L.S.D. ANALYSIS

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L.S.D. analysis is the treatment of neurotic disorders with the drug called L.S.D. (Lysergic Acid Diethylamide), together with an analytical and behaviouristic technique. It differs from the usual L.S.D. method as described by Sandison (*Journal of Mental Science*, 1954) and Ling ("Lysergic Acid with Ritolin in the Treatment of Neurosis", 1963) in (*a*) not giving psychotherapy between treatments, except on rare occasions; (*b*) sitting with the patient during most of the treatment; (*c*) giving direct and active support to the patient of his emotional needs when necessary; and (*d*) developing quickly a transference relationship with the patient and giving analytic interpretation when suitable. This method differs from psychoanalysis only in the more direct approach to the patient and his or her emotional needs, and acting the rôle that they need you to take. This involves acting a different rôle and being a different person to every patient. This active participation of the therapist is needed, since the drug regresses the patients to the earliest experiences so dynamically that they literally feel as a baby and unable to cope or fend for themselves; but this is no longer frightening if their present mother, that is the therapist, is warm and understanding and can supply their needs at that level in some practical way, such as giving warm milk, holding their hand or putting an arm round them, and also talking to them at a conscious level, since consciousness is always maintained in the treatment, and reassuring them that it is good and normal to want these things, which all babies need and want but do not always get.

It seems important here that we are not only establishing a new and more favourable or positive response to the mother stimulus, and so breaking down the former negative response of fear and frustration, but we are also giving not just another artificial response, but one that is fulfilling the natural laws of Nature and which must, therefore, be more effective and truly satisfying than any other. In other words, we are not just giving a dummy, but something nearer to the original breast and the beginning of a love relationship. Once the patient develops emotionally from the oral to the Oedipal phase, we no longer give him physical support in any way, since this might incur too strong a physical transference, which might then be difficult to resolve.

The whole aim of our technique is to make use of the special qualities of this drug, which stimulates the hypothalamus and endothelial system, which enhances the normal feeling response and automatically produces a transference relationship to the therapist. The other special feature of the drug is its recapture of early memories and experiences right back to birth or pre-birth, such memories being not merely intellectual recollections, but dynamic experiences accompanied by strong abreaction and affect and the feeling of being a child or a baby again. This automatically puts the patient in a dependent position and so exaggerates his need for the parent figure, thus facilitating the development of a transference relationship. Once this is established, we can enable him to face up to all the painful factors in his life and upbringing, which originally the ego was not strong enough to accept; but now, with the transference to the therapist, these things can be accepted. And it is, in fact, the therapist's job to point them out, so that they

are accepted, however unpleasant, which is possible when the therapist, unlike mother, does not criticize or reject the patient for these things.

For example, a patient developed symptoms of violent headache and vomiting every time some unbearable aggression against her mother was coming out, which could not be faced and had to be converted to hate symptoms against the therapist. If the latter had responded with annoyance at the symptom of vomiting all over the bed and carpet, then the patient would have walked out and never returned. On the other hand, since the therapist did not show any annoyance, but only warmth and understanding, and explained to the patient what she was really feeling, which had produced these symptoms, the patient was able to accept it and said that she realized she had been furious with her mother about childhood events, which had been coming up in her mind recently. She had never dared show aggression to her mother, as she was dependent on and frightened of her, but now felt she could admit it to the therapist, at any rate.

This is our aim, therefore: to develop the transference relationship as quickly as possible to enable the ego to be strengthened and allow the previously unbearable feelings to be accepted and assimilated into the conscious personality, thus relieving the conflict and curing the symptoms and eventually integrating the personality.

In order to develop the transference, we had to observe each patient carefully, particularly in the first interview, and decide in what rôle he needed the therapist most: whether it was the warm and loving mother to the unwanted child, or the cool, aloof mother to the power-driven patient, or the firm but kind mother to the hysterical patient, for by following this rôle we knew that the transference would have a chance to develop. Freud maintained that in certain types of neurosis, called the narcissistic neuroses, the transference relationship did not develop, which made psychoanalytic treatment very difficult and lengthy, and was the cause of much criticism. We have, however, had many narcissistic neuroses to deal with under L.S.D., and find that, if we know the right rôle to play, then they gradually respond and develop a transference, and develop and integrate. For example, a man of forty-nine, obsessional schizoid, suffering from extreme sexual frustration causing tenseness, irritability, inability to communicate with others and depression, was eventually able, through the right attitude of the therapist, to communicate freely with her and eventually to have sexual feelings and show his penis to her, which was the first time in his life that he had done such a thing, but he felt pleased and not ashamed of it.

I will now give examples of this method of treatment in relation to a few cases in more detail.

(*a*) A man of forty-four, an obsessional phobic with paranoid anxiety and delusions about his appearance, extremely narcissistic and unable to make friends or communicate with people, came for private treatment through the hospital where he had been having treatment for the past three years without improvement. He had previously been a commercial artist, but had not worked for three and a half years and was utterly incapable of doing it, having lost all creative ability and living a monotonous routine life, afraid of everyone and everything, and had become desperate and suicidal.

History: He was the only son, between two sisters, one older and one younger than himself, and he had been very attached to his mother, although she was very

strict and used the cane on him, and was also rigidly religious. Unfortunately, she died when he was six years old, and a grandmother took over, whom he disliked. He was frightened of his father, who was a solitary type and who had never shown much interest in him. He never got over his mother's death and never formed a good relationship with the father, but had repressed homosexual feelings towards him, which carried much guilt and later were manifested in the symptom of acne.

Procedure: The therapist decided that the rôle to be played in this case was that of the warm and understanding mother, compensating his mother deprivation. During the first session, she found that the patient had a handkerchief over his face, which he said was covered with acne, and he was too ashamed for her to see it. He was unable to communicate and said he felt nothing, so the therapist began to ask him about his mother's death when he was six years old, and how it happened, etc. When he told her stoically about it, without showing any feeling, she then showed great sympathy, murmuring, "How terrible it must have been for a little boy of six, so devoted to his mother", etc., and this eventually enabled the patient to feel the incident more poignantly, so that he started to weep and weep, which he had never been able to do before, and this relieved him a good deal and made him less tense.

During the second and third sessions he chewed the pillow in a need for oral satisfaction and he continued to hold the handkerchief over his face, still saying it was covered with acne, although in reality there was none there. The therapist thought this shame might be connected with his sex life and asked him about this, but he denied having any sex feelings now, but had masturbated occasionally in the past. He remembered boys at school doing this openly but, although he wanted to, he could never join in because he thought it wrong. After the mother's death, he slept in the same bed as his father from six to eleven years of age, but could not remember any physical interest in him, although his dreams showed there had been some. His ego, however, was not strong enough to accept this, until the transference relationship had developed. The therapist therefore thought it advisable to stimulate his heterosexual feelings by talking extremely freely about sex herself and how it was available and acceptable to almost everyone in this day and age, and so she influenced his superego, which had rigidly repressed his sexual feeling, to become less rigid and to be able to accept his instinctive urges as good and not bad, so that eventually he lost his terrible guilt feeling. With it the acne delusion cleared up and also his agarophobia, so that he was now able to travel on buses and also to mix with people much better than previously. Eventually his confidence fully returned and he was able to get a job in designing and drawing, and is now in charge of a department with eight men working under him. He has heterosexual feelings and has asked one or two girls to go out with him.

Conclusion: After two years this man has remained completely well and happy, and has become emotionally stabilized. If he had been treated in a detached Freudian manner, he would never have responded or developed a transference, but the more direct approach of the therapist giving him the sympathy and understanding he had never received but always wanted enabled him to break down his resistances and express his feelings and form a new pattern of development. In behaviouristic terms, one could say that the original conditioned reflex

had been deconditioned and a new response had replaced it. On the other hand, this could not have occurred without the development of the transference situation and an understanding of his unconscious needs.

(*b*) In contrast to this case was that of a hypochondriacal man of fifty-two, with a hysterical overlay, who had previously been treated by two psychiatrists over four years for his sex phobia, but without success, so that he had now become completely despondent and apathetic, without interest in anything, and often unable to work. He had always liked girls and had become engaged to be married twice, but when it came to the sexual act he became terrified and was unable to continue the relationship and broke the engagement.

History: He had been very fond of his mother as a child, although she was cold and aloof and later had a schizophrenic breakdown, and spent most of the rest of her life in a mental hospital. His father died a few years later and he now lived with his sister.

Procedure: Each time under the drug he became extremely frightened, miserable and hysterical, saying he was dying and must have the best physician in London called in immediately, since he could not stand it. In his case, however, the therapist was extremely firm and reassured him that his fear was only due to his own instinctive feelings, which were so repressed, and he must now face up to them and the unconscious factors that his fear was hiding. He was gradually able to do that and brought out each time various sexual memories, for instance of having seen his parents together in intercourse, of having himself shared a bed with his mother at eight years old, when they both had measles, and of having strong physical feelings towards her, about which he felt terribly ashamed and so had never wanted to remember them. Now, however, with the support and understanding of the therapist, he was able to do so, and felt better for it. He had, however, to go through a great number of these experiences and then found that he was transferring much of his early desire for mother on to the therapist and eventually was able to resolve this, and to feel free sexually, and to approach another woman and have a normal sexual relationship for the first time at the age of fifty-three. Without the transference relationship and the direct and firm attitude of the therapist, this could not have been achieved.

(*c*) In another case of an obsessional schizoid man of thirty-three, the rôle of the therapist had to be entirely different. Here she noted, as she entered the room at the first session, that he gave her a quick glance and then closed his eyes and never looked at her again for six sessions; so she felt that he was full of guilty hostile feelings towards her and so just sat quietly by him, waiting for some sign or expression from him. He was sitting up in the bed very straight and rigid, with his arms stretched out along the bed and a tense hostile expression on his face, but he could not express what he was feeling and did not move or speak for one hour. Then he suddenly lifted up his arms and kept them stretched out for some minutes, then lowered one arm and pointed towards the floor and then withdrew his arm suddenly and stroked it. The therapist then very gently suggested that he had perhaps been feeling as a baby stretching out his arms to mother, and he immediately replied, yes, of course, that was it. The therapist then suggested that perhaps, when he was pointing to the floor, it might have been to some mess he had made and then have his hand slapped and have to stroke it, and he again said, yes, that had happened, and then seemed more relaxed and

content. In this way the therapist gradually won his confidence and broke down his mistrust and hostility and established a good transference relationship, which enabled him to overcome his fears and mature sexually to a genital level. This, however, was only possible as a result of the conscientious attention of the therapist, who did not leave him throughout the whole of the session of five hours, giving constant support and interpretation, without which the patient could not have resolved his hostilities.

DISCUSSION

These cases show that a different rôle has to be played by the therapist for every patient, and a direct approach must be taken to replace the unsatisfactory responses by new, more satisfactory, ones, and supplemented by analytical interpretation when necessary.

RESULTS

We have treated sixty cases in the last three years, between twenty-two and fifty-eight years of age, mostly very severe neurotics of the obsessional and schizoid type, who have had previous treatment with no success. Out of these only two females have not responded, since, although they improved to start with, they were unable to face up to their deeper conflicts and became too frightened to continue, and one man aged forty-nine, a paranoid depressive, who, after making great improvement and losing all his conversion symptoms, went on holiday with a girl friend who let him down and cheated him, and he relapsed. The others all remain well and only two come up occasionally for a psychotherapeutic interview.

CONCLUSION

An account has been given of our method of L.S.D. analysis, which consists of seeing the patient once weekly for L.S.D. and playing the rôle specially needed by him to build up a transference relationship, which will strengthen his ego and allow him to face up to his hitherto unresolvable conflicts. This often requires both a direct and an analytical approach by the therapist, thus combining a behaviouristic and psychoanalytical method of therapy, and staying with the patient during most of the session of six hours.

The average number of treatments was twenty, only two having sixty, and psychotherapy between sessions was rarely needed. Results showed a radical change in personality in forty-five patients and great improvement with increased drive in thirteen, with three only discontinuing treatment due to possible psychotic trends.