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Psychedelic Drugs as Therapeutic Agents

By Kenneth E. Godfrey, M.D.

At this symposium we have studied many of the intriguing aspects of psychedelic drugs. This panel is dedicated to the discussion of clinical applications, specifically the use of psychedelic drugs, as an adjunct to psychotherapy and as a treatment of alcoholism.

In our discussion of evaluation there is a point concerning psychedelic drugs and their uses that we need to define clearly, so as to avoid traps which tend to interfere with communication and understanding. We must, as with any other drug, clearly separate the medical uses from the illicit use of these drugs. Psychedelic drug use is either illicit or medical, hedonistic or treatment oriented. Our discussion today concerns the medical or treatment uses of these drugs, with the goal of helping patients, independent of diagnostic categories. Diagnostic categories may sometimes be helpful, but often enough categorizing carries certain liabilities.

The illicit users of hallucinogenic drugs are referred to by many names, such as: hippy, flower-child, schizophrenic, sociopath, etc. Used in this context, these names usually connote disapproval. The use of terms like these as generalizations with reference to the illicit users of psychedelic drugs is not only inaccurate, but tends to widen the gap between the "establishment" and the drug user, and communication between professional clinicians and investigators and a significant segment of our society becomes even more difficult. I am not referring here to the appropriate use of diagnostic terms in clinical situations, but to inappropriate generalizations which take the form of name-calling. The general use of derogatory terms in association with drug use not only aids in the alienation of the users from the non-users, but even casts a shadow of suspicion upon the legitimate medical use of these drugs and upon serious and potentially important medical research.

Psychedelic Therapy

The Topeka V.A. Hospital LSD treatment program for alcoholics began in 1963, and was designed as a 90-day program, in which 20 or 21 alcoholics were treated during each 90-day period. After slightly over two years the program was reduced to 60 days, and was incorporated with a Human Relations Laboratory program. LSD was used in the middle of the 60-day program. A year later the use of LSD in that program was discontinued and at that time I was given the opportunity to design a new program using LSD treatment.

In our new LSD program the total treatment period has been reduced to 26 days, and the size of the treatment group to between 5 and 10 patients. The patients come in on a Monday, are examined physically and psychiatrically, take psychological tests, and begin group psychotherapy, occupational therapy, bibliotherapy and orientation for their LSD experiences. On Monday of the second week, with the en-

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tire group assembled, each patient is given 50 mcg. of LSD. This is done as a group procedure to help allay fear and to "jell" the patients as a group. On the third Monday and Tuesday we give each patient 500 mcg. of LSD, in his own treatment room, and in the presence of his own therapists. Following this LSD experience each patient is asked to paint in a free associative way, to speak about his experience, and to write out that experience. An attempt is made to help him integrate whatever insights he has obtained. On the following weekend, the patient is allowed to go home and return the following afternoon with his significant relatives, to attend a 4 hour workshop. For the first hour the patients show their relatives around the hospital, particularly demonstrating the areas where they were treated. In the second hour there is a meeting of the treatment personnel with the patients and their visitors. At this meeting the program is explained to the visitors, clarifying for them the way in which LSD is used as a therapeutic agent. During the third hour, the treatment personnel meet with the visitors alone and discuss alcoholism and the part the family plays in the problem. The alcoholic "game," and its problems are discussed. Then, in the fourth hour, the patients and their visitors meet together with the treatment personnel to begin planning for the patient's discharge on the following Friday. The patients return to the hospital for follow-up study at 4, 12 and 24 months from the date of discharge.

On two year follow-up of the first two years of our treatment program (that is, of the 90-day program) results were: 25% abstinent and much improved, 25% much improved in the other areas of life, 25% slightly improved, and 25% no better or worse.

In contrast to the non-medical user, those who are given the drug in a medical setting are called either patients or subjects, and are often further identified by a diagnostic classification. This is difficult to avoid, but in the treatment setting also, generalizing, categorizing people as "types" and speaking of patients as diagnostic objects often has a negative effect, placing the treatment process within an atmosphere of pre-conceived pessimism.

Since our aim is to become more therapeutic, I believe we should keep in mind the law of the self-fulfilling prophecy: Once a prophecy has been made, it is that much more likely to occur. This is probably because we then tend, both consciously and unconsciously, to give that prophecy our support in becoming a reality. At least we are not as likely to accept failure prematurely, and we are not as likely to introduce a negative bias into the dynamics of the treatment situation. We can use this awareness to point towards success, rather than failure, I believe.*

I have been working in the area of experimentation with psychedelic drugs in psychiatric treatment since 1963, at which time we began treating alcoholic patients at Topeka V.A. Hospital, using an LSD experience in the middle of a 90-day pro-

*Ed. Note: Many researchers with psychedelic drugs as therapeutic agents (including some of the speakers at this symposium) have noted that suggestion may play a significant part in the therapeutic process, and have considered the attitude of the therapist concerning the possible therapeutic potential of the drug to be an important factor in the effectiveness of treatment. It may be that this consideration is more applicable to some forms of treatment and less to others, but it seems generally to be the impression of experimenters with these drugs that a negative attitude has a negative influence on treatment situations in which LSD is used.

gram as one of the modalities of treatment. Since that time we have treated about 400 individuals and have given the drug between 600 and 700 times with little or no lasting adverse effects. In fact, we have seen only four experiences which we thought should be stopped or interfered with through the administration of Chlorpromazine. However, if we had it to do again we probably would not have stopped any of them.

We began using this drug after reading publications about its use in the treatment of alcoholism. It was not until I had visited Drs. Unger and Osmond, at the suggestion of Dr. Abraham Hoffer, that I really learned about giving the drug to patients. I am certainly thankful to these men for the help they gave me.

Our alcoholism therapy group had set aside the latter two weeks of May and June, 1964, to administer LSD to all treatment personnel. However, at the 1964 APA convention the situation at Harvard was a central point of interest, fear, and warnings. Because of the problems surrounding the utilization of the drug by professionals, our plans to personally take the drug were interdicted. We feel we lost something by not taking LSD, but also believe we gained something. We feel that when one works closely with patients taking LSD, and observes well, one can learn to do excellent therapy with LSD without having personally undergone the psychedelic experience.

Since that time we have used the drug also as an adjunct to psychoanalytically oriented psychotherapy. One of the previous speakers has mentioned adverse reactions during the first year of his program. I can't help wondering why we didn't have these adverse reactions, especially in the first 6 months of our work. It may have been because we were using hypnosis with the groups, to see if we could use suggestability as a screening test for those who were to get psychedelic therapy. Contrary to our hypothesis, we found that people who had a "good" reaction to LSD were subsequently good hypnotic subjects, while those having psychotomimetic reactions were very poor hypnotic subjects.

When one attempts to evaluate any method of psychotherapy he inevitably finds himself in a very difficult situation. One has difficulty demonstrating the qualitative as well as the quantitative changes wrought by psychotherapy. There are those who state that psychotherapy has never been proved to have cured or helped any emotionally ill person beyond what might be accounted for by pure chance. The difficulties of measuring change in emotional illness, have to do with the inability to assign relevant numbers, such as are used in measuring concrete objects or as are assigned even to some psychological tests.

Even though we may utilize psychological tests and attempt to quantify the different manifestations of change in emotional illness, no test or group of tests provides a complete measurement. We still must take into account factors unaccounted for in our measuring devices, such as time, function and the environment. Regarding time, we must be able to show that a former patient has, over a certain period, not manifested signs and symptoms of his illness in a demonstrable way. We must also show how he functions in his different roles in society, i.e., as employee, employer, father, husband, citizen, etc., and not simply how he functions on a particular group of tests. The environment in which the person functions, over a given period of time, is also important. An alcoholic in the environment of a jail or

a closed hospital situation, away from any source of alcohol, cannot practice alcoholism. Of course even this may be uncertain, since alcoholics tend to be most adept at smuggling alcohol into prisons and hospitals. Another example is that of an obese, neurotic, woman patient, who during psychotherapy lost weight and also divorced her husband. Her psychological tests showed positive changes. Her therapy was terminated after her weight returned to normal and she had gained "insight" into her emotional life, for which she was extremely grateful. She functioned beautifully in the business world for 20 months, but when she returned for follow-up she had regained her weight, and was anxious and inefficient in her personal life. Her psychological test results had returned to what they had been at her pre-treatment evaluation. It was noted that once again she had a man in her life whom she intended to marry. As long as her environment did not include involvement with a man she had functioned well. As soon as she became emotionally involved with a man her symptoms returned even though she had gained "insight."

We who have worked with the psychedelic drugs as therapeutic tools in psychotherapy, agree that the psychological set of the treatment personnel and the patient, plus the environment or setting in which the treatment is conducted, strongly influence or even dictate the reaction to the drug. One must look at the complete treatment program, including the functioning of both the personnel and patients, to know the psychological set. It is perhaps not possible to accurately evaluate a drug treatment program without observing and evaluating the aforementioned factors, plus a number of others (e.g., the administered dose of the drug, the illness for which the drug is given, how often it is given and over how long a period).

Nevertheless, the final test of such programs rests with the follow-up evaluation of the patients who either were or are still being treated. The following rating scale is used by our research social worker to assess the success or failure of alcoholic patients treated in our program. We measure or evaluate the following points: Abstinent six months or more: 1 point. Abstinent eleven or twelve months: 1 additional point. Employed six months or more: 1 point. Employed eleven or twelve months: 1 additional point. Belonging to a social organization: 1 point. No trouble with the police or courts: 1 point. No DTs or convulsions: 1 point. No subsequent hospitalization: 1 point.

Scores are then broken down into the following classifications: Good adjustment: 6-8 points. Fair adjustment: 3-5 points. Poor adjustment: 0-2 points.

In an informal check of the validity of this scale, agreement was obtained between scale ratings and the social worker's subjective impression of adjustment.

Each center usually has its own point system, which is correlated with certain conditions and variables. Much of our information as to the results of psychedelic therapy comes from subjective reports by the patients treated, and pertains to their individual drug experiences and consequent outlook on life. In evaluating these data we may use a point scale to assess change. There tends to be good correlation on these scales when scored by different judges. However, since these point ratings are subjective variables, it is imperative that we find correlations with more objective tests.

We have found that the results of projective tests, as well as those of the

personality inventories, have a tendency to change after psychedelic experiences, and in many instances remain changed. Again, however, we must assess these changes with reference to time, function and environment. During psychedelic therapy, as a guide to the progress of the patient one may use the same clinical criteria which are used in the analytic therapies (depth of regression, character of the transference, capability for utilizing insights, etc.) However, even though the process, when evaluated in this way, may appear to have provided stable, therapeutic changes, one may still find that when the patient returns again to his previous environment he may be unable to control himself or retain adequate ego strength for more than a brief period.

Psycholytic Therapy

One therapeutic method used to treat neurotic illnesses and some psychoses is the employment of LSD as an adjunct to psychoanalytically oriented psychotherapy. This method has been used by a number of men both in Europe and America. Ling and Buckman in England, Grof (formerly of Czechoslovakia) and Leuner were the first to use LSD as an adjunct to psychoanalytically oriented psychotherapy in Western Europe, beginning in 1956. They were soon followed by a number of colleagues, notably Arendsen-Hein, Hertz, Gordon Johnson and others. In the United States Clay Dahlberg, Harold Abrahamson and myself, among others, have utilized LSD with psychoanalytically oriented psychotherapy.

In evaluating the on-going treatment process in this type of treatment, the therapist must depend upon the usual psychoanalytic criteria for determining the status of the transference, resistances, ego-functions and progress of the patient in resolving intrapsychic conflict. However, our primary concern here is with the evaluation of final results when psychedelic drugs are used in treatment.

A number of psychological tests may be given before and after therapy for comparison, and judgments may be made concerning the patient's activities and relationships. Finally, the collected data of the pre-post treatment assessments may be judged to represent a certain level of progress and may be scored. Leuner, for instance, reported his results by utilizing the categories "cured," "substantially or greatly improved, slightly improved," and "unimproved." We have as yet no system of judging results which is irrefutable nor even sufficiently reliable to permit any complacency about results.

At our hospital we have treated 14 individual patients with varying results over the last 14 years. I have personally treated four patients with LSD, two of whom are still in treatment. The first patient I treated was a 26-year-old jet fighter pilot who had a "break with reality" in May, 1964. After six months in an armed service psychiatric hospital he was placed on temporary, total disability with a diagnosis of schizophrenic reaction, schizo-affective type. His request to come to our hospital was granted and therapy was begun shortly after he arrived. After nine months of intensive psychotherapy and 13 experiences with LSD (generally at two-weeks intervals), the patient was discharged, obtained a job as an industrial engineer, and bought a new home. This was just before his wife gave birth to a third child, a normal boy. He has functioned well for more than three years. The psychotherapy was conducted along psychoanalytic lines. Strong resistance was encountered until the 9th LSD experience. During that experience he was able to accept manhood,

make peace with his dead father and become free from guilt derived from repressed feelings towards his mother. Dr. Harold Voth and I have submitted a paper elsewhere for publication analyzing the process of the LSD experience and the therapy hours of this patient.

The second patient had been ill since 1950, and was addicted to several drugs. He had lost his professional license. After just over a year of therapy and 28 LSD experiences he returned to his professional work and continued it without resorting to self-use of drugs, until an instance to be described shortly. The nodal points of his therapeutic process were (1) an experience following LSD, of "climbing a lightning-bolt ladder to God". This seemed to provide him the beginnings of a sense of self-esteem, which enabled him to feel *he* was worth the effort it would take to get well. (2) He soon came to perceive me as speaking to him in other than an accussatory way. (3) He dreamed of having intercourse with women, with encouragement from his father. (4) He was at peace with his parents. This was shown in his forgiving them, planting evergreens at their grave sites and using his father's roll-top desk and other pieces of his father's furniture. He was a success in his new practice. His illness, however, had set up a number of factors which converged on him at about the same time. When he resumed meeting with his county professional society, for example, two men he thought of as his friends neither spoke nor waved in return to his salutation. "They just looked at me as if I were a zoo exhibit." He was estranged from his second, sick wife, and there were other family problems. He was found dead by a combination of barbiturates and a new synthetic analgesic. Presumably the death was accidental. It was believed that he had not been sufficiently aware of the actions of the new analgesic and miscalculated the dosage he could tolerate. This abuse of drugs was otherwise the same way he had reacted before, whenever he had become successful.

The third man already had 12 years of psychotherapy without changing, except for the worse (he had experienced frequent changes of therapists in a clinic setting). Now after 2 years of psychoanalytically oriented psychotherapy and adjunctive LSD sessions, he is coming much closer to understanding himself and the crippling way he relates to people.

He is currently taking a look at his ambivalent motivation for seeking help; that a major source of his motivation for treatment has been to seek the transference gratification of having a parent-figure fulfill duties he still unconsciously wished to receive from his parents. He is also learning about the nature of his dependence on his illness — that while hating that dependence, he has been too frightened to release it. Until now he has shown more improvement in the previous constrictions of his professional career than in those of his social life or integrative patterns. These latter aspects of his difficulties, however, are changing also. This patient has noted that food tastes differently. Before treatment everything tasted like dry milk. He and patient #2 gained insight slowly, by small bits at a time, while patient #1 seemed to gain his largely in one LSD experience.

My fourth patient is a menopausal woman who has been severely ill for almost 20 years. Another therapist treated her for 3 years (1 year with LSD) but moved away, leaving her in my care. Like many of Gordon Johnson's patients, she may be classified as having an endogenous depression. Despite her numerous attempts at suicide, however, and her being bound in a paradoxical way to fighting any

closeness with a therapist, because of fear of rejection and her projective type of thinking, she also appears to be making strides. I have hope that she can get well, and there are signs which point in that direction. For example, although the idea that she might need a real relationship with another person, especially a man, for her emotional well-being has been unthinkable in the past, she is beginning to look at this possibility, and speak of her need. One thing that has helped her is that what both she and I had initially believed was purely psychosomatic dyspareunia has turned out to be due to numerous adhesions and pelvic edema.

Problems of Evaluation

The problems of evaluating therapeutic procedures in which LSD is used are not yet solved. Work on the design of pre-post tests should help. How to identify and control variables and to objectively evaluate therapeutic effects is still pioneering work. The difficulties in carrying out single and double-blind procedures with psychedelic drugs are formidable.* Still, it behooves us to work out research designs which will enable us to carry out valid and reliable studies.

The sources of our difficulties are far-reaching. A great many variables have been thrust upon us which cause the evaluation of these drugs to be more difficult than is usual. These variables are both extrinsic and/or intrinsic to the scientific milieu. Major extrinsic sources of difficulty have been: the notoriety with which these drugs have been burdened; the curiosity and confusion with which the general public views them, the acting-out behavior of individuals, groups and even movements in our society by using these drugs illicitly; the prejudices that have been built up within the general society between so-called progressive and conservative groups; the tendency on the part of the public to moralize where drugs such as the hallucinogens are concerned, and to act in a hysterical, arbitrary or puritanical way toward youth and the problems associated wtih their use of hallucinogenic drugs. Widespread publicity of their illicit use has tended to make hallucinogenic drugs more alluring to some, like a naughty toy for those who would play in this area. Certainly there is little question, that to the extent that we react as a puritanical, materialistic society, we manufacture more problems for ourselves than we solve. At the same time, paradoxically, we have a tendency to ignore other seriously threatening problems that have always been, and probably will remain with us. We have incorporated those problems into our society and our national character. In a similar way we are incorporating certain of the by-products of psychedelic usage. The clothing industry would indeed be more hard pressed today to find new color schemes and to achieve acceptance of them, were it not for the impetus furnished the world freely by some of those who experienced hallucinogenic drugs. Advertising organizations use "psychedelic" subjects in such a way as to draw attention to the products they advertise. Though there is much exposition on the dangers of the so-called psychedelic drugs in the media, they are also given so much intense, romanticised attention, and claims about them are so exaggerated, as to seduce many of our young people into using them, in a self-destructive way.

**The Reader is referred to Dr. Carl Salzman's paper, page 23 of this book for further discussion of this problem.*

The confusion which exists about these drugs, and the concern for their effects on society fosters prejudices, not only in the general society, but even among scientists. Prejudice resists truth. Very few scientists feel encouraged to work in an area stigmatized by prejudice. As scientists and physicians we want to learn the truth about these drugs so we will know when and where and how they may help or hurt people. Any drug or procedure has its dangers. Such a simple, helpful drug as aspirin, as we know, poisons hundreds of people yearly, and breaks WBC chromosomes. There is hardly a neighborhood that does not witness the aspirin poisoning of a child at least once a year. Yet, serious as this hazard may be, aspirin remains a drug with which few doctors, or for that matter households, would willingly part.

Marijuana carries a much higher legal, federal prohibition to its use or possession than some more powerful drugs, such as LSD. Stories about the dangers of marijuana have been so greatly expanded as to become absurd. This exaggeration tends to cause distrust, and many people who are inclined to self-experimentation with marijuana readily see through this exaggeration. Understandably, they are then inclined to disbelieve the "scare propaganda", factual or not, put forth about the more potent hallucinogens, the narcotics, and other dangerous drugs.

There is really little question, among those scientists who have been responsibly working with hallucinogenic drugs, that LSD and the other hallucinogens, when used as an adjunct or tool in treating emotional illnesses, offer certain distinct advantages in some situations. We recognize that there are variables which may favorably or adversely affect the results one gets by using these drugs. It was noted in the early nineteen-fifties that LSD treatment by a therapist with a paranoid, destructive, angry, psychological set toward his patients resulted in some patients committing suicide. I believe the greater danger we face, as investigators with these drugs, is the danger of failing to adequately study these drugs, leaving the professions more in the dark than the non-professional drug user — the very position we find ourselves in at this time with respect to the hydrocannibinols. Marijuana has been used extensively for centuries, and yet, as we know, has only been subjected to sound medical research so recently that we still know very little about its actions, in the psychological or emotional sense, at this late date.

My conclusion, concerning the problem of evaluating therapy with psychedelic drugs, is that as medical and social scientists we must dedicate ourselves first, and continuously to a most difficult task — to know ourselves. The key to effective investigation rests first of all in the personal qualities of the investigator. We are an integral part of the therapeutic procedures we seek to evaluate. We must know ourselves in a way that will permit us to effectively design and apply scientific methods of evaluation, with regard for all significant extrinsic and intrinsic variables, including ourselves and our co-workers. And, we must be able and willing to perceive the truth, if and when we find it.

Finally, we must communicate clearly to both the professional and non-professional communities that while we require that scientific principles be followed in this field, we must insist also on the avoidance of emotionally inspired restrictions, through which clinical investigation may become sterile and fruitless.