shortly thereafter able to return home where she remains at this writing. Of the remaining 23 patients, five in the first group and two in the second group had a partial temporary improvement. However, within four to six weeks, they again returned to their pre-mescaline state.

Discussion

The significance of the mescaline-induced state as a therapeutic tool in chronic schizophrenic patients appears to be minimal. Long-term chronically ill schizophrenics do not benefit from large doses of mescaline. Psychodynamic material cannot be obtained in a large percentage of these individuals. The basic personality structure comes to the surface under the influence of mescaline but apparently cannot be handled in a therapeutic fashion for the eventual clinical improvement of the patient. It appears that in chronic schizophrenia, at least, the induction of anxiety by intravenous mescaline is not in itself sufficient to produce any results leading toward a significant relief of symptoms.

Conclusion

1. Twenty-four chronic schizophrenic patients were studied in an effort to determine the clinical effectiveness of mescaline sulfate as a therapeutic agent. Doses varying from 0.50 grams to 0.75 grams were given in 34 experiments to 24 patients.

2. Two significant reaction patterns were noted.

3. One patient showed sufficient clinical improvement and was discharged. Seven patients were temporarily improved, 16 showed no change.

4. It is felt that mescaline sulfate does not appear to be clinically effective as a therapeutic agent in chronic schizophrenic patients.

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Central Islip State Hospital
Central Islip, New York

THE RESOLUTION AND SUBSEQUENT REMOBILIZATION OF RESISTANCE BY LSD IN PSYCHOTHERAPY

CHARLES SAVAGE, M.D.

At the American Psychiatric Association meetings on mescaline back in 1932, Sullivan stressed that in psychotherapy a drug can be therapeutic only by altering the relationship between the patient and the doctor. By establishing a changed relationship with the doctor, the patient has the possibility of changing his relationship to other people in a manner which is more satisfying to him. If mescaline and LSD act therapeutically, they do so by favorably altering a relationship. But let us remember that while a relationship may be altered in a favorable direction, it is not necessarily permanent. The direction can always be reversed, particularly if the relationship moves too fast.

Do mescaline and LSD move the relationship too fast? I recall a paranoid alcoholic treated in 1949, a burly brute of a man with great popping eyes. He was so guarded that he would not even admit to drinking. During the third mescaline interview (250 mg.), he talked with me for four hours. He relived the shame and agony of his mother's death and shed many tears. It was as though a stone had suddenly wept. He also related that everything he had been telling me for the past three months was a mass of ingeniously constructed

fabrications, nay even lies. I thought I had thrown open wide the gates of therapy, but I could not have been more wrong. He gradually became more suspicious, more demanding, more paranoid and finally refused to see me. The relationship had progressed too rapidly for him.

Does mobilizing unconscious conflict with mescaline or LSD help? A year ago I treated a girl who asked for LSD because she was blocked in her relationship to her therapist. She received LSD five times, in doses ranging from 50 to 150 mg. The paintings she did of the experiences illustrated no dearth of unconscious conflicts. She began to talk, but only with me and not with her therapist. She became depressed, had to be hospitalized for four days, then interrupted treatment for two months to go on a vacation. Her recent comments reveal some ambivalence about the experience: "It was the first time in my life I could talk to another human being and really experience what was going on within me. But it was premature. I was stunned by the disclosure of rape and incest."

Does insight obtained during LSD help? Another woman in the course of analysis acted out her transference by taking a lover. I pointed out in vain that her lover was only a projection of her incestuous wishes for me and father, that perhaps her husband might have some reservations. During LSD she gained a clear perception of this. She gave up her lover—*for a week*. Then the perception of him as father vanished. I cite this to illustrate that insights need not be permanent.

Does reliving painful experiences help? During LSD one patient reexperienced an incestuous relationship with her father which even today is crippling her relations with me. She refused further LSD.

Does overcoming resistance help? Two years ago Dr. Cholden and I tried to disorganize the pattern of regressed schizophrenics in a manner as to make them more accessible to treatment. There is no question that we introduced a temporary disorganization into their pattern of living. But despite the fact that LSD seemed to make them seek us out more actively, seemed to introduce a change into their psychic economy, it did not seem to have led to readaptation at a higher level of integration. I attempted, with one of the chronic regressed schizophrenics who was stabilized at a level of paranoia somatica, to reorganize the equilibrium by giving her LSD weekly. This girl had been sick for 10 years, had chronic somatic delusions of being dead, of having neither body nor nervous system for five years. The LSD had such a pronounced effect that it shattered her defenses. She now felt that she had a body and wanted to use it. She wanted to be out in the moonlight with me rather than poking around the ward. The LSD also mobilized tremendous rage and resentment against both her parents and myself. At this time, unfortunately, she was allowed to go home on a visit where she borrowed the family car and threw herself under a train. While LSD mobilized feelings and affects which had been successfully handled by nihilistic delusions, it also mobilized the supreme resistance: suicide.

I should like to raise the question in dealing with resistance: are we not considering it a road block to be blasted out of the way? Do we view resistance as a devil to be rooted out with the modern fire and steel—mescaline and LSD—when customary methods fail?

What is resistance? It is not a basic part of the personality which serves a definite economic function? It is a security operation designed to prevent the organism from being flooded with anxiety. The patient does not part with his security unless some new security is obtained in its place and in psychotherapy. The security lies in the relationship with the therapist.

Our function in therapy is not only to mobilize anxiety but also to make it tolerable in the therapeutic situation without the necessity of creating newer and better defenses or resistances. Unless we can do that, the LSD and mescaline experience may work against, rather than for, therapy. Let us not forget that the character armor is an integral part of the personality. One must remember that the patient has defenses because he needs them; they are not archaic residues, but a living part of his being. Smashing defenses, making the unconscious conscious, experiencing affect, reliving trauma, providing insights, are of use only when they alter the relationship with the therapist and lead the patient to a new and corrective experience with him and ultimately with

other people. I think LSD and mescaline highlight rather than afford an outlet to our dilemma in therapy.

The patient is blocked in his dealings with the therapist in good part because of his transference distortions of the therapist. Active efforts to improve the relationship, whether by drugs or other ruses, may rob the patient of the opportunity to see his distortion in dealing with the therapist, and the experience then may become isolated. Unless he can actually see the distortion in dealing with the therapist, he loses the opportunity to see it in dealing with others.

The helpless dependent state induced by LSD poses a dilemma. If a patient is not looked after during this long period of anxiety and dependency, he will find the experience too disturbing to continue. If he is looked after by someone other than the analyst during this helpless dependent state, there occurs a splitting of the transference. If he is looked after by the analyst, then he develops a helpless dependency on the analyst, not based on transference, but rather on a realistic necessity.

What we are proposing is that a psychosis is beneficial. Now this has been maintained, but the evidence for it is not convincing. While we are saying that the acute psychotic illness should facilitate treatment, this does not seem to be the case. If so much panic, desperation and discomfort are endured, it may become necessary for the patient to mobilize all possible defenses.

At present we are studying two borderline patients who get 50 micrograms of LSD intramuscularly, once a week. We obtain recordings before, during, and after LSD to study the fate of resistance. Let me illustrate from one case how overcoming resistance with LSD is followed by renewed resistance. Her character resistance is an intellectual defense against feelings:

First day: She felt irresponsible. It was a good feeling—tremendous release from emotion. The following day she went out and got drunk (acting out).

Second day: She felt her defenses crumbling. The veneer was cracking. She felt closer to people. The following day she started to eat insatiably and eventually her weight went up to 200 pounds.

Third day: She had a strong feeling toward the therapist. She attempted to diffuse her feelings by talking to everyone but the therapist. Subsequently she asked for a new therapist.

Fourth day: Under the influence of LSD she recognized her intense sexual preoccupations, but refused to talk about them, saying it was not safe to talk about this question during LSD. She called the therapist that night and told him she was ready to talk. She then withheld the information for three months.

Fifth day: She gained the insight that she was a demanding little girl within her external intellectual façade. Instead of following up this insight, she developed an obsessive preoccupation about becoming schizophrenic.

Conclusion

It may be stated that both mescaline and LSD may increase blocking and autistic withdrawal. These drugs may also overcome blocking and resistance and increase rapport, as well as unearth unconscious material. They can release painful and repressed affects, lead to fresh insights with reliving of painful experiences allowing the patient to become aware of his feelings. These drugs can increase dependency, mobilize resistance, lead to splitting of transference, isolation, denial and even conscious withholding. The unconscious material may be repressed again and the insights wiped out. Although work with LSD is more difficult than without, I feel that in some measure it is satisfying to both patient and analyst. It increases our understanding of psychic processes and relationships. It permits the possibility of new perceptions, new-found empathy and understanding. With proper therapeutic handling, these intuitive processes can be kept in awareness and integrated into the conscious part of the personality.

Summary

LSD provides an effective method of overcoming resistance. It causes a reliving of previous experiences (1). It brings to the fore painful and repressed affects allowing the patient

to become aware of his feelings. It liberates unconscious material often in the form of hallucinations and perceptual changes. Dramatic insights occur. However, these affects may in turn mobilize defenses. The LSD experiences may then be utilized in the service of resistance.

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NATIONAL INSTITUTE OF MENTAL HEALTH
NATIONAL INSTITUTES OF HEALTH
BETHESDA, MARYLAND

THE ROLE AND REACTION OF THE PSYCHIATRIST IN LSD THERAPY

JULIANA DAY, M.D.

It is the purpose of this paper to direct attention to the therapist who participates in an LSD session. LSD alters the psychotherapeutic relationship, and this is exemplified, not only in the increased emotional lability and freedom of association, but also in the psychotherapist's reactions and expectations. It may be said without question that the behavior of a patient affects the therapist, and by examining some of the therapist's experiences in psychotherapy utilizing LSD we can increase our understanding of its effect on the patient and the therapeutic process as a whole.

The following observations for the most part are based on therapy with two borderline neurotics seen four times a week, each of whom received 50 micrograms of LSD once a week about two hours prior to the therapeutic hour.

As I recalled my various sentiments regarding these LSD hours, one stood out in particular—a tremendous sense of solicitude. Others have mentioned that holding the hand can often be extremely comforting to the patient at such a time. Of course, such a gesture was out of the question for me. As part of a scrupulous research team, I knew that the setting on "LSD days" was to be identical with other days: the same room, the same time of day, and as far as possible the same total life situation. Odd, then, to remember in the first few months of the LSD experiments that instead of awaiting the patient's arrival in the office, I would seek him out and conduct him to the room. I remember adjusting the venetian blinds with great care on these days to diminish the painful brightness of the room for the patient. When the patient wept, my hand also reached for the Kleenex more swiftly than usual.

Whence came all this solicitude? True, early in treatment, the patient often appears more helpless and stumbling, tremendously anxious and frightened—as was I. The therapist, then, finds himself reacting with anxiety, remorse and solicitude. Even though the therapist may not himself have planned the experiment, he may feel the responsibility for the anguish the patient experiences. There is also engendered within the therapist a certain sense of helplessness. The administration of LSD sets in motion certain processes within the patient which are out of the therapist's and the patient's control.

In watching Dr. Bercel's fascinating film of "The Schizophrenic Model Psychosis Induced by LSD", which he presented at the American Psychiatric Association meeting in May, 1956, I found myself observing the doctor and the audience. Why was the audience tittering? And why, when the patient described being transported by marvelous sensations, was the physician repeatedly asking him to eat? He *interrupted* him forcibly. When the patient complained, the physician said, "I thought the experience was getting too intense for you." Surely the psychiatrist was not so overwhelmed by the patient's refusal of food. Here was just the experience he wished to record—a subject with an impressive reaction to the drug. Yet, he attempted to interrupt the drug effect. The psychiatrist's anxiety was so forcibly communicated that it aroused the same emotion in the audience.

In the early LSD hours I found myself less