Part Three

PSYCHEDELIC DRUGS IN PSYCHIATRY

Many people remember vaguely that LSD and other psychedelic drugs were once used experimentally in psychiatry, but few realize how much and how long they were used. This was not a quickly rejected and forgotten fad. Between 1950 and the mid-1960s there were more than a thousand clinical papers discussing 40,000 patients, several dozen books, and six international conferences on psychedelic drug therapy. It was recommended for a wide variety of problems including alcoholism, obsessional neurosis, and childhood autism. Almost all publication and most therapeutic practice in this field have come to an end, as much because of legal and financial obstacles as because of a loss of interest. In the last decade only a few scattered articles and books have appeared, most of them based on earlier clinical work. Possibly those two decades of research and clinical practice that took up a considerable part of the careers of many respected psychiatrists should be written off as a mistake that now has only historical interest. But it might be wiser to see whether something can be salvaged from them, and also what the story suggests about the boundaries of psychiatry and the meaning of drug use in psychiatry.

There were two main sources of therapeutic interest. One was the afterglow effect: the belief of some experimental subjects after a single high dose that they were less anxious and depressed, and more tolerant and self-accepting. The other main interest arose from the possibility that therapeutic use could be made of psychedelic regression, abreaction, intense transference, and symbolic drama in psychodynamic psychotherapy. Two types of LSD therapy therefore emerged; one emphasized the mystical or conversion experience and its afterglow, and the other concentrated on exploring the labyrinth of the unconscious in the manner of psychoanalysis. Psychedelic therapy, as the first kind is called, involves the use of a large dose (200 micrograms of LSD or more) in a single session and was thought to be helpful in reforming alcoholics and criminals as well as improving the lives of normal people. The second type, psycholytic (literally mind-loosening) therapy, requires relatively small doses (usually not more than 150 micrograms of LSD) and several or even many sessions; it was used mainly for neurotic and psychosomatic disorders.

The theoretical basis of psychedelic therapy is rather underdeveloped, like that of the religious conversions it resembles or reproduces. The central idea is that of a single overwhelming experience which produces a drastic and permanent change in the way a person sees himself and the world (see Sherwood et al., 1962; Savage et al., 1967; Arendsen-Hein, 1972). It is assumed that if, as is often said, one traumatic event can shape a life, one therapeutic event can reshape it. Psychedelic therapy has a analogue in Abraham Maslow's idea of the peak experience. The drug taker feels somehow allied to or merged with a higher power; he becomes convinced that the self is part of a much larger pattern, and the sense of cleansing, release, and joy makes old woes seem trivial. In his great book on religious experience William James wrote that the drunken consciousness is one bit of the mystical consciousness and religiomania the best cure for dipsomania. One conception of psychedelic therapy for alcoholics is that LSD can truly accomplish the transcendence repeatedly and unsuccessfully sought in drunkenness.

In the psycholytic procedure, developed mainly in Europe, moderate doses of psychedelic drugs are used to aid in psychoanalytically oriented

psychotherapy by uncovering the unconscious roots of neurotic disorders. As many as 100 drug sessions ofer a period of 2 or more years may be required, although most treatments are much shorter. Patients may be hospitalized or not; they may be asked to concentrate on interpretation of the drug-induced visions, on symbolic psychodrama, on regression with the psychotherapist as a parent surrogate, or on discharge of tension in physical activity. Props like eyeshades, photographs, and objects with symbolic significance are often used. Music plays an important part in many forms of psychedelic drug therapy; detailed recommendations have been made about appropriate music for specific stages of the drug trip (Bonny & Pahnke, 1972). The theoretical basis of this kind of psychotherapy is usually some form of psychoanalysis. If birth experiences are seen as true relivings of the traumatic event, Rank's ideas may be introduced, and if archetypal visions are regarded as genuine manifestations of the collective unconscious, the interpretation will be Jungian. The patient remains intellectually alert and remembers the experience vividly. He also becomes acutely aware of ego defenses like projection, denial, and displacement as he catches himself in the act of creating them; and transference can be greatly intensified. This technique is discussed, with some case histories, in the papers by Jan Bastiaans and Hanscarl Leuner. In practice many combinations, variations, and special applications with some of the features of both psycholytic and psychedelic therapy have evolved; Stanislav Grof's ideas, described in his essay, are an example.

Case histories, however impressive, can always be questioned; placebo effects, spontaneous recovery, and the therapist's and patient's biases in judging improvement must be considered. It would be helpful if we could determine whether LSD is better than other treatments or no treatment in some definite range of cases. But evaluation of psychiatric results is difficult, since there are often too many variables to account for and no universally accepted criteria of improvement. For a methodologically sound evaluation, at the very least the patient's condition must be judged before treatment and for some time afterward, by independent investigators using carefully defined standards.

There should also be randomly selected control group of patients with similar problems who do not receive the same treatment. When drugs are used, ordinarily a double-blind experiment is essential; this means that neither the therapists nor the patients know whether they are receiving the drug or a placebo. Not many studies satisfy all these conditions; the most serious deficiencies are absence of controls and inadequate follow-up. In the case of LSD there is the special difficulty that a blind study is impossible, since the effects of the drug are unmistakable. As Jan Bastiaans points out in his essay, no form of psychotherapy for neurotics has ever been able to justify itself by these stringent standards; LSD therapy is no exception.

Almost all the interesting experiments are without controls. For example, in 1954 and 1957, R. A. Sandison and his colleagues at Powick Hospital in England issued reports on a series of hospitalized neurotic patients treated with LSD. Of 36 patients in the study, 30 could be reached for follow-up 2 years after treatment; four were described as recovered, eight as greatly improved, seven as moderately improved, and eleven as not improved. A 6-months follow-up for another 93 patients showed 65 percent substantially improved. This two-thirds rate is common in many kinds of

psychotherapy and does not by itself indicate any advantage for LSD. But Sandison and his colleagues point out that these were severe cases who had not been helped by other forms of therapy Sandison et al., 1954; Sandison & Whitelaw, 1957).

In 1964 Einar Geert-Jorgensen and his colleagues studied 129 LSD patients; some had been hospitalized, some were outpatients, and some were in group therapy. Diagnosis, dosage, and number of sessions varied greatly. A follow-up questionnaire answered by patients and their relatives revealed a 55 percent remission rate; this was not remarkably high, but the authors again point out that most of them were severe chronic neurotics who had been able to achieve nothing in long years of previous treatment (Geert-Jorgensen et al., 1964). Hanscarl Leuner reported substantial improvement in about 65 percent of more than 100 chronic neurotics, using an average of 38 LSD sessions per patient (Leuner, 1963; Leuner, 1967).

In 1967 E. Mascher summarized 42 papers on psycholytic therapy written between 1953 and 1965. Of the cases, 68 percent were described as severe. The diagnoses included anxiety neurosis, depressive reaction, borderline personality, obsessive-compulsive neurosis, hysterical conversion syndrome, and alcoholism; the mean length of treatment was 4½ months, with 14.5 psychedelic drug sessions. The rate of success (much improved or very much improved) was as high as 70 percent for anxiety neurosis, 62 percent for depressive reactions, and 42 percent for obsessive-compulsive neuroses. Fifteen studies included follow-ups, which took place, on the average, 2 years after treatment. At that time 62 percent of the successful cases were the same or better and 35 percent slightly worse than just after treatment; only a few actually relapsed. Mascher discusses the problem of evaluating the data from this very heterogeneous group of studies; he concludes that the relatively short treatment time and the possibility of handling difficult cases gives psycholytic therapy advantages over the psychoanalytically oriented psychotherapy on which it is modelled (Mascher, 1967).

Controlled studies are few, and these few show little or no advantage for psychedelic drug therapy (Robinson et al., 1963; Savage et al., 1973). But many psychiatrists who have done LSD therapy with neurotics would regard these experiments as far too brief and superficial to provide a genuine test, especially where so much may depend on the quality of the therapeutic relationship. For LSD therapy as in psychoanalysis, psychiatrists tend to favor neurotics with high intelligence, a genuine wish to recover, a strong ego, and stable even if crippling symptoms. Beyond that little is clear. How many sessions are needed? Should the emphasis be on expression of repressed feelings, on working through a transference attachment to the psychiatrist, or elsewhere? What should the psychiatrist do during the drug session? Must the patient be hospitalized? How much therapy is necessary in the intervals betwen LSD treatments? The fact that there are no general answers to these questions reflects the complexity of psychedelic drug effects; for the same reason a dose and diagnosis cannot be specified in the manner of chemotherapy. It seems that LSD treatment sometimes produces spectacular improvement in neurotic symptoms, yet so far no reliable formula for success has been derived from these results, and the few (admittedly inadequate) controlled studies are disappointing. In all

these respects, of course, LSD therapy is in no better or worse position than most other forms of psychotherapy.

Alcoholism

It is commonly accepted that one overwhelming experience which has the character of a religious revelation occasionally changes the self-destructive drinking habits of a lifetime. Inducing such an experience is the purpose of psychedelic therapy in the treatment of alcoholics. But can psychedelic drugs consistently produce an epiphany with lasting effects? There have been many positive reports in the literature. Albert A. Kurland reports the case of a forty-year-old black unskilled laborer brought to a hospital from jail after drinking uncontrollably for 10 days. He had been alcoholic for 4 years, and his psychological tests showed severe anxiety and depression. During the LSD session, he felt that he was being chased, struck with a sword, run over by a horse, and frightened by a hippopotamus. He said:

> I was afraid. I started to run, but something said 'Stop!' When I stopped, everything broke into many pieces. Then I felt as if 10 tons had fallen from my shoulders. I prayed to the Lord. Everything looked better all around me. The rose was beautiful. My children's faces cleared up. I changed my mind from alcohol toward Christ and the rose came back into my life. I pray that this rose will remain in my heart and my family forever. As I sat us and looked in the mirror, I could feel myself growing stronger. I feel now that my family and I are closer than ever before, and I hope that our faith will grow forever and ever.

One week later his score on a questionnaire testing neurotic traits had dropped from the 88th to the 10th percentile. Six months later his psychological tests were within normal limits; he had been totally abstinent during that time, and despite a temporary relapse when he lost his job, he was still sober after 12 months. Kurland points out how important it was that he had a loyal family; he also notes that it would have been difficult to reach this illiterate, culturally deprived man with psychotherapy (Kurland, 1967).

There is no doubt that LSD often produces such powerful effects on alcoholics; the question is whether they can be reliably translated into enduring change. Early studies reported dazzling success: about 50 percent of severe chronic alcoholics treated with a single high dose of LSD recovered and were sober a year or two later (Smith, 1958; MacLean et al., 1961; Kurland et al., 1967). Unfortunately, later research changed the picture. All the early studies had insufficient controls and most lacked objective measures of change, adequate follow-up, and other safeguards (Smart et al., 1967). When patients were randomly assigned to drug and control groups, it proved impossible to demonstrate any advantage for LSD in the treatment of alcoholism. The results have recently led two former advocates of psychedelic therapy, in a review of the literature, to admit that the evidence for it is not strong (McCabe & Hanlon, 1977). Apparently even the most profound and heartfelt resolutions to change—nothing is more deeply felt than an intense LSD experience—have to be regarded with skepticism. The great majority of alcoholics tend to improve after any treatment, since excessive drinking is often sporadic, periodic reforms and relapses com-

mon. At the time the alcoholic arrives at a hospital, he has usually reached a low point in his cycle and has nowhere to go but up.

The two major reviews of the psychiatric literature (Abuzzahab & Anderson, 1971; McCabe & Hanlon, 1977), although suggesting that LSD may be useful as an adjunct for some patients, understandably conclude that it is not a reliable treatment for chronic alcoholism, even when combined with psychotherapy, Alcoholics Anonymous, and other methods. But it would be wrong to conclude that a psychedelic experience can never be a turning point in the life of an alcoholic. Bill Wilson, the founder of Alcoholics Anonymous, declared that his LSD trip resembled the sudden religious illumination that changed his life. Unfortunately, psychedelic experiences have the same weakness as religious conversions. Their authenticity and emotional power are not guarantees against backsliding when the same old frustrations, limitations, and emotional distress have to be faced in everyday life. And when the revelation does seem to have lasting effects, it might always have been merely a symptom of readiness to change rather than a cause.

The fact remains that there is no proven treatment for alcoholism, or for any particular class of alcoholics identifiable in advance. Where so little is known, does it make sense to give up entirely on anything that has even a chance of working sometimes? There is also another issue. Some controlled studies show an improvement lasting from several days to several months; that is, they seem to confirm the reality of the psychedelic afterglow. The obvious recourse of supplementary treatments every once in a while has been suggested but never taken seriously, although the Native American Church peyote ritual is said to serve this purpose for some Indians. The peyote rite seems reasonably safe. No hospitalization or professional attention is required; psychoses, prolonged reactions, and drug dependence are almost never reported (Bergman, 1971). The majority of Americans are permitted to do almost anything in the name of psychotherapy or religion except use disapproved drugs. To grant non-Indian alcoholics in the name of psychotherapy the rights that the courts have given to Indians under the rubric of religious freedom, we would have to modify our social definitions of drug use drastically, and that remains unlikely.

Dangers

The main danger in psychedelic drug therapy is the same as the danger of any deep-probing psychotherapy. If the unconscious material that comes up can be neither accepted and integrated nor totally repressed, symptoms may become worse, and even psychosis or suicide is possible. But the potential for harm has been exaggerated, for two reasons. First, much irrational fear and hostility is left over from the cultural wars of the sixties. More generally, we tend to misconceive drugs as something utterly different from and almost by definition more dangerous than other ways of changing mental processes. The most serious danger is suicide; there are several reports of suicide attempts or actual suicides among patients in psychedelic drug therapy (Savage, 1959; Geert-Jorgensen, 1964). But many people who have worked with psychedelic drugs consider them more likely to prevent suicide than to cause it. Walter Houston Clark and G. Ray Funkhouser asked about this in a questionnaire distributed to 302 professionals who had done psychedelic research and also to 2,230 randomly chosen members of the American Psychiatric Association. Of the 127 answering in the first group, none reported any suicides caused by psy-

chedelic drugs, and 18 thought they had prevented suicide in one or more patients; of the 490 responding in the other groups, one reported a suicide and seven said suicidal tendencies had been checked (Clark & Funkhouser, 1970).

The available surveys suggest that therapeutic use of psychedelic drugs is not particularly dangerous. In 1960 Sidney Cohen made 62 inquiries to psychiatrists and received 44 replies covering 5000 patients and experimental subjects all of whom had taken LSD or mescaline—a total of 25,000 drug sessions. The rate of prolonged psychosis (48 hours or more) was 1.8 per thousand in patients and 0.8 per thousand in experimental subjects; the suicide rate was 0.4 per thousand in patients during and after therapy, and zero in experimental subjects (Cohen, 1960). Other studies have confirmed Cohen's conclusion that psychedelic drugs are relatively safe when used experimentally or therapeutically (see Malleson, 1971; Denson, 1969).

In a 10-year follow-up William H. McGlothlin and David O. Arnold studied 247 subjects who had received LSD either experimentally or therapeutically from three California psychiatrists between 1955 and 1961; 43 percent took it once, 34 percent two to five times, and 16 percent six to twenty times; 23 percent also used it later on their own. Of the 247, 26 reported some harmful effects: 9 said that they had lost some of the structure and discipline in their lives, or some of their competitive and aggressive tendencies, and that this had both advantages and disadvantages. Three thought they had suffered some physical harm (impaired eyesight, numbness in the legs); one thought he had suffered memory loss; one attributed marital problems to LSD use; seven spoke of increased anxiety and depression. Three regarded their drug trip as a horrible experience that left them with a painful memory; two said that they would have been better off without the knowledge that LSD gave them. There was one case of psychosis requiring hospitalization for a week. Most of the subjects regarded the experience as beneficial; 60 had had bad trips at some time; many regarded them in retrospect as useful (McGlothlin & Arnold, 1971).

All these studies have serious limitations. Many psychiatrists may have minimized the dangers out of therapeutic enthusiasm and reluctance to admit mistakes; a few may have exaggerated them under the influence of bad publicity; long-term risks may have been underestimated if follow-up was inadequate. The biggest problem is the absence of a basis for comparison between these patients and others with similar symptoms who were not treated with psychedelic drugs or not treated at all. Even where some information on adverse reactions during psychotherapy is available, we cannot be sure that the backgrounds and diagnoses of the patients are comparable. The rate of suicide in LSD therapy, for example, is apparently lower than the rate in psychiatric patients as a group, but possibly few patients with suicidal tendencies were given LSD. To repeat, however: psychedelic drugs were used for more than 15 years by hundreds of competent psychiatrists who considered them reasonably safe as therapeutic agents.

When a new kind of therapy is introduced, especially a new psychoactive drug, events follow a common pattern. At the beginning, there is spectacular success, enormous enthusiasm, and a conviction that it is the answer to a wide variety of psychiatric problems. Then the shortcomings of the early work become clear: insufficient follow-up, absence of controls, inadequate methods of measuring change. More careful studies prove disappointing, and the early anecdotes and case histories begin to seem less

impressive. But the rise and decline of LSD took an unusual course. In 1960, 10 years after it was introduced into psychiatry, its therapeutic prospects were still considered fair and the dangers slight. Then the debate received an infusion of irrational passion from the psychedelic crusaders and their enemies. The revolutionary proclamations and religious fervor of the nonmedical advocates of LSD began to evoke hostile incredulity rather than simply natural skepticism about extravagant therapeutic claims backed mainly by intense subjective experiences. Twenty years after its introduction it was scorned by the medical establishment and banned by the law. In 1974 a Research Task Force of the National Institute of Mental Health reported that there were no therapeutic uses for LSD. Today psychedelic drugs cannot be used in clinical practice but only in research, and only under a special license from the federal government. A few institutions still have the necessary licenses, but lack of money, restrictive rules, and public and professional hostility have made it almost impossible to continue the work. The situation in other countries is similar. In rejecting the absurd notion that psychedelic drugs are a panacea, we have chosen to treat them as entirely worthless and extraordinarily dangerous. Maybe the time has come to find an intermediate position.

Even the advocates of psychedelic drug use have become much more modest in their claims for its therapeutic virtues. Few now believe in immediate personality change after a single dose. The trend has been away from reckless enthusiasm toward caution, away from quick cures toward long-term therapy. Many now see psychedelic drugs as difficult to work with, emotionally exhausting for both patients and therapists, requiring much preparation and follow-up, and effective only in a restricted range of cases. They are no longer regarded as the main solution to any large problem like alcoholism. Nevertheless, psychedelic drug therapy did not die a natural death from loss of interest; it was killed by law. Even though many of the researchers who devoted a large part of their careers to psychedelic drugs have retired or died, and many more now ignore them entirely, there are still others who would like to use the drugs if they could.

No one who has studied the matter closely doubts the reality of psychedelic peak experiences, the capacity of psychedelic drugs to open up the unconscious, or the conviction of some who take them that they are gaining insight. Whether these can be put to any use is another matter. One of the best opportunities, as we have mentioned, is presented by the afterglow that may last as little as a day or as long as several months. If therapeutic research becomes possible again, it might be good to begin with the dying, since in this case only short-term effects have to be considered. Psychedelic drugs might also be used to get past blocked situations in ordinary psychotherapy, to help a patient decide whether he or she wants to go through the sometimes painful process of psychotherapy, or to help a psychiatrist decide whether the patient can benefit from the kind of insight that psychotherapy provides. In addition, MDA, harmaline, ketamine, nitrous oxide, and other psychedelic drugs with unique effects still need to be evaluated.

A persistent misunderstanding about psychedelic drug therapy creates special problems. It is felt that using these drugs means practicing a form of chemotherapy, like giving lithium to manic patients or chlorpromazine to schizophrenics: applying a chemical compound for specific, more or less uniform effect on a disturbed mind. It is not easy, especially in our society, to avoid thinking this way, and yet it is entirely misleading. The severe

mental illnesses that respond to chemical management are usually unaffected by LSD. Psychedelic drugs are used not as chemotherapy but to attain self-knowledge in a way that both resembles and allegedly intensifies the effects of other insight therapies like psychoanalysis, religious disciplines, and the forms of psychiatry collectively referred to as the human potential movement. (Shamans make this point metaphorically by saying that they use psychedelic plants not as a cure but as a means to pass messages to and from the spirit world where illness is produced.) As a Mexican Indian told a newspaper reporter who referred to peyote as a drug, "Aspirin is a drug, peyote is sacred." (Furst, 1976, p. 112.) Here psychotherapy borders on education as well as religion, and the Huichols accordingly say that peyote teaches. The emotional intensity of psychedelic drug therapy also has a counterpart in techniques like primal therapy, neo-Reichian or bioenergetic therapy, and encounter groups.

Thus, neither the virtues nor the dangers of this method are those of ordinary drug therapies. Patients are not maintained over a long period of time on LSD as they are on tranquilizers or antidepressants. The psychiatric use of LSD has produced nothing that can properly be described as a toxic overdose, and nothing remotely resembling drug dependence or drug addiction. On the other hand, the claims of psychedelic drug therapy are subject to all the same doubts as those of psychoanalysis or religious conversions: the impossibility of finding clear indications or suitable control groups when so much depends on the therapist's capabilities and training and the readiness of the individual patient; the difficulty of proving that the psychiatrist or guru and his patient or disciple are not deceiving themselves and each other; the danger of putting the patient in thrall to a charismatic authority or promoting illusory insight. The evidence for psychedelic drug therapy is poor by comparison with the evidence for treatments like lithium or chlorpromazine; it is fairly good by comparison with the evidence for other forms of insight therapy. But no one contemplates making these illegal, like a pill for which there is no proof of effectiveness.

The mixture of mystical and transcendental with therapeutic claims is another aspect of psychedelic drug therapy that troubles a society of irreligious or tepidly religious individualists. The pronouncements of drug enthusiasts are sometimes too much like religious testimonials to please either psychiatrists or priests and ministers. Pre-industrial cultures seem to tolerate more ambiguity about whether a medical treatment or a spiritual rebirth is being offered. But attitudes may be changing. There is a growing literature on the ideas and techniques shared by primitive shamans, Eastern spiritual teachers, and modern psychiatrists: the use of suggestion, confession, catharsis, reassurance, and relaxation; the effort to reinterpret the patient's or disciple's condition by articulating confused states of mind into a system and naming a cause; the necessity of creating confidence in the therapist or expectant faith; the emphasis on the healing powers of community; and often the induction of altered states of consciousness. Most of these methods are employed in both psychiatry and religion; they remind us that the word "cure" means both treatment for disease and the care of souls, and that all psychotherapy relying on insight in some ways resembles a conversion. That is why Jung compared psychoanalysis to an initiation rite.

Psychedelic drug therapy inherits this ambiguity from its shamanistic origins. The drug can be seen as a means of passage to the inmost self, the

collective unconscious, or the transpersonal realm; the voyage can be lived in Dante's terms or Freud's. Psychedelic therapy resembles a religious rite of rebirth; psycholytic therapy can be likened to a purgatorial travail as well as to psychoanalysis. And some drug users have gone "beyond LSD," but along the same road, by turning to the arduous disciplines of Zen and Tibetan Buddhism.

The role of the guide on a psychedelic drug trip partakes of this ambiguity. This social role is spontaneously reproduced in all cultures where psychedelic drugs come to be used. Just as the shaman undergoes an initiatory crisis and the psychoanalyst is psychoanalyzed, the guide trains by taking psychedelic voyages. He or she is a successor to the shaman or road man and may also be a friend, a psychotherapist, a physician, and at moments of intense transference a mother or father or some other charged symbolic figure. Since all this emotional intensity and all these manifold meanings are concentrated in the role, it is not surprising that much of the political controversy of the sixties was in effect about who was truly qualified to be a guide and how those qualifications should be established. For the moment we have made the curious and peculiarly self-disparaging decision that no one is qualified—that no one in modern industrial society should be allowed to do what a Plains Indian road man or a Mazatec *curandera* does.

It would simplify matters if we could be sure that those interested in psychedelic drug therapy are deceiving themselves, but we do not know enough about what works in psychotherapy to say anything like that. No panacea will be discovered here any more than in psychoanalysis or religious conversions. Nevertheless, the field may have potentialities that are not being allowed to reveal themselves. So we think it is worth listening to opinions like those presented in the essays in this volume, even though they are held by a small and diminishing minority of psychiatrists.

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