Psychotherapy with LSD: Pro and Con

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One of the not always dispassionate dialogues about LSD concerns its place in psychotherapy. The very forceful opinions range from a complete denial that a drug of this sort could have any usefulness to the bald statement that it induces miraculous cures.

In order to make some sense out of the contradictory and confusing claims, it would be well to consider first what psychotherapy is and then what its goals are. These matters are neither simple nor generally agreed upon, and part of the confusion stems from difficulty of definitions.

At the outset it can be asserted with a reasonable degree of confidence that psychotherapy is a learning process. It is the learning of new attitudes, new feelings and new behavior. This is a fair but overgeneralized description. The reason why most people seek psychotherapeutic help is because they finally realize that their present ways of living are distressing, ineffective or damaging. Their existing patterns of thinking, feeling and responding are the result of poor habits—maladaptive acquisitions of a lifetime.

Generally we learn in order to gratify some need or to avoid unpleasure. But our innate curiosity, the process of growth and cultural influences are also goads to the acquisition of new sequences of behavior. We seem to learn in two ways: by conditioning and by cognition. Some of our basic patterns are acquired by repetitive responses to stimuli associated with either a reward or punishment. If rewarded, the response is reinforced; if punished, it tends to be extinguished. Eventually, conditioning occurs, and the learned response becomes a part of our established psychological and physiological reaction pattern. Cognitive learning develops without conditioning and can result from single rather than from multiple events. The alternatives may be understood and the best response may be conceptualized rather than learned by trial and error. Cognitive learning can also be acquired by imitation; speech and other skills are mastered in this fashion.

The psychotherapeutic dilemma is how to get the patient to abandon the ingrained patterns for others which are more effective and mature.

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Neurotic patterns are especially resistant to extinction because, despite their discomfort, they seem to gratify some need of the patient. Such advocates of therapeutic conditioning as Skinner insist that retraining is a matter of repetition and reinforcement of proper stimuli which invoke the desired response until it becomes habitual. The Freudians claim that new emotional and cognitive insights are necessary before change can occur. At one time the recovery of repressed childhood conflicts and the emotional abreaction to them was thought to be the crucial factor. Later the "working through" of the patient's resistances and of his disturbed key relationships became the central issue.

Insight can be understood as the sense made by the therapist and the patient out of the obscure patchwork of words which the patient expresses. Some of the material is his life story, some of the fabric are dreams, free associations and other fantasy material. The nature of the insight will vary according to the mold the psychotherapist uses to formulate the material. Judd Marmor believes that although the explanation given by different therapists will vary, each interpretation has a definite relationship to the life pattern of the patient. A Freudian may express it in terms of unresolved Oedipal complexes, a Jungian will speak of archetypes, a Rankian of separation anxiety, and a Sullivanian of oral dynamisms. Marmor's point is that they are all structuring the data in their own terminology, but that a common core of reality underlies each of the explanations.

The value of the therapist's formulations can be looked upon more nihilistically. Any explanation of the patient's problems, if firmly believed by both the therapist and the patient, constitutes insight or is as useful as insight. It is the faith, not the validity, that counts. It is curious how under LSD the fondest theories of the therapist are confirmed by his patient. Freudian symbols come out of the mouths of patients with Freudian analysts. Those who have Jungian therapists deal with the collective unconscious and with archetypal images. The patient senses the frame of reference to be employed, and his associations and dreams are molded to it. Therefore the validity of any school of healing should not be based upon productions of the patient—especially LSD patients.

Intellectual insight is not as highly thought of as emotional insight. The latter is accompanied by an abreaction, or discharge, of emotion after the validity of the insight has been accepted. During this period of emotional turbulence the patient is supposed to be more amenable to change. If the patient "discovers" the insight with only a subtle assist from the therapist, so much the better. It is easy to see how new knowledge about the onset of neurotic behavior will be a fine opportunity to begin to alter it. But insight alone is not ordinarily enough to do the job. A repetitious, sometimes prolonged, relearning process must be instituted. Otherwise the patient backslides into the old habits.

Eventually the therapist becomes a highly significant figure to the patient. His notions of what is good and desirable tend to be adopted by the patient, and the therapist's overt or covert expressions of approval or disapproval come to constitute reward or punishment. Greater success in dealing with the immediate problems met with outside the therapist's

office is another source of reward which keeps the patient learning the more adaptive responses. More important than any other single factor is the relationship that develops between the patient and his therapist. Relearning occurs best in an atmosphere of trust and faith. When the patient sees the therapist as understanding, considerate and devoted, he is willing to begin the hurtful process of changing.

From what has been said, it can be deduced that insight into the devious behavior or the conflict underlying it may be necessary for therapeutic change to occur. It may be unnecessary, but it motivates the patient to work harder at his reconstruction. When someone has lived through decades of defective relationships and inconsistent communications with the important people in his life, this can be no simple or brief matter. Marmor states, "There is no substitute for the time-consuming process of patiently re-educating the patient concerning the nature of his perceptual, emotional, symbolic, and behavioral distortions, and enabling him by the working through process, to generalize and apply his increased understanding to many different life situations." (1)

A thoroughgoing personality reconstruction is the aim of some schools of therapy, such as the classical psychoanalysts. Others—the behaviorists, for example—are content with relief of symptoms. Analysts will claim that to relieve one symptom, such as hysterical blindness, will only lead to a substitute symptom; it is the buried conflict that must be resolved or its pressure will break out in new symptoms. The behaviorists reply that symptom substitution practically never occurs and that once the disability has been alleviated, further improvement in the emotional and perceptual distortions can accrue. The rapid removal of psychic symptoms, such as stuttering and enuresis, need not lead to the formation of new difficulties. If the loss of the symptom helps the patient adjust better, or if the need to retain the symptom is past, the substitution of other symptoms need not develop. One of the charges against LSD-type therapy is that it only relieves symptoms and does not alter the character structure. This is often true, but it need not be.

Since LSD therapy is often brief, it would be helpful to know whether rapid personality change can actually occur. When Pavlov's conditioned dogs were caged in a cellar that flooded one night, that single stressful exposure was so shaking that much of their conditioned learning was lost. In humans these stressful occurrences, during therapy or otherwise, have been called corrective emotional experiences. Behavioral and personality reshuffling has taken place following a momentous personal event. If it occurs at a time when the individual is psychologically ready to change, the personality realignment is dramatic and persisting.

It seems that intense and impressive psychic experiences make possible the sudden unlearning of ineffective ways of performing. After that, more satisfactory or more mature methods of functioning can be learned at an accelerated rate, perhaps even without outside help. This is far from invariable; most people will tend to slip back into the old, implanted habits. Rapid personality change is a possibility, but the hope for it exceeds its incidence.

If a question remains as to quick changes in ego structure, we know

that rapid superego alterations are quite attainable. Some of the more malignant emotional disorders of which patients complain are due to the excessive punishments their rigid and overstrict consciences mete out. Over and above what might be called appropriate guilt and shame, many patients belabor themselves with massive self-condemnation, which often evolves into a serious depression. Unjustified feelings of failure, constant self-depreciation or inordinately high standards lead to much unnecessary suffering. Unreasonable fears—for example, the earlier myth that masturbation led to madness—have marred many lives unnecessarily. These are quite readily amenable to re-education, especially during periods of nervous system arousal, as during the LSD state. Their resolution can be sudden when the extraordinary experience allows the patient a new look at his old values.

The various goals of psychotherapy are pertinent background information to assay LSD's role in psychotherapy. Naturally these will vary widely from person to person, according to his needs and his capacity to change. The following list of desirable aims which are generally agreed to be in the direction of personality growth are not given in order of importance.

1. The relief of distressing psychic or psychosomatic symptoms.
2. A reduction of neurotic anxiety with a retention of "realistic anxiety."
3. Personal feelings of worth, meaning and hope.
4. Feelings of self-fulfillment in work or other activities.
5. The ability to express "healthy" aggression in an acceptable manner.
6. A high level of functioning commensurate with one's capabilities.
7. The capacity to know oneself without too much distortion. This requires that one's defensiveness not be excessive.
8. The capacity to enjoy the physiological pleasures.
9. Flexibility and adaptability to life stress; the capacity to endure, or, when necessary, to compromise.
10. Low levels of stereotypy in thought content.
11. An appropriate sense of responsibility.
12. A capacity to love and be loved.
13. A satisfactory relationship to authority; the acceptance of good or necessary authority; the willingness to struggle against bad authority realistically.
14. An ability to tolerate ambiguity and dissonance in the environment.
15. An awareness of the immediate and distant situation.
16. Sensitivity to the needs, feelings and thoughts of others.
17. The ability to see oneself and one's culture with a measure of humor.

Naturally all these desirable objectives are never completely achieved. We spend a lifetime, with or without professional assistance, moving toward and away from maturity. The difficulties of evaluating the goals of psychotherapy are evident. They are intangible, shift with cultural movements and can be measured only crudely with the devices now available.

Some comparisons between brainwashing and psychotherapy techniques may be instructive. There are interesting parallels which have implications for our interest in LSD therapy. Brainwashing can be defined as an effort to rapidly change thinking and behavior to conform to a specific political value system. Its practitioners believe that it is justified since it is good for their system. A variety of practices are employed, many of them direct and harsh—exhortation, reward and punishment techniques, sensory, sleep or social impoverishment, persuasion, and the like. It is edifying to learn that strong emotional discharges for or against the political system are provoked and encouraged. In this period of excitation, suggestibility is heightened and established beliefs are more easily destroyed. New tenets, even beliefs opposite to those originally held, can be inculcated. Modern brainwashing methods depend less on physical violence and more on fomenting confusion, intense anxiety and on mobilizing guilt feelings. During the chaotic emotional state the introduction of false memories and ideas is possible, and they become fixed through repeated indoctrination. The victim is provided with an entirely new assumptive set.

It surprises people to read about an obviously absurd "confession" from a strong-willed prisoner after his confinement in some totalitarian jail. At the "trial" he does not appear to be under the influence of drugs or in any particular fear for his life. Even if he is released and deported, the instilled beliefs linger on for a time. The success of persuasion, hyperemotional abreactions and conditioning in revising long-held beliefs is impressive. It is a weird demonstration of the fact that attitudes can change and can change rapidly.

Psychotherapy, in contrast, is an effort to change attitudes and behavior in a direction which is good for the patient and permits him to live more successfully according to the value system of his culture as interpreted by his therapist. It has developed more indirect and subtle techniques—suggestion, insight, counseling, abreaction, the transference relationship, and the like. Both techniques employ suggestion to achieve their goal, especially during the abreaction, which is recognized as a hypersuggestible period.

From what has been said to this point, the question whether drugs like LSD could favorably influence the psychotherapeutic process can be split into two parts. First, can it accelerate learning? Second, may it provide a basis for rapid personality change by providing a profound emotional experience?

When the hallucinogens are used within the framework of conventional psychotherapy their proponents make the following claims:

1. They reduce the patient's defensiveness and allow repressed

memories and conflictual material to come forth. The recall of these events is improved and the abreaction is intense.

2. The emerging material is better understood because the patient sees the conflict as a visual image or in vivid visual symbols. It is accepted without being overwhelming because the detached state of awareness makes the emerging guilt feelings less devastating.

3. The patient feels closer to the therapist and it is easier for him to express his irrational feelings.

4. Alertness is not impaired and insights are retained after the drug has worn off.

Under skilled treatment procedures, the hallucinogens do seem to produce these effects and one more which is not often mentioned. That is a marked heightening of the patient's suggestibility. Put in another way, the judgmental attitude of the patient toward the experience itself is diminished. This can be helpful, for insights are accepted without reservations and seem much more valid than under nondrug conditions.

The part of the self that doubts, the observing ego, is in abeyance; the striking happenings and their interpretation by the therapist take on a "realer than real" significance. An overwhelming conviction in the value of the experience is felt. It is difficult to assess the contribution of suggestion to the psychotherapeutic effect of LSD, but it must be considerable. The therapeutic value of suggestion ought not be minimized. Although it is a "superficial" manipulation, it is a potent one. Suggestion and persuasion are part of every form of psychotherapy; under LSD their impact becomes a major feature of the procedure.

The previously mentioned enchancement of insightful recall and the emotional reliving of ancient traumas is a helpful take-off point for personality alteration. They by no means insure that beneficial changes will take place, but they facilitate the work to be done. Too many LSD therapists stop after the enormous insights and impressive abreactions have occurred. Actually, this point is really the start, not the end, of the re-educational process. After a patient has clearly seen himself for what he is, neither the sight nor the insight guarantees that he will be different in the future. One criticism of much LSD therapy is that the spectacular catharsis is considered sufficient to do the job. Most frequently, it produces a temporary period of glowing well-being, only to be followed by a gradual return to the old ways. Only a small number can, unassisted, use the dramatic events as a take-off point for progressive personality growth.

The difficult and more laborious process of relearning must still be undertaken and we have no evidence yet that this can be shortened with a drug like LSD. The desire to change may increase after one has clearly seen the burden under which one struggles, but hard, slow work still remains.

On the other hand, alterations of one's system of values can be rather rapid. One or very few LSD therapeutic experiences may modify the pressures of an overburdened conscience. By altering even for a few hours the habitual way of looking at ourselves, we might discover that the gnawing guilt was not due to a realistic transgression, but to the distor-

tions of a relentless, punishing superego. After the patient has taken a penetrating look at an alienated, misdirected life, he may still manage to acquire some degree of self-acceptance with a reduction in remorse. Many patients have an unrealistically low estimate of themselves; an increase in their self-esteem is most desirable. These superego manipulations are all that can be accomplished for some individuals. The decompression of the guilt-ridden may not only lighten their load, but can also improve their interpersonal relationships by making the subjects easier to live with.

Jackson sees psychotherapeutic value in the LSD experience as a new beginning—an existential encounter of decisive proportions to be followed by a realignment of the perceptual set. He believes that the LSD encounter can lead to character restructuring. Patients are apt to describe death and rebirth experiences during the period of drug activity. It is the rigid, punishing superego that dies and then is reborn free of the old guilt. It is a new start with the slate wiped clean. No doubt the process represents the use of strong denial, but this defense might be preferable to the previous manner of handling feelings of shame and self-condemnation.

A course of LSD for uncovering purposes is ideally given by a skilled, devoted psychiatrist to a suitable patient whom he knows very well from prior non-LSD interviews. The therapist should be familiar from personal experience with the nature of the changes that the drug induces. He must be flexible enough to use whatever psychotherapeutic techniques are suitable to the situation, which is much more intense than conventional therapy. The months following the LSD treatments are most important, to provide an opportunity for the client's retraining process.

Unfortunately these requirements are not always met; certain LSD practitioners are far from qualified. They have been attracted to the procedure because it is novel and spectacular, or because it puts the therapist in an omniscient position. The best of psychotherapists can obtain excellent results using almost any psychiatric system. They are therefore not inclined to revise their therapeutic technique. The unsuccessful ones are more likely to try every new approach, in the hope that the method will remedy their shortcomings. But more important, the LSD technique is so dramatic and powerful that it fills whatever occult needs some therapists may have to be a mighty, all-powerful figure. Such therapists can hardly be expected to guide their patients toward psychological maturity when they themselves have major unresolved problems. The "miraculous" result they obtain with LSD is the "honeymoon" effect that follows massive abreaction, the shattering death-rebirth ordeal with superego decompression. All too often the treatment terminates at what is really the starting point.

An evaluation of the role of LSD as an aid to depth psychotherapy cannot be scrupulously made now. The capable practitioners who use LSD seem to be able to help their patients through a reconstructive analysis quite successfully and at an accelerated rate. The activities of the "fringe" therapists make a sober estimate of its place as an aid to treatment difficult. The more spectacular claims of instantaneous character trans-

formation must be looked upon as conversions from one defensive repertoire to another—for example, from obsessiveness to denial and sublimation. These are the "cures" we read about in the Sunday supplements or hear about at cocktail parties. It must be restated that such shifts in the way life stress is handled can reduce tension and relieve such symptoms as impotence or psychogenic pain. It is like the lady who converts to Christian Science and trades her neurotic dyspepsia for a symptom-free sublimation of her troubles. This is fine until her appendix ruptures. Similarly, the patient who has had a transforming view of himself and the world through LSD may no longer see himself as worthless and the world as menacing. He can drop his guarded suspicious manner and become more open and outgoing. The hostility of others can be handled with denial. This is fine, provided the effect persists and is never fractured by events which cannot be ignored.

The adoption of a kindlier, more trusting approach to life by the LSD patient may in itself alter the attitudes of those with whom he interacts. They feel less threatened and insecure than when they are met with distrust. Thus the good feelings reverberate back and forth, converting the old, bitter world into a more amiable one. The patient's new adjustment is rewarded and reinforced. In this manner even a simple restructuring of the ego defenses can come to have a substantial and cumulative effect on the person and his problems. He has remade the old hostile environment into a benign one. The contribution of LSD in this instance is to substitute a less painful method of coping with existence, which is subsequently strengthened by a rewarding feedback from the environment. Jackson points out that when the immediate family is unwilling or unable to accept and foster the patient's new attitude toward them, it will be nullified and the patient will be worse off than before.

Some patients are completely unsuitable for a trial with the LSD type of therapy. The eternal adolescent who has never grown up or functioned effectively is a poor candidate. The extremely depressed, the hysterical and the paranoid personalities are poor risks because of the danger of accentuating their depressive, hysterical or paranoid tendencies. Although occasional claims have been made that psychotic patients have been helped, the consensus is that LSD is not for them. The borderline psychotic is a precarious patient because of the danger that he may decompensate and fall into a full-blown psychosis.

Ideally the LSD candidate will have the intelligence to understand the nature of the treatment and will have a strong desire to change. He should be willing to face and deal with considerable emotional pain during this more intensive treatment. The idea that the LSD phase is a beginning, not an end, of treatment must be acceptable to him.

People suffering from an excessively strict conscience, those who have lost confidence and self-esteem, and those who are unable to overcome the grief of a personal loss are the best candidates. Generally depressions due to situational factors are favorably influenced. Those "lost" people who are unable to find meaning in existence are particularly good candidates. Patients with anxiety or problems of passivity or aggressivity are amenable to treatment. Sandison claims that the psychopathic char-

acter disorders can be helped by LSD treatment. Sexual psychopaths and drug addicts have been given courses of LSD with some benefit. The problem of the chronic alcoholic will be considered separately.

The techniques of using LSD for uncovering therapy vary widely. After the general problem areas have become known to the therapist, the first LSD interview may be started with a small dose (perhaps 25 mcg) to give the patient a feeling of what the drug does. The dose is raised by small increments in subsequent sessions. Only rarely are more than 150 mcb needed for this type of therapy.

The effects of LSD last four hours even with the smallest doses and more than eight hours with the larger amounts. The protection of the patient requires hospital facilities and constant supervision by the therapist or another suitable person. These precautions, far from alarming the patient, reassure him that he will be cared for and protected.

The therapist has a more strenuous role to play than under ordinary treatment procedures. It is not only that the sessions last all day, but his active participation is required from time to time. For certain patients "letting go" is the most difficult part of the procedure. It means a surrendering of the façade, a giving up of the rationalizations, and a willingness to face up to what must be faced. The evasive maneuvers of the LSD patient are numerous and deceptive. He may try to intellectualize the experience to avoid the confrontation with himself. Conscious or unconscious efforts to suppress the drug effects are sometimes attempted. He may divert the therapist with somatic complaints or with fascinating descriptions of the visual wonders, a sort of flight into beauty. Delaying tactics of all sorts have been attempted. Instead of penetrating into crucial problem areas, the patient may try to skirt around them. An important part of the therapist's job is to identify the evasions and to concentrate on the ordeal of unswerving self-examination. He must insist that the material, overwhelming as it is, be completely dealt with. At the same time he must provide support and reassurance during the ordeal. It is a sort of "dig and fill" operation—an uncovering phase followed by a resolving and supporting phase. The patient cannot be allowed to flee from the frightening symbolism that comes up. If he does, there is danger of a period of psychotic disorganization. It is impressive how the terror disappears once the patient goes into the horrifying symbol and comes to grips with it.

A frequent question is, "How real are the LSD memories, how relevant is the symbolism that comes forth?" The memories may be completely accurate or they can be screen memories, protective memories which distort the actual event, and therefore less valid. Some memories may not represent events that actually happened but may symbolize underlying wishes or drives. The symbolism can be cast in abstractions, in the image of the person whose relationship is being considered or in strange, remote settings. Not infrequently feelings about the important people in the patient's life are projected onto the therapist, and his features and expression are then described as resembling them.

The common belief among psychotherapists that repressed memories for traumatic events must be released only over a prolonged period of

time, and then with great care and trepidation, should be reconsidered. Under LSD the most devastating of buried memories have been recovered and within a single session thoroughly relived and resolved. It requires courage by the patient and fortitude by the therapist, but it can be accomplished within hours. Perhaps it is the peculiar state of detachment or depersonalization which permits the LSD patient to exhume excruciating memories and, while reliving them, also be a calm observer to the events. Or, it may be the length of the session which permits the more intensive working through of the material.

Repetition is a valuable device for reducing the emotional load on recalled conflicts. Once the meaning comes to be understood, it is dealt with again and again, until it ceases to evoke an emotional response. Tape recordings of valuable sessions are used to re-expose the patient on future occasions.

A number of psychotherapists have used LSD in a group setting. Under these circumstances an intensified interaction and rapport between the participants is achieved, and the sessions tend to be more "gutty." Groups of hospitalized sexual deviates and of alcoholics have been studied. The use of LSD makes the proceedings more directly confronting and emotionally loaded. "Phoniness" on the part of the participants is quickly identified and rejected by the members of the group.

An unbiased careful study of the therapeutic effects of LSD on patients observed for a number of years after cessation of treatment would be highly desirable, but the difficulties of executing such a project are prodigious. It has already been mentioned that the therapist must believe in his brand of therapy if favorable results are to be expected. Naturally those who have faith in their type of therapy will be biased in their judgments of patient improvement. The patient himself is not necessarily a good judge of the therapeutic effect. The mere fact that he feels better does not necessarily mean that desirable changes have occurred. The goals of emotional growth are many, and their measurement is most difficult. For a proper study it would seem necessary to have a second set of impartial psychiatrists evaluate the patient for evidence of improvement, using predefined criteria.

The difficulties of doing a clear-cut study would be far from solved even with these precautions. A control group of patients matched as well as possible with the LSD patients must be given the identical treatment except that LSD is not used. A placebo or drug with some minor activity identical in appearance would have to be substituted. It is quite impossible to keep the therapist in the dark about who is getting the LSD because of its pronounced action. Will he invest as much energy and dedication to his non-LSD patients? The patients themselves will quickly know whether they have received LSD or not. Their expectations of its benefits will alter their therapeutic set. These difficulties and others are the reasons why a decisive test of the efficacy of LSD has not yet been performed. The problems are great but surmountable. Hopefully, this investigation will be done one day.

To state that other psychotherapies in current usage have not been exposed to a similar vigorous experimental survey is beside the point.

Psychiatry has entered a stage of development in which every new treatment procedure will require stringent proof of its effectiveness, and the older ones will also come to be scrutinized more critically. Thorough and convincing investigations of the tranquilizing and antidepressant drugs and of electroshock treatment have already been done to determine their relative values.

The second question is whether personality change can come about with LSD rapidly, safely and with some possibility of enduring. In this context change does not refer to the detailed examination of past relationships and attitudes so that they can be understood and worked through but consists of a sudden new look at oneself and the universe and a decision to abruptly alter the approach to the old problems.

Consider a man who had been living alone all his life in a private emotional fortress, busily engaged in deepening the moats and strengthening the parapets. Despite the prodigious defenses he still feels unprotected and insecure. Furthermore, the walls are now so high that he has separated himself from people. He can only shout to them from the battlements and cannot quite make out what they are shouting back, but the sounds are unfriendly. One day a tremendous storm destroys his stronghold. He is defenseless. To his great surprise he is not demolished or even attacked. People seem friendly. What had he feared? His own hostility? Why was he never loved? Was it those impregnable walls? Maybe it would be better to trust and rejoin the human race than retreat behind the barriers again.

A rapid personality conversion of this sort can happen spontaneously and without warning in the form of a religious experience, as described by William James in "Varieties of Religious Experience." Another type can be induced in a revivalist's tent by the fervid preaching of an evangelist. With proper preparation and guidance, drugs like LSD will also evoke this state. When it is chemically produced, it is called a psychedelic experience. The necessary elements are a stirring emotional encounter sufficient to change one's established values and the resolution to act upon the revelation. All degrees of confidence are placed in the event, from mild surmise to absolute certainty in the truth of the message. When credence is high, the need to change is great, and when the "significant other" rewards and supports the change, the possibility of an enduring conversion is favorable. Evangelical "cures" are too often impermanent because the incomplete conviction gained cannot withstand the harsh scrape of everyday living. Even spontaneous religious experiences which seem to have been divinely inspired may not resist the corrosion of disbelief and sabotage by the person closest to the convert. The transformation wrought by the psychedelic experience is subject to the same fate. In a favorable, rewarding environment it will flourish; inexorable punishment can destroy it.

The psychedelic technique fulfills the hopes of many troubled individuals for a magical intervention, a quick solution to their problems. For those who are unable or unwilling to undergo the major overhaul, a psychedelic resolution of this sort might be a feasible procedure.

There are hazards. If a person has seen the glory and goodness of life

via psychedelics and then backslides, the guilt of failure is added to the hopelessness of his situation. The depression may be deeper than before the treatment. Others who have been touched by the Light may develop so unrealistic a view of themselves and the world that they become most difficult to live with. These hazards demonstrate the need for counseling even when the psychedelic technique is employed.

The psychedelic type of psychotherapy has been administered to more chronic alcoholics than to any other diagnostic category. There are good reasons for this large proportion. The current estimate of problem alcoholics has been put at five million in the United States alone, and the supply is not diminishing. As a group alcoholics are disinclined to stay with a program of long-term psychotherapy. The recovery rate without treatment is very low (4 percent), and established treatments are far from cures. For those who can stay in Alcoholics Anonymous, the sobriety rate is understood to exceed 50 percent, but unfortunately this agency can reach only a minority of the total alcoholic population. The end stages of uncontrollable drinking are so deplorable that any measure that offers a possibility of success ought to be tried. Since the degree of drinking is something that can be estimated more easily than can personality change, one formidable problem—the evaluation of results—is eliminated. Although sobriety itself is not the highest of goals, nothing can be accomplished with the alcoholic patient unless he maintains sobriety.

While it may be rash to generalize about the causes of alcoholism or the personality of the alcoholic, perhaps something ought to be said about these matters. Alcohol has been defined as the liquid in which the superego is soluble. It may be even more of a universal solvent for our civilization than that. Some portions of ego function also dissolve in this socially acceptable form of surcease. Not only do the sense of responsibility, pride and self-respect melt away, but anxiety, depression, timidity and restraint also liquefy. Savage points out a further reason for the current epidemic of dipsomania. The drunk of an earlier era might have been drowning his sorrows; the modern drunk is filling the emptiness of his existence. It is the loss of purpose and meaning, the increasing alienation from life, that pushes many of our contemporaries into alcoholic excess. Many years ago William James suggested that one possible cause of alcoholism was the hope of finding something "out there," a search for a bit of a mystical experience. If this is so, the alcoholic is doomed to almost certain failure. He may get a flash of it in the instant before stupor prevails, but usually even that is denied him.

Alcohol is a valuable social item, and its moderate and even sporadically immoderate use is by no means decried here. It can procure feelings of friendliness, good cheer and relaxation. Some people want this aid to gaiety, gregariousness and well-being, and no reason exists why it should not be available to social drinkers.

As is the case with all psychochemicals, it is the difficulties of self-dosage which bring most alcoholics to heel. Those with the greatest unfulfilled needs and those who are seeking oblivion are the most vulnerable to the loss of dosage control. It may take many years of heavy drinking,

but eventually the addiction is established. Efficiency is impaired, jobs are lost, assets are wasted, families are split and health is broken. At this point guilt over the ruin that he has brought about and the sense of helplessness and hopelessness compound the alcoholic's reasons to drink. To attempt to rescue and rehabilitate an end-stage alcoholic can be a disappointing and formidable task. It is only rarely accomplished by the individual himself.

The notion that the drunk must hit bottom before he can be saved is well known and has implications for LSD therapy. "Hitting bottom" has a number of facets. It is usually brought on by a jolting disaster. The wife finally packs up and leaves, or the victim wakes up on Skid Row in DTs. It is usually the first occasion in which he unreservedly admits that he is a drunk. The admission is important, for it may start him looking for help in earnest. It is the point at which he realizes that he cannot go on; Tiebout calls it self-surrender. He gives up the inadequate positions of denial and rationalization and is finally willing to seek help from some external source. This may be found in religion (James suggested that religio-mania was a cure for dipsomania), A.A. or psychotherapy. Smith believed that some of his LSD-treated alcoholics experienced an artificial "hitting bottom" which was followed by marked improvement in the drinking pattern of half of his patients.

Some anthropologic evidence is available that hallucinogens used in a religious setting can combat alcoholism. The American Indians were a defeated people during the nineteenth century, deprived of their way of life, refugees in their own land. Too many of their number took to firewater. Most of those who later joined the peyote religion gave up whiskey. Obviously, the reformation was not due to peyote alone. It was the therapeutic combination of a faith, group solidarity and the ceremonial use of the drug.

LSD is generally utilized in a specific way when it is given to severe alcoholics for psychedelic therapy. The dose is much higher (200 to 600 mcg) than when it is employed for uncovering therapy, and only one or very few treatments are given. The aim is to achieve a profound transcendental experience. The massive amount of the drug defeats any possibility that the ego defenses will hold off psychic dissociation. A psychotic disorganization can be avoided by establishing a field of trust in the procedure and the participants. At the peak of the reaction the boundaries of the ego are lost, and a strong sense of unity with the world outside is felt. What is seen and felt are complementary to the egoless state. A new awareness of one's relatedness to others and to the universe is strengthened because the reality of these feelings is totally accepted. One's concept of self is drastically altered. The hopeless, sinful derelict is now an identity with meaning and worth. Experience becomes discontinuous. A break is made between the miserable past and the hopeful future. The old mess is over. It is a resurrection, rebirth, a new beginning. The rules of life have suddenly been changed.

What has happened? Obviously the "bad" superego has been demolished and replaced by a "good," nonpunitive one, thus reducing the load. The strong conviction of belonging and of having a personal worth

gives new meaning to the outer world and changes the perception of it. The drunk no longer has sorrows to drown, nor is his existence empty. The enormity of the experience, the total confirmation, in that it was all intensely seen, the clarity and "reality" of what was felt, all combine to break up the existing pattern of behavior.

Technically, this phenomenon can be analyzed in terms of an enormous use of denial mechanisms, superego introjects and regression. This is helpful, but another consideration is even more pertinent: can the experience actually produce abstinence in the severe alcoholic? The answer as might be expected is not capable of being reduced to a straightforward yes or no.

The half-dozen or so reports of the use of psychedelic therapy for the alcoholic indicate that over half the patients are considered much improved. The period of follow-up observation varies from a couple of months to a few years. The fact that the evaluators are enthusiastic believers in their method and that the studies are not controlled must be taken into account in appraising them. What seems established is that a certain number of confirmed alcoholics will actually stop drinking for years following this treatment and are able to rehabilitate themselves. Another group relapses immediately or after a period of time. It is an important matter to find out the precise results of his relatively short treatment over many years and what factors make for success and failure.

It is easy to be critical and say that only a faith cure is involved. It is true that nothing is changed—except that the patient has achieved a new faith, reinforced by the overwhelming experience of his sense and his senses. Faith can move mountains, faith can also stop a man's drinking for a lifetime—or a day.

DISCUSSION

Dr. Savage: I think that one of the difficulties common to all therapy is particularly true of the treatment of schizophrenics and the use of LSD. In therapy, you're working in such a superheated environment that it is very easy to pick up many of the patient's stresses and anxieties and worries. I don't think it should be limited to just LSD therapists. There was a paper on the occupational hazards of pyschoanalysis. A similar point was made. Essentially, therapy can be said to be a dangerous game; those who don't know it should stay out of it.

Dr. Cohen: I would agree. I would like to underline the fact that the psychotherapeutic position is a hazard in itself, but my only point is that LSD may add to the hazard.

Dr. Kramer: I don't feel that the fact that any particular medical therapy can perform a miracle, so to speak, and do something unusual for a patient, is a consideration in any other form of therapy. This objection

might also be raised: the surgeon who does an unusual heart or brain operation might feel a kind of omnipotent power, in a way, because he's saved a life which would surely be extinguished if it weren't for his operation. So I think if you raise that kind of question here, then you have to raise that kind of question with regard to all medical endeavor.

Dr. Cohen: Well, I agree that this is a problem for the doctor. Those of us who have occult, paranoid notions about ourselves are suspect, whether they be surgeons or other specialists. But again my point is with LSD you're using this phenomenal effect. We must be, I think, careful. I only offer this to you for your own observations; I don't offer it as proven. I have no data except the observations that I have.

Dr. Kramer: Let me just bring in a point of view with regard to the fact that you give a drug to the patient, and it also indirectly affects the therapist. In the animal kingdom this is not an unknown phenomenon; it's quite a common one. Injection of testosterone into male pigeons produces ovulation in the female. This is because the male then goes through very strong male behavior, and since the male is in relationship to the female and the female sees this, she starts ovulating. I've done similar things with my fish. If I put a female next to a male, I simply move my male to a tank with a glass partition, and a female who has been separated from males, say for a month, catches sight of that male. She not only starts ovulating, but deposits eggs without benefit of fertilization. This kind of effect, of treating one individual and getting an effect on another, is very common. As a matter of fact, it's common in the treatment of alcoholism in couples; the cure of one often disturbs the mate. So this is part and parcel of the dynamics of either a social relationship, a mating relationship or male-female bonds; and this is just one of the things that the therapist has to be aware of! Since it is a common phenomenon, he must take it into consideration in his treatment.

Dr. Cohen: In that regard I've had LSD therapists tell me that they, during the LSD session itself, had LSD effects. Here, too, this may be part of what you're describing. Again, it's a matter of emphasis rather than anything else.

Dr. Osmond: I think the people who are sensitive and good at this type of thing do run, as in any other kind of psychotherapy, an especial kind of danger. I think we are under an obligation, since not all of these people can be, by the very nature of this, professionally trained; we're under an obligation to understand this and provide them with the support and help which they need. We don't always carry out this obligation because I think, in part, we are unwilling almost to believe that their sensitivity could increase in this particular way. As Dr. Kramer points out, although it is quite well known among the biologists, we tend to believe that people are really well insulated although we talk about interpersonal relationships. They may impinge with immense force, but we prefer not to think of them that way. I think this does happen; I think it has to be studied; and I

think we have to develop the techniques for not allowing our therapists to be destroyed in the battle.

Dr. Grof: Dr. Cohen used a very appropriate parable in his most interesting paper in comparing a strongly defended neurotic with a man who builds and continually strengthens a tower with many moats and parapets, without being in real danger. I would like to project slides of pictures made by one of my patients who was undergoing the psycholytic series with LSD. The drawings illustrate Dr. Cohen's comparison in a most striking way.

The patient had an extremely severe case of cancerphobia, treated unsuccessfully for eight years preceding LSD therapy. During the sessions she was able to re-experience several traumatic events in her history, genetically connected with her complaints. The most important one was a sexual seduction by her foster father in the eighth year of her life. The final reconstruction, which she gave after she had re-experienced different parts of the event in many separate sessions, was as follows: the foster father was alone with her, and became sadistically excited after having killed a goose. He then turned to her, touched her on different parts of her body and finally put his penis into her mouth, promising that she would see it grow.

The patient had, in different sessions, a vision of a tower, indicating how far she had proceeded in therapy. The following interpretations of the pictures were made spontaneously by the patient:

1. A picture of the bathroom where the event was supposed to have happened. The patient drew a bird's-eye view and situated parts of the event in different parts of the room (noted in pencil).

2. A picture of the vision which the patient had when she approached in an LSD session the event in the bathroom for the first time. The mighty walls of the tower represent her defenses (built out of anxiety as denoted in the picture), which prevent her from getting to the traumatic event. The bathroom scene is situated on the inside at the bottom of the tower. The arrows represent the attacks of LSD aimed at destruction of the tower.

3. The tower was already damaged, but it was repaired with iron plates. The place where an arrow had already penetrated the tower is covered with crossed strips of plaster. This has, however, an ambiguous character, since it represents at the same time a part of the original bathroom scene with a red cross on the first-aid box.

4. Picture of a vision which followed immediately after the patient fell deeply into reliving the traumatic event. Blood flowing between the stones refers to the killed goose and perhaps also to a digital defloration by the foster father.

5. A vision immediately following that picture in four. On the left side there is a family house with the bathroom in the attic. The huge chimney of a factory bends over the street and touches the

small chimney of the house. In the same vision there is a target with the bull's-eye hit. ("That's it, here we are.")

6. In one of the following sessions the tower can be seen as a ruin or a monument. Grass and trees growing on the ruins represent the perspective of new life.

7. A full reliving of the traumatic scene, accompanied by a transitory ego disintegration which coincides with a vision of a mighty explosion, in which the tower and the patient are torn to pieces with blood flowing all over.

8. After the explosion the therapist enters the scene, picks up the pieces of the patient's body and puts them together. While he holds her in his arms a beautiful rainbow appears as an optimistic symbol.

9. In one of the following sessions only a few stones are left from the original tower, arranged in the form of a fireplace. A new, much smaller tower appears (reconstitution of defenses on a much lower level).

10. (a) An experience immediately following that shown in nine. The patient sits by the fireplace like a savage, cooking and eating the therapist. She terminates the feast by licking his femur. (b) She painted spontaneously, for comparison, how her attitude to the therapist appeared to her one year ago.

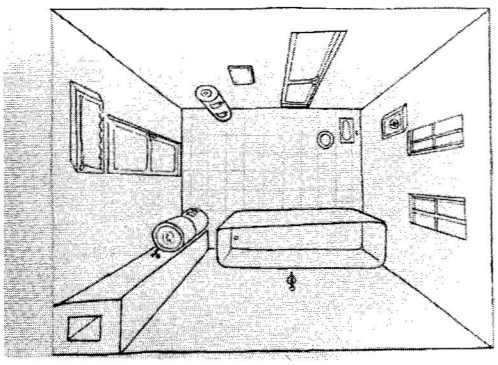
11. The smaller tower now has a spiral staircase. The patient describes how she can now mount the tower and see exactly what happened in the bathroom. At the same time her view is much broader and her horizon widened.

12. At a time when, in the clinical picture of LSD sessions and even in the free intervals, anxiety was partially transformed into libidinal tension, a vision appeared during one session: a hole in the earth could be seen at the place where originally the different forms of the tower had been perceived.

13. Later this hole was seen as deepened and broadened and contained different objects, a soldier's helmet, symbolizing the patient's marriage and some past traumatic experiences, and others.

14. In one of the later sessions the hole turned into a spiral formation ("screw") penetrating ever deeper into the earth. The patient herself discovered the sexual meaning of this vision.

15. The last vision of the "tower series" was that of a hot desert with a mirage of the tower. The patient now felt that the tower was only a useless fiction. The lower part bears a resemblance to the Eiffel Tower, being a symbol for "French" love which, at this time, formed the content of many daydreams and fantasies of the patient.



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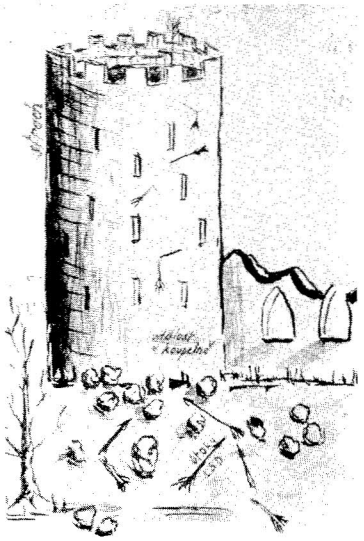

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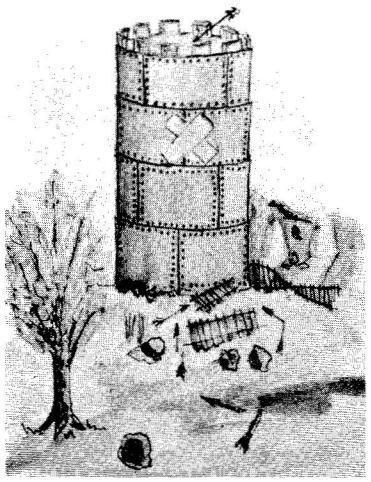

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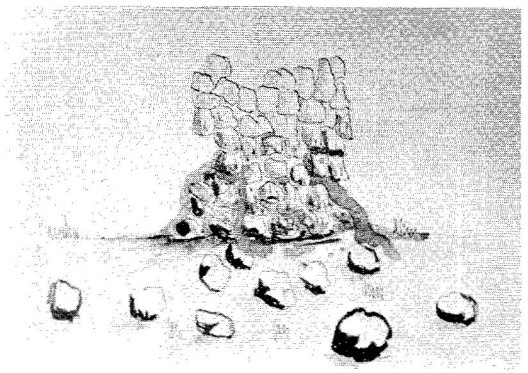

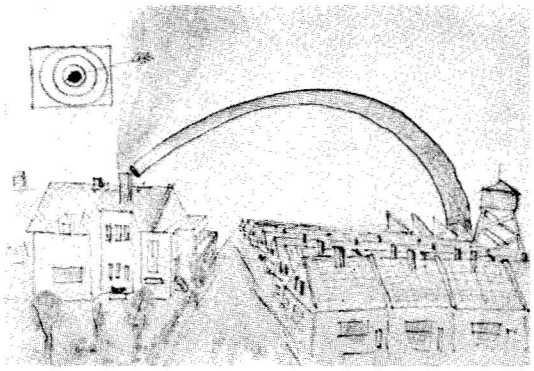

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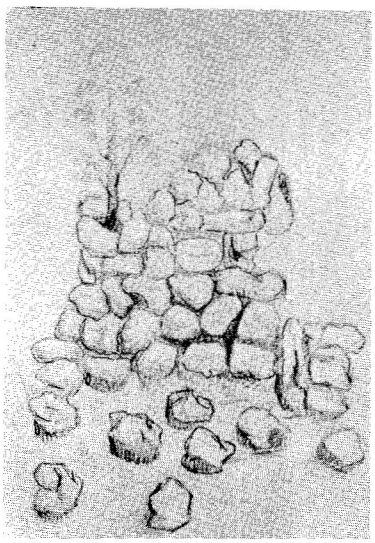

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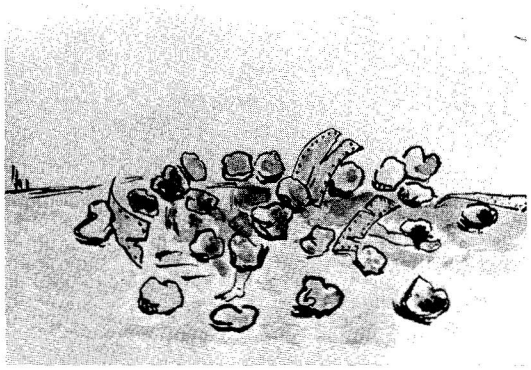

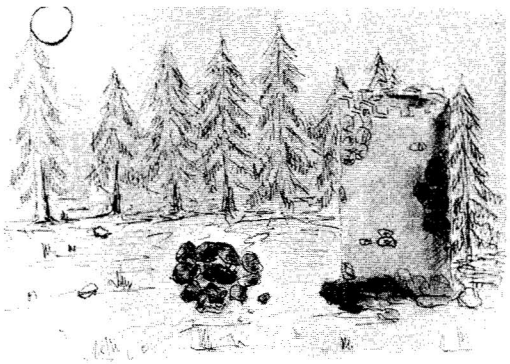

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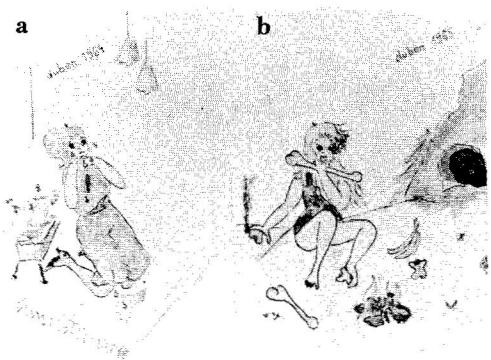

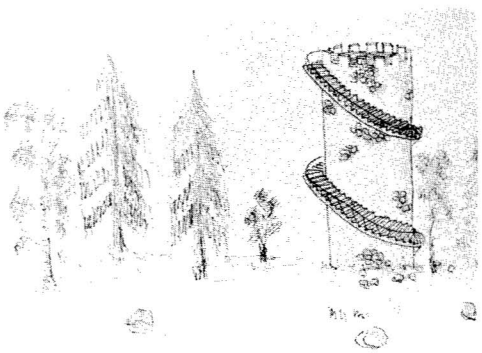

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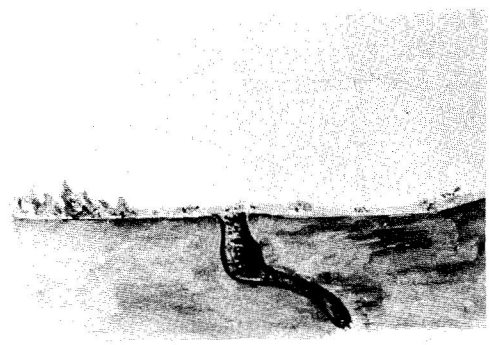

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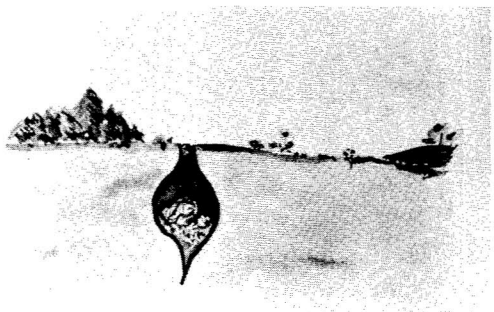

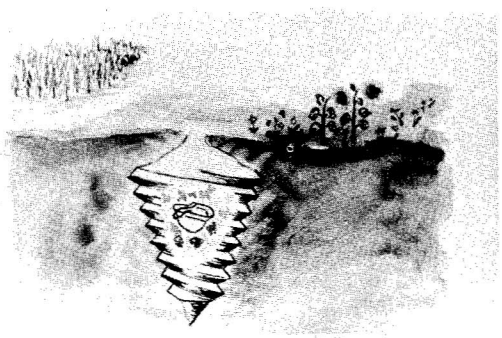

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