Chapter 12

MENTAL LIBERATION FACILITATED BY THE USE OF HALLUCINOGENIC DRUGS

Jan Bastiaans

General Remarks on Mental Freedom

By his nature man feels a need for freedom. Between total freedom and the total absence of it there are numerous levels of restraint experienced with or without acceptance. A mentally and physically healthy individual normally feels free, but not every human being has this privilege. A young child often experiences constraints on its freedom which can have a determining influence on its life. Deprivation of freedom at a later stage of life, if sufficiently protracted and severe, can also have permanent effects. Those who have once been deprived of freedom continue to live in fear that it might happen again. They may seek protection by assuming a role which deprives others of freedom.

The experience of being threatened and having one's freedom violated also produces mental isolation. The individual consciously or unconsciously locks himself into mental invulnerability-structures of a psychotic, psychoneurotic or psychosomatic nature. This kind of isolation is found in autism, narcissism, character neuroses, depersonalization, and psychosomatic character formation. The patient becomes isolated from his emotions by an excessive use of self-restraint. The loss of freedom in these patients is caused mainly by traumatic events or unresolved conflicts from early childhood or a later period in life. Psychotherapy should focus on liberating the patient from his mental entrenchment and helping him find his way back to freedom.

Experiences with Psychotherapy Facilitated by Hallucinogenic Drugs

My interest in hallucinogenic drug therapy was aroused during the years when I was a director of the National Psychoanalytic Institute in Amsterdam, 1954-1963. Three major factors entered:

1) My contact with war victims, including former prisoners of war and concentration camp inmates. Many of these people were severely traumatized. Facilities for adequate treatment were scarce, and only a few psychiatrists had developed the competence to treat this type of patient properly. The results of hypnoanalysis, narcoanalysis and regular psychoanalytic treatment were disappointing, if only in the long run.

2) My participation in the work of a psychosomatic research team at the University of Amsterdam during the years 1946-1954. During this period I became impressed with the mental isolation experienced by psychosomatic patients. Nearly all the psychotherapeutic techniques used with this group of patients had the common objective of opening the doors of expression and facilitating normal human contacts at the verbal as well as the nonverbal level. I also saw that many war victims suffered from psychosomatic diseases linked to their problems in adapting to postwar conditions.

3) The start of a long-term research program on *Prognosis and Effect of Psychoanalysis and Psychotherapy* by the staff of the Amsterdam Psychoanalytic Institute in 1964. Of the Institute's inpatients, 300 were put through objective tests based primarily on Eysenck's research. These patients were treated with various psychotherapeutic methods, and then tested again after periods of 2, 5, and 7 years. Although predicted shifts in personality functioning could be observed, we were disappointed to find that they did not reach the level of statistical significance. Among people for whom an adequate form of psychotherapy could not be found and among those still on the waiting list for treatment, comparable changes in neuroticism, sociability, intelligence and socio-cultural parameters such as social status, income, marriage, and career were observed.

The result of this ambitious research showed that the efficacy of psychotherapy is difficult to prove. As head of the research team, I concluded that much more attention should be paid to factors determining so-called resistance to change. Although much was known about the psychoanalytic technique for treating severe character neuroses, traditional psychoanalysis still required too much time. Having obtained much experience with narcoanalytic treatment of war victims, I decided to speed up the therapeutic process by the use of hallucinogenic drugs; but this time my goal included more than just catharsis.

Perusal of the literature convinced me that much of the resistance to this form of therapy had been caused by the risk of a so-called "bad trip." I thought that such adverse reactions could be avoided by proper conduct of the sessions, and I found further evidence for this in patients admitted to psychiatric hospitals for LSD psychosis. By treating them with LSD-25, I could often neutralize the consequences of the original bad trip and eliminate the psychosis.

In 1969 I presented a paper to the British Psychoanalytic Association in which I discussed the treatment of 36 patients at Leyden University in the period 1964-1968. Of these, 9 had improved considerably after an average of 5 LSD sessions, each lasting from 3 to 4 hours. There was visible improvement in 14 cases and no improvement in 11 cases. Two patients suffering from severe neurotic depressions became worse; it became clear that chronic depressive neurosis was not susceptible to LSD treatment,

since a relapse generally occurred after a brief period of improvement. It also became clear that young people with passive personalities are not the right candidates for LSD treatment, although they often ask for it. I concluded that LSD treatment is most promising for the following three categories of patients:

1. Psychosomatic patients with intensely rigid defenses and coping mechanisms.
2. Patients suffering from survivor or concentration camp syndromes produced by their war experiences.
3. Patients for whom many years of psychoanalysis have not produced the prognosticated positive results.

The best candidates are "inhibited fighters"—persons with rich and intense life experiences who have been traumatized psychically. Treatment was most effective when it started within a few years after the traumatizing events took place. These patients often find it impossible to express their emotions. Rigid psychoneurotic and psychosomatic patients who have become silent or mutistic because of severe traumatic events often say: "I cannot tell you what I went through. You would not understand because you did not go through it yourself." But I found that during LSD treatment they were quite capable of expressing what they had gone through.

Since 1961 I have treated over 300 patients with hallucinogenic drugs, mainly at Leyden University, where I became Chairman of the Department of Psychiatry in 1963. These include inpatients as well as outpatients. The latter are hospitalized for a limited number of days, and otherwise placed on an ambulatory treatment scheme with regular, but brief, sessions of psychotherapy and analysis in the intervening periods. Authorities in the Netherlands prohibited the general medical use of hallucinogenic drugs in 1967, and only a few psychiatrists obtained an official license to use them in research. It has still not been demonstrated that hallucinogenic drugs when applied therapeutically give rise to lasting pathological complications, but at present I am the only medical researcher in the Netherlands who is permitted by the Ministry of Health to continue this work.

In the period 1969-1979 I treated 200 patients in psycholytic therapy, predominantly with LSD-25, partially with psilocybin. The average number of sessions was 6 to 7, and the average duration of a session was 4 hours. This low number of sessions was possible because in the intervals the patients were obliged to listen carefully and repeatedly to tape-recordings of the sessions. In addition, twice a week their experiences were worked through in normal psychoanalytically oriented interviews. Only in a few cases was the number of sessions higher than 7; one case required 28 sessions. The patients belonged predominantly to the three groups mentioned above. The most impressive results were obtained in survivors of jails and concentration camps and in those whose childhood situation was a kind of private concentration camp; this is common in patients suffering from severe compulsive neurosis or psychosomatic disease, e.g. asthma, eczema, rheumatic disease, or hypertensive disease.

The average number of hours spent in sessions and interviews by the therapist was 50, far lower than the number needed for regular psychoanalytic treatment (in Holland usually 600-800 hours). In some cases in which psychoanalysis had become interminable, the psychotherapeutic process could be facilitated by combining psychoanalytic with psycholytic therapy.

Four Case Histories

Case 1. In 1970 a twenty-one-year-old saleswoman suffering from severe atopic dermatitis was referred to the author by a dermatologist for psychotherapy. She was very nervous and very neurotic.

The dermatitis had lasted for nearly 20 years, and she had been treated in many hospitals. She had all the character defenses described in the literature as specific to patients suffering from psychogenic eczema. The patient was very active in her job as an assistant to her father, who owned a bakery. In her personal contacts she was oversensitive and vulnerable and somewhat insensitive to the normal signals of mature interpersonal contact.

The treatment started with regular psychoanalytically oriented psychotherapy. After a few months it became clear that she could not properly express her deeper emotional experiences. Many traumatic experiences of her childhood were repressed, and during her first LSD sessions she relived dramatically the main trauma: being left alone by her parents who were nearly always working in the bakery. She was the youngest of three children, and the other children had dominated her in an unfriendly manner when the parents were absent. Intense separation anxieties came to the fore, especially those related to early stays in hospitals where she was treated for eczema with the traditional methods of wound-dressing and gauze bandages which painfully restricted her movements. She relived the early pains and the inability to move her hands and legs. These experiences had disturbed the normal sensations of interpersonal contact and during the sessions the therapist's touch on her fingers opened up a world of contact for her. It became for her the symbol of what human contact could really be. She became aware of what she had missed and how this had produced an intense inferiority complex masked by neurotic overactivity which functioned as a defense against feared passivity and symbiotic pleasure.

After the first sessions the eczema disappeared entirely, but now the psychoneurotic and hysterical nucleus of her personality required continued guidance and more or less "normal" psychotherapy. The therapy came to an end when the insurance company stopped paying the expenses. Although she herself could easily have afforded the therapy, she rejected the therapist, whom she now considered to be a strict father for whom she had to work.

After this form of allowed acting out had continued for more than 2 years, she returned timidly asking indirectly for continuation of the therapy. Some years later she was able to marry. At present she is functioning well and seems to have overcome all the inhibitions and unpleasant emotions of her early childhood. The psychosomatic symptoms of eczema and self-mutilation never reappeared.

Case II. This twenty-nine-year-old married woman had suffered from asthma since the age of three. In 1976 she was referred to the author by one of the psychologists at an asthma hospital in Holland. A few years before, she had spent many months in a Swiss asthma sanatorium, where she underwent treatment without showing any improvement. Her marriage was unhappy, and she was unable to manage her two young children. LSD therapy was indicated because she had rigid character defenses and non-directive psychotherapy could not help her sufficiently. During the first session, she constantly cried for help.

It became clear that she was fixated on a traumatic childhood period when she was three to five years old. In this period a younger brother was born and she felt rejected by her mother; she also felt dominated by an elder brother who was very unkind to her. She was unable to express feelings of hate and jealousy, and whenever these feelings came to the fore she would yell that she was going to suffocate. The therapist was not allowed to speak about her parents in an unfriendly manner. In the course of the session feelings of grandeur became manifest; she wanted to be a queen with many slaves. She remembered that from time to time her parents had quarreled and that she had watched these quarrels in great panic. Possibly she had also witnessed parental sexual intercourse and interpreted it as a quarrel. When these memories were relived she had feelings of suffocation and closed her eyes to inhibit vision.

From early research by French and Alexander we knew that these inhibitions are more or less specific to asthmatics. We allowed her to enact her childhood situations as a psychodrama, and during this enactment she yelled constantly and cried impressively for help. Later she became furious, feeling restrained and oppressed by her family or by the therapist and his assistant. At the beginning of the therapy she had stated that she did not know what jealousy was; at the end she was able to admit how jealous she had been for many years.

The troubles in her marriage were produced largely by her feeling that her husband did not allow her enough freedom. After three LSD sessions over a period of 2 months, the asthma disappeared almost entirely. In the following months she wanted a divorce. Marriage counselling was given, and divorce was avoided. One year later a third child was born and the marriage now seems to be a happy one. There has been no relapse of asthma.

Case III. The third case is that of a fifty-two-year-old married man who suffered from intractable malignant hypertension (260/165 mmHg). He had been treated unsuccessfully in various departments of internal medicine. During the war he had been deported to Buchenwald concentration camp, where he more or less saved his life by working in a dissection room where he had to make lampshades of human skins. He continued this work in a state of chronic depersonalization. During LSD therapy he relived his horrible camp experiences and was able to express feelings of guilt about what he had been required to do in the camp. His ability to express these feelings led to a remarkable reduction of his blood pressure after the first session. In subsequent sessions he regressed to

childhood. He saw the therapist as a good father and for the first time in his life felt that his father understood what he had gone through in the camp and in his very unhappy childhood. Ten weeks after the start of the treatment, and after three LSD sessions, his blood pressure was normal. Later, it was also necessary to give marriage counselling, since his wife and children had suffered a great deal from his tension and masked psychopathic behavior at home.

Six years later his wife committed suicide. Once again he was admitted to a department of internal medicine. At that time his blood pressure, which had been normal for many years, was abnormally high again because of his guilt about the death of his wife, which he felt had in part been caused by his behavior towards her in the earlier postwar years. This time the blood pressure could be kept under control with the aid of normal psychotherapy in which we discussed these feelings of guilt freely.

Case IV. In 1977 a sixty-one-year-old Dutch Army officer was admitted to the Leyden Department of Psychiatry in a state of chronic depression with suicidal tendencies and alcoholism. During the war, the Japanese had decapitated some of his comrades before his eyes. He survived the horrors of prisoner of war camps in Burma and Japan, and later he fought again in Indonesia during the independence war. After his return to Holland he went through two marriages, which were unhappy because of his too strict behavior and inability to experience affective contact. These inhibitions finally drove him into premature retirement.

During the first LSD sessions all the horror of wartime were relived, but his behavior did not change afterward. He could not experience a feeling of relaxation. In the fourth session he suddenly remembered that on his third birthday he had received a special postcard picturing a Chinese man with a sword stuck into his neck and blood pouring out of it. His parents did not say a word about it and apparently did not understand what the son had felt at that moment. What he had gone through in the Japanese camps was the realization of his nightmares related to the postcard scene.

After this session his behavior began to change. The nurses and the other patients noticed that he was becoming more friendly. In later sessions he regressed to very early patterns of behavior, lying on the floor and crying for his parents, who had been very strict and cool. In the confrontation with a new father and a new mother in the transference relationship, he could experience psychodramatically a kind of rebirth in a well-protected environment. This finally produced a striking improvement in his behavior. His depression disappeared, and with a new woman friend he continued his life under much better circumstances than before. He was even able to help others in acute emergency situations.

Specific Difficulties in the Treatment of Severely Traumatized Patients

After years of experience in treating severely traumatized patients, such as war victims, victims of terrorist acts and other victims of man-made disasters, I have concluded that most psychiatrists and psychotherapists do not know how to handle these therapeutic situations and the related transference problems. Careful analysis reveals the following points:

1. *The Essence of the War Experience*

Many therapists, especially those who have never had any war experience, find it difficult to identify themselves with the victims. Many war victims use the defense of saying, "You cannot understand me if you have not gone through it yourself." This defense can only be handled in the transference relationship if empathy on the part of the therapist is sufficient.

2. *The Rigid Mental Fixation of the Victims on the Most Traumatic Period of Their Life*

Most of the victims are fixated on the most painful experiences of the war: being tortured, being beaten, being confronted with torture of comrades and friends, and so on. During these horrible experiences the victims could seldom cry; they had to repress their emotions and continue life in a state of hopelessness, helplessness, and chronic depersonalization.

3. *The Functional Alexithymia of the Victim*

The modern concept of alexithymia—inability to express emotions in words—is very useful to describe the inability of the victims to convey what they have gone through in wartime. Some victims become alexithymic as a result of brain damage, but for the majority alexithymia is psychogenic.

4. *The Rigid Association of War Traumata with Other Traumatic Experiences*

Survivors who had had a healthy childhood usually showed improvement after the cathartic expression and abreaction of the war traumata. But in many cases the war traumata had activated earlier childhood traumata. The irony was that childhood frustration and affective neglect had often served as a kind of training for war survival; but this very training made the victims resistant to therapy.

5. *Master-Slave Roles in the Transference Situation*

Hoppe (1971) has accentuated the importance of the dominant roles of the concentration camp situation, those of master and slave. Many victims continue their postwar life in the role of the slave. They remain too submissive towards the outside world, even towards their own children. Others identify themselves with the role of the master; they are very strict and sometimes cruel to their families and others. A third group is marked by a rigid fixation on both sides, sometimes with a distressing oscillation between the two. In the transference situation many therapists are seduced into assuming too rapidly one or both of these roles themselves. Some take on the role of the almighty scientist who has a solution for everything, and others tell their patients that they feel powerless against the horrible past. The only solution is better understanding of one's own behavior and attitudes in relationship with the patient.

Some Personal Comments

The use of hallucinogenic drugs is not acceptable to those psychoanalysts who believe that it involves giving up the "gold" of traditional psychoanalysis for the "silver" of psychotherapy. They think that an LSD procedure cannot possibly disclose to the patient all the details of his neurotic defense mechanisms or defensive styles. But this seems to me mistaken. True, in LSD therapy the patient is confronted with his own psychic strategies in a way which differs from traditional analysis. But it is not true that LSD therapy is an abreaction procedure only. During an LSD session many patients are confronted with their resistances and defensive styles in such a convincing way that afterwards the essence of this confrontation remains etched in their minds; whereas in traditional psychoanalysis repeated repression or denial of what was experienced is a regular phenomenon.

LSD treatment, based on psychoanalytic principles and combined with a kind of psychodrama, is a form of direct analysis related to the work described years ago by John Rosen and Marguerite Sechehaye. Less time is needed than in ordinary analysis, for there is no need to wait weeks or even months until the patient gives up at least part of his pathological defensive styles.

The therapist needs the expertise to follow the patient from moment to moment during the session. This requires a special kind of sympathy or empathy and possibly also a personal awareness of the actual workings of the LSD process. At the time of a critical evaluation one knows exactly when the encounter was effective and when it was not. Patients who were entirely cured can usually describe exactly which moments of human contact during their LSD sessions led to fundamental changes in personality functioning. Commonly one hears from these patients: "I can feel better and more deeply; I can see so much better; I can listen so much better," etc.

Paradoxically, while the therapist is constantly trying to help the patient overcome his alexithymia, he himself may be unable to find words to convey to his fellow analysts his knowledge about the LSD process. To explain why in certain instances one uses a particular word or gesture or why one switches to an atypical approach remains a most difficult task. Outside the atmosphere created by the LSD session, words can only fail fully to reflect the essence of the experience.

A serious disadvantage of LSD therapy is the misunderstanding it creates in one's own professional circle and even more among other colleagues and laymen. Sometimes this leads to accusations and misinterpretations of one's scientific activities. Most psychiatrists are reluctant to pursue this type of work. Some feel intuitively that the confrontation with the world of psychosis may be too much for them to bear; others fear misinterpretation of their efforts by their own scientific community. Moreover, LSD treatment demands from the therapist a high level of honesty and sincerity. During LSD sessions patients develop such emotional sensitivity that it becomes entirely impossible to hide one's thoughts and feelings from them. This can be a difficult situation to handle.

But if one overcomes one's anxieties and achieves a direct human encounter, it can produce an immense enrichment of one's own existence. I have felt repeatedly, as I try to help these patients who are struggling for their freedom, that my work touches on that which is really basic in psychotherapy.

REFERENCES

Abramson, H.A. (Ed.). *The Use of LSD in Psychotherapy.* Madison, NJ: Madison Printing Company, Inc., 1960.

Abramson, H.A. (Ed.). *The Use of LSD in Psychotherapy and Alcoholism.* New York: Bobbs-Merrill, 1967.

Arendsen Hein, G.W. Treatment of the neurotic patient, resistant to the usual techniques of psychotherapy, with special reference to LSD. In *Topics & Problems of Psychotherapy,* Vol. *4*: 50-57. Basel/New York: Karger, 1963.

Arendsen Hein, G.W. Dimensions in psychotherapy. In Harold A. Abramson, (Ed.). *The Use of LSD in Psychotherapy and Alcoholism.* New York: Bobbs-Merrill, 1967.

Bastiaans, J. General comments on the role of aggression in human psychopathology. In J. Ruesch, A.H. Schmale, Th. Spoerri (Eds.), *Psychotherapy and Psychosomatics.* Basel: Karger, 1972.

Bastiaans, J. Het KZ-syndroom en de Menselijke Vrijheid. *Ned. T.v. Geneesk.,* 1974, 118.

Bastiaans, J. Der Beitrag der Psychoanalyse zur psychosomatischen Medizin. In *Die Psychologie des 20. Jahrunderts,* Band II, Zurich: Kindler Verlag, 1976.

Bastiaans, J. The implications of the specificity concept for the treatment of psychosomatic patients. In P.E. Sifneos, (Ed.), *Psychotherapy and Psychosomatics.* Basel, Boston, MA: Karger, 1977.

Bastiaans, J. Psychoanalytic psychotherapy. In E.D. Wittkower and H. Warnes, (Eds.), *Psychosomatic Medicine.* Harper & Row, 1977.

Bastiaans, J. Control and regulation of aggression. In P.E. Sifneos, (Ed.), *Psychotherapy and Psychosomatics.* Basel, Boston, MA: Karger, 1978.

Bastiaans, J. The use of hallucinogenic drugs in psychosomatic therapy. Paper presented at the European Conference on Psychosomatic Research, Bodø, Norway; July 9-13, 1978.

Bastiaans, J. Psychotherapy of war victims facilitated by the use of hallucinogenic drugs. Paper presented at the Vth World Congress of the International College of Psychosomatic Medicine, Jerusalem; September 10-14, 1979.

Bastiaans, J. Gijzelingen. In Mensen Bij Gijzelingen, Sijthoff, Alphen a/d Rijn, 1981, in print.

Brandrup, E., & Vanggaard, T. LSD treatment in a severe case of compulsive neurosis, *Acta Psychiatrica Scandinavica,* 1977, *55*: 27-141.

Grof, S. *Realms of the Human Unconscious: Observations from LSD Research.* New York: E.P. Dutton & Co., 1976.

Hoffer, A. & Osmond, H. *The Hallucinogens.* New York: Academic Press, 1967.

Leuner, H. & Holfeld, H. Ergebnisse und Probleme der Psychotherapie mit Hilfe von LSD-25 und verwandten Substanzen, *Psychiatric Neurology,* 1962, 143: 379-391.

Mallison, N. Acute adverse reactions to LSD in clinical and experiemental use in the United Kingdom. *British Journal of Psychiatry,* 1971, 118: 229.

Naranjo, C. *The Healing Journey.* Pantheon Books, Random House, Inc., 1973.

Ree, F. van. LSD 25; *een experimental psychopathologisch onderzoek,* Thesis. Deventer, Kluwer, 1966.

Rhijn, C.H. van. Variables in psycholytic treatment. In H.A. Abramson (Ed.), *The Use of LSD in Psychotherapy and Alcoholism.* New York: Bobbs-Merrill, 1967.

Rosen, J.N. *Direct Analysis: Selected Papers.* New York: Grune & Stratton, 1953.

Sechehaye, M.A. La Réalisation Symbolique. Hans Huber, (Ed.), Nouvelle méthode de psychothérapie appliquée a un cas de schizophrénie. Berne, 1947.

Grof, S. *LSD Psychotherapy,* Pomona, CA: Hunter House Inc., 1979.

Leuner, H. Halluzinogene in der Psychotherapie, *Pharmakopsychiatrie Neuro-Psychopharmakologie,* 1971, Stuttgart, Vol. 4: 334-351.