PSYCHOTHERAPY:
THEORY, RESEARCH AND PRACTICE

PSYCHEDELIC (LSD) PSYCHOTHERAPY: A CASE REPORT

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The following case is presented to illustrate how LSD-induced *peak experiences* are used as adjuvants to brief, intensive psychotherapy. The procedure, called *psychedelic-peak psychotherapy* or, simply, *psychedelic therapy*, involves a technique of high dose (300-450 mcgs.) LSD administration similar to that first reported by Osmond (1957). The efficacy of psychedelic therapy with various patient populations has been assessed through a series of controlled investigations (Kurland et al., 1971; McCabe et al., 1972; Savage et al., 1969 & 1972; Savage & McCabe, 1973); this paper is a phenomenological, in-depth account of the psychedelic procedure, including descriptions of the effects of two LSD administrations, as reported by a 20-year-old, hospitalized college student.

PSYCHEDELIC PSYCHOTHERAPY AND PEAK EXPERIENCES

The rationale for psychedelic treatment has not been adequately conceptualized, the modes and mechanisms of action of LSD-type drugs being sufficiently obscure to allow interpretation along whatever theoretical lines to which one subscribes. However, two general assumptions underlying the approach are: (a) LSD and similar pharmacologic agents (e.g., mescaline, psilocybin, DPT, DMT, etc.) may occasion a temporary, altered state of consciousness (ASC) during which the organism's behavioral repertoire may be modified or "reprogrammed," and, (b) resultant behavior change may be for better or worse, depending on a diverse spectrum of extra-drug variables, including the personality of patient and therapist, the quality of preparation, and the emotional and physical atmosphere and surroundings; generally, these factors are subsumed under the rubric: "set and setting." The concept of "set and setting," particularly fostering in the patient a sense of trust in his therapist and in the procedure, is viewed as the most crucial ingredient of successful therapeutic outcome. Moreover, these extra-drug considerations provide the key to understanding the apparently unpredictable reactions to this class of drugs, not only in "open" settings with blackmarket LSD but also within the purview of formal psychotherapeutic endeavors where a variety of conflicting claims have been reported.

Given a positive working relationship between therapist and patient, the drug-induced peak experience is considered to be the major fulcrum for behavioral redirection in the psychedelic procedure. The psychedelic-peak experience is characterized by a transcendence of time, space, and subject-object dichotomies (unity), deeply felt positive mood, a sense of sacredness, and a feeling of transience, paradoxicality, and ineffability, yet an experience which seems as real or more real than ordinary consciousness. This experience purportedly brings in its wake permanent and positive changes in attitude and behavior (Pahnke & Richards, 1966).

The psychedelic experience as described by knowledgeable investigators and experients seems qualitatively similar to the spontane-

ously occurring, mystic-like *peak experiences* which Maslow (1962) observed in his study of self-actualized individuals.

Although this report conceptualizes the dynamics of the psychedelic drug-induced ASC in the language of a contemporary humanistic paradigm, the concepts of "regression in service of the ego," "visionary" experience, "satori," trance states, etc., are not alien to, and may be identical with, psychedelic-peak experiences and apparently are elicitable through other than pharmacologic means, e.g., intense interpersonal experience, prayer and fasting, sensory deprivation or overload, meditation, hypnosis, and more recently EEG (alpha wave) feedback.

ASC may be positive or negative, ecstatic or hellish—the nature and direction of which not always being predictable. The maladaptive functions which the negative LSD-type drug experiences may serve have been well documented in the mass media; in counterpoint, apparently adaptive. but less well publicized, effects have accrued from the more positive (peak) ASC (Ludwig, 1966). The latter is supported not only by our own clinical investigations and other researchers, but also evidenced by less formal, anecodotal accounts of individuals from St. Theresa of Avila to Aldous Huxley. In pursuit of tactics to maximize the probability of positive reactions, a systematic technique of psychedelic treatment has evolved of which the present report provides a sample.

THE CASE

The reasons for choosing this particular case for illustration are twofold: (a) the case, which proved unusually refractory to therapeutic intervention requiring two separate high-dose LSD administrations, illustrates how two very dissimilar reactions to LSD can occur with the same individual and suggests the determinants of those different reactions and, (b) the patient has provided exceptionally articulate accounts of his reactions under the drug.

The Presenting Problem

The patient (Arthur L.), a 20-year-old college student, was brought to Spring Grove State Hospital on transfer from a small private hospital in the company of his parents. The hospital pre-admission note is quoted in part:

> The patient was hospitalized because of increasingly severe rumination about harming his girlfriend with whom he had broken up earlier in the summer. The patient apparently has a great deal of difficulty adjusting to the break-up and his thinking with regard to this girl has taken on delusional proportions . . . the patient's work performance in college was markedly impaired by the obsessive ruminations . . . In addition to making various threats on the person of the girlfriend, he has expressed suicidal thoughts . . . It is the opinion of the referring psychiatrists that the patient should be hospitalized immediately.

Diagnostic Impression: Pseudoneurotic schizophrenia.

The patient was admitted to a closed ward and treated initially with Hydroxyzine 50 mgs. q.i.d. and placed on suicidal and homicidal precaution. He was then referred to the Research Department of the hospital which was engaged in an systematic assessment of LSD-assisted psychotherapy with severe, chronic neuroses. The Research Department's initial screening interview amplifies the precipitating problem.

> Arthur's problem centers around his 'going steady' and the breakup of this relationship. His girlfriend, the first and only girl he had ever dated, is three years his junior. They went together for almost two years and discussed marrying upon his graduation from college. Recently, he noticed signs of her wanting to date others, this shaking him badly. Perhaps indicative of his own culpability in the matter was his admission that most dates consisted of sitting around her house rather than going out. Similarly, he condescended to take her to her high school Prom, saying, 'If you really want to go, I'll take you.' However, upon being informed of the cost involved he rescinded the offer. The girl got another date. He became upset over the matter, telephoned her, and broke off the relationship. He subsequently has been continually obsessed with thoughts and plans for revenge, speaking freely of wanting to harm, mutilate, or kill her: 'I want to harm her badly so she could not have children, or so she would be disfigured, and when she thought of it or looked at herself, she would have to think of me.'
>
> On one occasion the patient lay in wait for his former paramour and approached her outside church to strangle her. However, a cheerful 'Hello' from her defused him so that he did nothing.

Arthur returned to college in the fall and lasted six weeks before his agitation and

rumination became so marked that consultation with the medical department at school resulted in his parents being asked to remove him and seek hospitalization. The parents seemed to view their son's problem rather superficially—something to get over as quickly as possible as one might a bad cold. Neither seemed capable of accepting less than the goals they set for him, namely, returning to college as soon as possible.

Background Data

A continuation of the initial social history report provides additional information regarding the patient's background:

> Arthur is the oldest of four boys raised by stable, reliable parents. His father is responsible and upright. The maternal grandmother has lived with this family for the major part of the young man's life. He sees his parents as meek and mild, guiding him and encouraging him in church and religious activities but not outgoing and close. Up into high school he was not socially active. He served papers for a number of years and had no time for extracurricular programs. Scholastically, his interests and achievements turned upward in the late years of high school. He did well in math and science and has centered his interests in physics. With a struggle and some help, the parents got him to college and he has done well. He is socially inactive on campus and at home in the summer, i.e., the whole period has been taken up by his 'going steady' and he has not reached out for other interests. His family have all been involved in Presbyterian church services and activities. He says that his parents had advised that his courtship had taken a spiritual toll because it was noticeable 'that my character was going down' and 'I had neglected my spiritual life.' About the breakup of his romance he rationalizes that God gave him the opportunity to get out of the situation for his own spiritual benefit. He denies having had sex relations.

Psychological Testing (Pre-Treatment)

As part of the initial pre-treatment assessment, a battery of intelligence and personality tests was administered to the patient. Arthur was found to be of superior intellectual capacity (Raven I.Q. - 128; WAIS Full Scale I.Q. - 150), but in extreme psychic distress. The patient's MMPI profile (See Figure 1) indicated psychotic, as well as neurotic features. There was evidence of a severe depression, obsessive-compulsive ideation, irritability, nervousness, social withdrawal, bizarre thinking, and long-standing feelings of inadequacy and insecurity. On the Eysenck Personality Inventory the patient scored at the 94th percentile on "Neuroticism" and at the 4th percentile on "Extroversion." The Personal Orientation Inventory, a measure of self actualization, showed extensive evidence of poor self-worth, denial of aggression, dependence, and tendencies to see man as essentially evil and the opposites of life as antagonistic rather than meaningfully related. The test data consistently validated the obvious severity of the patient's clinical condition.

Pre-LSD Session Psychotherapy

The initial stages of therapy with Arthur were devoted mainly to (a) establishing the relationship, (b) allowing (verbal) ventilation of aggressive impulses, and (c) identifying and reinforcing indications of positive potentialities in the patient. Little attempt was made to penetrate and lay bare the dynamics of the case; in fact, particular care was taken to avoid not only premature depth interpretations but any behavior on the therapist's part which might further lower the patient's self-esteem or impede the development of a positive relationship. Although there was a transient exacerbation of symptomatology (anxiety, murderous impulses, and confusion) when the therapist fostered the discharge of tenuously suppressed rage, the hostility catharsis seemed to provide the patient some relief from his somatic distress, depression, and suicidal ruminations.

Despite conflicts being uncovered at numerous levels, the patient claimed after several sessions that the problems he was having could be reduced to a central, common denominator,—a "lack of spiritual conviction," or more precisely the fear that the spiritual convictions he held were false. Parenthetically, it might be noted that, prior to the breakup with his girl, the patient was afraid that his preoccupation with her was affecting his spiritual life; that God had something in mind for his life that might be incompatible with his relationship with the girl; that he was being "guided." So that, in addition to the loss of a love object and the resulting depression, there was the patient's greater concern that there might not be any meaning in that loss; that is, if the loss of his

girl was part of God's plan for him, it was admittedly painful but perhaps bearable, but if not, the loss was meaningless and, therefore, unendurable. Similarly, he had been frustrated in his attempts to find a "personal relationship" with God; therefore, he reasoned, if no relationship existed, there was no real reason to live.

Arthur showed considerable paranoid ideation in the form of frequent "day dreams" about being watched and talked about by other people. He feared strangers to the point of labeling the fear, a "phobia." Self-doubt and self-dislike were recurrent themes in every session as were his feelings of spiritual alienation. Although initially he remained obsessed with the desire to seek revenge on his ex-girlfriend, because of increasing empathy for her own dynamics, and the possibility that his loss might have spiritual implications, these impulses dissipated. The ambivalence and conflict generated, however, was of such magnitude that his functional incapacitation was of psychotic proportions.

The obsessive tenacity with which the patient engaged in self-depreciatory rumination and his claimed estranged status from God, were extremely resistant to therapeutic intervention. Eventually, he was able to acknowledge the extent to which these same attitudes had been subtly conveyed to him by his parents through unrealistic aspirations which he could not live up to.

The patient's parents were members of the Evangelical Presbyterian Church. His father, an elder in the church, taught the men's Sunday School classes; similarly, Arthur's mother was a teacher of the women's classes. So engrossed with church activities were his parents, that the patient found it difficult to remember instances when he was growing up when both parents were home on the same evening; one or the other would be at church for one activity or another. In the patient's words:

> Being the son of prominent church members, I was reminded by my parents constantly that other kids would always be looking to me as an example of church behavior and that I should prepare myself to be a leader among church kids. This never worked out, however. I never became a youth group president or the like; possibly because of my almost utter lack of leadership quality and my contentment to work alone and not bother much with other people. Nevertheless, I was in all the activities of the church that a kid could possibly be in. I cannot think of my life in the '50's without thinking of youth groups on Sunday night and Sunday night services, Christian Service Stockade on Friday nights, and numerous other church activities.

The patient, being unable to live up to standards set by his parents, inferred that the fault lay within him rather than in the standards, themselves, and became a receptive host for other signals regarding his lack of worth. Readily accessible to his consciousness were the memories of unpleasant experiences *vis a vis* his maternal grandmother:

> It was shortly before I entered school that my grandmother came to live with us. This arrangement was to be permanent. From the start I was continually in disfavor with her and began to feel after a while that she didn't like me. She highly favored my brother over me in everything and it seemed as though I could do nothing to please her; and even in the exceedingly rare instances when I did do something, such as a chore, to her satisfaction, she would quickly stick in a few words of praise for my brother. Being a quiet child and basically non-combatant, I grew to ignore her adverse comments about me and my accomplishments. I was happy when she'd leave to visit her other children and would look forward with unhappiness to the time she was to return to us. I was never really comfortable with her around and feared her in some ways more than my mother. At least provocation, she would accuse me of being intolerably lazy and helpless and say that I was running my mother to an early grave. I came to ignore her and kept away from her whenever possible.

Although there were few indications of a blatantly schizoid lifestyle, it was evident that by school age a pattern of social alienation and "turning inward" had been established.

> In school, my attitude toward studying was somewhat less than serious. As I moved up into the higher elementary grades, I seemed to take school less and less seriously, and even, on occasion, became a behavior problem. I often got into trouble by doing things during lunch period which weren't allowed, such as sneaking around the building. I wasn't usually in with the "gang" of classmates, but rather played by myself. The grades I pulled were strictly average and almost all my teachers informed my parents that I should be doing much better, that I lived in a world all my own, and often didn't pay attention in class. I can remember getting punished just as

> often for just sitting and staring out the windows as for talking or causing a disturbance in class. To the charge of being a daydreamer I would have to plead guilty. The most minor incident or distraction would wrench my attention away from the teacher and start me off on a private adventure that would be brought to an end only by the teacher calling my name.

The patient claimed never to have had sexual intercourse. Although religiosity and scrupulosity were pre-potent motives underlying much of his behavior, the specific avoidance of sexual interaction seemed less a function of his moral upbringing and overdeveloped superego than his general distance-promoting operations in social relations.

Generally, his pre-morbid personality was characterized by a successful relegation of such primitive impulses as sex and aggression to subterranean levels, with his obsessiveness seemingly in the service of maintaining this inhibition and control. It is difficult to convey the empty, constricted existence which Arthur had been living. Without close relationships, even within his family, frustrated in his clumsy attempts to establish human contacts, punished by an unrelenting conscience for even the least impulse to act out aggressive or sexual urges, obsessed with the need to make sense of his existence, the breakup of his relationship with Linda was tantamount to a rupture in an emerging lifeline to a meaningful universe. Through overwhelming unconscious needs for love, acceptance, and approval, the road was paved for his vulnerability to rejection.

After approximately six weeks (28 hours in all) of preparatory psychotherapy, the LSD session was scheduled. The day before his session the patient was given what has come to be designated by former patients as "pre-flight instructions." This is literally a dress rehearsal, in the same room where the drug will be administered, in which all session procedures are simulated save the actual drug ingestion: The potential experiences—physical, emotional, and ideational—elicitable by LSD are explained. The patient is asked to lie down on a couch provided specifically for such sessions, sleep shades are placed over the eyes, and several selections of music are played through stereo headphones. The final enjoinder to the patient is "put everything out of your mind, follow the music, and just be." This traditional preparation was followed uneventfully with Arthur and the drug session was scheduled the next day at 9:00 A.M.

LSD Session 1

On the morning of the session, Arthur was administered 350 mcgs. of LSD in two stages (200 and 150 gamma, respectively). The session began smoothly and at no time was difficult to manage; however, in the late morning the patient showed signs of distress and fear which prompted the therapist periodically to hold his hand while telling him not to resist the experience, to go forward, to let the music take him, to just "be," etc. The intensity of the experience was such as to make verbal communication impossible during most of the day, thereby, forbidding accurate assessment of the nature of the experience until the late afternoon, or "reentry" period.

At that time it became evident that the patient's obsessiveness, rigidity and pessimistic view of man had not been sufficiently altered in the preparatory therapy to keep him from validating his Calvinistic *weltanschauung* via a dysphoric ego loss experience where his suffering seemed eternal and his despair ultimate. Arthur describes the experience:

> The first effects I felt after taking the chemical were physical and occurred within a half-hour. I began to feel jittery and slightly woozy. It became difficult to move my arms. After lying down with the eyeshade and headphones, the physical effects became more pronounced. My heart was beating fast and my breathing became short and shallow. Gradually I began to feel that the sofa was accelerating upwards and pushing against me. The sensation was unpleasant and I found it impossible to get comfortable. Visions began to appear. They were very random and difficult to make sense of. The feeling of being rapidly propelled through them continued. At times my direction of movement through the visions would change and I'd feel sideways forces on my body. This made me shift around on the couch, trying to adjust. I lost consciousness of being in the room. My body began to disintegrate. It seemed that spiritual beings were dancing around me and I was giving up my body to them, piece by piece. I can remember talking to them and saying, 'here, take my arms, my legs . . . etc.'

I completely lost consciousness of having a body —of being human. I was becoming much more comfortable as I was hurled from scene to scene. My mood was positive at this time. The scenes consisted of such things as blue and purple clouds, colored spirals and geometrical designs. I felt simultaneously male and female for a short time. Time began to lose its meaning. I remember hearing the beginning of the Moonlight Sonata and then almost immediately heard the ending.

As time ceased to exist and I lost the sense of having a body, I seemed to enter eternity. Everything in my experience seemed to take on a single essence; sound, sight, smell, all seemed to become a single thing. At this point, the experience began to take on an ultimate quality, as though what I was experiencing was deepest reality. This was somewhat frightening because the sensations were not entirely pleasant. The unpleasantness began to increase as I began to hear eerie, ugly sounding noises, which resembled strings vibrating irregularly at low frequencies. In a 'normal' state of mind, there probably would have been nothing particularly unpleasant about these sounds, but now there seemed to be a peculiar and profound ugliness about them. The visions also began to take on a profound ugliness. I saw shapes which were somehow very familiar, as if I had seen them thousands of times previously, but not since early childhood. They were ugly and they seemed to be a visual representation of the core of my very being. Most of the shapes consisted of pieces of garbage, such as prune pits and hunks of fat and gristle. With the onset of this, I became sure that I was experiencing Hell. Everything took on an eternal flavor. I felt myself to be in caverns and cavities of raw flesh with strips of fat and gristle connecting the walls. There was no sense of past or future—only an inescapable *Now*. I felt trapped by it.

Around this time I was asked to sit up. I can remember very explicitly a feeling of surprise and bewilderment at seeing my body. I had to look at my legs for a few seconds before I realized what they were—so complete had been my loss of a sense of having a body. Even after remembering that I was a human being and that I had a body, a feeling of detachment from it continued. It felt as though the real 'me' was suspended in space at about eye level and I was looking on my body as something foreign. One result of this was that it was difficult to move around, and especially hard to talk. I was able to think clearly and as rapidly as usual but it seemed difficult to control my vocal chords and say what I felt. I was astounded and overwhelmed by the reality of what I had just experienced and wasn't sure which was more real, my experience in eternity or my sitting there in the treatment room. I looked at the rose in front of me. The petals seemed to exhibit a strange waving motion which one could interpret as 'breathing.'

Going back down on the sofa with the music, the unpleasantness began to grow. As it grew, however, I became more aware of myself and gradually began to return to 'reality.' I knew that the height of the experience was over and that the effect of the drug was wearing off and I desperately wanted to let myself go and try to experience something which I hoped would be deeper and thus more pleasant. But I felt bound by a part of myself that refused to let me rise above all this unpleasantness, added to its quality of being ultimate and eternal, came a feeling that I was experiencing a taste of Hell. This thought was nearly unbearable, but I couldn't drive it out of my mind. I was helpless with fear. The feeling of being in Hell became a conviction and at one point I tried to call to my father so that he could pray me out of my doom. I remained in this state of mind for most of the re-entry period.

After 'coming down,' the feeling of intense fear and hopelessness continued for quite a few hours. I was sure that the Hell I had experienced was what awaited me at death. It took a day for this conviction to subside.

The session, although subjectively unpleasant for the patient, nevertheless, was a productive and valuable diagnostic experience which delineated the course of subsequent therapy. Specifically, by apparently providing a caricature of the patient's fears and defenses, the LSD experience underscored the need to further puncture the negative assumptions Arthur had about himself and the shell of distrust in which he was enveloped. The experience provided an emotional validation of insights before only tenuously grasped at an intellectual level. Through LSD he seemed to live the fear, the self-hate, and the defenses against these feelings.

In preparation it had been emphasized to the patient that LSD "puts nothing into the system," i.e., what one experiences is a function of one's own dynamics: conflicts, attitudes, coping mechanisms, etc., what is already there and then released. Selections from his LSD session report are consistent with this hypothesis. To wit:

> The visions . . . began to take on a profound ugliness. I saw shapes which were somehow very familiar, as if I had seen them thousands of times previously, but not since early childhood. They were ugly and *they seemed to express something . . . about me* [author's italics]; they seemed to be a visual representation of the core of my very being . . . pieces of garbage. . . .

After 21 additional hours of therapy in three weeks, during which the LSD-induced insights provided the major focus of attention, LSD was administered a second time.

LSD Session 2

On the morning of his second LSD session, Arthur was given 350 mcgs. of LSD in the traditional two-stage procedure. Arthur's complete verbatim verbal report of this experience follows:

> The physical effects that set in in the beginning of the experience were very pronounced. My heart beat very strongly and rapidly and my breathing was heavy. My hands became almost completely numb. Parts of my anatomy began to feel distorted in size.
>
> Then I began to sink into the experience proper. I began to see shapes and images that reminded me strongly of my first LSD session and these were accompanied by negative feelings. I felt that I must be starting where I left off in the first session. This seemed reasonable since fear, which these things represented, had not been overcome in the first session and I could expect them to recur until fear was conquered. This negative portion of the experience extended for some time and gradually became neutral. The fear-associated visions gradually disappeared and were replaced by a stream of passing visions which were neither ugly nor beautiful, but simply passed by without arousing feelings in me.
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> Rather suddenly, the visions did begin to appear very attractive. What previously had been bleak forms which evoked fear now became strings of jewels and patches of richly colored silk and satin. The transition occurred in a manner which made it seem like this was what these fear-evoking images had been all the time, but that I had just not seen them properly. The music began to sound more and more beautiful and I began to feel happy and excited. Around this time I was taken out of the music for a few minutes. The colors of the various objects in the room were richer and more intense. This, however, did not give the impression of being unreal or faked—such as would be the case if one were looking at a touched-up color photograph. On the contrary, it seemed to me that I was seeing objects around me for the first time the way they really should appear—as though something had previously been dampening my ability to see color sharply and clearly.
>
> Going back into the music at this time, the visions became more beautiful and my mood much more positive. The jewels and other objects seemed to be dripping in a sparkling fluid that can only be described as the essence of beauty itself. Time became wildly distorted and all the experiences seemed to take on an ultimate and eternal quality. It seemed like this could be nothing but a taste of Heaven. I was approaching what proved to be the peak of the entire experience. The visual component became fantastically beautiful. Each piano note from the music appeared as a dazzling explosion of color with each streamer from each explosion terminating in a burst of thousands of multi-colored splinters. At the *peak* itself, the experience was far from simply sensory. In fact, the visual component became less distinct at this point. My entire being seemed to blend into the Universal Scheme. The feeling was that I had arrived—arrived at the core of the ground and meaning of existence. It was not at all an intellectual grasp of Reality, but rather an awareness of it—a merging with it. Emotionally I was overwhelmed with joy; and for what I believe was the first time in my life, I cried out of sheer joy.
>
> These feelings gradually subsided into a warm glow. I was brought out of the music again. As I looked around the room, it seemed like a compartment in Heaven. The rose on the table in front of me seemed to sway and pulse as if some stream of life-energy flowed through me and caused my limbs and body to slowly wave, like a tree in a breeze. This energy flowed around the entire room and through the windows to the outside. Never before had I felt so alive.
>
> I went back into the music this time and became aware that the experience was subsiding. Another sharp decline in feelings accompanied this. Through the rest of the 'bounce-down' period, the feelings rose and fell in waves between fairly positive and slightly negative.
>
> Later in the session, I was taken outside, where I felt a special closeness to all things, expecially living ones. I could sense in the grass and weeds and trees the flow of the same life-energy that flowed through me.

On the day following the session and the days thereafter before he was discharged (one week after the session), the patient's mood was elevated and, ostensibly, he was completely free from the symptomatology that marked all of his five month stay at the hospital. When later assessed of his experience and the effects it had on him he said:

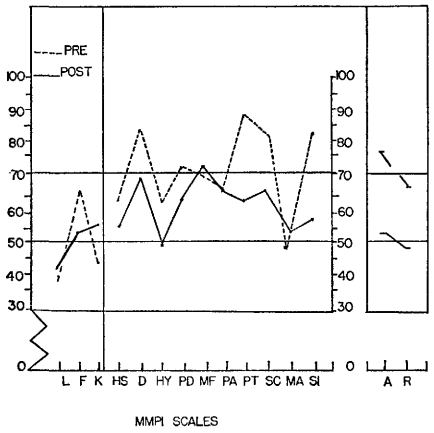
> The profound and wonderful beauty of existence and of life, and the feeling of being a part of the Source of life-energy in the universe is the experience which was of greatest meaning to me. People have told me that my face seems to show forth a kind of inner light, as though I know something very profound. The severity of my problems seems to have been reduced across the board; basically, they have not changed in *kind*.

Psychological Testing (Post-Treatment)

The dramatic alteration in the patient's clinical condition was substantiated in the post-treatment psychometric assessment.

Figure 1 shows Arthur's pre- and post-treatment MMPI profiles. The decrement in scales comprising the neurotic and psychotic

FIGURE 1- PRE- AND POST- TREATMENT MMPI PROFILES OF CASE N-726



triads as well as the changes in the F and Si scales reinforce the clinical observations of marked improvement in the patient's functioning and outlook.

Follow-Up

As part of the project's research design, follow-up assessments were made by an independent evaluation team. Follow-up interviews and ratings were carried out at 6, 12, and 18 month follow-up points. On the basis of a 0 to 10 rating scale for Global Adjustment, the patient received ratings of 9, 10, and 10 for the 6, 12, and 18 month follow-up periods indicating optimal adjustment at each of the respective evaluation points.

The following excerpt is from the report of the final evaluation interview with Arthur's parents:

> (The parents) feel that he is doing well in all areas and shows no evidence of his previous symptoms. The girl that was involved before is now his friend but he has not dated her. The patient has done well in school and has worked steadily during the summers. They are most optimistic about his future.

As an addendum to the report of the formal treatment and follow-up course, the following verbatim transcript is produced for additional elucidation of psychedelic treatment as viewed retrospectively (four years post-treatment) by the patient (Interviewer's questions in italics):

What, if anything, did the LSD therapy you received four years ago do for you?

It made me less afraid of things in general. Up until my therapy my chronic state was a kind of cosmic fear—a fear that I didn't belong in the universe—that I was completely valueless.

How did LSD therapy change all that?

I learned that I was valuable to my therapist—that he esteemed me as a human being. This enabled me to see that I was valuable to other people in general and, therefore, to the universe as a whole. Before, I had filtered out all data that might indicate that I was worthwhile.

Specifically, how did you learn from your therapist that you were valuable?

Well, the thing I remember most is after my first LSD session, which seemed to validate all my negative assumptions about myself and the world, I felt guilty. Guilty for letting Dr. McCabe down —guilty because I disappointed him. I thought, I'm such a no-account I couldn't even be 'therapized' right. When my therapist told me that we were going to continue working in therapy including another LSD session, for the first time I thought: Gee, he's going to stick by me, I must be worth something.

When you came into the hospital before LSD therapy you were supposedly preoccupied with hurting or even killing a girl who jilted you. What is the likelihood that you would have attempted this? That is, how dangerous were you?

I definitely had enough feelings to act out those impulses. I was becoming paralytic by trying to keep them under control. I knew that I had to do something or I wouldn't be able to live with myself. The feelings were festering, getting worse, with the probability of acting them out greatly increasing. Shortly before being referred to LSD therapy I remember thinking about myself, 'You're nothing if you can't even carry out your strongest feelings.'

How could LSD therapy change all that?

Well, I soon learned that Linda was not really the main issue; she was a symbol, a scapegoat. She was just another human being trying to make it in this world. My therapist helped me understand that she, like me, had fears, conflicts, needs, defenses, etc., that determined what she did and that her hurting me was not necessarily out of maliciousness or any other evil intent.

Is there anything that the LSD did for you that the psychotherapy could not have done?

Well, in therapy I learned *at one level* that I was of value; however, the second LSD experience enabled me to make contact with my 'goodness' at quite another level—a level I could describe only as more basic, more essential, i.e., when I penetrated these superficial levels of self-images, defenses, fears, distorted perceptions—I seemed to make contact with the real me, my essence, and this was good in an ultimate sense. And this experience enabled me to approach people, thereafter, more on a level of love than fear.

CONCLUDING NOTE

Since the final follow-up assessments, a letter from the patient indicated that he continues to do well, has been elected to Phi Beta Kappa, and has won a scholarship to Yale graduate school to study Physics.

It should be noted that, although the therapeutic gains that attended this treatment were apparently related to the therapeutic intervention described, the data presented in this paper are not offered as proof of same; the uncontrolled, idiographic nature of the data precludes such an interpretation. Moreover, were such a position tenable, it would be difficult to differentiate the specific contribution of LSD vs. the psychotherapy, or the psychotherapy-induced improvement vs. that which would have occurred spontaneously and independent of either LSD, psychotherapy, or the combination as utilized. However, as an example of the psychedelic method of treatment the case is representative.

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