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SOME ASPECTS OF AN OFFICE PRACTICE UTILIZING LSD 25*

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The author became interested in shifting an ordinary private, analytically oriented, psychotherapeutic practice into a routine utilizing LSD 25 exclusively. This has resulted in a unique series of treated patients, who are not psychotherapeutically naïve and who have been known to the therapist for several years. Treatment for these individuals had consisted, as opposed to orthodox psychoanalysis, of a more direct and flexible method of approach, in which the patient could experience acceptance in many areas and acceptance of many facets of his personality.

The approach was a modification of the Whitaker method of brief psychotherapy. Although this was successful in a small number of patients, certain—and the same—disquieting questions arose during and following treatment. The patient often felt, for example, that treatment aimed at "adjustment" or mere conformity to the culture; and, whereas, conformity might allow him to remain in society without penalty, it did not always insure a "cure" within himself. Such a patient would feel that acceptance in a therapeutic situation only confirmed the fact that peace and happiness depended, not so much on himself alone but on the desires, or perhaps the whims, of outsiders. In addition, many of these sophisticated patients could not reconcile such an adjustment with their personal philosophical and ethical beliefs. For the more immature and dependent patient, the psychotherapy would stimulate further infantile and insatiable demands, of which resultant frustrations caused anxiety and guilt, so that deep insight therapy became an impossibility. Also acting-out mechanisms made possible in this technique became so intense at times that there was a termination of the psychotherapeutic relationship. In all of these therapeutic failures, there seemed to be broader deprivation than mere nonacceptance. There was, within these patients, a really deep need for the understanding of the meaning of life and of their own specific roles in it.

The ordinary conception of "being well" thus became superficial, meaningless and worse to these patients—mere ritualistic gymnastics. What was perhaps more disappointing and frustrating was that the concept of simply living with one's self and getting

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along with one's neighbors seemed, as a result, an existence that was flat and without challenge. This adjustment concept as the therapeutic goal then ultimately produced cynicism and appeared to be a sort of final humiliation of man. In short, these patients who had been treated with a generally orthodox approach in psychotherapy accepted without question, intellectually and emotionally and in a personal sense, for example, the Oedipus complex, but this fact seemed not at all profound, nor did it help to fit them into a meaningful life. Within these patients, there was a need to know as much of "the truth" as possible—not necessarily as intellectual exercise, but as an emotional need to "belong." Therefore, this group of patients, well known to the therapist, readily accepted the possibility of the benefits of LSD 25, with the hope of a more complete understanding of self and with the hope that crippling symptoms might no longer be necessary.

In the preparation of these patients for therapy with LSD, very little was divulged regarding possible experiences under the drug although the therapist and assistant had undergone several episodes by that time—a requirement confirmed in this series as necessary to the successful use of the drug. There were a few questions of the nature of "What will it do for me?" An answer was given much in this way: "This treatment could help in broadening and intensifying already present emotions." Fortunately, there was little delay in starting administration of the drug, since rapport and some idea of the good faith of the therapist were established. No attempt was made to cover up the somewhat small therapeutic gains made in the past years under conventional psychotherapy.

The first treatment episodes were difficult, tedious and took much longer than the time indicated in the literature. It was necessary to use dosages at a higher level than originally recommended, probably because the patients were naïve about the drug but curious, and it was as though they clung to control in order to see what might happen—attempting a strictly observer role. There was little opposition from "well meaning friends and advisers," because the patients had learned long before, while undergoing the more orthodox psychotherapy, that such advice was confusing and frustrating.

Most of the patients reacted intensely after the first episode and since most were articulate, they verbalized a great deal of

otherwise hidden material. Most of them reacted characteristically after the first few weeks with a great outpouring of libido, sublimated into enthusiasm for LSD 25, into a hyperactive desire to help others, and into other similar reactions.

The outcome of the first few months of using this drug is encouraging. Of course, many of the group are still in treatment, and many other cases have been tentatively terminated but are still being followed. It appears that all of the 52 patients have been benefited in some manner. Although some of the episodes have been unpleasant, there have been no cancellations and no abortive terminations. Dosages have usually varied from 50 to 250 μg. (micrograms), usually given in 50 μg. intramuscular injections spaced about one-half hour to an hour apart. The amount given was extremely variable and was, of course, based on the judgment of the intensity of the previous episodes. The frequency of the treatment was decided jointly by the patient and the therapist, and this joint responsibility was strongly emphasized to the patient—a "pull" on the patient might help him to decide the time of the next episode. Generally, episodes are spaced three to four weeks apart. Tolerance is built up rapidly with these drugs, and time is necessary for the scheduling of appropriate adjunctive therapy (group or personal), matters that account for the long intervals.

Initially discouraged patients sometimes became overenthusiastic later in attempting to "sell" other potential patients, and it was pointed out to them that, like other psychiatric procedures, there must be a need by the individual in order to initiate treatment with any hope of success. Almost without exception, during and following treatment, patients from this series have returned to the office informally to discuss and interpret their own experiences and those of others. This type of activity prompts one to consider an additional routine period of group psychotherapy a necessary adjunct to the drug itself.

Since the level that the treated patients ultimately reach often results in a change of values generally, it was felt that people living intimately with a patient should have an opportunity to "catch up." If the usual secondary gains are lost—of rolling in the luxury (for projective reasons) of owning a "sick" mate—some initially "well" individuals react with resentment and with attempts at sabotage of the mate's positive gains. Because of the

"well" mate's steadily increasing anxiety in the loss of a figure for projection, the previously comfortable spouse can often be brought into a trial episode with LSD 25.

The actual episode is induced in the morning with a moderate dose of LSD, sometimes with the addition of a small amount of ataraxic drug if the therapist thinks it necessary. Insulin in small amounts is sometimes given to lower the blood sugar further and potentiate the effects of the LSD. The patient reclines on a comfortable couch listening to pleasant music from a record player while a trained attendant sits with the patient, giving reassurance only. Suggestion, both for the episode itself and for the possibility of long-term gains is avoided completely, not only to further the study of this series but so that the patient may experience fantasies more freely and spontaneously. At about the fifth hour after the drug administration, the therapist may have a brief interview with the patient, pointing out the therapeutic need of the patient's interpretation of the material uncovered. It is pointed out that insights and understanding will continue over the next few weeks following the actual LSD episode. The patient's closest personal intimate is then allowed in the treatment room, and time is given for a conversation in privacy between them.

An ataraxic drug and a protein-glucose drink, administered to increase blood sugar and show the aftereffects of the LSD 25, are then given, and the patient is allowed to go home under supervision. In cases where there is a lack of supervision, the office is equipped to allow a patient to remain over night. Some sedation is prescribed for two days, and an appointment is made for a similar interview in a fortnight. After the initial and usually apprehensive episode, an attempt is made to send the patient into an intense episode. Factors encouraging such an episode are: reassurance, selection of meaningful music, absolute quiet and privacy, with discouragement of analysis and discussion of the episode while it is in progress.

Breakdowns of the presenting picture, the personality, the procedure, and the follow-up for each of the 52 patients are shown in the table.

The author has estimated the extent of the different variables noted in the table on scales of +1 to +4: as intensity of motivation, slight (+1) to great (+4); presence of character traits, slight (+1) to marked (+4); degree of "cure," slightly improved (+1)

Presenting Picture, Personality, Procedure and Technique, and Clinical Follow-up of Each of 52 Patients Treated with LSD 25

	PRESENTING PICTURE				PERSONALITY			
Patient	Diagnosis or Presenting Complaint	Motivation	Type of Previous Treatment	Length (years) of Previous Treatment	Boldness	Humility	Need for Change	Estimated IQ
R. H.	Character disorder	**	0	0	***	***	***	122
S. McV.	Char. dis.	**	0	0	***	***	***	120
M. O'T.†	Char. dis., dep.	****	Psychoan.	2	****	****	****	132
D. H.	Char. dis.	***	0	0	****	***	**	128
V. R.	Char. dis.	*	0	0	***	**	*	110
R. S.	Char. dis.	***	Hospital., EST	2	****	**	***	128
C. B.	Char. dis.	***	Psychoan.	2	**	**	**	124
R. P.	Char. dis., hysteria, depression	***	Psychoan., EST	8	****	***	****	128
J. M.	Char. dis., anti-social trends	***	0	0	****	****	***	128
J. M.	Char. dis., anti-social trends	**	0	0	***	**	***	122
A. B.	Char. dis., cyclothymic personality	****	Psychoan.	1	****	***	****	137
L. M.	Char. dis.	***	Psychoan.	1	***	****	****	136
M. S.‡	Char. dis., cyclothymic personality	****	Psychoan.	4	****	****	****	142
P. V. W.	Char dis., homosexuality	***	Psychoan.	2	***	***	***	124
F. G.	Char. dis., homosexuality	***	Psychoan.	5	***	****	***	120

The asterisks in all cases indicate the author's estimates of the different variables tabulated, on scales of +1 to +4, each asterisk representing 1 point. Under "Type of Previous Treatment," the entry, "Psychoanalysis," generally represents a modified form.

†Case 2 of histories reported in text.

‡Case 1 of histories reported in text.

Presenting Picture, Personality, Procedure and Technique, and Clinical Follow-up of Each of 52 Patients Treated with LSD 25 (continued)

Patient	No. Treatments	PROCEDURE AND TECHNIQUE: Dosage, μg. (micrograms)	Lengths of Episodes (hours)	Intensity Reached	Additional Psychoan.	Follow-up (years)	CLINICAL FOLLOW-UP: Symptom Relief	Sustained Feeling of Well-Being	Clinical Estimate of "Cure"	Relapses During Treatment
R. H.	1	75	6	***	0	1½	**	***	***	0
S. McV.	2	75-100	8-10	***	0	1½	**	***	***	0
M. O'T.	6	100-200	6-8	***	*	1½	***	****	****	0
D. H.	1	200	8	****	0	1	***	****	****	0
V. R.	1	250	10	*	0	1½	*	**	*	1
R. S.	6	100-500	6-12	***	**	1½	**	***	***	1
C. B.	2	50	4	*	*	1½	**	*	*	1
R. P.	8	100-350	4-10	***	**	1½	***	****	****	1
J. M.	1	150	10	***	0	1½	***	****	****	0
J. M.	1	150	6	**	0	¾	*	*	*	0
A. B.	14	25-200	4-10	****	***	1½	***	****	****	6
L. M.	10	50-250	4-9	**	**	1½	**	***	***	4
M. S.	6	75-300	6-8	****	0	1½	***	****	****	0
P. V. W.	12	75-550	8-10	**	**	1½	****	***	****	0
F. G.	10	75-200	8-10	**	**	1½	****	***	****	0

The asterisks in all cases indicate the author's estimates of the different variables tabulated, on scales of +1 to +4, each asterisk representing 1 point. Under "Type of Previous Treatment," the entry, "Psychoanalysis," generally represents a modified form.

Presenting Picture, Personality, Procedure and Technique, and Clinical Follow-up of Each of 52 Patients Treated with LSD 25 (continued)

	PRESENTING PICTURE				PERSONALITY			
Patient	Diagnosis or Presenting Complaint	Motivation	Type of Previous Treatment	Length (years) Previous Treatment	Boldness	Humility	Need for Change	Estimated IQ
R. H.	Char. dis.	*	0	0	**	**	*	118
M. V. W.	Char. dis.	*	0	0	*	*	*	120
R. G.	Char. dis.	**	0	0	**	**	***	134
R. H.	Char. dis., anti-social trends	***	0	0	***	***	***	128
A. P.	Char. dis.	**	Psychoan.	1½	***	**	**	118
D. D.	Char. dis.	**	0	0	***	**	*	124
C. H.	Char. dis.	***	0	0	***	***	***	132
B. P.	Char. dis., alcoholism	***	Psychoan.	7	****	****	****	135
M. S.	Char. dis., addiction (demerol)	***	Supportive, custodial care, etc.	7	****	****	**	130
B. G.	Char. dis., alc.	**	Imprisoned-0	0	***	***	*	125
A. D.	Char. dis., alc.	***	0	0	**	***	***	110
J. G.	Char. dis., alc.	***	Supportive psychoan., amine oxidase inhibitor	3	**	***	***	115
R. B., Jr.	Char. dis., alc.	***	Psychoan., insight type	3	****	***	***	120
J. P.	Char. dis., alc.	***	Psychoan., hospital.	12	***	**	**	130
J. S.	Char. dis., alc.	***	Hospital.	3	**	**	*	130

The asterisks in all cases indicate the author's estimates of the different variables tabulated, on scales of +1 to +4, each asterisk representing 1 point. Under "Type of Previous Treatment," the entry, "Psychoanalysis," generally represents a modified form.

Presenting Picture, Personality, Procedure and Technique, and Clinical Follow-up of Each of 52 Patients Treated with LSD 25 (continued)

		PROCEDURE AND TECHNIQUE					CLINICAL FOLLOW-UP			
Patient	No. Treatments	Dosage, μg. (micrograms)	Lengths of Episodes (hours)	Intensity Reached	Additional Psychoan.	Follow-up (years)	Symptom Relief	Sustained Feeling of Well-Being	Clinical Estimate of "Cure"	Relapses During Treatment
R. H.	1	50	8	**	*	1½	***	***	***	0
M. V. W.	1	25	6	*	0	1½	*	*	*	0
R. G.	1	75	10	**	*	1½	**	***	***	0
R. H.	1	250	12	***	0	1½	*	***	***	0
A. P.	3	50-100	4-10	***	0	1½	*	**	**	1
D. D.	1	75	8	**	0	1½	**	**	***	0
C. H.	1	75	6	***	0	1½	**	**	**	0
B. P.	27	50-900	3-12	****	0	1½	****	****	****	4
M. S.	1	150	6	***	0	1½	*	***	***	1
B. G.	6	100-150	6-8	***	*	1	**	**	***	3
A. D.	3	50-100	6-8	***	0	1¼	***	***	***	1
J. G.	6	100-200	6-8	***	0	1¼	*	**	**	1
R. B., Jr.	6	100-250	6-10	***	*	1¼	*	**	***	1
J. P.	3	100	6-12	**	*	¾	*	**	***	1
J. S.	1	100	8	*	0	¾	0	*	*	1

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Presenting Picture, Personality, Procedure and Technique, and Clinical Follow-up of Each of 52 Patients Treated with LSD 25 (continued)

	PRESENTING PICTURE				PERSONALITY			
Patient	Diagnosis or Presenting Complaint	Motivation	Type of Previous Treatment	Length (years) Previous Treatment	Boldness	Humility	Need for Change	Estimated IQ
M. B.	Char. dis., alc.	***	Psychoan., chemother.	10	***	****	***	132
D. G.	Char. dis., alc.	***	Psychoan., insight type	½	***	**	***	120
T. B.	Char. dis., alc.	*	0	0	**	*	*	120
M. F. B.	Cyclo. pers.	*	Psychoan.	4	***	*	**	116
R. S.	Obsession-compulsion neurosis	****	0	0	***	***	**	134
M. L.	Obs.-comp., dep.	**	Psychoan., EST, hospital.	8	**	***	***	130
R. D.	Obs.-comp.	**	Psychoan., EST, hospital.	4	***	***	***	130
C. H.	Obs.-comp., dep.	***	Psychoan., amine oxidase inhibitor	2	***	****	***	132
R. D.	Obs.-comp.	***	0	0	***	***	**	128
A. A.	Obs.-comp., dep.	**	Psychoan., a.o.i	1½	**	***	***	122
P. D.	Obs.-comp., dep.	****	Psychoan., a.o.i	2	****	****	****	134
G. P.	Obs.-comp., dep.	***	Psychoan., EST, hospital.	6	***	****	***	128
A. D.	Obs.-comp.	**	0	0	**	***	**	110

The asterisks in all cases indicate the author's estimates of the different variables tabulated, on scales of +1 to +4, each asterisk representing 1 point. Under "Type of Previous Treatment," the entry, "Psychoanalysis," generally represents a modified form.

Presenting Picture, Personality, Procedure and Technique, and Clinical Follow-up of Each of 52 Patients Treated with LSD 25 (continued)

	PROCEDURE AND TECHNIQUE						CLINICAL FOLLOW-UP			
Patient	No. Treatments	Dosage, μg. (micrograms)	Lengths of Episodes (hours)	Intensity Reached	Additional Psychoan.	Follow-up (years)	Symptom Relief	Sustained Feeling of Well-Being	Clinical Estimate of "Cure"	Relapses During Treatment
M. B.	1	250	14	***	*	1½	***	****	****	1
D. G.	1	250	14	***	0	1½	****	***	****	0
T. B.	1	125	6 (contr'l'd.)	*	**	1½	0	**	*	1
M. F. B.	4	50-275	6-8	***	0	1½	*	**	**	2
B. S.	2	100-250	8-10	***	0	1	**	****	***	1
M. L.	5	50-150	6-12	**	**	1½	**	***	***	1
E. D.	6	50-100	6-7	**	0	1½	**	**	**	1
C. H.	8	100-300	6-12	****	*	1½	***	****	****	0
R. D.	2	100-200	6-8	***	0	1½	***	***	***	0
A. A.	1	100	8	**	0	1	**	**	**	0
P. D.	4	200-300	6-10	****	*	¾	***	****	****	0
G. P.	2	50-100	6-9	****	*	1½	***	****	***	0
A. D.	1	50	6	**	0	1½	***	***	***	0

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Presenting Picture, Personality, Procedure and Technique, and Clinical Follow-up of Each of 52 Patients Treated with LSD 25 (continued)

	PRESENTING PICTURE			PERSONALITY			
Patient	Diagnosis or Presenting Complaint	Motivation	Type of Previous Treatment	Length (years) Previous Treatment	Boldness	Humility	Need for Change	Estimated IQ
W. T.	Obs.-comp.	**	0	0	*	*	**	116
J. M.	Obs.-comp.	**	Psychoan.,	8	*	***	***	112
F. G.	Involutional melan.	**	EST, hospital. Tranquilizers, supportive	4	**	***	***	120
J. T.	Invol. melan., encephalopathy	***	Ect and a.o.i.	8	**	*	**	128
M. H.	Invol. melan.	**	Psychoan.,a.o.i.	4	**	**	**	122
L. M.	Invol. melan.	***	Psychoan.,EST	5	****	***	***	123
M. F.	Schizophrenia, paranoid	**	Psychoan.	12	**	*	**	126
M. W.	Schizophrenia, paranoid	**	Psychoan., hospital.	10	***	*	**	124
R. B.	Encephalopathy, dep.	**	EST, hospital.	1/6	**	***	***	121

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Presenting Picture, Personality, Procedure and Technique, and Clinical Follow-up of Each of 52 Patients Treated with LSD 25 (concluded)

	PROCEDURE AND TECHNIQUE					CLINICAL FOLLOW-UP			
Patient	No. Treatments	Dosage, μg. (micrograms)	Lengths of Episodes (hours)	Intensity Reached	Additional Psychoan.	Follow-up (years)	Symptom Relief	Sustained Feeling of Well-Being	Clinical Estimate of "Cure"	Relapses During Treatment
W. T.	2	50	6-7	*	*	1½	***	**	*	0
J. M.	4	50-150	6-8	***	0	1½	**	***	***	1
F. G.	1	150	6	**	*	1½	**	***	***	0
J. T.	1	75	6-7	**	0	1½	*	**	*	1
M. H.	5	150	6-8	**	***	1	**	***	**	0
L. M.	7	100-150	8-14	****	*	1½	****	****	****	0
M. F.	4	50-70	6-12	***	****	1½	**	***	***	0
M. W.	9	50-250	6-8	***	***	1½	**	***	***	0
R. B.	4	50-100	6-9	**	*	1	**	**	***	0

The asterisks in all cases indicate the author's estimates of the different variables tabulated, on scales of +1 to +4, each asterisk representing 1 point. Under "Type of Previous Treatment," the entry, "Psychoanalysis," generally represents a modified form.

to social recovery (+4). In the table, each degree of + is shown by an asterisk.

Case Histories

Two case histories are reported, with detailed notes of one typical episode each, written by the patients concerned.

Case 1

M. S. is a 36-year-old white woman, married seven years. She is childless, has an M.A. degree, is a competent and talented pianist, and teaches for supplemental income.

M. S. was born in Indiana in a small urban area. Her parents were intellectual but ineffectual. She was rejected by her mother shortly after birth and was never again more than tolerated. The mother withdrew and was in an apparently psychotic episode for several years. The patient remained an only child. She soon demonstrated superior intellectual abilities in school, although she was isolated and virtually held a prisoner at home until her mother died when the child was nine. The father cared for this unusual and gifted child but was apparently completely baffled by her precocious personality. Due to her father's unnamed fears, she was not allowed to relate to other children, growing lonelier—living a fantasy life with an overabundance of unused toys in her insulated room. At this time she became depressed and withdrawn, but on the presentation of a piano as a gift, she experienced a sudden surge of optimism, fully believing at this early age that she was to have a musical career. Her father was killed when the girl was 14, and shortly afterward she suffered a dangerous attack of poliomyelitis.

Soon after this, she was taken into the home of a married but childless aunt. She was promptly seduced by her uncle when she was 15. There was absolutely no understanding or love for her in this home and only her interest in music was sustaining. She was sent to a conservatory at 18 and subsequently received a bachelor's degree there. During this time her only close relationship was a homosexual one with an older woman which left her merely confused, lonely and guilty. She received her master's degree at a Chicago college where she met her present husband. He was kind and gentle, so that she was able to marry him and follow him South to his professional appointment. She became rather successful in teaching and judging music during this period,

but felt exploited, since she hated instructing others, feeling that her outlet was in performance. Her arranging ability is considered superb, but the situation did not admit the use of this talent. She quickly discovered that she was superior to her husband technically, professionally and intellectually. This conflict and her supreme efforts to avoid competition filled her with more guilt and fear. Her only pregnancy resulted in a miscarriage while her husband was visiting his sick mother. At some time during this period, she discovered that alcohol and amphetamines would carry her through the teaching day. But after several scenes in which she attempted to stab her husband with a knife from her extensive collection, her iron will enabled her to abstain completely. Complete abstention was accompanied by a clinical worsening, and she stood at the brink of suicide and possibly homicide. Her hatred and contempt for everything in general, and her husband in particular, knew no bounds.

She is a creative and articulate individual, and was quite able to embarrass her husband unmercifully at faculty functions where she wished apparently to be considered something fearsome and an iconoclast. Underneath the bravado and cynicism of her cocktail party role, was also a deep and sincere desire to fulfill her feminine role. She was simply unable to verbalize this and felt that she could never fit in anywhere.

She conscientiously obtained psychotherapy in three-a-week sessions, but showed little improvement. Treatment with the amine-oxidase inhibitors and ataraxic drugs was to no avail. As the time grew near for her husband to leave his home in the area and go north for work on his Ph.D., she became openly rebellious and was adamant in refusal to accompany him. He in turn set down an ultimatum for her compliance.

At this time, LSD 25 was offered to her; and, due to her "essential love for the truth" and an inability to resist "adventure," she readily consented with enthusiasm. No suggestions were made to her except that she might be able to "live easier." On two occasions, her husband volunteered to take the drug himself, and both he and she obtained intense and high reactions. A new bond arose between them as a result of this and letters from her during the past year and a half have borne out the fact that there is a new meaning and satisfaction in her role. This patient is considered improved to the +4 degree and fills the requirements to

be considered "cured." "Cured," in the sense used in this paper, is the attainment by the patient of a meaningful life.

A report of the patient's sixth session with LSD 25 follows. The patient does not speak while she is in an episode, and this is an account some 15 hours after the drug was administered.

At first I wondered where I was going. I felt that I was going somewhere and also I felt sorry for myself because I was being forced to take the trip. But it seemed to be somehow a personal responsibility I shouldn't need to avoid because I was quite capable of doing it. I wasn't sure whether others could not or would not do it but at any rate, I had to go.

First I went through the now familiar place of rolling clouds and mists and fogs—where winds blow wild and free. And I thought, "I recognize this—I know the way to go now." Then I began to feel bad, very bad. I was heavily burdened with chains, irons, brass, all sorts of heavy, uncomfortable, hard metals. I was extremely restless because I just could not get away from all this. I ached and hurt all over and could find no comfort or ease or respite from my struggle. Later I realized that this was an attempt to free myself of all awareness of my body and everything physical in this world—the things that hurt and worry and trap the attention, all the discomforts and distractions of the earthly environment.

Then I became captivated with elements of great beauty: fragments of melodic lines, musical rhythms, linear rhythms, colors and color relationships, harmonic colors, textures, forms. I didn't know whether I was seeing or hearing and decided it was both but above all I was *feeling* beauty intensely. These things were charming, fascinating, hypnotic—and I forgot myself and reached a state of peace and rest. I wondered why these things appealed so deeply and how could they possibly be analyzed or described. What could I do about it? Then—quietly, subtly, I *became* these elements of beauty. It was such a tremendous experience that I tried it many times. I followed a melody around its course; I became a moving curve of line; I fused into a color. There was nothing particularly identifiable—just anything beautiful of the moment. It was something I had tried all my life to do—sometimes with fair success. For example, when I was a child I would lie quietly outdoors in the early evening and know that if I concentrated and relaxed sufficiently, I could go right up to the sky and become part of it and the stars. And very often when I am playing the piano, everything and all awareness disappear and I become the music which I am playing.

But this day with LSD I finally achieved the experience completely and realized the full success of my lifelong endeavor. Then I went on—through this peace and quiet—to a place filled with shining light, where Beauty was perfection and Love and Joy reigned. I was then entirely out of contact with the earth—I wondered where my body was and what it was

doing because I could no longer feel it at all. I am told that at that time my arms slowly raised and remained "floating" in midair. My spirit left its earthly body completely and basked in a glow of beauty, goodness, and love which is heaven. Three times I went through this same entire routine. Then about 2:30 p.m. I awoke, feeling sick and exhausted.

About four hours later I became fully conscious of the meaning and importance of the experience. The spirit is free and is meant to be that way. But we trap it in our environment—in our little worries and troubles and struggles. Now I realize that I need not be trapped in my environment, no matter how uncomfortable it might be at a given moment. I can always allow my spirit to follow the things of beauty which surround us always. I can be "here" and "not here." I can rise above the body and leave worry and suffering. Those "negative" experiences are always with us too—because after all our life is inhabiting a physical body. But we need not be limited to or by that natural circumstance. The spirit knows many other things and is capable of going many other places.

I am at the moment in a most uncomfortable position of great stress —moving out of my home for a year. I do not want to go at all and I am having to work very hard at the mechanics of doing it. But I was able to sit down with the intention of writing this report and within a few minutes I had forgotten my immediate environment and again was back in the place of beauty which I found yesterday. I know that my true life is in the spirit and that I need never be a slave to my tribulations.

Case 2

M. O'T. is a woman of 55, a teacher in elementary school. She arrived for treatment with a chief complaint of irritability and increasing difficulty in management of her classroom. She was suffering from a depression of a generally involutional type that had been developing for five or six years. Increasing symptoms of insomnia, anorexia, ideas of worthlessness, and uselessness had been developing. It had become most difficult for the patient to handle children in the nine to 10-year-old group, much less the problems of the parents. Several uncontrollable outbursts of hostility occurred which seemed entirely inappropriate, since the patient usually appeared obsequious, docile, and somewhat mousy in manner. The patient denied having suicidal ideas although she did admit having fantasies of dying.

Born the third of seven siblings, a typical ugly duckling, she was the only child in the family who did not marry. The mother was overbearing and dominating, creative and flighty, but was organized enough to write several children's books that were

published. The father was ineffectual and not as colorful as his wife and quite easily dominated by her. He was quiet and did not have much impact on the personality of the patient. Early in the patient's life, the oldest sister died in an asthmatic attack, which precipitated much guilt in M. O'T., due, no doubt, to her underlying hostility.

The patient grew up in a city and, early, felt different from other children. She was guilty over sexual activities, and they were repugnant to her. She became more interested in girls than boys as sexual possibilities, although her first actual overt homosexual experience was entered into because she thought it was a bohemian, smart and somewhat fashionable thing to do. During or shortly after college, the only heterosexual experience that the patient has ever had generated no personal meaning to her. Since she was 22, she has lived with one homosexual partner more than 30 years. This partner, although dressing mannishly and appearing rather masculine, is really a gentle if ineffective person who is identified closely with the patient's father.

The patient entered into weekly psychotherapeutic sessions relating coolly to the therapist. She spoke mechanically of her dreams and interpreted them intellectually in a Freudian structure. She did not improve clinically until she was put on marsilid and later marplan, which lifted her depression.

She entered willingly into the LSD program and had four episodes spaced three to four weeks apart, with one episode at a +3 intensity. She received supportive and interpretive psychotherapy and was followed for a year when she requested two more episodes. Her depression was lifted after the first series, and she took a tour of Europe. "Philosophical questions" prompted her to undergo the two later episodes. She felt "free" after this. Her irritability and depression lifted, +3, and she became very enthusiastic in reference to the drug. Her "cure" was considered to be at the +4 level.

Following are the details of the fifth episode, in the patient's own words, 12 hours after administration of the drug and a note several days after its administration.

This was an awful session. As I think back it was something like a horror story—only worse. The whole time my conscious thoughts were blocked and I was inarticulate. I had lost control, could no longer perform like a trained seal, could no longer say the right thing at the right time

and the realization of this caused extreme apprehension. I tried frantically to pull myself together but couldn't. I was miserable and embarrassed because of the effect it would have on the attendants in the room. I remember having apologized for being stupid.

In addition I felt physically sick, confused, restless, hostile, and had a loathing for my own person. I tried desperately to analyze these feelings. To what person or thing was I hostile? Why did I bear this consuming hatred toward myself? I couldn't find the answers. The Doctor said it was because I was fighting love but this made no sense to me whatever.

In the beginning I was a petulant child and wanted to be alone. But on the other hand, why not have the Doctor stay, just to punish him? Yes, that would please me greatly. I was sly and cute.

Later there were waves of pressure in my lower abdomen. And these waves extended down into my limbs draining all their strength. There was pain. I hated these recurring waves of pressure, pain and weakness and was very much ashamed. "A barren woman trying to give birth to an orgasm," I thought, and was filled with renewed loathing. My body seemed messy and unclean. The sight of my hand lying there on the sheet was an object of repulsion.

Again I was troubled by the presence of the Doctor. I wanted him to leave because I didn't want him to be witness to what I felt. Then I recalled what had been said before I had taken the drug—that perhaps this treatment would be an easy, even a pleasant one. Now I was letting the Doctor down and I simply must not do that. I must not do that! I must not do that! I was driven by a compelling force to fight this ugly feeling and change it into a pleasing one. I tried and tried but couldn't conform. It was impossible because I was as tired as death.

At another time I felt like an animal at bay. I was lying on a ledge close against a wall of rock in a grotesque position. I was weak as though I had been hurt but still I wished to stay this way and wanted no interference.

The music so carefully arranged, so far as I know, meant absolutely nothing to me. I was too far removed and was conscious only of time, place and the two persons who sat with me. The people were the ones who made the big impact. In fact my own private misery took second place to the anxiety caused by the nagging thought, "What will they think of me?"

The following additional note was written by the patient several days later:

As I reread the above several days later it seemed like so much drivel. It is incredible, even to me, that something that reads so utterly insignificantly could hold (unconsciously) such anguish and suffering.

Yet there is no doubt—I am this person in essence, eighteen hours each day and have been since I can remember.

Conclusions

1. Encouragement in this early impression of a series of 52 cases is noted with treatment with LSD 25 on an office basis. Most patients of this series were known to the author for several years and were failures in an analytically oriented psychotherapeutic practice with its more superficial goals.

2. Patients tending to react successfully were: A. Those desiring a philosophical approach to life compatible with psychological facts. B. Those with a curiosity and a great need to search for the "truth."

3. It is pointed out that the patients of this series were co-operative and helpful and had little need to take the secondary gains of the neurotic.

4. There was a characteristic return of the LSD patient to the office to discuss the significance of the experiences with others, prompting the idea that group psychotherapy would be helpful.

5. The need is noted to "catch up" persons who are intimate with and living with the patient, lest these become panicky and feel rejected.

6. An outline of the procedure used is given with emphasis on reassurance without suggestion and without analyzing under the drug.

7. The author's definition of "cure" with LSD is the discovery of a meaningful life.

8. Relapses are common during therapy unless stability is reached.

9. All patients treated with LSD 25 were benefited to some degree, and the degree of the "cure" varied directly with the intensity reached during a series of episodes. Of this series of 52 cases of several types of ambulatory neurotics, two paranoid schizophrenics, several involutional depressives, and one patient with organic encephalopathy, a +4 "cure" was obtained in 13 cases, +3 in 23 cases, +2 in seven cases, and +1 in nine cases.

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