to become aware of his feelings. It liberates unconscious material often in the form of hallucinations and perceptual changes. Dramatic insights occur. However, these affects may in turn mobilize defenses. The LSD experiences may then be utilized in the service of resistance.

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## THE ROLE AND REACTION OF THE PSYCHIATRIST IN LSD THERAPY

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It is the purpose of this paper to direct attention to the therapist who participates in an LSD session. LSD alters the psychotherapeutic relationship, and this is exemplified, not only in the increased emotional lability and freedom of association, but also in the psychotherapist's reactions and expectations. It may be said without question that the behavior of a patient affects the therapist, and by examining some of the therapist's experiences in psychotherapy utilizing LSD we can increase our understanding of its effect on the patient and the therapeutic process as a whole.

The following observations for the most part are based on therapy with two borderline neurotics seen four times a week, each of whom received 50 micrograms of LSD once a week about two hours prior to the therapeutic hour.

As I recalled my various sentiments regarding these LSD hours, one stood out in particular—a tremendous sense of solicitude. Others have mentioned that holding the hand can often be extremely comforting to the patient at such a time. Of course, such a gesture was out of the question for me. As part of a scrupulous research team, I knew that the setting on "LSD days" was to be identical with other days: the same room, the same time of day, and as far as possible the same total life situation. Odd, then, to remember in the first few months of the LSD experiments that instead of awaiting the patient's arrival in the office, I would seek him out and conduct him to the room. I remember adjusting the venetian blinds with great care on these days to diminish the painful brightness of the room for the patient. When the patient wept, my hand also reached for the Kleenex more swiftly than usual.

Whence came all this solicitude? True, early in treatment, the patient often appears more helpless and stumbling, tremendously anxious and frightened—as was I. The therapist, then, finds himself reacting with anxiety, remorse and solicitude. Even though the therapist may not himself have planned the experiment, he may feel the responsibility for the anguish the patient experiences. There is also engendered within the therapist a certain sense of helplessness. The administration of LSD sets in motion certain processes within the patient which are out of the therapist's and the patient's control.

In watching Dr. Bercel's fascinating film of "The Schizophrenic Model Psychosis Induced by LSD", which he presented at the American Psychiatric Association meeting in May, 1956, I found myself observing the doctor and the audience. Why was the audience tittering? And why, when the patient described being transported by marvelous sensations, was the physician repeatedly asking him to eat? He *interrupted* him forcibly. When the patient complained, the physician said, "I thought the experience was getting too intense for you." Surely the psychiatrist was not so overwhelmed by the patient's refusal of food. Here was just the experience he wished to record—a subject with an impressive reaction to the drug. Yet, he attempted to interrupt the drug effect. The psychiatrist's anxiety was so forcibly communicated that it aroused the same emotion in the audience.

In the early LSD hours I found myself less

inclined to question or to attempt to relate a present experience to a past one, or vice versa. In fact, during the LSD studies, the patient verbalized without interruption. My first impression was that this related to the same sense of solicitude mentioned before. "Poor guy, he's contending with quite enough. Why increase his discomfort?" That may have something to do with it, but would such a solicitude exist in the normal therapeutic hour? I doubt it. I was an onlooker of an experience *within* another person. These patients were less with me in the office. This lack of interpersonal awareness showed itself to me in minor ways. I found myself less concerned on these days with what I said, or my state of dress, *because* I felt myself an observer of a process rather than an interactor.

The patients experienced a similar lack of interpersonal awareness. One said, "I am entirely apart, in a different world, my private dream world, and yet I am aware of this world too." Another patient was attempting to describe how the defenses against loving the therapist were crumbling, and mentioned a sense of self-consciousness in describing them. When asked how the self-consciousness related to the therapist, he denied a connection, stating emphatically, "You're just a piece of furniture!"

This example illustrates the intensity of the patient's feeling for the therapist, and yet the feeling is dissociated from the person of the therapist. Whether a patient speaks of a sense of closeness or vents his fury, these emotions are experienced by the therapist less warmly or painfully than outside the LSD experience. Even though one learns with experience in therapy under LSD that it is not only possible but useful to question and interpret, the sense of distance from the patient during LSD hours remains.

It might be questioned as to whether there is something contradictory in feeling a strong concern for the patient and at the same time a sense of distance. When the therapist feels solicitude and when he is somewhat helpless to alter the course of events, he has already removed himself from intimate interaction with the patient and has become an observer.

To summarize, when a patient receives LSD, the psychotherapeutic relationship is altered. The LSD situation produces solicitude, anxiety and helplessness in the therapist, and may increase the feeling of distance between the therapist and patient. The ability to relate successfully is the essence of treatment. LSD is given with the hope of establishing a better therapeutic relationship and of undermining defenses which prohibit the development of such a relationship. And yet the secondary effects of the administration of this drug can defeat the very purpose which one has set out to achieve.

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## COMMENTS ON THE PSYCHOLOGICAL EFFECTS OF MESCALINE AND ALLIED DRUGS

IAN STEVENSON

This report refers to observations of incidental and unintended therapeutic effects of mescaline and LSD and some comments on their relevance to our understanding of the schizophrenic process.

Most reports of the therapeutic value of these agents have stressed their role in freeing the expression of thoughts and emotions connected with events of the past (1–4). I have observed this in a number of our subjects, volunteers from our staff and medical students. We have not used these drugs on patients. I believe that this abreactive effect is somewhat greater with the hallucinogenic drugs than it is with the barbiturates. Mescaline and LSD do not dull consciousness. Therefore, a person is able to recall the past under their influence while preserving at the same time full vividness of present experience.

Other psychological effects of these drugs