugs after failure of other forms of treatment, and three used them only in difficult, refractory cases. Alcoholism, drug dependence, obsessional neurosis, atypical schizophrenia, psychosomatic disorders, paranoid personalities, chronic neuroses, chronic sexual disorders and chronic schizophrenia were reported as examples of difficult cases.

All but 3 of the psychiatrists conducted psychotherapy during the drug session (though this is apparently not universal practice overseas or in some other states). Most regard this and interim therapy as essential for success. Seven reported the treatment to be a strain on their personality but worth the effort, and one regarded the effort as worthwhile professionally but not economically!

Incidentally, it is worthwhile noting, costwise, that the fee for an intensive session of treatment, extending over several hours, is only a fraction of the cost of the average suburban appendicectomy lasting ½ hour.

Understandably, there were no reports of "therapist breakdown" as has been reported overseas especially by Cohen (1964; 1969) and La Barre (1964).

As regards genetic effects and chromosomal damage, one psychiatrist who had used L.S.D. during pregnancy (before the thalidomide tragedies) had encountered no ill effects; several remarked that their patients had reported normal pregnancies and normal children subsequent to treatment, and one psychiatrist who is participating in a survey commented that though most of his patients showed evidence of chromatid breaks, the changes were sometimes minimal even after very extensive treatment, no worse later than early in treatment, and often enough present even before treatment had commenced, which raises the interesting query as to whether other forms

of psychiatric treatment, *e.g.*, other drugs commonly prescribed, have similar effects, or whether psychiatric patients for some other reason are more prone to show these changes (Garson, 1969). Obviously, this whole question is still *sub judice*, and it would at this stage be unwise to issue premature and possibly misleading reassurances, but it would also be injudicious (and possibly an unnecessary deterrent to some potentially curable patients) to issue pontifical prohibitions on evidence that is by no means confirmed, let alone proven. The two extremes of the situation are well expressed by patients who said respectively, "What is the use of being cured by L.S.D. if it cripples my chromosomes?", and "What is the use of sparing my chromosomes if life is such a misery that I refuse to endure it?"

Practically all the psychiatrists would prefer to use psilocybin (or even psilocin if still available) rather than L.S.D., except in the most difficult and stubborn cases. None felt that these drugs provided a complete or absolute answer, and most felt that their use greatly increased rather than decreased the psychiatrist's work load. Most were prepared to continue such treatments, though the overall impression is that their use is progressively declining somewhat as the years pass.

The future is uncertain. If some definite genetic danger is proven, it will no doubt spell the end of this form of drug therapy. If not, it is probable that such therapy will gradually continue to decline in popularity and be supplemented by other therapies, possibly less arduous and more safe and rewarding, though it is probable that a certain number of psychiatrists will never forget the gratitude of patients who responded to no other form of treatment, and will continue to carry on therapy and research, and to illuminate what has been one of the most stimulating and challenging chapters in medical history.

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THE "TURNED-ON" PSYCHIATRIST

In 1969, Council of the Australian and New Zealand College of Psychiatrists ratified the formation of a Social Issues Committee. The College had, in the previous twelve months, been made aware of a major social issue — Abortion Law Reform — and it had become abundantly clear that the College would need to have an informed opinion on an ever increasing number of social issues in the future. The contributions of social scientists, social physicians and social workers have pointed to a need within psychiatry to interest itself in the sociocultural *milieu* in which it is practised.

Some psychiatrists have a view that they are unable to give an expert opinion on any but phenomenological illness with which they are familiar — that the doctors can practise only in the areas for which they are trained. But is it possible for a physician, whether he be involved with the chronic psychoses, geriatrics, neurotic disability, child or forensic psychiatry, to be unaware and uninformed on the attitudes, misgivings and hopes of the community?

Christian Barnard, a pioneer cardiac surgeon, protested publicly at the prosecution of a Chinese woman and a white man under the *Immorality Act* in South Africa. They had been living together for thirty years. He was told to steer clear of politics and to leave it to more capable people. He replied, "What do I do as a Doctor? Where does my duty lie? This type of suffering is so great it cannot be compared to the suffering of a patient with a hole in the heart."[1] Dr Barnard is clearly refusing to be placed in the category of a cardiac plumber. Can psychiatrists afford to be content with the role of cerebral electrician?

Kenneth Weintrout, American sociologist, has stated, "In our present day world, it is not enough to be scholarly; one must also be concerned enough to shout. It is not enough to understand the world; one must also seek to change it."[2] The title of this paper might well be a subtitle to the Social Issues Committee. To "turn on" is a term used by drug users, particularly those on marihuana, when they become more aware of their surroundings, and, it is said, more appreciative of the functions of their senses and their relationship to their environment. An examination of the controversy surrounding marihuana may serve to point out how an interest in this problem, even to those of us who may never see a user, leads inevitably into a wider examination of many issues of social psychiatry and of prophylactic medicine.

Those drugs in common social usage which produce mortality and morbidity are probably alcohol, nicotine, barbiturates, amphetamines, bromides and hallucinogens. There is no real debate on measures for their control and the education of the public regarding them. Despite this, there are pressures from certain quarters, particularly those engaged in