

PSYCHOTHERAPY FOR THE DYING: PRINCIPLES AND ILLUSTRATIVE CASES WITH SPECIAL REFERENCE TO THE USE OF LSD*

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It is time to introduce humanism into the American way of death. The recent sociological work of Glaser and Strauss (1965, 1968) on the sociology of death in American hospitals portrays with anguished precision the frightful manner in which the dying and death are handled. They are a very much discriminated-against group in our culture.

In America the living ignore death. This attitude prevails to the death bed, for death is ignored both by the dying and by those attending to the dying. Even when the dying person comes to the awareness of his dying, he is not allowed, much less aided, to work with the many conflicts that arise out of his impending death. Medical personnel vigilantly maintain massive denial and offer the dying little that is useful. The family of the dying, unless absolutely insistent on the physician sharing his prognosis with them, are treated with the same attitude. At best, they are given basic medical information. The physician who has difficulty with his patient's dying and/or working with the very intense emotionality elicited by impending death, protects himself by assuming the dying and the dying person's family really "do not want to know the facts;" he therefore does not divulge this information to the patient or family. The paramedical staff are essentially in the same position, having neither the skills, training, nor inclination to deal with the problems surrounding death. The result of this state of affairs is that the patient is most often left to himself to die, and the isolation imposed upon him makes it virtually impossible for him to deal with conflicts that emerge when he becomes aware he is dying.

ISSUES RAISED ON AWARENESS OF DYING

There are two basic types of issues that arise when the patient becomes aware that he is dying; one concerns his total conception of death reflected in his attitudes and beliefs, and the other concerns the nature of his relationships with his significant others. The first issue we shall call personal and the second, interpersonal.

Personal Issues

The personal issue encompasses a plethora of phenomena but central is the identity phenomenon. When the individual's identity is restricted to experiences emanating solely out of personal ego, the identity is, to borrow Allan Watts' phrase, a "skin encapsulated" one. When an individual with this type of identity

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realizes he is dying, a crisis ensues and the crisis is essentially an identifying crisis. This identity crisis is no different from any other identity crisis he has experienced in his lifetime, but typically it is not recognized as such. Affective reactions of fear, panic, anxiety, anger and dependency are common. Unless the individual is permitted to explore the basis of these reactions, he does not comprehend that they are in response to the life constant: change.

It seems obvious that the problem of the death of our physical self is a problem insofar as we identify the self with our physical body. When we do this and we see a person's dead body, then we assume that he is dead because we have identified 'him' with his body and its actions, its appearance, its smell, its sound, its color, and so on. Thus, when we see that these things are gone, we assume that he too is gone. Identifying ourselves with our bodies and others with their bodies then makes physical death a cessation of individuality and awareness. In one of the Buddhist sects, the novice must sit and watch the decomposition of the body of someone he has known well. This practice is to help cast some doubt on the assumption that body and individual being are one and the same thing. It would be difficult to go on believing that one's friend, after a couple of weeks of decomposing, was just that mess of maggots, worms and bone before one's eyes. The emphasis in Zen, of making an experience, of concretizing an abstraction, so that it becomes a felt reality, is meaningful and leads to knowing. Rather than abstractly thinking that man is more than his body, and rather than having an intellectualized concept of this possibility, as is Western man's inclination, the Zen approach has us experience it.

The problem of physical death, then, has something to do with our identity and what is considered to be 'me.' When we identify ourselves with our 'skin encapsulated ego', we naturally face annihilation. When we can identify with something beyond our skin-self, death has a different face. The problem, of course, is a process of coming to know parts of ourselves that we do not already know. Or, stated differently, identifying with things that we do not now know and, therefore, have no identity with. The solution is to identify with the life process—to experience, for instance, our cellular consciousness (awareness of that fantastic neurophysiological activity) and to experience another's cellular consciousness, and on the other extreme, to experience (in Eastern religious terms) the 'void', the unmanifested energy (the absence of any thing), the source of all life (Fisher, 1969).

Interpersonal Issues

When an individual is not allowed to work out interpersonal conflicts before his death, he experiences his days of dying as burdensome, is often guilt-ridden and resentful, and suffers terrible loneliness from his isolation. As a result of his altered states of consciousness, he very often experiences new insights into his relationships and he wishes to share them with his significant others. Often these insights are laden with conflict resolution, and when he is unable to share this knowledge with his loved ones, he experiences sadness. Sometimes the individual experiences ego-free states prior to his physical demise and this experience of transcendence gives new meaning to his past personal life and his relationship with others. He develops a new perspective, as it were, of life, and this perspective typically has at its base a profound acceptance of the life constant, change. He experiences himself in a transitional state and welcomes a new state of equilibrium and consciousness. Sometimes this is interpreted specifically by the individual that his after-death consciousness will have specific characteristics. Sometimes the individual experiences himself simply as part of the life process, as being "at one", and for some that they again have touched the life source. We have found these experiences

to be very useful to the individual while he stays alive. These experiences become very pragmatic and functional.

First of all, he ceases to be concerned about his own physical demise—accepting it as a natural phenomenon of the cycling of life force. Second, this acceptance drastically alters his life style—he no longer reacts with panic, fear, pain and dependency to the changes that are occurring in him. Third, he is willing and eager to share his new knowledge with those he cares for—and often, this is a highly expanded group. He devotes his attention to the needs, anxieties and apprehension of his loved ones. He attempts to relate, talk and respond to them in ways which will enlighten them as to his state of consciousness. In current popular parlance, he attempts to “turn them on.”

One of the very significant results of his having experienced a transcendental state of consciousness is his willingness to engage in the life process. No longer is death an excuse for not living. In American culture, the myth of death is in the service of denying the life process. At some level of consciousness, some of one's daily behavior is geared to a time when one does not have to engage in the life process and confront oneself. There is the myth that “some-day I will die” and therefore if you just hold out long enough, you won't have to deal with basic issues such as “the condition of my humanity.” The attitude is “business as usual”, “nobody rock the boat” and this business of my consciousness will be over soon. An additional result of this myth is that one can get away with his destructiveness—i.e., death is a way out—I can get by with my own and other destructiveness because I will die and that will be the end of it. In western religion, most people don't consider the concepts of heaven and hell as seriously as eastern religionists take the concept of Karma. When a man experiences himself as life force and feels that the quality of his life force is vital to the human condition and trans-human consciousness, he begins to take his own destructiveness very seriously. He becomes a humanist. Now the persistent question as to whether one stays around forever in an identifiable (to himself, of course) form is perhaps unimportant. That one identifies with the human condition and craves for its perfection, i.e., of becoming human, is pragmatically useful, useful to himself and useful to those with whom he relates. That life becomes richer and fuller, with greater feeling, trusting and loving relationships for the patient and for his loved ones should certainly be sufficient for the severest of critics of aiding the patient in achieving a state of transcendence.

Achieving Transcendence

It has been my good fortune to have had the opportunity to utilize LSD in working with terminal cancer patients. LSD has been used extensively in psychotherapy with many psychopathologic types. This work continues outside of the United States, most notably in England, Czechoslovakia and Chile. Eric Kast of Chicago did the early work utilizing LSD in the management of pain in terminally ill patients.

Kast and Collins (1964) studied 50 gravely ill patients who were having difficulty in the management of pain. They compared LSD, dilaudid and demerol for their analgesic effectiveness. The investigators found LSD to be

a much superior analgesic but were surprised that many of their patients did not want a second treatment. "Although the analgesic action of LSD was profound and the patients were relieved of the oppressive ideation accompanying grave illness, eight patients refused a second administration, 30 were indifferent, and 12 wished for it. An explanation for this peculiarity is difficult to conceive. It seems that the LSD experience required a great deal of psychic energy and represents hard work. This statement, which was frequent, probably reflects the heightened subconscious activity under lysergic acid which places strain on ego control and consequently is felt as a laborious task. If ego disintegration threatens, this experience may be felt as panic. In addition to pain relief, these patients displayed a peculiar disregard for the gravity of their situations and talked freely about their impending death with an affect considered inappropriate in our western civilization, but most beneficial to their own psychic states. This approach to their disease was noted usually for longer periods than the analgesic action lasted."

In a later study of 80 terminally ill patients in severe pain, Kast (1966) reported that three weeks after the administration of LSD, 90% of the patients felt they had gained insights through the experience and 85% were willing to repeat the experience. This was a marked increase in the number of patients favorably inclined to repeat the experience, and Kast believed this to be a product of terminating the sessions relatively early, before the patient became exhausted and began to have negative experiences. Again, Kast found considerable analgesic effectiveness from LSD; before the treatment the median amount of pain experienced by these patients was labelled between severe and intolerable, whereas ten days later the median amount of pain was between none and mild.

Kast also comments at some length on the psychological sequelae of the LSD experience, particularly in the change in mood and patient's acceptance of his disease. He states, "A definite lifting of the mood was noted for approximately two weeks, and a certain change in philosophic and religious approach to dying took place which is not reflected in the numerical data presented. During and after LSD administration, acceptance and surrender to the inevitable loss of control were noted and this control was anxiously maintained and fought for in non-drug patients. LSD administration apparently eases the blow which impending death deals to the fantasy of infant omnipotence not necessarily by augmenting the infantile process but by relieving the mental apparatus of the compelling need to maintain the infantile fantasy." He states in general the LSD experience "creates a new will to live and a zest for experience which against a background of dismal darkness and preoccupying fear produces an exciting and promising outlook. In human terms the short but profound impact upon the dying patient is impressive."

Pahnke (1969) and his associates in Baltimore extended this work using a psychedelic psychotherapeutic model to work not only with the management of pain but also with the psychological problems elicited by impending death. Their model was somewhat different from Kast's: (1) they did extensive preparation of the patients for the LSD experience, (2) they incorporated the family into the treatment plan, (3) they had a staff of thoroughly trained therapists in utilizing the LSD psychotherapeutically, (4) they gave ten to fourteen-hour treatment sessions, and (5) they also did extensive follow-up and support for their patients.

Reporting on six patients, their initial results are certainly very dramatic, both in terms of psychological sequelae and of psychological adjustment of the individuals and their life styles, as well as dramatic reduction in pain.

Our own work, although in its beginning phases, has been promising. We are administering LSD to terminally ill patients who have either one of two problems (a) intractable pain and (b) anxiety and fear over their impending death. We have primarily been treating terminal cancer patients where the medical and surgical management of the pain has been complicated and difficult. Other patients have been referred who have been difficult management patients in terms of their inability to cooperate medically with their treatment because of emotional instability.

One interesting aspect of our current work concerns the socio-political-psychological climate surrounding LSD. One of the major difficulties in the work has been obtaining the approval for the treatment by all those people involved with the patient. Our current project was set up as a double blind experiment testing the efficacy of LSD and an experimental analgesic in the management of the problems that were outlined. Patients referred were hospitalized and came through the Department of Nuclear Medicine and Radiation Therapy. Thus, they were initially screened by medical personnel. After the patient's approval was obtained, his private physician's approval became necessary. Next came our evaluation of the suitability of the patient for treatment in light of our general criteria developed over the years. This evaluation essentially involved the judgment as the patient's ability to utilize those markedly altered states of consciousness induced by the drug. We wanted some assurance that the patient was motivated toward psychotherapy, had sufficient ego strength to deal with heretofore repressed and traumatic historical events, was of sufficient intelligence and sophistication to integrate the uncovered material, and had the potential to work through and accept the fact of the fatal disease and resolve the problem of death.

We usually had one hour to do this evaluation, and, sometimes, an additional hour to prepare the patient. Parenthetically, we must mention that there was a 50% chance that, instead of LSD, the patient would receive the experimental analgesic, the possible psychic effects of which we had not personally experienced but had read about in professional literature.

After evaluating the suitability of the patient, the family members were approached and the nature of the experiment was explained. Because of the LSD publicity, a great deal of this conversation surrounded the possible risks involved.

After the relatives approved and signed releases of responsibility (which listed all the known possible untoward results of LSD, including psychosis and grand mal seizures), the patient was approached for his approval and signed release. As is obvious, the psychological state of the patient following all this was hardly optimum in creating a state of trust, relaxation and faith in the procedure. Making the situation still worse was the general attitude of the hospital staff toward subjecting the dying patient to the publicized horrors of the LSD "bummer" trip.

These negative attitudes run counter to the very encouraging results reported with LSD with a variety of psychiatric syndromes. In a literature review, Mogar (1966) states that, in spite of the great diversity in the conduct of the

research studies, "Impressive improvement rates have been almost uniformly reported with both adults and children, in groups as well as in individual psychotherapy—in patients representing the complete spectrum of the neurotic, psychosomatic and character disorders. Particularly noteworthy are the positive results obtained with cases highly resistant to conventional forms of therapy."

Hoffer (1965) in a long review of LSD research concluded, "So far there have been no therapeutic studies in which LSD was used as a psychedelic agent where similar success rates were not found. It is odd that there have been no negative papers."

Case History Material

The patient was a 65-year-old, married female who had had radical mastectomies for breast cancer and who was now in the terminal stages of lung cancer. The patient was rather suspicious of having this treatment as she had had negative attitudes towards psychiatry because her daughter-in-law had been unsuccessfully treated for a psychiatric condition by the Department of Psychiatry with which we were associated. However, because she did have confidence in her physician and he was most anxious for her to have these treatments, the patient agreed. She was a fairly verbal, bright woman, but was considered to be a difficult management patient because she was very demanding.

During the initial interview the patient spontaneously described dreams that she considered to be prophetic, two of which particularly related to her disease. The patient's elder sister had died of cancer of the lung. Two years after the sister died, the patient had a dream in which the sister wanted something. Although the patient did not know what the sister wanted, she kept telling the sister that she could not have it. In retaliation, the sister became very angry and placed her hand over the patient's right shoulder, touching her breast. As she did this, the patient felt an injury to her right breast and became aware that the sister was injuring her. She called out for help, whereupon a white winged object removed the sister from her. A year later the patient developed breast cancer.

Following this, another of the patient's sisters died of breast cancer. The patient claimed to have had a good relationship with this sister, who had in fact been the surrogate mother. After the sister's death, the patient dreamed that her sister came to her and demanded something of her; again when the patient would not comply with this unknown demand, the sister reached out and the patient felt a sharp pain surging through her chest and believed that she had been harmed. A few months following this dream, the patient started developing symptoms and was subsequently diagnosed as having lung cancer.

The patient spontaneously expressed concern about a possible relationship between these dreams and her cancerous condition. When the therapist inquired as to the specific nature of the relationship, the patient could not specify.

The patient was rather weak, depressed and apprehensive and was having difficulty with pain. She was taking percodan four times a day and also was taking valium as frequently but was having almost constant pain in spite of the medication.

The patient was administered 200 mcg. LSD orally and it took approximately one hour for psychological changes to occur. The materials that the patient became involved with was the relationship between her sister who had acted as a mother towards her. The patient's first comment was, "Why did my sister want to punish me? My sister made me walk out into the rain where I have been ever since." She began to complain of pain in the back of her head; at this point the therapist attempted to have her become totally in contact with her pain and to experience it completely. The patient began to experience pain in the chest and this pain increased in great intensity. As the patient experienced more pain, the therapist became more and more insistent that the patient go into her pain to see if there were messages in her pain for her.

This approach lasted for over two hours; then the patient sat up, looked the therapist straight in the eye, and said, "I am nauseated." When asked what was nauseating her, she said, "I finally accepted it: I finally have accepted the fact that I've got cancer and that's enough to make anybody sick." She made this statement with great meaning and with that touch of humor that acknowledged emotional acceptance. The patient then became relaxed and was able to discuss her relationships with her sister. For the first time she became aware that the sister had actually committed suicide by taking an overdose of barbiturates and that the sister had done this because she could not tolerate the pain from her cancer. The patient then said, "Well, it won't be necessary to do that now." When I inquired as to what it wouldn't be necessary to do, she replied that it wouldn't be necessary for her to commit suicide. She then said that she had been planning to commit suicide because she could not tolerate having cancer and suffering the pain. She also began to recognize that her sister had been a very controlling and dominating person, while making her think that she was a very loving, giving and martyred person. She recognized that the sister was selfish, that she was only interested in the patient performing the way she wanted her to perform, and that she was far from kind and giving. The patient was amazed that she had been duped for so long in such a relationship, even to the final controlling act expressed through her own planned suicide. She explained that she had been going to take her own life to absolve the sister of the sin of committing suicide. The patient stated that she had never been aware that her sister had actually committed suicide, but only became aware of this during her treatment as she reconstructed the events on the evening of her sister's death.

After four hours of treatment the patient became agitated because she felt she was losing control of herself and her thinking. She was very much concerned that she was going to "fall to pieces," complained of feeling helpless, and said that she could not maintain the kind of control psychologically that she wanted. Her agitation increased and finally, in response to the question as to what she was afraid of, answered, "That I will die." After some five hours of the treatment, the patient was given thorazine to decrease her agitation.

The following day the patient said she felt considerably better and that she felt a calmness and peace which was very new to her. She was not having any pain and she had not taken any analgesics. She was very much impressed with having understood the relationship with her sister and felt that she had finally been freed of the sister's domination. She also was convinced that she would

have committed suicide, had she not worked through these dynamics regarding her sister. She was now perfectly assured within herself that she would not take her own life.

During the seven months she continued to live, she was seen a number of times and a marked change in her psychological state was evident. Previously, she had been a rather demanding, passive-aggressive woman who was a management problem; she now seemed a pleasant, outgoing individual who became involved in people and in activities. Staff members also commented upon the great improvement in her psychological attitude and now found her to be very different in relating to them.

What was most outstanding, however, was the lack of pain that this woman had subsequent to one LSD treatment. Three months later she was not having any pain and was not taking any analgesics. The pain only began to become a problem after the fifth month following the LSD treatment and never became unmanageable since she started to take codeine occasionally; apparently this controlled the pain. A month before she died, she became apprehensive about being left alone and was having separation anxiety. Her relationship with her husband was very much improved. Whereas it had previously been rather competitive and she had used her dependency in a controlling fashion, they now had a much more open and free and relaxed type of relationship. They seemed to enjoy each other a great deal more, in marked contrast to the strained and anxiety-ridden relationship when they had been seen initially. During the last two weeks she became afraid of being left alone and wanted him with her most of the time. She denied, however, that she was afraid of death *per se* and said that through her LSD experiences and her prophetic dreams that she was not apprehensive about dying.

The most meaningful aspect of the use of LSD in this case was the patient's ability to work through her relationship with her sister. She then gained a state of peacefulness and tolerance and understanding of other people which was new to her. The reduction in her pain was most remarkable. Certainly, the remaining months of the woman's life were very much influenced by this experience that made life much more meaningful and peaceful.

The second case is that of a 45-year-old female, who has terminal cancer of the bone, spine, and who had recently developed brain tumors. She was hospitalized because of inability to manage the pain and was suffering nausea and vomiting from the medication. She was being medicated with demerol, morphine and thorazine. The patient was a quiet, soft-spoken woman who was psychologically naive and unsophisticated. She knew she had cancer and knew that her disease was fatal but did not know how long she had to live. She was depressed but attempted to maintain control over depression. Her major defense mechanisms were massive denial and avoidance. This avoidance was so pervasive that she did not want her family to visit her while she was in the hospital. When questioned as to this attitude, she explained that their visits reminded her that she was hospitalized and if she was in the hospital then there must be something wrong with her and she did not want to think that there was anything wrong with her.

This woman had had a very unsatisfactory 20-year marriage with an alcoholic. Because of her strict Catholic faith, and at the insistence of her father, she

remained in this marriage. Finally, however, she was unable to tolerate the relationship and obtained a divorce. This action was very unacceptable to her father and to her church; when she remarried some four years later, her father disowned her, and she was refused her church sacraments. Five months following her marriage, she developed breast cancer and, subsequently, cancer in other organs. She had seen a priest and attempted to absolve her sins with relation to her marrying outside of the church. She tried to reassure herself that she was not living in sin but obviously had great difficulty believing it. She was able to state that she felt cheated because, for the first time in her life, she had a good marital relationship and had achieved some happiness, only to develop cancer.

It was impossible to prepare this patient for an LSD experience because her total attitude was one of avoidance and denial of feelings. We repeatedly told her that the LSD treatment was not for her cancer but rather an attempt to help her with her emotional problems. She was incapable of hearing this message and kept repeating that she would cooperate totally with any procedure that the doctors were recommending because "they are trying to do so much for me." She also told us that she had a great deal of difficulty in bearing any pain, relating this to the death of her child through leukemia. She had watched him die in great pain and she was not terrified of experiencing her pain in the terminal phase of her disease. Thus, this woman obviously met none of our established criteria for individuals suitable for LSD treatment. Understandably, we felt quite ambivalent about treating her, because she used denial so extensively, had poor ego strength, and was approaching the LSD experience, in our view, with totally wrong intent, i.e., that it would cure her cancerous condition. With trepidation, we gave her 200 mcg. of LSD. At the beginning of the session, the patient was in considerable pain and discomfort but did not have any specific anxiety about taking the LSD. Onset of psychological changes was quite rapid, occurring in approximately 20 minutes. She immediately started verbalizing her experiences. For the first three hours of the treatment there was a very intensive interchange between the therapist and the patient.

The patient was not given her usual medication on the morning of the treatment and was in considerable pain, writhing around, grimacing and beginning to cry because of the pain she was experiencing. An example of how the therapist tries to deal with that is as follows:

Therapist: "Let yourself feel the pain. Let yourself totally experience it."

Patient: "It hurts, it hurts. I don't want it."

Therapist: "I know you don't want it, but let yourself feel the pain. Let it become worse. Let yourself totally feel it. Either let the pain totally come to you or else you go to the pain, whichever you find easiest to do."

Patient: "No, no (patient writhed about to try getting away from the pain), I don't want it."

Therapist: "I know you don't want it, but see what the pain can tell you. See if there is any message in the pain. Let it overcome you, totally become your pain. Let it completely take over, don't try to stop it, just let it come. Let yourself become the pain."

Patient: (screaming) "No, no. I don't want it. Make it go away.

Therapist: "Let it come, let it come. Let yourself let it come. Give in to it completely. Let it come.

Patient: (crying) "It's my daddy, it's my daddy. He doesn't want me, he doesn't love me. He pushes me away. Oh, daddy, I just wanted you to love me. He's laughing at me. He wants me to suffer. Oh, daddy, shame on you. It's not fair. You have no right to treat me in such ways. (Patient starts showing anger) He doesn't want me to be happy. He's jealous because I have someone who loves me now."

Therapist: "How is your pain?"

Patient: "What pain?"

Therapist: "Do you feel any pain in your body?"

Patient: "No, I don't have any pain."

This particular sequence of the conversion of physical pain into psychological pain was repeated over and over again. When the patient would be experiencing severe pain, writhing around on the couch, the therapist would continue to insist that she totally experience the pain. Each time she did so, the pain represented rejection by her father; later, it extended into the rejection by her sisters and by her church. This was followed by her resentment and anger over the way her family members and her church treated her their rejecting judgment of her. At these times, whenever the patient was questioned as to her experiencing physical pain, she always said, "What pain? I don't have any pain."

Her first concern was her rejection by her church and her family over having divorced her husband. At this point the section of the Casals Montserrat choral where a chorus of males and females alternately sing was playing. To the female voices she verbalized, "They are pleading. It is depressing. They are pleading, but they won't let me in. They turn their backs on me. I am an outsider, that's why. They don't think I belong in the church. They think I am a bad girl because I didn't get married by the church. The family didn't like that. They didn't want me to get a divorce. They are pleading. They are pleading, but they won't let me in. Oh, I want in, I want in."

She then became involved with material concerning her father and the rejection of her by her father and by her sister. She experienced them as taunting her, laughing at her and pretending concern without really feeling it. She cried because they were angry at her, resented her for remarrying, and particularly resented her happiness in her new marriage. When she asked them why they were so cruel to her, they replied that they wanted her to stay and to suffer and remain married to a man whom she did not love and who did not love her. She felt them laughing and talking about her and now obtaining their revenge because she did not have a happy marriage because she was going to die.

She then started to go back earlier in her life and deal with her father's rejection of her as an infant. She apparently was dark skinned whereas the rest of the children were light skinned and she was taunted and rejected because of the skin color. She said, "The color of skin means nothing. Daddy, I just want you to love me. They said I came in a charcoal freight car because I'm black. He said I wasn't pretty like my big sister. My daddy never did love me, I just wanted him to love me. Oh, daddy, why don't you love me?" All this was said with a

great deal of affect, a great deal of crying, and a great deal of horror and surprise.

In the next sequence, she began to resolve her feelings of rejection by her father, by the extended family and then by the church. It appeared that she finally accepted her father the way he was, and this acceptance removed her anger and resentment toward him. As she began to accept her father and her family, her whole mood changed dramatically, and she became happy, radiant, very peaceful, in a tranquil state.

After working through this acceptance, she then very quietly put out her hand to the therapist and said, "I am going now. Please walk with me." The therapist took her hand and said, "Yes, I will go with you." The patient's face became illuminated and her nostrils started quivering and she began to sniff the air. The patient verbalized, "The smell of the trees is so fresh. They are so fragrant. The flowers, they smell so beautiful. The air is so clean and so fresh, this is the garden." The patient became ecstatic and verbalized her tremendous delight with this experience. She said, "Death is a place you go to rest. It's such a beautiful road. It smells so fresh. Look at the light shining through the trees. It is so beautiful. Everything is so beautiful. Everybody has such beautiful faces. No one is ugly. I can go there too. I am not ugly. My daddy loves me. He really does love me. He's not laughing at me any more."

We present this material to indicate that the patient had worked through her feelings of rejection by her father, her family, and the church, she had come to an acceptance of those individuals and their attitudes and still could maintain that their attitudes were not valid with respect to her own worthiness. Through discovering that she was acceptable, she could experience them as human beings and accept them and their limitations. By releasing herself from their attitudes she was able to have a transcendental experience and experience the beauty of love; her previous notion and fear that she would burn in the fires of hell no longer held any validity for her.

Near the end of this type of experience the same music was played that was played earlier when she was experiencing such agony of being an outcast. Her response to this music was as follows: "The monks have come back and they say everything is going to be all right. We are all together now. They are answering and they are saying that everything is all right."

Following the session the patient required considerably less medication for her pain. The pain became manageable and she was discharged home.

The following day the patient verbalized remembering positive emotional experiences she had had and stated that she found these to be very, very helpful. She said that for the first time she was able to feel that her father did care for her and that she was able to accept him and no longer had any conflict in her relationship with him. She also said that she did not want to go back into the past any more but wanted to look towards the future.

Some five weeks later the patient's physician was contacted by telephone. The patient's physician had been out of town during this period, but I assumed that he had known of the LSD treatment. When I inquired as to the patient's status, the physician said that he had just been discussing the patient's case with other medical personnel and that in his vast experience with patients dying of this particular type of brain cancer, he had never before witnessed a patient dying in this way. He stated that most such patients had great emotional

lability and were subject to fits of severe anger and rage and also to periods of despondency and apathy. This patient, however, seemed to be very much at peace and was showing none of the usual signs. He stated that she seemed to be reliving delightful and joyous events in her past life and that she seemed to be totally peaceful and at ease. He continued to talk about the perplexity of the case. Because I still assumed that he had known about the LSD treatment, I said, "Well, I attribute those changes to the fact that the patient was able to work out many of the conflictual relationships in the LSD treatment and that she is not troubled by them." He responded to that statement with, "What LSD treatment?" It is of value to have had this independent observation of the psychological sequelae of the LSD experience.

The last case was not conducted within our current project, but was done outside of the United States under the auspices of another research project involving the therapeutic use of LSD. The patient was an 83-year-old woman with terminal lung cancer. She was a small, physically frail and debilitated woman. Her mood is best described as being one of apathy and withdrawal. She complained of being tired most of the time and had little interest in her surroundings. Her husband at 81 was a small, wiry man full of anxiety, fear, and apprehension over his wife's impending death, after 56 years of marriage. He appeared to be very dependent on his wife and, although reluctant to admit it, he was very much concerned about how he was going to survive and fare after her demise. He was in a general high state of anxiety and could best be described as being distraught, depressed and agitated. The investigators decided that both the husband and wife should have the LSD experience at the same time. Consequently, each had one LSD session on the same day but were initially treated separately by two groups of therapists. The patients were thus physically separated, each having two to three therapists with them for approximately the first seven hours of the experience. Much of the husband's individual therapy work revolved around his dependency on his wife and his tremendous separation anxiety precipitated by her impending death. The wife basically worked through her defensive maneuver of withdrawing and of isolating herself from the emotional trauma of the separation and her fearfulness of dying.

After about seven hours of therapeutic work the couple were united and this was one of the most touching and dramatic scenes I have witnessed. Age had totally disappeared from both of them. He, the excited Romeo, approached his loved one with the ardour and anticipation of the innocent youth. She, Juliet, totally fascinated by her Romeo, opened her arms to him with that full acceptance so delicately needed by an unsure lover. It was as though their love for the first time was totally unencumbered. Each saw perfection in the other. They were young sweethearts, and as we discreetly left them in her boudoir, they became lost in each other's arms.

The sequelae to this treatment was most encouraging. She had again become involved with life because she had fallen in love again. His anxiety, fear and apprehension were gone. He became so enthralled with living life with his Juliet that fear became unknown to him. They lived a full and meaningful life for the next four months until she died. She had no fear of dying and he, no fear of her dying. He did not experience mourning because, as he said, he

did not feel that she was truly gone from him. His warmth, vivacity and ability to give remained, and he became involved with other human beings and lived in his "here and now." He was seen some three years later and still maintained this positive mood, a sense of fulfillment and an interest and involvement with life.

These cases dramatize the need for the establishment of some setting where people can come to do the work of dying—with dignity, nobility and an opportunity for fulfillment. Such a facility would be dedicated to the living—both for the individual who is in the process of dying and for those who care for and love him.

But what is it to die but to stand naked in the wind and to melt into the sun; and what is it to cease breathing but to free breath from its restless tide that it may rise and expand and seek God unencumbered; only when you drink from the river of silence shall you indeed sing; and when you have reached the mountain top you shall begin to climb; and when the earth shall claim your limbs, then shall you truly dance.—Gibran.

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