OUTLINE OF HYPNODELIC THERAPY

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There is no need to review the therapeutic efficacy of either hypnosis or psychedelic drugs. If any generalization is warranted, it would be that the efficacy of either technique is still a subject of much controversy. Moreover, despite the enthusiasm of the proponents of either technique, both forms of therapy are still regarded as "fringe" forms of therapy by the general professional psychiatric community. It may well be that simultaneously combining these two controversial techniques into a single treatment procedure may raise skeptical eyebrows even further. Nevertheless, this is exactly what we have done in evolving the technique of hypnodelic therapy. Our major justification for continued work with this technique is that it appears to be a more potent therapeutic tool than ordinary forms of therapy for certain patients.

In other articles [2, 3, 7], Dr. J. Levine and I have commented on the development and rationale of hypnodelic therapy. Summarizing our results, we found that the combined simultaneous use of LSD and hypnosis in conjunction with psychotherapy produced significantly greater symptom relief and constructive attitude change in drug addicts than either hypnosis+therapy, LSD+therapy, LSD alone, or psychotherapy alone. Currently, the technique of hypnodelic therapy is being further investigated in the treatment of alcoholics *. It is still too early to evaluate the results from these latter investigations.

Before proceeding to a discussion of the technique, I should like to comment on our choice of the term "hypnodelic". The term is a contraction of "hypnosis" and "psychedelic" and would seem to be appropriate, since it indicates the technique and class of drug used in treatment. Although we have employed a standard form of hypnodelic therapy for research purposes, I should like to emphasize that many variations of our basic approach are possible. Hypnodelic therapy can be used as an adjunct to therapy or as the principle form of therapy. It can be adapted to insight-oriented, inspirational, moral suasion and other theoretical approaches to psychotherapy. All these possibilities still remain to be explored. At this point, though, I should like to comment briefly on our clinical impressions and experiences to date with this technique.

TECHNIQUE

A. Pre-treatment

Before the actual treatment session, it seems important that the therapist have at least one psychiatric information gathering interview with the patient in order to assess his major problem areas, conflicts, and defense mechanisms. Since the technique has been developed primarily as an ultra-brief form of treatment, the therapist may find it more helpful and practical to select and focus on the patient's predominant pathology and current reality problems for discussion during therapy, and not feel compelled to deal with all areas of potential pathology.

* This investigation is supported by Public Health Research Grant #MH 11275-01 from the National Institute of Mental Health.

In previous work with this technique, we felt it necessary to train the patient in hypnosis prior to the actual treatment. Our research data, however, indicated that there was no significant correlation between the patient's degree of suggestibility and therapeutic results attained. In more recent work, we have abandoned the hypnotic training session. It is my present impression that the lack of a training session in hypnosis has very little if any effect on the hypnotic induction which will take place during the actual therapy or on the subsequent results.

Concerning criteria for patient selection, the main requirements are that the patient have no serious physical illness, not be overtly psychotic nor have more than minimal organic brain damage. Since the patient's ability to concentrate during therapy is of prime importance, the hypnodelic technique becomes difficult to employ on patients who lack this ability for either organic or emotional (i.e., psychosis, severe depression, anxiety) reasons. Needless to say, the voluntary consent and cooperation of the patient is a prerequisite for therapy.

B. Treatment session

The actual treatment session is begun one or several mornings following the pretreatment interview. The patient is encouraged to eat a regular breakfast and go to the bathroom prior to the treatment. The patient is then brought into the treatment room (ordinary clinical office setting), seated on a comfortable chair, and baseline vital signs (blood pressure, pulse) are taken.

In our previous experience, we have found 2-3 micrograms/kg LSD to be sufficient to induce the desired effects. The patient is given the drug orally and then told to relax as much as possible. During the 30-45 minute time lag before the onset of drug action, a hypnotic induction is begun. Generally, we have employed the high-eye fixation method to standardize our induction technique and also because of our feeling that we can achieve a more rapid induction with this method than with other methods. Aside from achieving eye closure, I do not feel that the use of other hypnotic challenges is necessary during the induction. Instead, suggestions of relaxation, peacefulness, drowsiness and sleep (employing various metaphors to vividly portray these states) seem quite effective in achieving as deep a trance as possible. The main problem in employing the hypnotic challenge (i.e., "you can't bend your arm," etc.) during the induction procedure is that if the patient breaks the challenge, the therapist is forced to begin induction again with a patient who has now lost some confidence in the therapist's control. Also, much valuable time may be wasted. It is especially important to attain as deep an hypnotic trance as possible before the onset of drug effect while the patient can still concentrate adequately. It has been our experience that it is extremely difficult to hypnotize a person after the drug has begun to take effect.

Toward the end of the induction period, the patient is instructed to share all his feelings and thoughts with the therapist. He is also told that the voice of the therapist will become increasingly important to him, and that he is to attend to everything the therapist says. The therapist then sets the tone of the ensuing session by telling the patient that this is his day for treatment and that he will better be able to understand and experience things that have been bothering him for a long time. Not only will he be able to "feel" and "see" his problems in a "new light", but he will be able to communicate all his experiences to the therapist.

After these initial remarks, the therapist then asks the patient what he is currently feeling in an effort to determine whether the drug has begun to take effect. The therapist then proceeds to devote the remainder of the session to discussion of the major problems facing the patient. During the two hours of active therapy, the therapist directs the patient's attention to major problem areas, encouraging the patient to recall certain traumatic experiences, discuss, experience and relive his "true" feelings toward important persons in his early and present life, and comprehend some of the major "dynamic" reasons for his self-defeating behavior. When the patient finds it difficult to express certain ambivalent feelings or resists direction by the therapist, the therapist can feel free

to comment on the patient's behavior, make simple and obvious interpretations, give a dynamic formulation, and encourage the patient to actively and emotionally respond to these statements. It has been our general impression that the greater the intensity of an appropriate emotional experience (emotional abreaction) during therapy, the greater the reported benefit following therapy.

We believe that the hypnodelic technique can be administered best by therapists who are thoroughly familiar with the psychological and physical effects produced by LSD and hypnosis [1, 4, 6, 8]. Familiarity with these effects opens new channels of communication between the therapist and patient. Since the patient can experience phenomena on both a secondary and primary process level, the therapist need not be bound by the strict dictates of logic and causality in making interpretations or directing the therapy session. For example, the therapist may wish to suggest hallucinatory scenes of past traumatic events or instruct the patient to vividly "live" some future event. He may direct the patient to experience all the hurt of his childhood within a short interval of time or to simultaneously experience love and hate toward some parental figure, and so on. The therapist therefore has available a much greater repertoire of communicational possibilities and a much greater flexibility in his approach than in ordinary psychotherapy. We also feel that the technique will prove more effective the more the therapist attempts to integrate the hypnotic induction, drug effects and psychotherapy into a unitary whole. All the patient's productions, regardless of their cause, can become grist for the therapeutic mill and are interpreted and treated as symbolic communications on the part of the patient.

Toward the end of the session, the therapist should make some attempt to summarize all the important material discussed during treatment. We have also found it helpful to provide the patient with a plausible dynamic interpretation of his current difficulties and symptoms by relating them to past traumas, frustrations, disappointments and conflicts when the patient is unable to make these connections himself. Moreover, the patient is given post-hypnotic suggestions to continue working on his problems and to make a greater effort in accepting responsibility and leading a more productive life.

The patient is then awakened from trance and brought to an overnight room where he is provided with a pad of paper and a pencil should he desire to write down any of his subsequent experiences. We regard the ensuing 8 to 10 hours while the patient is in the room alone (the "cooker") and still under the influence of LSD as a vital part of the treatment experience since it is during this time that many patients report fitting "all the pieces of the puzzle" together and filling in many of the details not discussed during the formal therapy session. When he first comes into the treatment room, the patient's mind may be "racing," but within 3 to 4 hours his thoughts begin to slow down and an "integrative period" seems to set in.

Throughout the afternoon and evening the specially trained nurse periodically checks the patient's vital signs and offers him emotional support for short periods of time if this should become necessary. The patient receives no lunch, but may have light snacks in the afternoon and a regular meal at supper. We also have found it useful routinely to order sleeping medication to combat the common insomnia on the night of the treatment session. After his day-long "ordeal," the patient seems grateful for the good night's sleep and the refreshed feeling he experiences on awakening.

TECHNICAL PROBLEMS

A. Resistance to hypnotic induction

In the course of our work with this technique, we have encountered a number of patients who were resistant to hypnotic induction and who would achieve at best only a very light trance prior to the onset of drug action. At first, we automatically regarded such patients as poor candidates for hypnodelic therapy but we have subsequently modified our views in light of certain theoretical considerations concerning hypnosis. Adopting R. Shor's [10] conceptualization of the three dimensions of hypnotic behavior (i.e., uncon-

scious role-playing, transference, and trance), we have found that even when trance is minimal, the therapist can still control and direct the therapy session by capitalizing on the patient's strong need for role-playing and his need to comply to an authoritative figure. In other words, the "demand characteristics" [9] of the hypnotic relationship are such that powerful forces are still operative and can be used to modify and channel the drug effects. Therefore, even though the patient may not be "hypnotized", he still will feel the need to behave and comply as a hypnotized person as this behavior is implicitly or explicitly defined by the therapist. Conversely, from the vantage point of the therapist, the hypnotic relationship seems to give him greater freedom or licence to be more directive and become more actively involved in therapy than in an ordinary psychotherapeutic setting.

Occasionally, during the hypnotic induction or therapy phase, the resistant patient may begin rubbing himself, shifting posture, moving his fingers or opening his eyes. In general, we have viewed this behavior as a defensive attempt on the patient's part to keep from losing control and to maintain contact with reality. We have also found it best to handle this behavior by reassuring the patient, directly interpreting his behavior to him, and strongly encouraging him to refrain from continuing such behavior. Even if he is not in trance, he is told to keep his eyes closed for the remainder of the session and is still treated as though he were deeply hypnotized. The purpose of insisting that the eyes remain closed is to induce as great an alteration in consciousness as possible by cutting off an important channel of perceptual feedback.

It is our definite clinical impression that the greater the degree of trance attained during the hypnotic induction, the greater the therapist's ability to direct, structure, modify, channel and control the patient's productions during the therapy session. Nevertheless, even in the absence of trance, the powerful forces operating during the hypnotic relationship still seem to allow a greater amount of control than can be achieved when therapy is conducted with the patient under the influence of the drug alone.

B. Trance lightening

Even when moderate to deep trance is achieved during the induction phase, there is the common tendency for the trance to lighten during active therapy and/or the increase in drug effect. This technical problem can be largely overcome by the therapist's periodically reinforcing previous suggestions of relaxation, sleep, trance, etc., during the session. With many patients, trance deepening suggestions may not be necessary if they have attained an adequate depth of trance initially, but the therapist should be alerted to the possibility of trance lightening and be ready to deal with it should this occur.

C. Drug symptoms as a defense

One problem that we occasionally have encountered is the tendency for certain resistive patients to avoid dealing with problematic or traumatic areas by focusing their attention on subjective sensations and various perceptual aberrations associated with LSD instead of confining themselves to the matter under discussion. When neutral topics are broached, they are able to converse freely about them; when emotionally charged topics are brought up, they become preoccupied with the panorama of psychedelic drug symptoms. In dealing with this situation, we have found it helpful to directly interpret their resistances and the defensive maneuvers they are employing. When this does not seem to have much effect, the therapist's periodic forceful insistence that the patient keep his attention focused to the problem at hand may be a useful maneuver.

D. Therapist's fatigue

In general, we have found such long, intensive and active therapy to be very fatiguing and emotionally exhausting for the therapist. Since the therapist is continually confronted with the need to structure the session in the most therapeutic manner as possible, to be constantly alert for manifestations of drug effect, and to integrate the content of the session into some type of structural whole, the demands on him seem much greater

than in a more loosely structured, more non-directive form of therapy. We know of no easy solution to this problem except for the personal satisfaction the therapist might derive from working with the patient so intensively and the possibility of helping him.

ADVANTAGES OF THE TECHNIQUE

One of the major advantages of the hypnodelic treatment technique is that it seems ideally suited to capitalize on and take advantage of most of the "non-specific" healing factors in almost all forms of psychotherapy. Because of some of these non-specific factors, some persons may be tempted to regard the technique as a type of "super-placebo". Personally, I would have no qualms in accepting this derogatory label if we could also regard the therapeutic efficacy of other forms of psychotherapy as due to placebo effect. Moreover, as we learn more about all forms of psychotherapy, I suspect that we shall find that the so-called non-specific factors may well be primarily responsible for the "specific" benefit.

The hypnodelic treatment technique appears to share a number of common features with other short-term or ultra-brief healing techniques and practices, such as religious conversion, faith healing, incubation, shamanistic practices, revelatory and possession experiences, drug abreactive treatments, hypnotherapy, and phychedelic therapy. It may well be that these common denominators represent the necessary and sufficient conditions for healing or therapy to take place in any context. In all of these practices, we find the patient experiencing a sense of urgency and anticipation prior to therapy, techniques designed to heighten emotion (anxiety, depression, guilt), emotional catharsis, the liberal use of suggestion, and explanations for troubling symptoms and problems.

Certain other common factors appear to play a significant role in the healing experience. In almost all *brief* "healing" practices we find the production of an altered state of consciousness as a crucial prerequisite for therapeutic change to occur [4]. In previous experimental work, we found a significant alteration in consciousness when employing hypnotherapy, psychedelic and hypnodelic therapy compared to baseline levels. Of interest was our finding that hypnodelic therapy produced a much greater alteration in consciousness than any of the other techniques [1]. We have speculated on the possible correlation of the degree of alteration in consciousness due to certain therapeutic techniques and the amount of therapeutic changes observed.

The importance of inducing an altered state of consciousness in brief psychotherapy seems mainly related to the tendency of patients to attribute an increased meaning and significance to their own thoughts and interpretations by the therapist while in this altered state. Ideas tend to become imbued with a sense of profundity and the patient seems emotionally primed to experience insights of all varieties. Regardless of the established validity of the particular interpretation, the patient is much more apt to regard it as a new and profound insight into the true nature of his problems or the meaning of life [5].

I should like to emphasize that we do not regard the production of an altered state of consciousness as a sufficient condition for therapeutic change. We cannot see where any lasting benefit can come from a patient merely experiencing unusual or unstructured feelings while under an altered state of consciousness due to drug effect. It seems especially important that interpretations be given during this time so that the patient can understand or interpret his behavior or feelings within some consistent theoretical framework. Although our specific theoretical orientation toward psychotherapy might be regarded as psychoanalytic, I seriously doubt this has been a crucial factor in the results obtained. I basically feel that any theoretical orientation (i.e., Jungian, existential, Rankian, etc.) would prove equally effective provided that the theoretical framework be internally consistent, fit in with the current state of our knowledge of mental illness, and make sense to both the patient and therapist. It is the framework of the theoretical system which appears to be more crucial than its particular content [5].

Associated with the altered state of consciousness and the profound nature of the experience is another important feature. As the patient emerges from this state, he tends

to feel a sense of rebirth, rejuvenation or renaissance. Now that he has undergone this "ordeal," he senses that something profound and unique has happened to him. The experience tends to be viewed subjectively as a new starting point or foundation in his life or as a springboard for further action.

In addition to all these features, the hypnodelic technique makes explicit and full use of the power of suggestion in directing and guiding the patient's thoughts and behavior. This is in contrast to most other forms of psychotherapy where suggestion seems to play a large role but its use is often disguised or implicit. Not only is suggestion used to control and structure the patient's productions while under the hypnodelic state, but post-hypnotic suggestions are utilized to encourage the patient to continue working on his problems and to behave constructively in the future.

In conclusion, I should like to state that our investigations with the hypnodelic technique to date leave little question in my mind that a single profound experience can produce dramatic symptom relief and constructive attitude change in many patients. However, it will take much further research to determine how lasting these changes are, the relationship of this change to actual behavioral change, the spectrum of patients most suitable for this treatment, and the efficacy of this procedure compared to other forms of psychedelic and psychiatric therapy.

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