J. ALTERED STATES OF CONSCIOUSNESS, Vol. 5(4), 1979-80

PSYCHEDELIC DRUG-ASSISTED PSYCHOTHERAPY WITH PERSONS SUFFERING FROM TERMINAL CANCER

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ABSTRACT

An overview of an experimental program of psychedelic drug-assisted psychotherapy for terminal cancer patients suffering from psychological distress is presented. Therapeutic procedures are described in detail. Discussion focuses on the categories of altered states of consciousness reported by patients and their respective import for psychotherapy.

To introduce you to the cache of research experience that we will explore together, let us first go back in time to the year 1965. At that time, while the psychotherapy research staff of the Spring Grove Hospital Center near Baltimore was conducting federally-funded investigations into the possible usefulness of LSD in the treatment of severe neuroses and alcoholism, a forty-two-year-old female member of the research department staff was found to be terminally ill with cancer of the breast and widespread metastases. In an attempt to help mitigate her psychological distress, and to do whatever might be within the staff's capability to help her live the time remaining in as meaningful a manner as possible, the decision was made to offer her the opportunity to participate in a process of brief psychotherapy that would include a single administration of LSD, essentially in accordance with the procedures being investigated at the time in the projects with persons suffering from neuroses [1] and alcoholism [2]. After discussing this possibility with her physician and family, she gave her consent and began a brief period of

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intensive therapy that included both individual sessions and meetings with her husband and children. Then, in a supportive physical and interpersonal environment, she was administered 200 micrograms of LSD. Her own words, taken from a subsequently written report, best describe the apex and essence of her experience:

> I was alone in a timeless world with no boundaries. There was no atmosphere; there was no color, no imagery; but there may have been light. Suddenly I recognized that I was a moment in time, created by those before me and in turn the creator of others. This was my moment and my function has been completed. . . .
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> Without the time-space boundaries, life reduced itself over and over again to the least common denominator. I cannot remember the logic of the experience, but I became poignantly aware that the core of life is love. At this moment, I felt that I was reaching out to the world—to all people—but especially to those closest to me. I wept long for the wasted years, the search for identity in false places, the neglected opportunities, the emotional energy lost in basically meaningless pursuits. . . .
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> Later as members of my family came, there was a closeness that seemed new. . . All noticed a change in me. I was radiant, and I seemed at peace, they said. I felt that way too. What has changed for me? I am living now, and being. I can take it as it comes. Some of my physical symptoms are gone: the excessive fatigue, some of the pains. I still get irritated occasionally and yell. I am still me, but more at peace. My family senses this and we are closer.

Encouraged by this response of our first patient, described in more detail elsewhere [3], collaborative arrangements were made with the oncology department of Sinai Hospital in Baltimore and, during the next twelve years, ninety-one cancer patients participated in explorations of this form of short-term psychotherapy. Fifty patients, including most of the persons treated between 1965 and 1969, received LSD in the course of their treatment; forty, including the majority of those treated after 1969, received dipropyltryptamine (DPT), a shorter-acting drug; one of the most recent patients received psilocybin.

With the exception of a few of the early pilot subjects, screening criteria included: 1. the presence of psychological distress, defined as depression, anxiety, psychological isolation or physical pain; 2. an estimated prognosis of at least three months of life; 3. absence of brain metastases, organic brain disease, or other central nervous system involvement; 4. absence of recent history of myocardial infarction or imminent danger of cardiovascular accident; and 5. absence of current psychosis or history of chronic psychosis. Both men and women have been treated, ranging in age from twenty-four to eighty-one.

The initial motivation to participate in the brief psychotherapy offered varied markedly. Some persons explicitly requested inclusion in the research; others appeared to be responding primarily to the recommendation of their referring physician and expressed a willingness to try a new "treatment" that

might prove helpful in coping with physical pain and/or emotional distress. In the screening interview, all prospective subjects were informed that the experimental drug-assisted psychotherapy was not offered as a direct treatment for their physical condition, but rather was intended to help them cope with it more effectively. Questions regarding the safety and efficacy of the drug employed were discussed openly on the basis of available data.

THERAPEUTIC PROCEDURES

Therapy usually was conducted on an individual basis and typically proceeded in four stages: 1. approximately ten hours of interaction over a period of from two to three weeks to establish rapport, facilitate the initial resolution of conflicts when possible, and prepare for the drug-assisted therapy session; 2. a single session of intensive therapy on one day, assisted by psychedelic drug administration; 3. several hours of interaction during the week following the day of drug administration, and 4. periodic contact during the next three weeks and, when appropriate and desired by the patient, until death occurred.

The psychotherapists were psychiatrists and clinical psychologists who had been specially trained in the conduct of therapy assisted by psychedelic drugs, and had worked with alcoholics, neurotics, narcotic addicts, and normal volunteer subjects in the contexts of other studies. The therapists viewed the drug-assisted session as a unique psychotherapeutic opportunity, as opposed to a more distant orientation of "trying out" a new psychopharmacological substance. It was accepted that the value of psychedelic drugs in psychotherapy is strongly dependent upon the quality of the interpersonal interaction that precedes, accompanies, and follows the drug administration. As was expressed by Savage and Stolaroff over a decade ago, the therapists realized that, "Contrary to the belief of many investigators, the hallucinogens do not produce experiences, but inhibit repressive mechanisms that ordinarily operate and simply allow subjects to explore the contents of their own minds." [4]

Therapy Before the Day of Psychedelic Drug Administration

If issues of diagnosis and probable prognosis had not been clarified prior to the beginning of therapy, these matters were dealt with in as sensitive a manner as possible. Diagnostic or prognostic information never was "forced" on a patient; conversely, under no circumstances did a therapist participate in any plan to intentionally deceive a patient, as it was felt that such behavior would inhibit significantly the development of the quality of rapport that was considered prerequisite for an optimal response to the psychedelic drug.

The therapeutic orientation of most of the therapists could be labelled "existential-humanistic." [5] In essence, an attempt was made to "be with" the patient wherever he or she found himself or herself, and to offer strong support and tempered optimism in confronting and attempting to facilitate

resolution of material introduced by the patient, either from the past or the present. With some patients the resolution of interpersonal conflicts with family members became a major focus of therapy.

One week prior to psychedelic drug administration, any phenothiazine medication a patient was receiving was discontinued. Otherwise, narcotic, cytostatic and/or hormonal medication was administered as usual. A day or two before the drug-assisted therapy session, the patient became acquainted with the nurse who would assist and function as a cotherapist during the period of drug action. Besides meeting in whatever interpersonal depth was possible, the nurse appraised the medical nursing needs of the patient for which she would take responsibility on the session day.

Usually on the day prior to psychedelic drug administration, the range of possible types of experiences during the period of drug action was surveyed in order to mitigate undue anxieties during the session. Typically the metaphor of a journey was employed, and the patient was told that, in the course of his or her "travels," both pleasant and unpleasant experiences might be encountered. The patient was encouraged to accept and explore both negative and positive memories and emotions, and was informed that experiences of emotional suffering in retrospect often had been deemed beneficial by previously-treated patients. In general, emphasis was placed on the patient's psychological strength, and assurance was given that, with the support of the therapist and nurse, there was no experience that would emerge that could not be encountered and productively explored.

Patients were told that time often is experienced differently during the period of drug action and were instructed to trust the "arc" of the experience—that the same "force" that carried them deep within themselves also would return them to the everyday world as the drug effect wore off. Following the period of preparatory instructions, patients became accustomed to wearing a sleepshade and listening to music through stereophonic headphones, both of which would be employed during the drug-assisted session.

Therapy on the Day of Psychedelic Drug Administration

Drug dosage was determined by both body weight and assessments of psychological resistance, and tended to be moderately high. LSD dosage ranged from 200 to 500 micrograms with a mode of 300 micrograms. DPT dosage ranged from 75 to 127.5 milligrams, with a mode of 105 milligrams. Both usually were administered intramuscularly to prevent the possibility of loss of LSD dosage through vomiting, and because DPT is inactive orally.

The drug usually was administered after a brief period of conversation, at a time when the patient appeared to be reasonably at ease. With LSD, a sleepshade was put in place as the patient began to feel the drug effects, approximately ten minutes after injection, in order to help the patient focus attention on the internal phenomena that were beginning to unfold, and to

prevent distraction from external visual stimuli. Similarly, headphones were put in place, through which carefully selected, predominantly classicial music would be played throughout most of the period of drug action to help channel affective expression, facilitate relaxation, and provide an enhanced sense of nonverbal support and continuity during the various altered states of consciousness that would occur. With DPT, the patient was asked to recline on his or her back and was given the sleepshade and headphones immediately following the injection as the effects of DPT usually begin within two or three minutes and may be quite intense. With DPT, the therapist or nurse usually held the patient's hand as the initial drug effects occurred.

Patients who accepted the nonordinary states of consciousness quite readily and became engrossed in their experiences usually were not interrupted during the intense part of their sessions. In general, they were encouraged to "collect experiences" and to defer description and discussion until the effect of the drug had abated. Occasionally, the therapist would remove the headphones and sleepshade and give the patient an opportunity to communicate, having previously given instruction to remain silent in such situations if the patient felt that communication would interrupt an important experience that was in process. As the drug effect gradually abated, verbal communication typically increased in frequency.

When feelings were expressed, emotional support was given and the patient was encouraged to explore and permitted to express the feelings as completely as possible, irrespective of whether the emotions appeared to be pleasant or unpleasant. If a person began to become frightened by emerging psychological material, he or she firmly was enjoined to trust his or her own inner resources and to confront the conflict. In almost all instances when this situation occurred, the patient rapidly experienced a sense of resolution and relaxation, and reactions of panic and paranoia were circumvented. For example, if a conflict was symbolized in the form of an ominous mythological creature, the patient was supported in confronting the creature—a procedure that usually led to the transformation of the symbol into a significant person in the patient's life, or most commonly, into the patient himself or herself, accompanied by a sense of resolution and insight.

Transient autonomic effects occurred in some patients that often were reported to have a meaningful subjective component. Episodes of vomiting, for example, usually seemed to be correlated with experiences of psychological catharsis, and typically were followed by reports of reduction of fear, guilt or anger.

After the drug effects had abated, family members and close friends were encouraged to interact with the patient in accordance with the judgement of the therapist. Frequently rather poignant and effective family interactions took place at this time, and it was not uncommon for the patient to take the lead in counseling the family. Often young children were also granted permission to visit at this time.

Therapy After the Day of Psychedelic Drug Administration

Patients were visited by the therapist on the day immediately after the drug-assisted therapy session and on several occasions during the following week. During this period of time, the patient usually discussed in detail the experiences of altered consciousness that had occurred. Generally, patients had an intuitive comprehension of the meaning of most of their experiences, but occasionally remained perplexed about specific sequences of images. Through free association and the employment of mental imagery procedures similar to Leuner's "Guided Affective Imagery" [6], these patients often could be guided towards a recognition of meaning in such sequences.

Primary emphasis was placed on the application of insights gained to the problems and issues of everyday life. Often patients expressed an intensified desire to resolve various interpersonal conflicts and were supported in taking active steps in that direction.

THE COMPARISON OF LSD AND DPT

The same range of altered states of consciousness was reported by subjects who received DPT that had been encountered previously in research with LSD, including insightful personal experiences—sometimes entailing regression and encounter with either literal or symbolic psychodynamic material—and also phenomena of an archetypal and/or mystical nature. Indeed, there appeared to be no form of experience that was facilitated uniquely by either one of the drugs. Thus, from a phenomenological perspective, the potential contribution of the two drugs to the process of psychotherapy appeared comparable. Similarly, both drugs seemed well tolerated by cancer patients, even though many were severely debilitated physically. Differences between LSD and DPT, as discussed in detail elsewhere [7], consistently were found in terms of duration of drug action, rapidity of onset, and abruptness of termination.

CATEGORIES OF ALTERED STATES AND PSYCHOTHERAPEUTIC IMPORT

Let us now focus more closely on the phenomenological content of the drug-assisted therapy session, irrespective of the drug—or perhaps the method—employed as the facilitating agent.

There are three general types or levels of experiences reported by patients that appear to be potentially significant in facilitating decreases in psychological distress and increases in personal growth or self-actualization.

First, is the range of psychodynamic experiences well known in psychiatry and clinical psychology. Included are vivid experiences of regression, often to infancy or early childhood, that entail the literal or symbolic reexperiencing of emotionally charged material. Not uncommonly patients may encounter

unresolved grief, guilt, or anger that has been repressed and avoided for many years. Some patients have described intense existential experiences of condensed loneliness, sometimes including feelings of never having really lived, but only existed. The positive and negative emotions arising from interpersonal relationships with parents, siblings, spouses, and children also often are encountered in all their fullness.

A second type of experience, usually felt to be "higher" or "deeper" than the usual psychodyamic processes, is encompassed by the rubric of "symbolic–archetypal" phenomena. These experiences often include sequences of images or "visions" that are less obviously related to the person's life history. Often in the language of dreams or classical mythology, a fascinating array of symbolic experiences is encountered that often poignantly illustrates themes of personal relevance when subsequently analyzed. The so-called "deepest levels" of this type of experience typically are imbued with religious or philosophical significance, and it is not uncommon for persons to report intense encounters with personages or symbols described in various world religions. Common themes are those of purification, acceptance, and forgiveness.

A third type or "level" of experience is that of the so-called "realm" of peak experiences–sometimes called mystical consciousness. This state of consciousness, described in detail elsewhere [8], is characterized by a merging of the usual sense of self into an all-encompassing unity, described as being "beyond space and time." Often the experience is described in a framework preceded by the so-called "death" of the everyday personality, and followed by its "rebirth."

The meaning of mystical experiences to terminally ill patients–or to most persons for that matter–though verbalized in unique and diverse manners, inevitably entails an expressed conviction that, in spite of the reality of death, life somehow makes sense. Whether reference is made to "God," to "the core of being," to "the cosmic design," to "the void that contains all reality" or to some other religious or philosophical construct, persons who have mystical experiences during the period of psychedelic drug action typically report a subsequent sense of profound security and an intuitive awareness, called "noetic" by William James [9], that their lives are part of a vast, nontemporal order that ultimately is trustworthy, indestructible, and permeated by love. It is of interest to note that, in light of this awareness, the question of personal immortality–that is, the continued temporal existence of the everyday personality after death–generally ceases to be of importance.

Whether one chooses to view such mystical experiences as symptoms of psychopathology–even as merciful deceptions of a bedrugged brain–or as genuine ontological insights into the actual structure of reality depends upon one's own philosophical assumptions. Cognition may be somewhat different following mystical experiences, especially in terms of greater tolerance for paradoxes, but it is questionable whether this phenomenon should be labelled

"impairment." Similarly, although the model of regression may be useful and the unitive aspect of mystical consciousness may be suggestive of prenatal existence, the "noetic" aspects of such consciousness are not readily explained by traditional psychoanalytic theory. Those who might tend to interpret mystical consciousness as a "schizoid flight from reality" must confront the perplexing task of explaining why most patients who have such experiences do not manifest interpersonal withdrawal afterwards, appear to be relatively free of anxiety, and seem fully capable of mature behavior and decision-making.

Although persons who reported exclusively psychodynamic and/or symbolic-archetypal content during the period of drug action appeared to derive benefit from the intensive therapy session, the persons who also reported mystical experiences appeared to be those who lived the time that remained most fully and also approached death with the greatest degree of serenity. Quantitative support for these impressions has been published [10], including statistically significant positive correlations between the occurrence of peak experiences and rapid therapeutic progress, as measured by the Personal Orientation Inventory (POI) and the Mini-Mult, a brief form of the Minnesota Multiphasic Personality Inventory (MMPI). It would appear that mystical experiences indeed may contribute a significant element to the therapeutic process—a suggestion essentially congruent with the psychoanalytic concept of "regression in the service of the ego." [11] I would suggest that optimal treatment with this mode of therapy might be understood to include both a thorough exploration of conventional psychodynamic issues and an experience of a mystical nature in which one's life may be perceived from a new perspective.

The three forms of experience mentioned—psychodynamic, symbolic-archetypal, and peak or mystical—all of which appear to make significant contributions to the therapeutic process, need to be clearly distinguished from so-called "sensory-aesthetic" and "psychotic" phenomena, potential responses to the action of psychedelic drugs that have been sensationalized by the mass media. Sensory-aesthetic experience includes intriguing illusions, bodily sensations, displays of color and patterns, and alterations of environmental perception—a "level" of experience that appears to have little intrinsic import for psychotherapy. Similarly, experiences of panic, paranoia or confusion, which rarely occur when the drugs are administered in the context of a constructive therapeutic relationship, must be viewed as intrinsically antitherapeutic.

DISCUSSION AND CONCLUSIONS

A series of articles have been published that detail results of various phases of our work with LSD and DPT as adjuncts to brief psychotherapy with cancer patients [3,7,10,12–14]. Statistically significant decreases in such variables as depression and anxiety have been reported, supporting the overall efficacy of this approach to psychotherapy.

With LSD and with DPT some patients appeared to manifest impressive decreases in the intensity of physical pain, not only during the drug-assisted therapy session, but for days or even weeks afterwards; other patients, however, reported no noteworthy difference in pain intensity. With some patients, it appeared as though the fear of pain, perhaps interpreted as the herald of death, was abated during the drug-assisted session and thereafter, with an alleged loss of the fear of death, it became easier to permit muscular relaxation. Also it appeared to be easier for some patients to focus attention on persons and issues of importance, thereby relegating pain more to the periphery of conscious awareness. In addition to reducing the psychological factors that may aggravate pain, it is possible that pharmacological factors alone may play a significant role in some persons. Our attempts to gather reliable data on the variable of pain were minimally successful, limited to the analysis of records of narcotic consumption or independent ratings of "preoccupation with pain." It may be noted that one of the physicians who has observed our work is of the opinion that reported reductions in pain were more prevalent and more lasting in the work with LSD than was apparent with DPT. Although we found the measurement of pain in cancer patients to constitute a difficult research problem, a comparative study could be designed to explore this issue in a systematic manner.

Our positive findings are for a "therapeutic package" comprised of many variables, only one of which is the psychopharmacological action of the psychedelic drug. In order to attempt to isolate the unique contribution of the drug, a well designed controlled study would need to be pursued, ideally entailing random assignment to a group that receives therapy of comparable duration without drug administration, or with an active placebo. Although our attempts to obtain funding for such a project in the past have been unsuccessful, some of my colleagues and I remain interested in conducting such research or in supporting its conduct elsewhere.

Persons who have specialized in counseling with terminally-ill patients, such as John Hinton and Cecily Saunders in England, or Elizabeth Kübler-Ross in the United States, have indicated that therapy interventions unassisted by psychoactive drugs, often of very brief duration, sometimes can be of impressive efficacy with this population. Our experience similarly has been that considerable psychotherapeutic progress often appears to occur during the period of therapy that precedes the day of drug administration. However, it has been our clinical impression that the drug-assisted therapy session often facilitates a dramatic advance in the therapeutic process. Even some of the insights that have been verbalized prior to the drug-assisted session appear to be experienced in a fullness that seems to engender a more complete degree of resolution than previously was evident. Not uncommonly insights verbalized and concommitant expression of behavioral intent in resolving interpersonal conflicts that have been expressed ambivalently prior to the drug-assisted therapy session, have been manifested in concrete, decisive actions afterwards.

In conclusion, it may be stressed that DPT and LSD appear to have little usefulness as purely psychopharmacological agents. As potent tools within a constructive therapeutic relationship, however, their value could prove to be quite substantial. Throughout the research with psychedelic drugs at the Maryland Psychiatric Research Center, it became increasingly apparent that these agents provide not an "experience," but rather an opportunity for the resolution of conflicts and further self-actualization. Whether one retreats from the opportunity engendered by the drug action, thereby entering into anti-therapeutic sequences of panic; or whether one attempts to control the experience, thereby ensuring that little change of any kind will occur; or whether one responds fully to the opportunity, thereby permitting confrontation, resolution and insight, clearly depends on extrapharmacological variables. Paramount among such variables appear to be the quality of trust inherent in the therapeutic relationship and the personality structure and current conflicts of the patient.

It also may be noted that, in addition to the benefit this form of drug-assisted psychotherapy often has for the cancer patient, indirectly it has appeared to facilitate decreased stress in members of the patient's family. As mentioned above, not uncommonly it has been the patient who has become the primary counselor for family members. The shared anticipatory grief appears not only to make possible open communication between the patient and family and so-called "death with dignity," but also may be seen as potentially significant preventive medicine for the family members.

At the present point in time, this promising avenue of research lies essentially dormant, inhibited by limited research funding, other institutional priorities, an irrational climate fueled by psychedelic drug misuse, and other factors thoughtfully explored in recent books by Grinspoon and Bakalar [15] and Grof [16]. It is my hope that we will soon see its rebirth and continuation.

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