LSD 1455

Reprinted in Canada from
THE CANADIAN PSYCHIATRIC ASSOCIATION JOURNAL, Volume 11, Number 4, August, 1966.

LSD-25 AS AN ADJUNCT TO LONG-TERM PSYCHOTHERAPY*

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Introduction

To the list of the pathogenetic processes involved in the causation of medical illness, a new one was added towards the end of the nineteenth century. Freud, in psychological terms, and Pavlov, in physiological terms, added a pathogenetic process which for the sake of convenience we will call 'faulty learning'. They gradually began to understand the possible significance of learning, that is the incorporation of past, conscious or unconscious experience for the development of pathology in both voluntary and autonomous functioning of the organism.

In the meantime medicine gradually abandoned its oversimplifying obsession with one particular pathogenetic process in the aetiological consideration of a particular illness. This selective focusing with the omission of the incongruent was being exchanged for the assumption that any clinical syndrome is the result of a multiplicity of causes, in which case each cause can only be usefully considered in relation to the total set of causal factors.

In the light of these developments the medical specialty of psychiatry may now be considered to have two aspects:

1) In reference to all clinical syndromes in medicine: the study of one particular pathogenetic process, i.e. *Faulty Learning* (cf. bacteriology);
2) In reference to all pathogenetic processes in medicine: the study of one particular group of clinical syndromes, i.e. *Psychopathological syndromes* (cf. haematology).

This concept of the role of psychiatry within medicine permits us to view psychiatric therapy in general as follows:

1) In reference to the pathogenetic process of faulty learning:
   a) Blocking, suppression, inhibition of response;
   b) Modification of learning process (unlearning, re-learning);
   c) Combinations.
2) In reference to the psychopathological syndrome:
   a) Aetiologically oriented:
      (i) in reference to faulty learning (see sub (1))
      (ii) in reference to pathogenetic processes other than faulty learning;
   b) Symptomatically oriented;
   c) Combinations.

E.C.T., I.C.T., lobotomy, tranquillizers and antidepressants, metabolic agents, behavioural therapy and psychotherapy of whatever type or method, etc., all may be fitted into one or the other category of this scheme or in combinations thereof, according to the particular hypothesis of its active principle.

The author's interest in the pathogenetic process of faulty learning in the causation of illness in general, led him to the long-term use of the doctor/patient relationship for unlearning and relearning. The term 'long-term' does not necessarily refer to the duration of treatment but to the intention on the side of the therapist only to impose limits on the length of the sessions, not on the total number. The following represents a summary of some of the aspects of the psychotherapeutic process used:

Psychotherapeutic process (non-advisory, i.e. 'non-directive')

A. *Primarily on conscious level:*

1) *Educative — informative procedure* (*rationale* of procedures and adjuncts; explanation of expectations, cultural-social factors, models used, norms, etc.; training of methods, etc.);
2) *Psychedelic procedure* (with aid of free association, mirror-techniques, hypnosis p.r.n., etc.);

*Paper presented at the Fifteenth Annual Meeting, Canadian Psychiatric Association, Section on Psychotherapy; Halifax, N.S., June 18th, 1965.

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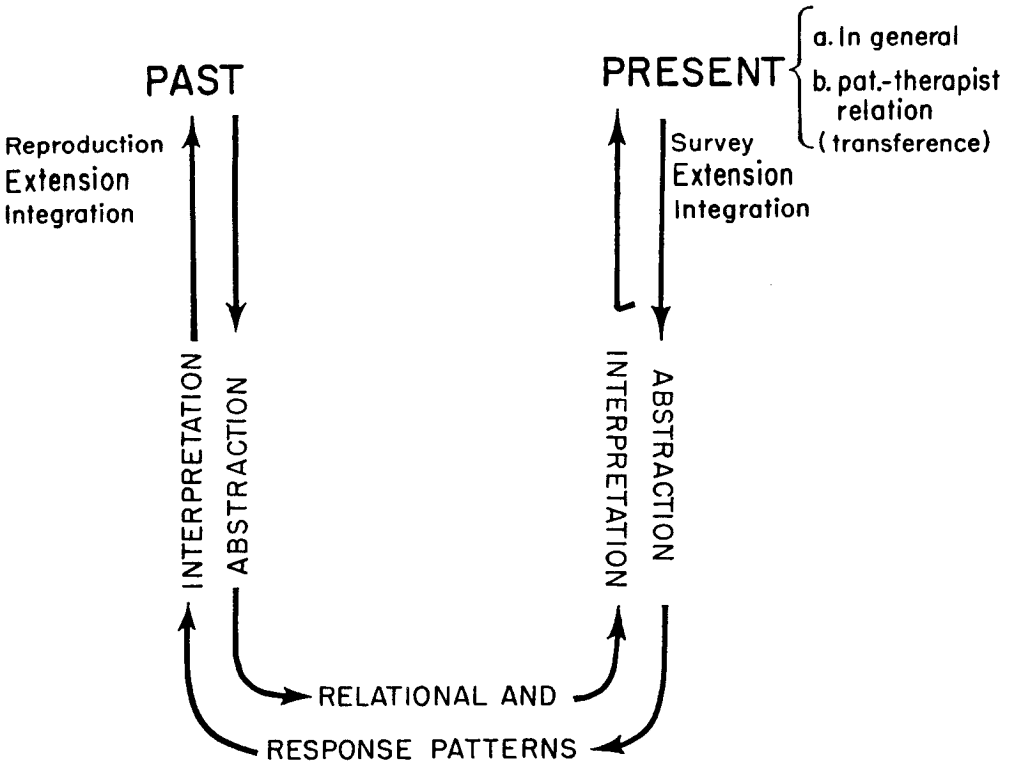

FIGURE 1

a) Exploration of primary process (dream study, etc.);
b) see Figure 1.

B. *Primarily on automatic (unconscious) levels*
3) *De-patterning of transference* (with or without secondary clarification: 'corrective emotional experience').

The educative-informative procedure, the psychedelic procedure and the de-patterning of transference do not occur in sequence but more or less in a parallel fashion. The educative-informative procedure makes use of the sectors of thinking, not involved in ego defence. The psychedelic procedure familiarizes the patient with the 'logic of the unconscious' and extends the awareness of the patient in reference to his past and present functioning, relating these to each other.

In due course, ego defences and transference patterns may grossly interfere with the psychedelic procedure, notwithstanding analysis and clarification of these therapy blocks. Tranquillizers and antidepressants may diminish this difficulty or facilitate the whole procedure from the beginning, and are administered if the patient does not consciously or unconsciously resist them. If the therapeutic block cannot be overcome, narcoanalysis with sodium amytal and with or without methylphenidate† may be used as an adjunct to the psychedelic procedure. This is not always successful or may only provide temporary progress.

In August, 1962, LSD-25 was introduced on an experimental basis as a possible adjunct to the psychedelic procedure where therapeutic blocks had developed which could not be overcome with narcoanalysis.

While it may or may not be true that LSD-25 interferes selectively with the sensory input, or that it may or may not increase *per se* the dream time of a patient etc., thus influencing his psychological

†Ritalin.

functioning, there is very little evidence to assume that LSD-25 primarily affects pathogenetic processes other than faulty learning, i.e. that its possible action would be through neurophysiological or chemical mechanisms unrelated to the learning process. Our assumption, therefore, has been that LSD-25 may act therapeutically through primarily providing a particular learning process due to a temporary modification of the learned responses and changed neurophysiological functioning.

The Clinical Assessment of LSD-25: General Considerations

One way of categorizing the current approaches in the clinical assessment of LSD-25 in psychiatric therapy may be as follows: (see Figure 2)

LSD-25 given:	as the 'only' procedure:	as part of a psychotherapeutic program:
According to diagnostic category:	1	3
Not according to diagnostic category:	2	4

FIGURE 2

A frequent approach has been to use LSD-25 'as the only procedure undertaken', assuming it to be the 'main treatment variable' and then relating it to a particular diagnostic category, for example, alcoholism. Among others, Dr. A. Hoffer followed this approach, concluding after a great deal of investigation by him and others and relating 'alcoholism' to 'LSD-25 as the main treatment variable', that there is no controversy within the medical literature about the usefulness of LSD-25 for alcoholics. Alcoholism, however, is not a uniform condition nor is the LSD-25 state. To correlate quantitatively the two abstractions 'LSD-25 state' and 'alcoholism' and to find a positive correlation only means that the administration of LSD-25 helped in some cases called 'alcoholism' but it does not mean that this positive correlation is due to the fact that the patient took alcohol or was subjected to LSD-25 *per se*.

We have suggested that the possible therapeutic benefit in relation to LSD-25 is likely to be due to the experiences or responses occurring during the LSD-25 session. These experiences or responses and, therefore the therapeutic outcome of an LSD-25 session, is dependent on the following factors:

1) *LSD-25 session — variables*:
   a) Experimental variables:
      i) Dosage and route of administration of LSD-25; length of the session, etc.
      ii) The presence or absence of personnel (familiar or unfamiliar, of same or different sex, age, etc), physical restriction, structured tasks, created expectations, the reactions of the environment (the dynamics of the therapist with or without counter-transference, with or without recognition of the dynamics of the patient, etc.) etc.
   b) Response variables:
      i) Genetic variables, physiological variations, cultural-social variables, etc.

ii) Personality patterns and, in general, previous life-experience including previous experience with LSD-25, with self, and with the therapist in therapy, etc.

2) *Variables influencing the dynamic response to the LSD-25 session*:
Whereas the LSD-25 experience during the session may be 'psychedelic', the question as to whether the patient is going to use this experience in a therapeutic fashion is further dependent on his over-all personality dynamics; there may be, immediately or later, for example, repression, or denial, or displacement, or, in the context of a particular transference relationship, the patient may try to bind the therapist by maintaining his symptoms, or there may be other factors contributing to a significant secondary gain in the illness interfering with the therapeutic use of the LSD-25 experience *per se*, etc.

The presence of all these variables determining whether LSD-25 sessions will have therapeutic value or not, suggests that for practical purposes there is no such thing as 'the LSD-25 state' which can be considered as 'the main treatment variable', or: whatever all the different sessions under LSD-25 have in common in different patients may not be what is therapeutically significant.

As we do not consider any of the current diagnostic groupings to represent homogenous conditions, our choice of experimental subjects was made on a different basis and was in general determined by our over-all treatment approach which I pointed to before and which now may be brought into the following scheme: (see Figure 3)

Every patient referred for psychiatric consultation has been considered in this light without reference to the diagnostic category or descriptive label. The group of patients who have received LSD-25 treatment is therefore a group which engaged in exploratory reconstructive psychotherapy with or without the aid of drugs of a symptom-reducing variety; early or late in the procedure therapeutic blocks developed and narcoanalysis was considered; this was either undertaken, in which case early in the process or later blocks appeared, or the narcoanalytic procedure was thought of as being contra-indicated, for example in cases of drug addiction or alcoholism. Finally, LSD-25 was undertaken when there were no realistic considerations holding the patient back, where there were no physical contra-indications such as heart failure, and where the therapist judged their ego weakness to be not too severe.

Under these circumstances 24 out of 614 patients who were referred for psychiatric consultation *via* the private office or *via* the Toronto General Hospital, came for treatment with LSD-25 between September, 1962 and May, 1965. The total number of LSD-25 sessions in this period was 56, for a total duration of 119¼ hours. The patients fell into two groups: Group A consisting of 15 private patients receiving LSD-25 as a part of the over-all treatment program by the author, and Group B consisting of nine patients where LSD-25 was administered by the author as a psychiatric consultant in cooperation with another psychiatrist. This may be summarized as follows:

The clinical investigation of LSD-25 (September, 1962 — May, 1965):
Total number of patients: 24
Group A: LSD-25 as part of investigator's program: 15 patients
Group B: LSD-25 as part of program with investigator as consultant: 9 patients
Number of LSD-25 sessions:
total: 56
per patient: 2-3 (range: 1-10)
Duration of LSD-25 sessions:
total: 119¼ hours
per patient: 2+ hours (range: 1½-3)

Some data pertaining to Group A and further illustrating the general use of LSD-25 within the over-all treatment program, are demonstrated in the following summaries:

Summary 1:
Group A: 15 patients
Number of contacts pre-LSD-25 (total number of contacts) n.a.: not applicable

		Exploratory therapy	
	With or without drugs:	With narcoanalysis:	With LSD-25:
Total for Group A:	394(847)	126(148)	n.a.(45)
Average:	26½(57½)	8½(9)	n.a.(3)
Range:	4(12)-46(66)	0(0)-29(29)	n.a.(1-10)

Summary 2:
Group A: 15 patients
Number of hours pre-LSD-25 (total number of hours) n.a.: not applicable

		Exploratory therapy	
	With or without drugs:	With narcoanalysis:	With LSD-25:
Total for Group A:	305¼(649½)	127½(149½)	n.a.(97)
Average:	20¼(43¼)	8½(10)	n.a.(6½)
Range:	3¼(6)-69¾(178¾)	0(0)-29(29)	n.a.(1¾-20½)

The Clinical Assessment of LSD-25: General Information about the Group of Experimental Subjects

The group of 24 patients subjected to the LSD-25 procedure showed the following general and clinical profile:

Section 1:

Age:	average: 32 range: 21-50
Sex:	male: 8 female: 16
Marital status:	single: 5 married: 18 divorced: 1
Religion:	Protestant: 20 Roman Catholic: 2 Jewish: 2
Country of Birth:	Canada: 16 Fr. Canada: 1 U.K.: 4 Germany: 1 Holland: 2

Section 2:

Diagnostic labels:

Chronic anxiety state:		11
non-specified:	1	
with cardiac neurosis:	3	
with alcoholism:	2	
with alcohol and drug addiction:	2	
with hypochondriasis:	1	
with depression:	1	
with profuse sweating:	1	
Phobic state:		1
Conversion syndrome:		5
dysphagia:	1	
blindness:	1	
temper tantrums:	2	
grand hysteria:	1	
Neurotic depression:		5
acute:	1	
subacute:	2	
chronic:	1	
with alcoholism:	1	
Obsessive compulsive neurosis:		1
Sexual perversion:		1

Section 3:

A. Length of illness: average : ± 8 years
range: acute (with 3 previous episodes) -38 years

B. Length of psychiatric care preceding present treatment program:
13 patients: average: ± 2 years
range: 4 months—11 years
3 patients: previously seen by psychiatrist
8 patients: no previous contact with psychiatrist

C. Referral source of 15 Group A patients:
By psychiatrist: 7
Other: 8 (3 had previous contact with psychiatrist)

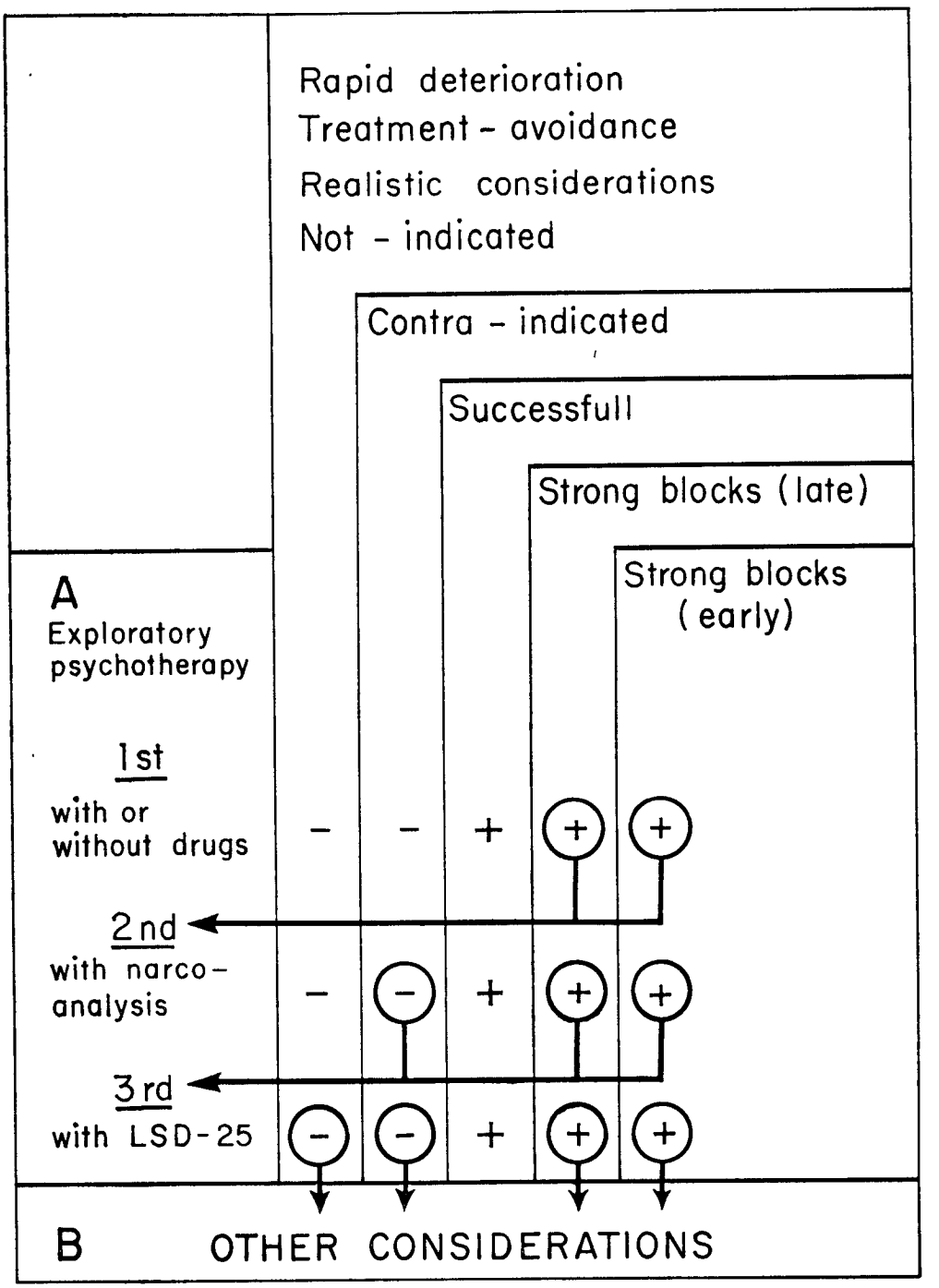
Rapid deterioration
Treatment - avoidance
Realistic considerations
Not - indicated
Contra - indicated
Successfull
Strong blocks (late)
Strong blocks (early)
A
Exploratory psychotherapy
1st
with or without drugs
2nd
with narco-analysis
3rd
with LSD-25
B
OTHER CONSIDERATIONS

FIGURE 3

It should be noted that almost all of these patients were suffering from disabling long-standing psychiatric difficulties. Two-thirds had been in contact with a psychiatrist previously: more than half underwent previous treatment with other psychiatrists, averaging about two years. Almost half of the patients referred to the author for treatment were referred by psychiatric colleagues.

LSD-25 Sessions: Procedures

Some of the significant practical points involved in the LSD-25 procedure are outlined in the following:

1) Information of patient by therapist
2) Consent for each session
3) Tranquillizers discontinued 48 hours previously
4) Sedative night before; nothing orally after midnight
5) Session initiated ± 8.00 a.m. by intramuscular injection of LSD-25 by therapist; lasting from 1½ to 3 hours with therapist being present; terminated with intramuscular chlorpromazine†† (200 mg.); therapist leaves within ± 15 minutes
6) One female R.N. present during session and until midnight; other personnel allowed with permission
7) Verbal record of session kept; patient encouraged to write down his experience as soon as possible
8) Food intake permitted during and following session as wished
9) Night-time sedation following session; other medication started p.r.n.
10) Follow-up interview next morning with therapist.

A significant variable is involvement in the preceding therapeutic process. This involves the informative-educative procedure dealing with the patient's expectations of LSD-25 and, hopefully, motivating him to tolerate the new experience as the rationale is known. He is informed about the approximate length of the session, the way of its initiation and termination, the fact that the therapist and others will be present and that the therapist will leave at the end with an R.N. remaining in attendance until midnight. Any tendency to dramatize the situation is antagonized. It also involves significantly the patient's experience with self during the previous psychedelic procedure, i.e. the presence and meaning of certain conflicts and emotions, his ego defences and transference mechanisms, etc. Transference mechanisms have frequently had a chance to develop and may have been interpreted already. The general approach and reactions of the therapist are known to the patient.

The sessions all took place in the Private Section of the Toronto General Hospital and where possible in the patient's own room or on his own floor, so that he was usually in familiar surroundings. He was exposed to as little strong stimulation as possible (visual and auditory), except when continuously repetitive behaviour occurred. In the later phases of our investigation softly playing music was introduced.

A female person was always present during the session, usually a registered nurse, sometimes a female social worker or a female intern. Others might be present with the previous permission of the patient, but were usually kept out of his field of vision.

Although in the first few sessions undertaken with LSD-25 a mild restraint was applied, this was omitted later and the patient was allowed a relatively full freedom of action. He was permitted to leave his bed, move through the room, yell if he so desired, etc. Some acting out towards the therapist and his female assistant was permitted, i.e. touching, holding hands, mild aggressive behaviour, etc. The patient was allowed to eat or drink or smoke, but he was not allowed to leave the room during the session or until midnight following the session. No structured tasks were imposed except occasionally when this seemed to be indicated for dynamic reasons, e.g. one patient was encouraged to 'smash a plastic glass', another to take food. The patient was mildly encouraged to communicate his experiences but not forced or pressed. He was informed about the remaining length of the session if this was asked.

††Largactil.

Following two occasions on which the patient mistook the terminating injection of chlorpromazine for more LSD-25, the syringe with chlorpromazine in subsequent sessions was identified at the beginning of the session and placed where it would be visible to him.

The intramuscular dosage of LSD-25 was as follows:

56 sessions
Average: 369 micrograms
Range: 200 - 1000 micrograms

The minimum dosage of 200 micrograms was determined arbitrarily. Higher dosages were administered when the illness was complicated by drug addiction and/or alcoholism, when previous sessions had been unsuccessful, and when strong therapeutic blocks under narcoanalysis were evident. The maximum length per session of three hours was determined by the amount of time available to the therapist; the minimum duration was one hour as this was assumed to be the minimum length of time necessary for LSD-25 to develop its maximum action when administered intramuscularly. Within these limits the session was interrupted when it was judged that the responses of the patient had become repetitive.

LSD-25 Sessions: General Observations

Very little uniformity between the 56 LSD-25 sessions was noted; on the contrary, there was an extreme variability between one session and another, though it should be stated that the sessions were usually quiet. Only three patients left their beds: one acted out her agitation and the regressive reliving of her conflict; another continuously 'rolled out of bed', wanting to sit on the floor, expressing her sense of fainting; one patient left his bed at the end of the session in order to avoid the chlorpromazine†† injection which he mistook for more LSD-25. This patient tried to escape through the window, and had to be restrained, but apart from this no self-destructive tendencies were witnessed during the sessions. Mild physical violence occurred in this case. A similar though milder reaction was seen in one other patient, and one patient hit out at the experimenter when he tried to touch her throat for psychodynamic reasons. Screaming took place in only one of our 56 sessions. Vomiting or gagging occurred not infrequently for short periods. On a few occasions it was rather continuous, necessitating the injection of dimenhydrinate*. Sometimes vomiting had a clear symbolic significance; at other times such meaning could not be detected.

The mental status of the patients usually showed fluctuations evidencing increased and then decreased reality orientation and insight into the experimental nature of the situation, though this was sometimes rather constant. Different degrees of anxiety occurred in relation to inner experiences or distortions of the environment; startle reactions were sometimes present. At other times the patients were quite emotionally detached from the experiences. Intense hostility, satisfaction or extreme pleasure were also observed. The perceptual process varied extremely within one session or in one session as compared with another from normality, to distortion, to visions with insight, to hallucinatory experiences which were acted out (though this was rather rare). Thought processes varied from normal to mild loosening to complete incoherence. They were sometimes speeded up, in other cases frozen in an obsessional way; again, at other times quite normal. The communication of experiences was occasionally fairly complete, at other times spotty or almost lacking. The full extent of the psychedelic experience could, therefore, be only judged the next day, although at that time ego defences sometimes had taken over and repression was partial or fairly complete.

The psychedelic experience in itself also varied widely from one patient to an-

*Gravol.

other in scope and variation. The assumption that LSD-25 provides 'Instant Zen' or 'Instant Analysis' was in our hands and with our approach and methodology not supported in any of the 24 patients and 56 sessions.

Some sessions were characterized by one particular personality feature (which was previously known) being obsessively kept in focus, such as the fear for the loss of decorum or the loss of control, or the continuous verbalization of an exaggerated sense of insufficiency or fear to be abandoned. In other sessions nothing but meaningless forms and shapes were experienced. Some patients avoided any meaningful experience by an ongoing obsession, for example with the question whether a particular object in the room was real or hallucinated, or by continuously insisting that a particular person should be present, or by a persistent focusing on bodily feelings perceived during the session and the description thereof. One patient's only experience during the session was a crying spell of two hours, for which he later could not account. Another patient's only production was the continuous expression of a satisfaction that she could say whatever she wanted, without actually saying anything else.

On the other end of the continuum patients realized and, to a certain extent acted out, an entirely hitherto unknown side of their personality; others relived many meaningful past experiences through which they became aware of conflicts present within their personality. Sometimes past experiences which until then were not connected with each other were relived and realized as an integrated whole. Infrequently the meaning of symptoms was concretely realized: a back pain became the mother's unwillingness to let the patient relax; in the case with dysphagia the hand of the father on the throat of the patient was seen as preventing her from swallowing; a headache was seen as a vice keeping the patient's emotions under control. Transference phenomena also were experienced concretely, though infrequently, and acted out with the nurse representing a punishing or rejecting mother, or the therapist appearing as a devilish father or a sexual love object with paternal features or both. The psychedelic experiences as a whole varied from the very limited to the fairly extensive.

LSD-25 Sessions: Therapeutic Outcome

If, in the judgment of the author, the LSD-25 procedure seems to have been instrumental in bringing about a therapeutic breakthrough which was sustained during an adequate follow-up period, the procedure is judged to have been 'successful'. 'Adequate' remains in this respect a relative concept. 'Successful' does not necessarily imply discharge from treatment, but it may mean that ego defences and/or transference blocks interfering with further reconstructive exploratory work have been overcome for the time being. In this respect the following results were obtained:

Section 1:

A) Successful (sufficient follow-up):	5 patients
Disposal:	
Continued exploratory therapy:	1 patient
Discharged:	4 patients
B) Possibly successful (insufficient follow-up)	2 patients
Disposal:	
Continued exploratory therapy:	1 patient
Simple follow-up	1 patient
C) Initially successful with gradual relapse:	2 patients
Disposal:	
Discharged:	1 patient
Transferred to Psych. Hosp.:	1 patient
D) Successful with immediate relapse:	3 patients
Disposal:	
Discharged:	2 patients
Supportive therapy:	1 patient
E) Immediate blocking to LSD-25 treatment:	12 patients
Disposal:	
Discharged:	4 patients
Transferred to Psych. Hosp.:	1 patient
Supportive therapy:	7 patients
	1 remission
	2 improving
	4 unchanged

Section 2:

Disposal of patients with LSD-25 treatment: 24

Discharged:	11	patients
	4	successful
	7	failures
Continued exploratory psychotherapy:	2	patients
	1	successful
	1	? successful
Simple follow-up:	1	patient
	1	? successful
Supportive therapy:	8	patients
	1	remission
	2	improving
	5	unchanged
Transferred to a Psych. Hosp.:	2	patients

Discussion

The most simple set of expectations as to the therapeutic value of LSD-25 was that, if successful, it would lead to the temporary neutralization of ego defences and transference blocks, thus providing the patient with a psychedelic experience which would be incorporated consciously, making previously unconscious functioning accessible to voluntary control with either a cure or a breakthrough in therapy. This seemed to have been the case in three, possibly four, patients. In the case that LSD-25 would not be successful it would be unable to overcome the ego defences and/or transference blocks, without improvement in the patient's condition. This seemed to occur in about ten patients who showed obsessional preoccupation with the maintenance of control, the reality or unreality of an object, the increase of bodily symptomatology or the projection of threatening feelings, or they experienced meaningless shapes and forms. The repression of significant unconscious material which the therapist would like to become part of the psychedelic experience, is rarely lifted.

In a number of patients, however, the situation was not simply of the either/or variety. In two patients an extensive psychedelic experience took place, followed by what seemed to be changes into the direction of a cure lasting for many months; then, however, decompensation again took place with a return to the previous condition. We assumed that in one case hostile transference leading to attemps to defeat the therapist, overrode the gain of improved functioning, and in the other the secondary gains of illness seemed to be greater than the benefit from increased adjustment.

In two or three patients we saw extensive psychedelic experiences which either immediately following the session, or after a few days, were dealt with in their usual way by the very ego defences and transference mechanisms which the therapist had tried to overcome with LSD-25. The usual motives for ego defence as well as transference blocks and secondary gain involved in symptoms, all seemed to play a role in this process.

Somewhat more difficult to understand is why an LSD-25 session without any significant psychedelic experience would lead to even slight and temporary improvement even of a transient nature, as we saw in at least three patients whom however, we did not include under the successful cases. It may be that the great amount of attention had some non-specific supportive value, or that the LSD-25 procedure had some non-specific 'shock value' notwithstanding the preceding therapeutic experience.

Two patients puzzled us most. Both had hardly any significant psychedelic experience, yet both showed dramatic changes in behaviour. One patient, for example, who had been suffering from grand hysteria in the form of hallucinatory spells and seizures for a number of years, and who was treated with intensive psychotherapy, including hypnosis, frequent hospitalizations, E.C.T., etc., went through the first session of about two hours only repetitively and perseveratingly stating "I can say anything I like". Following the first session she experienced a detachment from her past traumatic experiences, and although the following two sessions were exact replicas of the first one, the detachment increased and her seizures completely disappeared. The

session was experienced as neither pleasurable nor unpleasurable: the improvement was maintained. It was unlikely that the patient had reached a stage in which the symptoms had lost their dynamic significance as she had been continuously under treatment until the institution of our own treatment program, the last preceding treatment procedure including extensive use of hypnosis. Another patient who during the session only experienced obsessional concern with increased bodily symptomatology could suddenly realize afterwards that the whole treatment procedure preceding the LSD-25 session and and particularly including the interpretation made by the therapist 'made sense'; he proceeded to make decisive changes in his life which until then he had been unable to execute and all this with disappearance of symptomatology.

While there was, in summary, sometimes a correlation between the wealth of the psychedelic experience and the therapeutic benefit thereof, this was far from always the case.

It was impossible to predict the outcome of the LSD experience on the basis of the session itself, or even on the basis of the first days or weeks following the session. Furthermore, our predictions as to what would happen in the session, and as to the outcome of the treatment with LSD-25 on the basis of our often considerable experience with the dynamics of the patient, were almost consistently out of step with the actual course of events. Though LSD-25 obviously was of considerable benefit in certain cases it remained an unpredictable variable within our treatment program. On the other hand, LSD-25 within the over-all matrix of our treatment program does not seem to have had any untoward psychodynamic effects to date. It must, however, be stated that LSD-25 was not administered indiscriminately or in a random fashion, but rather the patient reaching the stage was carefully selected according to our previously outlined treatment philosophy.

One possible exception was a female patient who six hours following the termination of the LSD-25 session escaped supervision and jumped out of a window, fortunately without fatal consequences and with a good recovery. Every possible gap in the supervision of the patients following LSD-25 sessions was filled following this incident. The patient had made several serious attempts on her life before the institution of our treatment program; six months later her mental condition was judged to be unchanged from her condition at the beginning and she had made yet another serious suicide attempt.

Apart from this incident we were not unduly impressed with the increase of suicidal tendencies under the influence of LSD-25. Our experience in this respect is demonstrated in the following summary:

Suicidal attempts previous to present treatment program: 6 patients.

Suicidal attempts as reason for initial consultation in hospital: 4 patients.

Suicidal preoccupations at initiation of treatment program: 10 patients.

Suicidal preoccupations acted out during treatment program, but previous to LSD-25: 4 patients.

Suicidal attempts during LSD-25 sessions: 1 patient (?).

Suicidal attempts within 12 hours following the injection of LSD-25: 1 patient.

The serial use of LSD-25 sessions did not deliver consistent results, nor did the concomitant increase in dosage. Sessions were always spaced at least four days apart, but usually one week or longer. In one patient who exhibited a poverty of psychedelic experience, no change in this pattern was observed in a series of ten sessions with increasing dosages. The addition of intravenous methylphenidate† or sodium amytal in the last sessions did not change this situation. In another patient the benefit of the experience seemed to increase with following sessions though the experience itself remained limited, whereas in a third patient the productivity and neutralization of ego defences in the earlier session was fol-

lowed in later sessions by a poverty of experience with the domination of ego defences.

It should be noted that in all patients the therapist's insight into the dynamics of the patients was considerably increased by the LSD-25 procedure, though unfortunately this could far from always be translated into therapeutic benefit. Furthermore it should be stated that the teaching value of LSD-25 exceeds its therapeutic value. Nevertheless, though LSD-25 remained as an adjunct in the therapy of this predominantly chronic and seriously disabled group of patients unpredictable as to its therapeutic value, the fact that in this group of 24 patients the sessions seemed to have been successful in five patients, possibly successful in two and temporarily successful in two, leads us to conclude that this chemical compound, used as an adjunct in the present treatment program, is worthy of further exploration.

Summary

The author describes his experience with LSD-25 as an adjunct to long-term psychotherapy in 24 patients between September, 1962 and May, 1965, involving a total of 56 LSD-25 sessions for a total duration of 119¼ hours. Where therapy blocks developed which could not be overcome, narcoanalysis with or without methylphenidate† was used and if this was not successful LSD-25 was considered. The 24 experimental subjects were almost all suffering from disabling and long-standing psychiatric difficulties. In five out of 24 patients LSD-25 did seem to help the patient to overcome therapeutic blocks successfully; five patients showed only temporary movement and relapsed; 12 patients showed no therapeutic movement whatsoever; in two patients the follow-up was insufficient. There was no stable correlation between the extent of the psychedelic experience and the amount of therapeutic benefit. The events of the LSD-25 sessions could not be predicted on the basis of pre-LSD-25 experience with the patient, nor could the therapeutic outcome of the LSD-25 sessions be predicted on the basis of the session itself, or even on the basis of the first days or weeks following the session. LSD-25 appeared as a sometimes helpful though usually unpredictable treatment variable within the over-all treatment program. When introduced as an adjunct late in the treatment procedure it did not seem to have any untoward psychodynamic effects and no undue increase in suicidal tendencies was noted. The therapist's insight into the patient's dynamics was always increased, though this could far from always be translated into therapeutic benefit.

Résumé

L'auteur décrit l'expérience qu'il a faite en se servant du LSD-25 comme adjuvant de la psychothérapie à long terme, introduit assez tardivement dans le programme de traitement. Les tranquillisants, les antidéprimants et(ou) les calmants ont été employés dès le début s'ils étaient acceptés et n'étaient pas contre-indiqués. Lorsque les défenses du moi et les modèles de transférence intervenaient d'une façon grossière ou persistente en dépit de l'analyse et de la clarification, la narcoanalyse au moyen de l'amytal de sodium avec ou sans méthylphénidate fut instituée; en cas d'échec, on avait enfin recours au LSD-25.

Ainsi, 24 malades sur 614 envoyés à une consultation psychiatrique ont reçu du LSD-25 entre septembre 1962 et mai 1965, ce qui a représenté en tout 56 séance au LSD-25, d'une durée totale de 119 heures et quart. Les 24 sujets de l'expérience souffraient presque tous de troubles mentaux invalidants d'origine lointaine. Leurs antécédents, les diagnostics posés, la durée de la maladie et les soins psychiatriques antérieurs font l'objet de mentions. Le rôle du LSD-25 dans le programme global de traitement est illustré au moyen de quelques statistiques simplifiées.

Quelques-unes des variables qu'ont comportées l'emploi du LSD-25 et le résultat thérapeutique sont exposés dans

l'article. On examine d'un oeil critique la supposition que *l'état de LSD-25* puisse être considéré comme la principale variable du traitement qui soit rattachable aux diagnostics actuels, d'une façon significative. L'auteur expose la façon dont il a employé le LSD-25 et il fait quelques observations générales sur les séances d'administration de LSD-25. On a constaté bien peu d'uniformité dans les 36 séances. L'expérience psychéidélique même a également beaucoup varié d'un malade à l'autre tant en ce qui regarde la portée que les différences.

Chez 5 des 24 malades, le LSD-25 a semblé aider le malade à surmonter les blocs thérapeutiques avec succès; cinq malades n'ont manifesé qu'un mouvement provisoire et ont fait une rechute; douze malades n'ont manifesté aucune réaction thérapeutique; chez deux malades, l'observation ultérieure a été insuffisante. La supposition que le LSD-25 offre une "analyse immédiate" n'a été appuyée chez aucun des 24 sujets ni durant aucune des 56 séances. Il n'y a pas eu de corrélation stable entre l'importance de l'expérience psychéidélique et la somme d'avantages thérapeutiques. Les événements des séances au LSD-25 ne pouvaient être prédits en se fondant sur l'expérience antérieure à l'administration de LSD-25 au malade, non plus qu'on ne pouvait prédire le résultat des séances sur la base de la séance même ou même sur la base des premiers jours ou des premières semaines suivant la séance. Le LSD-25 s'est parfois révélé un outil utile mais ordinairement une variable imprévisible au sein du programme global de traitement. Lorsqu'on l'a introduit tard au cours du traitement, il n'a pas semblé avoir quelque effet psychodynamique et on n'a constaté aucune augmentation des tendances au suicide. Il ne faut pas oublier cependant que le LSD-25 n'a pas été administré sans discernement ou au hasard, mais que les malades ont été soigneusement choisis en raison de la philosophie particulière de traitement.

L'emploi en série des séances d'administration de LSD-25 n'a pas donné de résultats constants ni d'augmentation concomitante de la dose. Dans tous les cas, le thérapeute a pu mieux comprendre la dynamique du malade bien que cela ne pouvait toujours se traduire, loin de là, par un avantage thérapeutique. Les séances d'administration de LSD-25 se sont révélées une aide utile à l'enseignement.