The doctor is the modern master of the mythological realm, the knower of all the secret ways and words of potency. His role is precisely that of the Wise Old Man of the myths and fairy tales whose words assist the hero through the trials and terrors of the weird adventure. —Joseph Campbell

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 aroused the interest of many psychiatrists who were in no sense cultural rebels or especially radical in their attitudes. 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 five years 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 would be wiser to see first 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.

Despite the example provided by non-Western cultures, there was little interest in the therapeutic use of psychedelic drugs until thirty years ago. In 1845 Moreau de Tours recommended hashish for the cure of hypomania, melancholia (especially with idée fixe), and other chronic mental illness; Baudelaire criticized him for it harshly in a footnote (Baudelaire 1971 [1860], p. 27). As we have mentioned, peyote was marketed by drug companies and occasionally prescribed for minor psychosomatic symptoms in the late nineteenth and early twentieth centuries (Prentiss and Morgan 1896); but deeper explorations were confined to experimental rather than therapeutic situations. In 1936 two psychiatrists studied the use of mescaline in cases of depersonalization, a condition in which the patient feels as though his body does not belong to him and his actions are not willed by him; they found that it produced temporary relief in some of them and a distinct therapeutic effect in one (Guttman and Maclay 1936). But this kind of research did not take on substantial proportions until the invention of LSD and the end of World War II.
Aside from the use of LSD and mescaline to produce effects which were thought to simulate natural psychoses (discussed in the next chapter), there were two main sources of therapeutic interest. One of these was the belief of some experimental subjects after taking a psychedelic drug that they were less depressed, anxious, guilty, and angry, and more self-accepting, tolerant, deeply religious, and sensually alert. For example, in one study normal subjects were given a single high dose of a combination of LSD and mescaline; on questionnaires three to twelve months later 83 percent said that the experience was of lasting benefit: 74 percent considered themselves happier, 66 percent less anxious, and 78 percent more able to love; 88 percent said that it gave them a better understanding of themselves and others, and 78 percent described it as "the greatest thing that ever happened to me." In the same study, psychological tests of seventy-four psychiatric patients before and six months after their psychedelic drug trips showed marked improvement in twelve, some improvement in twenty-two, and slight improvement in twenty-six (Savage et al. 1964; Savage et al. 1966).

In another experiment seventy-two normal subjects were divided into groups of twenty-four that received 200 micrograms of LSD, 25 micrograms of LSD, and 20 mg of amphetamine respectively; each drug was administered three times. All subjects were questioned and tested before the experiment and again two weeks and six months later. Fifty-eight percent of the experimental (high-dose) LSD group, as compared with 0 percent in the low-dose group and 13 percent in the amphetamine group, reported lasting changes in personality, attitudes, and values after six months—especially enhanced understanding of self and others, more introspection, a tendency not to take themselves so seriously, more tolerance, less materialism, more detachment, and greater calmness in frustrating situations. Seventeen percent of the high-dose group reported a pronounced lasting effect on personality. Questionnaire scores were less impressive, but they did indicate a small but significant relative decline in defensiveness and increase in frustration tolerance in the high-dose group. Thirty-three percent of this group also reported less anxiety and tension, compared with 9 percent and 13 percent of the other two groups. Tests measuring susceptibility to annoyance and embarrassment did not confirm these subjective impressions, but the high-dose group did show a significant change in galvanic skin response, a laboratory measure of emotional reaction to psychological stress (McGlothlin et al. 1970).

The other main interest was using the powerful experiences of regression, abreaction, intense transference, and symbolic drama in psychodynamic psychotherapy. A psychoanalyst, Mortimer A. Hartman, commented at a conference on LSD therapy in 1959, "About a year and a half ago, Dr. Wesley told me that Dr. Cohen and Dr. Eisner had achieved some spectacular results with a hallucinating [sic] agent called LSD. . . . When I took the drug myself, I found that I was suffering from the delusion that I had been psychoanalyzed. I had spent seven and a half years on the couch and over $20,000, and so I thought I had been psychoanalyzed. But a few sessions with LSD convinced me otherwise" (quoted in Abramson 1960, p. 20).
Two polar forms or ideal types of LSD therapy emerged; one emphasized the mystical or conversion experience and its aftereffects, 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.

Psychedelic therapy was originated in Canada in 1953 by A. M. Hubbard and popularized by Humphry Osmond. At first there was an ambiguity about its purpose. Osmond had observed that some alcoholics were able to recover only after they had hit a terrifying low point by going through the full alcohol withdrawal syndrome including the hallucinations of delirium tremens. He conceived the LSD trip as at least in part a controlled version of delirium tremens, somehow combined with a mystical revelation. There is no necessary contradiction here, since a purification rite can have hellish as well as ecstatic moments, and the experience of death and rebirth encompasses suffering as well as transcendence. In any case, the emphasis soon shifted away from the horrific and toward the mystical.

The theoretical basis of psychedelic therapy is rather underdeveloped, like that of the religious conversions it resembles or reproduces. The central idea of a single overwhelming experience that produces a drastic and permanent change in the way a person sees himself and the world is a familiar one. 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 an 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 (see Sherwood et al. 1962; Savage et al. 1967; Arendsen Hein 1972). In his great book on religious experience, William James wrote that the drunken consciousness is one bit of the mystical consciousness and that religiomania is the best cure for dipsomania. One conception of psychedelic therapy for alcoholics is that LSD can truly accomplish the transcendence that is repeatedly and unsuccessfully sought in drunkenness.

Psychedelic therapy was popular mainly in North America. Psycholytic therapy, was developed in Europe, and by the middle of the 1960s there were eighteen treatment centers in Germany, Holland, Czechoslovakia, Denmark, and Great Britain, all loosely associated in the European Medical Society for Psycholytic Therapy. In the psycholytic procedure moderate doses of psychedelic drugs are used to aid in psychoanalytically oriented psychotherapy by uncovering the unconscious roots of neurotic disorders. As many as a hundred drug sessions over a period of two 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 and Pahnke 1972).
Hypnotism has been employed to intensify the psychedelic effect, and so have other drugs,
especially amphetamines. The material is drawn from what Masters and Houston call the
recollective-analytic and symbolic levels of psychedelic experience. 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 interpretations will be
Jungian.

Instead of bypassing the complexities of personal history in a direct reach for mystical
communion, psycholytic therapy works its way into the patient's past through regression to a
childish state, recollection and reliving of early experiences, abreactive release of rage and fear
associated with emotionally charged events, and the enactment of daydream and nightmare
symbolic fantasies. The peculiar advantage of psychedelic drugs in exploring the unconscious is
that a fragment of the adult ego usually keeps watch through all the fantasy adventures. 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. Finally, transference can be greatly intensified, as Grof shows in the
following passage:

When Peter was working through the most superficial layers of the described COEX system, he
saw the therapist transformed into his past sadistic partners or into figures symbolizing
aggression, such as a butcher, a murderer, medieval executioner, Inquisitor, or cowboy with a
lasso. . . . On several occasions he asked to be tortured and wanted to suffer "for the doctor" by
withholding urination. . . . When the older layer from World War II was dealt with, the therapist
was seen as Hitler and other Nazi leaders, concentration-camp commanders, SS members, and
Gestapo officers. . . When the core experiences from childhood were emerging in these
sessions, the therapist was perceived as punishing parental figures. . . . The treatment room
was frequently turning into various parts of his home setting in childhood, particularly into the
dark cellar in which he was repeatedly locked up by his mother. (Grof 1975, p. 81)

Psycholytic therapy has been recommended to speed up psychoanalysis and psychoanalytically
oriented psychotherapy, especially for people with excessively strict superegos and a lack of
self-esteem; it has also been used to overcome the resistance of severe chronic neurotics with
defenses so rigid that they would otherwise be inaccessible to treatment. It has been found
most effective in anxiety and obsessional neuroses, sexual problems, neurotic depression, and psychosomatic syndromes. It is generally not recommended for patients with weak egos—passive-dependent and immature personalities, schizoid characters, and schizophrenics—or for alcoholics, drug addicts, and criminals. But there is no universal rule; even successful treatment of schizophrenia has been claimed (see Chandler and Hartman 1960; Van Rhijn 1960).

In practice many combinations, variations, and special applications with some of the features of both psycholytic and psychedelic therapy have evolved. Although obsessive-compulsives, for example, are not very susceptible to mystical experiences, and alcoholics are unlikely to tolerate long psychodynamic investigations of their lives, nevertheless the transcendental and the analytic aspects can never be entirely separated during a drug trip. Grof regards the form of treatment he developed in Czechoslovakia as a bridge between psycholytic and psychedelic therapy. The -systems of condensed experience- brought into consciousness by LSD (see chapter 4) are said to incorporate the most significant events in the patient's emotional life and permit a systematic exploration of personality along Freudian lines. This is followed by reliving the birth trauma and then passage into the realm of archetypes and transpersonal experience.

The last stages of treatment, he says, resemble the initiatory rites of mystery religions. In his opinion therapeutic effects occur at both personal and transpersonal levels, but the healing potential is greatest for those patients able to go through symbolic death and rebirth (Grof 1967; Grof 1970). Parallels for many mystical and visionary LSD experiences can be found in one of Jung's favorite books, the Bardo Thbdol (literally translated, "Liberation by Hearing on the After-Death Plane"—the Tibetan Book of the Dead), an ancient guide for the journey of the soul after death which is said to have been whispered into the ears of dying or dead men and may also have been meant esoterically as a guide for a living journey to other realms of consciousness. A Danish psychiatrist has used Timothy Leary's shortened version to guide LSD therapy sessions (Alnaes 1964).

Salvador Roquet, a Mexican psychiatrist, practices another kind of psychedelic drug therapy. He calls his method psychosynthesis, but it is not related to the technique of the same name used by Assagioli. Borrowing ideas from Huichol and Mazatec shamans with whom he has worked, Roquet conducts a large group marathon session in which the participants may take a variety of psychedelic drugs, including the dissociative anesthetic ketamine and even datura. With the help of a slide projector, eyeshades, and appropriate music, he forces patients to confront repressed feelings and memories by going through a bad trip and even a temporary psychosis. The aim of the purgative ritual is to bring the patient to confront his fear of death and to achieve rebirth. There are readings of brief autobiographies and group discussions afterward, while defenses are still weak and sensitivity high. This procedure is repeated several times at intervals of a month or more, with therapeutic interviews in between to integrate the unconscious material brought out during the drug sessions (Clark 1976; Clark 1977).
The Chilean psychiatrist Claudio Naranjo has pioneered in the use of psychedelic drugs that do not produce the same degree of perceptual and emotional disturbance as LSD. Harmaline and ibogaine, which he calls fantasy enhancers, permit the use of guided fantasy techniques borrowed from gestalt therapy to explore unconscious conflicts; MDA and MMDA, the "feeling enhancers," give a heightened capacity for introspection and intimacy along with a temporary freedom from anxiety and depression. In chapter 4 we quoted a passage from one of Naranjo's MDA psychotherapy sessions; illicit users have also described what they consider to be its therapeutic effects (Zinberg 1974). A reviewer of Naranjo's book refers to "a graduate-student commune of MDA enthusiasts whose friends observed that in the course of a year they had moved from a somewhat paranoid cast of mind to the benign conviction that the world was conspiring to do them good- (First 1974). Andrew Weil reports that users often achieve heightened physical coordination and freedom from allergic responses under the influence of MDA (Weil 1976). There is very little to add to this informal testimony and Naranjo's work (see Naranjo et al. 1967) except some experiments in the treatment of depression conducted in the 1950s (Friedhoff et al. 1958) and a recent study of neurotic outpatients (Yensen et al. 1976). Psychiatrists have hardly begun to explore 1the therapeutic potential of this unique drug.

We proceed to examine some cases of psychedelic drug therapy in more detail.

**Psychosomatic and Neurotic Disorders**

Here the theory is often psychoanalytic and the method can usually be described as a form of psycholytic therapy. In a book about her LSD treatment, one woman described the result this way:

"I found that in addition to being, consciously, a loving mother and a respectable citizen, I was also unconsciously, a murderess, a pervert, a cannibal, a sadist, and a masochist. In the wake of these dreadful discoveries, I lost my fear of dentists, the clicking in my neck and throat, the arm tensions, and my dislike of clocks ticking in the bedroom. I also achieved transcendent sexual fulfillment. . . ."

"At the end of nine sessions, over a period of nine weeks, I was cured of my hitherto incurable frigidity. And at the end of five months, I felt that I had been completely reconstituted as a human being. I have continued to feel that way ever since. (Newland 1962, pp. 20, 47)"
These passages were written three years after a five-month period during which she took LSD twenty-three times. Before that she had had four years of psychoanalysis, but it was only after taking LSD that she became fully convinced of the value of Freud's theories.

The actor Cary Grant went through a hundred sessions of LSD therapy. More than ten years later he said that he had been "reborn":

*The first thing that happens is you don't want to look at what you are. Then the light breaks through; to use the cliché, you are enlightened. I discovered that I had created my own pattern, and I had to be responsible for it. . . I went through rebirth.*

*The experience was just like being born for the first time; I imagined all the blood and urine, and I emerged with the flush of birth.* (Hoge 1977, p. 14)

He called himself a "zealous missionary" for the therapeutic use of LSD. He said that it had reduced his emotional immaturity, shyness, and egocentricity and transformed his relations with women, and added, "All my life I've been searching for peace of mind. I'd explored yoga and hypnotism and made attempts at mysticism. Nothing really seemed to give me what I wanted until this treatment." (Geller and Boas 1969, p. 220)

Huichols and Plains Indians commonly use peyote for relief of psychosomatic symptoms (Schultes 1938), and LSD too is often said to cure migraine, skin rashes, asthma, and hysterical paralysis. For example, the English psychiatrists Thomas A. Ling and John Buckman describe how they treated a severe case of psoriasis in a girl of fifteen, who had developed the disease when she was six. She was anxious, depressed, and ashamed of her body. During twelve sessions of LSD combined with the amphetamine congener Ritalin (methylphenidate), she relived her birth, remembered "what her natural mother looked like," and expressed anger at her adopted mother. With each session her skin became clearer, and she herself decided when to stop. Six months after the last treatment she was free of psoriasis, calmer and happier than ever before, and going out with boys for the first time (Ling and Buckman 1963, pp. 146-160).

Dietrich W. Heyder recounts the treatment of a welder who developed stiffness and immobility in his right arm after an accident at work. No physical cause could be identified, but the patient denied any emotional problems and was inaccessible to psychotherapy, even under hypnosis.
Séven months after the accident he was given sodium amytal and remembered several incidents that had occurred while he was a soldier in Korea; two friends had hurt their right arms, one of them in battle and the other at the hands of an enemy interrogator, in circumstances in which he blamed himself. The abreaction led to a temporary improvement, but soon the symptom returned and he denied any memory of what he had said under the drug. Since he was still unable to work and about to lose his job, LSD was used as a last resort, thirteen months after his accident. He received 300 micrograms three times in eight days. The first two sessions had no effect, but after the third he walked out with free movement in his arm; the symptoms did not return (Heyder 1963).

Ling and Buckman also describe several cures of chronic migraine headaches. In one case, a twenty-two-year-old woman who had suffered from migraine for eleven years went through nine LSD sessions. She relived trips to the dentist, her fear when she was given anesthesia for a tonsillectomy, and her desolation at being abandoned in a hospital when she was eleven years old. The migraine disappeared; three years later she and her husband wrote that she felt less tense, more at peace with herself, and more mature; the migraine never returned (Ling and Buckman 1963, pp. 38-40; see also ibid., pp. 40-51, and Sicuteri 1963).

Neurotic symptoms of many kinds—anxiety neuroses, obsessional neuroses, neurotic depression, and sexual disorders—have also been treated with the help of LSD. That obsessionals can be exceptionally resistant to the effects of LSD is illustrated by the following account:

The initial dose of 100 micrograms was increased by fifty to one hundred micrograms every week, since he barely showed any response. Finally he was given 1500 micrograms intramuscularly.

... Between the second and third hour of the session, when the effect of LSD usually culminates, Erwin felt bored and a little hungry; according to his description as well as external manifestations, nothing unusual was happening. . . It took thirty-eight high-dose sessions before Erwin's defense system was reduced to the point that he started regressing into childhood and reliving traumatic experiences. (Grof 1975, pp. .30-31)

And yet the effect can also be immediate and intense. The patient in the following case was a thirty-five-year-old accountant who had been in psychotherapy for five years for chronic depression and crippling obsessive symptoms. He was given 100 micrograms of LSD, and the psychiatrist suggested a fantasy about castrating his father:
The effect was electric. He exploded with laughter. The feelings and fantasies about father came pouring out, as though Moses had smote the rock. For the balance of the afternoon we reveled in an exchange of fantasies about his father. From that day he was a changed man. Previously he had been a Milquetoast at work, whom everyone pushed around. Now he became self-assertive and positive. He no longer let advantage be taken of him. He was poised and comfortable. . . . During the next LSD session (150 micrograms) he was able to continue the work of the preceding session. With the dread of his father laid to rest, . . . he expressed for the first time the desire for a girl. In the months following, astounding changes developed. He developed a sense of humor; he became efficient; he began to date; he made plans to leave his job and set up his own business, and this he actually accomplished. He enjoyed dating and experienced intense sexual feelings. . . . In seventeen (now nineteen) years of practicing psychotherapy I have never seen as much change in an individual with a rigid obsessional character. The change has been permanent. (Savage et al. 1962, p. 437)

Two Danish psychiatrists have given a remarkable account of their treatment of a severe case of compulsive-obsessive neurosis. The compulsive behavior began in 1958 and took the classical form of an exaggerated fear of contamination and infection, washing rituals, an insistence on neatness in dress, and fear of body contact. The patient felt no anxiety, but only an accretion of tension that required a release in the rituals. He received LSD from the fall of 1962 to January of 1964 a total of fifty-seven times, 100 micrograms each time. As he regressed to childhood and relived his harsh toilet training, the compulsive behavior diminished while anxiety rose. He began to remember dreams for the first time in his life. He realized that he had never been allowed to show his emotions and permitted himself to feel anger at his parents for the first time. In the thirty-second session he went through a rebirth experience and said that from then on he would consider that day his real birthday. He was now able to pick an object up from the floor for the first time in three years. When the LSD sessions ended, he was partially cured but retained some of his washing rituals; he continued in therapy until the summer of 1967, and by that time his compulsions had entirely disappeared. Psychological tests before and after LSD treatment confirmed a great increase in spontaneity, openness, fantasy, and humor. The authors say that they know of no other effective way to treat a genuine compulsive neurosis (Brandrup and Vanggard 1977).

As the enthusiastic reports of some experimental subjects and illicit users suggest, psychedelic drugs can also be used as a treatment for the more ordinary forms of neurotic depression and anxiety. The following is an example:

A 55-year-old man with a university education, good at his responsible post in a fairly large company, had a breakdown with anxiety, depression of the neurotic type, extreme lack of
self-confidence and sleeplessness. . . . When LSD treatment started he had already been unfit for work and on the sick list for several months. He had 15 LSD treatments, first twice and then once a week, with doses of up to 400 microgrammes. During the first ten treatments he had—in addition to the typical disturbances of perception—many vividly experienced memories of his childhood, right back to his earliest years. Through these he came to "understand himself better." All things considered, his condition improved during this period and he started work again. When I saw him during his 12th and 13th treatment a state of increasing anxiety had developed during the last few treatments. . . . He described this state of anxiety as a "terror in the absolute—connected with nothing." In his 15th treatment it reached a climax, with the feeling that he was "in a grip." Then he had a typical birth experience which he described in detail. He felt as if he were lying "curled up like a foetus," then as if "something" was done to his navel, and suddenly he realized that he had been through the experience of being born. . . . "I felt my mother, I felt her fear and I felt her sexual fear of father." After this experience he felt that he was "through in a double sense of the word" and that he needed no further treatment. . . . The improvement in this patient has been lasting. He is capable of carrying out his work and claims that he is "a different person." For example, he is no longer irritable over small everyday matters as he used to be, and in this respect the change in him is so pronounced that for a long while his wife thought he was keeping strict control of himself all the time. A habitual disposition towards overconscientiousness, perfectionism and an easily aroused sense of guilt are also now considerably diminished. Before treatment he often had anal cramp after intercourse. This has now completely disappeared....

His wife gives a similar description. (Vanggard 1964, p. 428)

Leuner describes the cure of another neurotic condition:

J. M., a twenty-six-year-old intelligent chief gardener, who had been suffering from a religious mania for five years and a compulsive neurosis (compulsive thoughts) for four years. Accompanying symptoms: inability to think and make decisions, derealization, work problems (inability to work) . After a conversion by Billy Gaham the patient had -received the holy ghost- and repeatedly experienced a state of ecstatic joy with speaking in tongues and other phenomena. He refused to take charge of his parents' plant nursery and became a lay preacher for a Dutch religious community. The compulsive thoughts, with which he engaged in a -severe inner struggle," began with -unclean thoughts" ... soon he thought himself possessed by the devil. Finally powerful apprehensions, with the need to invoke God, became associated with trivial everyday decisions, for example buying shoes, and this crippled all his activities. Treatment in a university psychiatric clinic and a state psychiatric hospital had no effect. After four months of inpatient psycholytic treatment he succeeded in returning to his occupation; after a further eight months of treatment (at intervals) the patient was essentially free of
compulsive and pathological religious thoughts. After more irregularly spaced treatment for ten further months, the patient married and returned to his parents’ gardening business, which he has successfully taken over. A change in stability of character was clear. Follow-up three years. (Leuner 1971, p. 347)

A striking and unusual case is the following:

... 31-year-old house painter sought treatment for his falsetto voice, which he was constantly conscious of, felt ashamed of and which made him unsure of himself, Inhibited, and nervous in associating with his fellow men. Amongst other things he never dared take a girl out because he was ashamed of his voice... .

He had 18 LSD treatments, with weekly doses of up to 500 microgrammes. During the 14th treatment his voice altered to normal pitch. Concerning the way this happened, he said that at first he saw a little newborn baby in a hallucination. Then he himself was the baby and lay in the same position as the baby had done, and felt his hair wet with some sticky liquid. This sensation was so vivid that he tried to wipe the liquid off with his hands. At the same time he heard a deep voice speak to him. To begin with the voice stammered incomprehensibly, then it changed to a normal man’s voice—the one I have got now”—which addressed him repeatedly with the admonishing words: -Go into manhood." For the next two or three days his voice leaped up and down, then it settled into its normal pitch which it has kept since. He now feels "a thousand times better," he can mix with people and go out with girls without feeling shy. (Vanggaard 1964, p. 429)

Ling and Buckman treated a case of severe anxiety in a thirty-two-year-old man who had had 200 hours of psychotherapy in the preceding six years. He had never had a deep love affair, and was frightened of women:

"I felt about once a year what I feel all the time now. This would occur for a short time if a girl told me she loved me. I was in a state of unhappiness the whole time with acute worrying and acute anxiety about all sorts of little things."

He had sixty-five LSD sessions, first with Methedrine and then with Ritalin, and one hundred sessions of psychotherapy.
"Hate of my mother was the first feeling that came up. At first I didn't dare accept that I hated her. I also found under the drugs that I greatly feared my father. Fear and hate of my mother and father have dominated my life for thirty years. . . .

He remembered, or thought he remembered, sexual play with his mother as a young child:

"We were discovered by my father and it was an appalling traumatic experience for me, because I found that she lied about it and said it was all my fault. I found in this instant, because it all happened so quickly, that my world collapsed. . . . I couldn't find any way of living with her, and therefore I had to cut her out of my life, which I have done for the last thirty years, and with her, of course, all other deep human contacts, particularly with women. . . . Now I realize that this lifelong need to get other people's approval was dictated by the feeling that otherwise they would kill me."

Since the release of his fear and hatred,

"I don't see how I could have changed more than I have. Now life to me is thoroughly enjoyable. I can't explain why, but it just is fun.... I get a tremendous lot of pleasure out of living, and previously I just didn't know what happiness was. . . .
"I have been in love twice in the last two years and I now feel able to love and have a full life. . . .
"I would say that instead of maturing at the usual age of fifteen to twenty, I have matured since I started LSD. The process is still going on." (Ling and Buckman 1963, pp. 135-145)

Grof reports the following case:

Richard was a twenty-six-year-old student who had suffered for several years from severe, unrelenting depression that resulted in six serious suicidal attempts. In one of these, he ingested rat poison, which according to his words, reflected his feelings about himself and his critically low self-image. In addition, he had frequent attacks of intense free-floating anxiety, excruciating headaches, agonizing cardiac pains and palpitations, and severe insomnia. The patient himself related most of his complaints to disturbances in his sexual life. Although he had many friendly relationships with women, he was not able to approach them sexually. . . . At irregular intervals, he got involved in homosexual activities in which he always played a passive
role. Here he was able to achieve momentary sexual satisfaction, but [suffered from] subsequent feelings of guilt. . . .

One of the most important COEX systems uncovered during Richard's LSD therapy was related to his passivity, helplessness, and the role of the victim that he had tended to assume in a variety of life situations. . . .

A deeper layer of the same system contained condensed memory material related to Richard's experiences with his brutal, despotic, and autocratic father, a chronic alcoholic who used physically to maltreat the patient as well as his mother in the most cruel way. . . . Richard relived many such episodes of abuse in a rather complex and realistic fashion. . . .

The next layer of this COEX system consisted of several traumatic memories from childhood. . . . [for example, he] tried to explore the inside of the family radio and got a strong electric shock. . . . drowning for a short time in his bathinette. . . .

He came to the conclusion that the birth trauma was the fundamental prototype of all the situations in which he felt absolutely helpless and at the mercy of a destructive external force. After the experiences of rebirth, positive ecstatic feelings of long duration occurred in Richard's sessions. They brought about a far-reaching improvement of the clinical condition. His depressions, anxieties, and psychosomatic symptoms completely disappeared, and he felt full of activity and optimism. His self-image improved considerably, and he was able to form an erotic relationship with a woman and have the first heterosexual intercourse in his life. (Grof 1975, pp. 57-60)

LSD treatment can apparently also resolve sexual problems:

A forty-one-year-old schoolteacher, who since his divorce twelve years earlier had suffered from total coital impotence. There were also important character::neurotic traits. Psychotherapeutic treatment, in part with well-known psychoanalysts, over a period of more than six years was unsuccessful. The patient can however think a little in psychoanalytic categories. After fourteen psycholytic sessions in nine months, combined with group and individual therapy, there was a clear change in his character structure: the patient is freer, more relaxed, more open to contact, and his prudish timidity in sexual matters has diminished. Successful and continuing sexual contacts. Follow-up after eight years without relapse. (Leuner 1971, pp. 346-347)

Ling and Buckman describe the case of a forty-nine-year-old man who had been engaging in flagellation and mutual masturbation for four years with his sixteen-year-old son. He had been continually unhappy and often clinically depressed for most of his adult life. Three years of analytically oriented psychotherapy at the age of twenty-six and later treatment by a hypnotist were ineffective. He did not enjoy sexual intercourse and had not had any sexual intercourse with his wife for eighteen months when he was first seen. He was treated as an outpatient in forty-six LSD sessions and an equal number of therapeutic interviews; after the forty-third session he wrote the following:
I was conscious of three "centers of personality" which were myself (a) as a small child, (b) as a boy and (c) at the present time. . . . I feel after a great struggle I clung to the boy idea and rebelled against my mother, but her domination over me was terribly strong and it was well nigh impossible to break free. I was breathing heavily. At length, still breathing in this heavy way, I felt that I had made a great discovery or as if another personality had been born. It was so terrific that at the moment I felt that it was world-shattering and that I must tell everybody. (Ling and Buckman 1963, p. 78)

After this his mother never reappeared in the LSD fantasies. In the next session he relived boyish masochistic feelings, and then -it seemed that after great suffering, everything came to a climax and I could see God, and life, and everybody and myself in its reality and true proportion. It is wonderful and full of meaning after all. The way I have looked at life for all these past years has really made it seem meaningless..." (Ling and Buckman 1963, p. 79).

After the treatment his beating fantasies disappeared; he was able to have sexual intercourse with his wife again and enjoyed it more than ever before. He no longer felt inferior or self-conscious and could talk more freely to his wife. He commented,

Through all the sessions I seemed to go through all possible experiences and feelings. Thus rejection by my mother, horror of being born and coming out into a cold world, alone, unprotected, naked, passionate identification with Christ, especially in his Passion and Death, bi-sexuality, love and hate for my mother, extreme sadism, extreme niloischism, self-hate and self-betrayal, longing for death and thoughts of suicide, feelings that I am losing my consciousness and centre of personality, dying to be reborn etc., etc. These all came out in LSD experiences and all had their place and use once I had accepted them as a real part of me, and not tried any longer to run away from them. (Ling and Buckman 1963, p. 84)

His wife wrote:

If you imagine life as a sea, with every incoming wave bringing a new experience or trial of some kind, before he began the LSD each new wave either sent him hurrying to the shore, or completely engulfed him. Now he goes forward eagerly to meet each oncoming wave and is borne on its crest to the next one, and there is no thought at all of returning to the shore. (Ling and Buckman 1963, p. 85)
Seven months after the treatment ended, he wrote on a postcard sent to a nurse who had helped to care for him:

*All that I have learned and experienced has been of the greatest benefit to me and I shall always look back upon the treatment as one of the greatest experiences of my life. Without it I am afraid life would have been to a large extent meaningless and very difficult to cope with.*

(Ling and Buckman, p. 86)

Individual 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 a 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.

No form of psychotherapy for neurotics has ever been able to justify itself by these stringent standards, and LSD therapy is no exception. Almostall the interesting experiments are without controls. 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 thirty-six patients in the study, thirty could be reached for follow-up two years after treatment; four were described as recovered, eight as greatly improved, seven as moderately improved, and eleven as not improved. A six-month follow-up for another ninety-three 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. They also note that the treatment was as effective in long-standing neuroses as in ones of shorter duration: fifteen of twenty-four patients whose symptoms had lasted more than ten years improved (Sandison et al. 1954; Sandison and Whitelaw 1957). In 1961 Sandison allowed a Danish psychiatrist to examine twenty-two severely neurotic patients who had been treated with LSD at Powick. He found that nine showed some improvement; of these, five improved greatly
or were cured, and LSD was almost certainly the reason; the improvement in the other four was probably not related to LSD treatment. Thirteen patients were unchanged or had deteriorated (Vanggard 1964).

Other uncontrolled studies have shown results similar to Sandison's. A. Joyce Martin, using a method in which she provided physical mothering for patients regressed under the influence of LSD, found an unusually high improvement rate of 90 percent (forty-five out of fifty cases) in a day hospital, but more than half of them were only slightly improved, and on follow-up two years later 20 percent had relapsed (Martin 1957). In a summary of later work she reported that of sixty cases, fifty-seven were essentially well and forty-five had achieved a radical character change, after treatments ranging from six to sixty-five LSD sessions (Martin 1967). No one else has claimed such spectacular success. David J. Lewis and R. Bruce Sloane found that twelve of twenty-three hospitalized obsessional neurotics improved during LSD treatment, and they regarded that as about what could be expected in most psychotherapy (Lewis and Sloane 1958). Betty Grover Eisner and Sidney Cohen treated twenty-two patients, five of them hospitalized, with small doses of LSD up to sixteen times. Diagnoses included neurotic depression and anxiety, character disorders, and borderline schizophrenia. After periods varying from six months to two years, sixteen were improved (Eisner and Cohen 1958). Arthur L. Chandler and Mortimer A. Hartman reported on 110 patients treated in private practice who had a total of 690 LSD sessions. The main diagnoses were neurosis, schizoid and compulsive personality, and alcoholism; most of the cases were regarded as too difficult for psychoanalysis. Ratings of improvement were based on the patients' own opinions as well as more objective measures. Fifty showed -outstanding,- -marked,- or -considerable- improvement, and seventy-three (66.4 percent) showed some improvement. Of thirty-two patients whom the authors treated first without LSD, twenty-two began to show better progress in therapy when LSD was introduced (Chandler and Hartman 1960).

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 fifty-five 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 sixty-five percent of more than one hundred chronic neurotics, using an average of thirty-eight LSD sessions per patient (Leuner 1963; Leuner 1967); this result was confirmed eight years later by an independent research team (Caldwell 1969 [1968], P. 110). Again, many of them had been treated in other ways unsuccessfully. In 1966 Robert Pos reported the use of LSD in treating twenty-four hospitalized patients who were in long-term therapy, mostly for anxiety, depression, and other neurotic symptoms. More than half had had previous psychotherapy for an average of two years. With two or three high-dose sessions (average 369 micrograms), he obtained five therapeutic breakthroughs with sufficient follow-up to guarantee their permanence (four of these patients
were discharged), two possible breakthroughs, and two recoveries that lasted for several months until a relapse. Despite their knowledge of the patients, the psychiatrists were unable to predict either the nature of the LSD experience or the outcome of the treatment. In spite of this unpredictability, Pos concludes that LSD is worth exploring further as an adjunct to therapy (Pos 1966).

In 1967 E. Mascher summarized forty-two papers on psycholytic therapy written between 1953 and 1965. Sixty-eight percent of the cases were described as severe and chronic, and most of the rest 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 four and a half 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; it was 62 percent for depressive reactions and 42 percent for obsessive-compulsive neuroses. Fifteen studies included follow-ups, which took place on the average two 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 inadequate. In one of them, J. T. Robinson and his colleagues treated 101 patients suffering from various forms of tension and anxiety. They were randomly divided into three groups. One received LSD weekly before therapeutic sessions for eight weeks in a dose that started at 50 micrograms and was raised by 25 micrograms a week; the trips were terminated with chlorpromazine after five hours. The second group received an amphetamine-barbiturate combination under the same conditions, and the third had standard psychotherapy, without drugs. An independent rater as well as the treatment team evaluated the patients before and after treatment. The rate of improvement was the same in all three groups at the end of eight weeks and also three and six months later. However, one category of patients, those suffering from free-floating anxiety, did better with LSD than with the other treatments (Robinson et al. 1963).

Two later controlled studies showed no differential advantage for LSD. Robert A. Soskin randomly assigned twenty-eight hospitalized patients to five LSD or five control (amphetamine and barbiturate) sessions over thirteen weeks. Eighteen months later the control patients reported themselves to be in slightly better condition; the clinical ratings for both groups were the same. Soskin concluded that LSD was of little value for these unmotivated and unsophisticated patients who would never have sought psychiatric help on their own, and would not normally be considered suitable for insight therapy (Soskin 1973). Charles Savage and his
colleagues made a controlled study of ninety-six hospitalized patients with severe and chronic neuroses, showing symptoms like sleeplessness, crying, agitation, loss of appetite, and suicide attempts; they were diagnosed as depressive reactions. The patients were randomly assigned to one of three groups: conventional treatment, 50 micrograms of LSD, or 350 micrograms of LSD. The LSD was administered after three to five weeks of preparation in a single dose, on the psychedelic therapy model. Results were measured by the Minnesota Multiphasic Personality Inventory and other psychological tests. All three groups remained in the hospital for six to eight weeks, and all were improved at the end of that time; but the LSD patients improved more and those who took the high dose most. Six months later, however, improvement in all three groups was the same; twelve months later the high-dose group again seemed more improved, but the number of patients returning the tests was too small to allow any conclusions; after eighteen months, all three groups scored the same again. The authors observe that in retrospect men seem to have done better on the high dose of LSD and women better on the low dose, at least at the six-month follow-up. Unfortunately, by chance a disproportionately small number of men were assigned to the high-dose treatment (Savage et al. 1973). It should be emphasized that most psychiatrists who have done LSD therapy with neurotics would regard all three of 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 between 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 is hard to doubt 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.

Schizophrenic and Autistic Children

No one has been permitted to give LSD to children since the early 1960s, but before that time it was tested on child schizophrenics and especially on children described as autistic. Autism is a form of developmental deviation characterized by total absence of emotional contact or communication, apparent difficulty in distinguishing animate from inanimate objects, and incapacity for speech. Brain dysfunction is now considered the probable cause. Lauretta Bender
and her colleagues did the most extensive work in this field (Bender et al. 1966). They gave
LSD to a total of eighty-nine children ranging in age from six to fifteen years, some of whom
received doses of 150 micrograms periodically for as long as two years. It was said to produce
better digestion and sleep, higher scores on tests of social maturity and intelligence, lower
anxiety, improved understanding of speech, more emotional response to adult attention, and a
reduction in behavior like rocking and head-banging; often it eliminated the need for
tranquilizers, antidepressants, and sedatives. However, it did nothing for the speech of mute
autistic children.

Unfortunately, this research lacked controls and statistical analysis. The results of other studies
vary. André Rob o and his colleagues tested a twelve-year-old schizophrenic boy on social and
motor tasks four times after giving him a moderate dose of LSD and four times without it; they
filmed the tests and showed the films to observers, who could see no difference (Rob o et al.
1967). James Q. Simmons and his colleagues gave LSD to autistic and schizophrenic children
in several experiments. In one study they compared two sets of autistic identical twins randomly
assigned to LSD (50 micrograms), a placebo, and no drug on different days; the observers were
not told when the children had taken LSD. The results were similar to Bender's; LSD was
especially effective in producing smiles and eye contact with adults (Simmons et al. 1966). The
results of a second study on a mixed group of seventeen child schizophrenics were more
equivocal. Some became happier, others fearful; rhythmic self- stimulation (for example,
rocking) and aggressive behavior were reduced; the children sought more contact with adults
but responded less to their commands (Simmons et al. 1972).

In only one study is there any suggestion of a change that outlasted the immediate effects of the
drug. This is G. Fisher's account of the psychedelic drug treatment of a twelve-year-old girl in an
institution for the mentally retarded. She had been diagnosed at various times as schizophrenic,
mentally retarded, and suffering from a brain injury at birth; she was also nearly blind and had
other congenital defects. A number of drugs and ten sessions of electroconvulsive therapy
produced no improvement. When LSD treatment began she was acutely psychotic and spent
most of her time sitting in a corner twirling bits of paper in her fingers, rocking, and incessantly
talking in a meaningless stream of words. After sixteen LSD and psilocybin sessions she was
much improved; she spoke rationally, did chores on the ward, and helped with the smaller
children. The improvement was apparently maintained for at least five years, until she was
discharged to live with her parents (Fisher 1970).2

Rehabilitation of Criminals

The psychopathic or sociopathic personality is a character type said to be common among
Chapter 6 Therapeutic Uses
Written by Lester Grinspoon

criminals; it is defined by shallow hedonism, callousness, lack of self-restraint, inability to feel true regret or responsibility for one's actions, and incapacity for permanent emotional attachments, sometimes accompanied by a con-man's superficial charm and plausibility. There is some question how many criminals actually have these characteristics and also whether they constitute a psychiatric diagnosis. The use of psychedelic drugs can be defined either as a treatment for sociopaths or simply as a means to reform criminals. In any case, the purpose is to induce in the normally cynical and indifferent criminal an unaccustomed introspective confrontation with his motives and acts, in the hope that it will lead to a change of heart and a new way of living. Symbolic representation of internal conflicts and reliving the past as well as transcendental experiences can contribute to this. There are many reports on psychedelic drug treatment of people described as sociopaths, some of whom had never been in jail (see, for example, Masters and Houston 1966, pp. 267-298). But Timothy Leary in the United States and G. W. Arendsen Hein in the Netherlands have done the most directly relevant work with recidivist criminals.

Leary, Ralph Metzner, and their colleagues worked with inmates at the Massachusetts Correctional Institution in Concord from 1961 to 1963. They used psilocybin to produce insights that would cause the men to -give up the bad-boy game- and find more effective ways to live. The therapy consisted of two high-dose psilocybin sessions in small groups of three or four men, interspersed with other meetings over a period of six weeks. When compared with a control group, men in the program showed no significant changes on the Minnesota Multiphasic Personality Inventory, except greater trust indicated by less apparent lying; but on the California Psychological Inventory there were improvements in sociability, well-being, self-control, socialization, and intellectual efficiency (Leary and Metzner 1967-68). The following quotation is from a forty-eight-year-old man who had been arrested thirty times and had spent fourteen years in prison since the age of twelve.

At the time of the peak of the drug's effect I had a terrific feeling of sadness and loneliness, and a feeling of great remorse of the wasted years. ... It seemed to me that I was crying inside of me and a feeling as if tears were washing everything away. And I was hollow inside, with just an outer shell standing there watching time stand still. (Leary et al. 1965, p. 65)

Later he described the influence of the project on his life this way:

... Before taking the drug my thinking always seemed to travel in the same circles, drinking, gambling, money, and women and sex as easy and I guess a fast life. ... Now my thoughts are troubled and at times quite confusing, but they are all of an honest nature, and of wondering. ... You also get a better understanding of yourself and also the people who are in your group.
You feel more free to say and discuss things, which you generally do not do. (Leary et al. 1965, p. 66)

Two years after his release he was still out of prison and working.

Another project member reported:

People I hated for no sound reason I have come to love. . . I know that this is a new me. . . the drug does things that nothing else could do. . . everyone should be confronted with its virtues. . I saw how foolish the game I played was, and it sickened me. (Leary 1968a, pp. 199-203)

The best and most objective measure of success, according to Leary and his colleagues, is ability to stay out of prison. Eighteen to twenty-six months after release the rate of return among members of the psilocybin project was the same as the rate for the prison population as a whole (sixteen of the twenty-seven were back in prison), but the psilocybin group had proportionately more parole violations and fewer new crimes; the authors suggest that they were supervised more strictly than other parolees. Nevertheless they admit that life on the street put the transformative virtues of the psilocybin revelations to a severe test that they often failed (Leary et al. 1965). They recommend halfway houses and other ways of preventing a relapse into old habits. By 1963 Leary and his associates had lost interest in playing what he was then calling the scientific research game, and the Concord project was not pursued further.

Arendsen Hein treated twenty-one chronic criminal offenders with doses of 40 to 450 micrograms of LSD in group sessions once every week or two for ten to twenty weeks, producing abreaction, symbolic representations of internal conflicts, self-confrontation, transcendent experiences, and changes in behavior and attitudes. At the end of treatment fourteen of the twenty-one were clinically improved, and two were much improved. He withheld judgment on the results because there was not enough follow-up time (Arendsen Hein 1963). Several years later, he was disillusioned; he had become convinced that LSD was therapeutically useful only for dying patients (Arendsen Hein 1972).

Charles Shagass and Robert M. Bittle compared twenty patients who took LSD in a single high-dose session with twenty controls chosen retrospectively from hospital files and matched for age, sex, marital status, education, and diagnosis. Ten of the LSD subjects had been
referred to the hospital by courts or had some legal problem connected with their psychiatric disorders; nine of them were classified as psychopathic personalities. At follow-up after six months and one year, the patients and their relatives were asked to rate changes in symptoms and behavior. After six months the LSD group was significantly more improved than the control group. After one year the difference in amount of drug and alcohol abuse was even greater, but school and job performance and family relationships were the same in both groups. Shagass and Bittle also studied those patients in the LSD group who had what they defined as an insightful response: that is, they related early memories and new self-conceptions to present problems and made a convincing resolution to change. Of the eight patients described this way, seven had been diagnosed as psychopaths. They were much more improved than the others after six months and still significantly more improved after twelve months. Those who showed the most immediate and striking changes had some tendency to relapse after six months; some who feared a relapse asked to be given LSD again (Shagass and Bittle 1967).

The studies available are not very rigorous, and the results are not unequivocal. Nevertheless, it is not inconceivable that psychedelic drugs might be useful in the rehabilitation of criminals.

**Alcoholism**

If we assume that one overwhelming experience sometimes changes the self-destructive drinking habits of a lifetime, can psychedelic drugs consistently produce such an experience? Nowhere in this field have stronger claims been made, and nowhere have they been investigated more thoroughly. The desired effect is something like the following, from a forty-seven-year-old man who had been an alcoholic and a thief most of his life:

*I found myself somewhat at a loss as to just how to describe, in a few words, what took place after some 47 years of beating my brains out against a wall of indifference, self-centeredness, and ignorance, plus the inability to believe there could be a greater power than me. Today that wall was ripped apart.*

*Suffice it to simply say that after a period of emotional upheaval during which various phases of my childhood occurred, I finally began to realize that this session was centered around the fact that I had to make a choice, a choice as to whether I was the greater power or whether there was a God which I had to recognize and accept. At first I tried to bargain ... and then I tried to take refuge in reservations.... This did not work either and it became increasingly apparent that there could be no alternative to complete surrender, to a clean sweep of the past. I realized that I had attempted to bargain with God all my life. I can see now why I have struggled in vain all my life, refusing to accept anything but*
myself. Suddenly out of nowhere came the decision, I would make the choice, I would accept
and hope to be accepted by Him. I could write for years and not be able to describe that
exquisite moment of accepting and being accepted. It was without a doubt the most beautiful
moment of my life and as I write this I am still amazed at the exquisite feeling of release, peace
of mind, and complete realization which took place at that moment. (Jensen and Ramsay 1963,
pp. 184-185)

Albert A. Kurland reports the case of a forty-year-old black unskilled laborer brought to a
hospital from jail after drinking uncontrollably for ten days. He had been alcoholic for four 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 ten 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 up 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
eighty-eighth to the tenth 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 twelve 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 powerful immediate effects on alcoholics; the
question is whether they can be reliably translated into enduring change. Early studies reported
dazzling success: about fifty percent of severe chronic alcoholics treated with a single high dose
of LSD recovered and were sober a year or two later. For example, in a 1958 study, twenty-four
severely alcoholic patients (average duration twelve years) were given two to four we'eks of
preparation and then a single high dose of LSD or mescaline. Eighteen months later, six were
much improved (abstinent or nearly abstinent), six somewhat improved, and twelve not
improved (Smith 1958). Another sixteen patients had the same treatment with music,
photographs, and other sensory and emotional stimuli added during the LSD session; after six
months ten were much improved, five moderately improved and one not improved (Chwelos et
al. 1959). In 1961 J. Ross MacLean and his colleagues gave a similar treatment to sixty-one alcoholics; thirty-six of them had failed in Alcoholics Anonymous; they had been alcoholics on the average for fourteen years, and they had an average of 8.07 admissions to alcoholism clinics in the three preceding years. After three to eighteen months, thirty (49 percent) were much improved, sixteen (26 percent) moderately improved, and the rest (25 percent) not improved (MacLean et al. 1961). In 1967 MacLean reported that after fifty-five months, there was a decline to 25 percent much improved, 23 percent improved, and 52 percent unchanged. By that time 500 alcoholics and other patients had been treated with psychedelic drugs at Hollywood Hospital in British Columbia, where MacLean worked (MacLean et al. 1967).

In the same year Albert A. Kurland and his colleagues reported on sixty-nine long-term alcoholics who were given three weeks of preparatory therapy followed by a high dose of LSD; 75 percent had a mystical or peak experience, and there were immediate substantial improvements on psychological tests; after six months, twenty-three of the sixty-nine had maintained abstinence (Kurland et al. 1967). In 1967 Keith Ditman and Joseph J. Bailey reported on the treatment of ten chronic alcoholics (five to fifteen years) with 200 micrograms of LSD; after a year four were abstinent and two improved (Ditman and Bailey 1967). In that same year Osmond's associate, Abram Hoffer, in a long article defending psychedelic therapy for alcoholics against incredulous critics, tabulated the results of eleven studies showing 45 percent of 269 patients much improved (Hoffer 1967). In a later pilot study by Grof and his colleagues using several weeks of residential treatment followed by administration of DPT, there were striking improvements on psychological tests three to five days afterward, and after six months 38 percent of the fifty-one alcoholics were abstinent (Grof et al. 1973). This line of studies caused Osmond to complain, after legal restrictions made it difficult to use LSD in psychiatry, -It seems grotesque that a simple and safe chemical substance which, when properly used, lacks danger and has a fair chance of benefiting very ill people should not be used widely by competent physicians" (Osmond 1969, p. 223).

Unfortunately, as the results of more careful research began to come in, the picture changed. All the early studies had insufficient controls and most lacked objective measures of change, adequate follow-up, and other safeguards (see 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. Some of these studies were conducted by skeptics whose lack of enthusiasm or failure to provide a proper therapeutic environment might be said to have vitiolated the effects of the drug. But others were the work of psychiatrists who had used LSD themselves, were convinced of its virtues, and had high hopes for it as a treatment for 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 and Hanlon 1977).
Sven E. Jensen and Ronald Ramsay conducted the only experiment with even minimal controls that ever showed a clear advantage for LSD treatment (Jensen 1962; Jensen and Ramsay 1963). It is interesting to look at this work more closely, because it illustrates some common deficiencies of psychiatric experiments. Jensen and Ramsay describe their study as follows. Fifty-eight patients, all severe chronic alcoholics, received two months of group therapy followed by a single high dose of LSD; thirty-five patients received only group therapy for an unspecified time; and forty-five patients admitted to the hospital during the same period had only individual therapy. Six to eighteen months after the end of the treatment, thirty-four of the LSD patients were completely or nearly abstinent, seven were improved (drinking less), thirteen were the same, and four had broken contact. Of the group therapy patients only four were abstinent and three improved; of those who had individual therapy, seven were abstinent and three improved. In each of the control groups more than half the patients could not be reached for a follow-up.

This description is obviously inadequate, especially in the way it characterizes the control groups and the treatment they received. Suspicions are aroused by the much greater accessibility of the LSD patients to follow-up contacts. It is possible that a large number of patients not followed up in the two control groups were also abstinent. And even if that is unlikely, the difference could be explained by the fact, revealed only as an aside, that control groups were not chosen at random; the reason patients were not given LSD was that they refused it, or were considered physically unfit, or left the hospital early. Jensen and Ramsay believe that their LSD patients stayed in touch longer because the drug created a feeling of warmth and community between them and the psychiatrists. That may be so, but it must be remembered that these were patients who had already remained in group therapy for two months and then trusted the psychiatrists enough to accept LSD from them. What must have been even more important—and this goes for all the early work with LSD—was the psychiatrists’ own enthusiasm, aroused by profound drug experiences and the excitement of discovering an apparent solution for an intractable old problem. Nothing that keeps a psychiatrist interested in his patients is to be disdained, but this kind of interest may lead to neglect of patients not belonging to the favored group; and it may be hard to sustain when the novelty is gone. In any case, the unsystematic procedure for controls and follow-up makes this experiment inadequate to demonstrate the powers of LSD. The authors even say that their data should be regarded as a preliminary evaluation, but they never completed a more thorough study.

Some of the early controlled studies were conducted by skeptics who meant to disprove what they regarded as extravagant claims. For example, in 1966 Reginald G. Smart and his colleagues compared ten alcoholic patients given LSD (800 micrograms) with ten who were given ephedrine, an autonomic stimulant that produces many of the same physical symptoms as LSD, and ten who had only routine clinic treatment. After six months the changes in drinking habits were the same in all three groups; on the evidence of questionnaires, eight out of ten in each group were improved or much improved. There was little preparation for the LSD experience and no effort to work with the patients afterward, but all the therapists had taken
LSD themselves and had done LSD therapy before (Smart et al. 1966).

In 1969 Leo E. Hollister and his colleagues reported a controlled comparison of dextroamphetamine and LSD (600 micrograms) in seventy-two alcoholics. Patients were given no information beforehand about the drugs to be tested and therefore no preparation. On tests of drinking behavior and the ratings of an interviewer who did not know which patients had received LSD, both groups improved considerably after two and six months; the LSD group showed more improvement after two months but not after six months (Hollister et al. 1969).

F. Gordon Johnson divided ninety-five alcoholic patients into four groups and treated them as follows: (1) 300 micrograms of LSD with a therapist present; (2) 300 micrograms of LSD without a therapist; (3) an amphetamine-barbiturate combination; (4) routine clinic care. One year after treatment all four groups showed equal improvement in drinking habits and employment. All of the drug combinations produced a short-term loss of depression, irritability, and isolation and an increase in optimism, but it did not last. In this case the therapists had taken LSD themselves and had found it meaningful and helpful to them, but no patient was told that he might be getting LSD (Johnson 1969).

Even the most enthusiastic advocates of LSD have not been able to produce consistently promising results. In 1966 a group of researchers that included Humphry Osmond compared twenty-eight patients given LSD (two large doses) with thirty-four controls in a six-week program at an alcoholism clinic; the methods of Alcoholics Anonymous were used as a model for both groups. Despite an enormous relative improvement at the end of treatment in the LSD patients’ self-esteem and attitudes toward life, there was no statistically significant difference between the two groups on measures of sobriety, employment, and family relationships after three, six, and twelve months. The wives of the LSD patients also reported more favorable changes in their family life for a while after treatment, but six months later the difference had almost disappeared (Sarett et al. 1966; Cheek et al. 1966).

Wilson Van Dusen, the psychologist whom we quoted in chapter 4 on the psychedelic mystical experience, has also studied LSD as a treatment for alcoholism. He and his colleagues administered the drug to female alcoholics one to three times in group therapy sessions. Most of them considered the LSD trip one of the most important experiences in their lives, and those who could be reached for a follow-up six, twelve, and eighteen months later were usually improved. The authors admit that they would have been more impressed if a control group that had only routine clinic care had not done just as well. (Van Dusen et al. 1967).
William T. Bowen and his colleagues compared forty patients who had human relations training in group therapy with forty-one patients who had the same training and also a single large dose of LSD. The investigators made every effort to get the most out of the psychedelic experience, but after a year there was no difference between the two groups in drinking habits, employment, and legal problems. In another study Bowen and others compared twenty-two patients who took 500 micrograms of LSD, twenty-two patients who took 25 micrograms, and fifteen who took none. Although the patients who got the high dose of LSD showed greater immediate changes in self-confidence and optimism, there were no differences on any important measure after a year. In neither study were those who responded most intensely to the drug any better off a year later (Bowen et al. 1970; Soskin 1970). J. C. Rhead and his colleagues investigated the comparative effectiveness of psychedelic therapy with DPT, conventional psychotherapy, and routine hospital care in treating alcoholism. The DPT was administered up to six times, at least once in a high dose (75 to 165 mg). Psychological tests and a social history questionnaire administered just after treatment and six and twelve months later showed no difference among the three groups (McCabe and Hanlon 1977, pp. 240-241).

Two related studies are of interest here. One compares the effects of a high dose with those of a low dose of LSD in alcoholics; the other is a controlled study of LSD in narcotic addicts. In the first experiment, conducted by Albert A. Kurland and his colleagues, ninety alcoholics who received 450 micrograms of LSD were compared with forty-five who received 50 micrograms. When rated by independent social workers on general social adjustment and drinking behavior, the high-dose group did better (53 percent vs. 33 percent greatly improved) after six months, but the two groups were the same after twelve months and eighteen months. More than half improved in both groups, as opposed to what was said to be an average rate of 12 percent for all patients, but this in itself proves little, since the patients were not chosen randomly and in any case received considerable special attention before and after the LSD sessions (Kurland et al. 1971). In the study of narcotic addicts, Charles Savage and O. Lee McCabe treated thirty-seven addict prisoners with a high dose of LSD (300 to 450 micrograms) during six weeks of residential therapy on a hospital ward; they were compared with thirty-seven matched subjects who had only weekly outpatient group therapy. To the addicts heroin represented withdrawal, sleep, and escape, while LSD represented awakening and self-confrontation. A year later a much higher proportion of the LSD group was totally abstinent from heroin (25 percent vs. 5 percent), but the general adjustment of the two groups was the same. Of thirteen patients in the LSD group who had a perfect rating on global adjustment, twelve had had a mystical or peak experience under the influence of LSD (Savage and McCabe 1973). As the authors admit, it is hard to distinguish the effects of LSD from those of the special residential therapy here; but they recommend further work with variations like narcotic antagonists, more LSD sessions, and outpatient LSD treatment.

Arnold M. Ludwig and Jerome Levine obtained promising results in an experiment on seventy narcotic addicts at the federal hospital at Lexington, Kentucky. They compared five short-term treatments: psychotherapy; hypnosis; LSD; psychotherapy plus LSD; and psychotherapy with
Chapter 6 Therapeutic Uses

Written by Lester Grinspoon

LSD and hypnosis (hypnodelic therapy). The purpose of hypnosis in the drug treatments was to relax the patient so that he would resist the drug less, and also to allow more control by the therapist. Two weeks after treatment, psychological tests showed the LSD groups more improved than the others; two months after treatment, only the last group was still better off (Ludwig and Levine 1965).

Ludwig, Levine, and their associates at Mendota State Hospital in Madison, Wisconsin then undertook the most elaborate and methodologically adequate study of psychedelic therapy for alcoholics that has ever been made (Ludwig et al. 1970). The 195 patients were divided into four treatment groups. All had thirty days of milieu therapy and three had in addition LSD alone, LSD with psychotherapy, or LSD with psychotherapy and hypnosis. Patients were assigned to different treatments at random, and the psychiatrist who attended the drug sessions did not do the testing or follow-up work. Blind raters used tests and interviews to determine the nature of the drug experience, attitude change, behavior change, and social rehabilitation. Despite impressive self-searching and eloquent declarations during LSD trips (see Ludwig et al. 1970, pp. 105-127), the results in all four groups were the same after three, six, nine, and twelve months; about 75 percent improved on measures of employment, legal adjustment, and drinking habits. Changes in attitude after therapy were not a good indication of changes in behavior after three months. No single treatment was significantly better for any particular class of patients; the depth of the psychedelic experience also made no difference.

This study is revealing in several ways. It provides a correction for psychiatric overenthusiasm, showing that 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. By making it clear that the great majority of alcoholics will improve after any treatment, Ludwig and his colleagues show that excessive drinking is often sporadic, and that periodic reforms and relapses are common. At the time the alcoholic arrives at a hospital, he has probably reached a low point in his cycle and has nowhere to go but up.

The two major reviews of the psychiatric literature (Abuzzahab and Anderson 1971; McCabe and Hanlon 1977), although they suggest 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. Ludwig and his colleagues demonstrate exhaustively by statistical manipulations that no element of the treatments could be consistently correlated with a good or bad outcome. Where so little is known, does it make sense to give up entirely on anything that has even a chance of working sometimes?

This question is raised by an experiment in which Louis A. Faillace and his colleagues treated twelve severe chronic alcoholics with DPT and other tryptamines. They represented the hardest kind of case; all had been hospitalized many times for alcoholism, all had been through an alcohol withdrawal illness, and most had been arrested for drunkenness. After two weeks of preparation, each received five weekly drug sessions, and all but one had profound psychedelic experiences. Two years later nine of them were no better, but three were sober and employed; in two cases the drug was at least partly responsible, and one patient had been abstinent ever since the treatment (Fail-lace et al. 1970). Supposing that a few alcoholics like Faillace’s two in twelve can benefit from psychedelic drugs—even if there is bound to be wasted effort because those who will benefit cannot be identified beforehand—should all alcoholics be denied the opportunity for this treatment? Faillace and his colleagues say yes, for two reasons: the time, trouble, and expense are too great; and the drugs are too dangerous. On the first point, the fact that something takes time and trouble should not be a reason for forbidding people to do it when they think they can get help from it; by that standard, psychoanalysis would be outlawed. We will comment later on the dangers; they have been exaggerated.

But there is also another issue. Some controlled studies show an improvement lasting from several days to several months; that is, they confirm the reality of the psychedelic afterglow. Hollister found some advantages for the LSD patients after two months; Faillace mentions that several patients improved greatly for a few weeks. The obvious recourse of supplementary treatments every once in a while has been suggested but never taken seriously, possibly because everyone is mesmerized by the vision of a quasi-miraculous single-shot cure and possibly because of the extremely unlikely danger that patients would turn into acidheads or become psychotic. When it becomes possible to continue therapeutic research with psychedelic drugs, an experiment along these lines might be considered, not only for alcoholics but for other patients. Does the afterglow diminish after a few psychedelic trips, or can it be renewed periodically to some useful effect? Can the patient take advantage of the temporary reduction in anxiety and depression to change habits and achieve further insights?

One analogy in current practice is the treatment of depressed patients every few months with what is called maintenance electroconvulsive therapy. Another model is the religious ceremonies of the Native American Church, where regular use of high doses of mescaline in the form of peyote is regarded as, among other things, part of a treatment for alcoholism. Obviously peyote is no panacea; otherwise alcoholism would not be the major health problem of American
Indians. Nevertheless, the Indians themselves and outside researchers believe that those who participate in the peyote ritual are more likely to be abstinent. For example, one observer estimates that 45 percent of the peyotists and 25 percent of the non-peyotists among the Menomini of Wisconsin are abstainers (McGlothlin 1967). Another investigator studying Indians in Saskatchewan found that by his standards almost all members of the tribe were alcoholics; the only exceptions were twenty communicants of the Native American Church (Roy 1973; see also Pascarosa and Futterman 1976).

It would be helpful to have an epidemiological study comparing the rate of alcoholism among Indians in general with that of Native American Church members or those who attend its ceremonies faithfully. Such a retrospective study could not establish the usefulness of peyote unequivocally, since it is certainly not the drug alone that does the work. The confessional rites and preachings of the church play the same role as those of a temperance society or Alcoholics Anonymous, and the discipline that keeps a person attending peyote meetings despite the physical and emotional hardships may be the same discipline that keeps him from getting drunk. But that can hardly be all. Maybe the best way of putting it is that peyote sustains the ritual and religious principles of the community of believers, and these sometimes confirm and support an individual commitment to give up alcohol.

In any case, even federal alcoholism clinics for Indians now recognize that peyote may have some value (Albaugh and Anderson 1974). If, for whatever reasons, psychedelic drugs work for at least some Indians some of the time, they might also help some non-Indian alcoholics. Peyote is not a magic cure but one instrument in a continuous effort to cope with the problems that lead church members to drink. By renewing the psychedelic experience every few weeks or months, the peyote ritual provides the kind of continuous follow-up implicitly suggested by the studies that indicate a short-term improvement after an LSD trip. Nor is there any evidence that the peyote ritual is especially time-consuming, wasteful, or dangerous. (If Native American Church meetings accomplished nothing else, they would be a much better way to spend Saturday night than going on a drunken binge.) 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 (see Anonymous, 1974).

Dying
In a letter to Humphry Osmond, Aldous Huxley recounted a mescaline trip on which he achieved direct, total awareness, from the inside, so to say, of Love as the primary and fundamental cosmic fact," and then came to the conclusion that "I didn't think I should mind dying; for dying must be like this passage from the known (constituted by life-long habits of subject-object existence) to the unknown cosmic fact" (Huxley 1968, pp. 139, 141). On November 22, 1963, at 11:45 A.M., the dying Huxley asked his wife to give him 100 micrograms of the drug he had portrayed in his last novel as the liberating moksha-medicine, After that he looked at her with an expression of love and joy but spoke little except to say, when she gave him a second injection of LSD, "Light and free, forward and up." He died at 5:20 P.M. Laura Huxley, who sat with him all that afternoon, writes, "Now is his way of dying to remain for us, and only for us, a relief and a consolation, or should others also benefit from it? Aren't we all nobly born and entitled to nobly dying?" (Huxley 1968, pp. 297-308, quotations on pp. 306 and 308).

There is a new concern today about dying in full consciousness of its significance as a part of life. As we look for ways to change the pattern, so common in chronic illness, of constantly increasing pain, anxiety, and depression, the emphasis shifts away from impersonal prolongation of physiological life toward a conception of dying as a psychiatric crisis, or even, in older language, a religious crisis. The visionary and ecstatic experiences of those who have come near death are eagerly examined. The art of dying is revived, and the last days are seen as an opportunity to take stock, make amends, resolve emotional conflicts, allow families to express gratitude and offer compassion. The purpose of giving psychedelic drugs to the dying can be expressed in many ways, all of them inadequate. Crudely, one could speak of living the last few weeks or months in a psychedelic afterglow. The central idea might be stated as reconciliation: reconciliation with one's past, one's family, one's human limitations. Granted a new vision of the universe and his place in it, the dying person learns that there is no need to cling desperately to the self.

However, experimental work with LSD on the dying began not with religious or psychiatric concerns but in an attempt to reduce the pain of cancer patients. Eric Kast and Vincent J. Collins compared the effect of LSD (100 micrograms) with the effect of two commonly used narcotics, hydromorphone (Dilaudid) and meperidine (Demerol), on fifty cancer and gangrene victims in severe pain. LSD relieved their pain for a longer time (several days as opposed to several hours) and enabled them to speak freely about their approaching death in a manner not common in our hospitals; but most of them found the experience emotionally exhausting and only twelve were eager to take the drug again (Kast and Collins 1964). In a later study Kast gave LSD to 128 cancer victims in their last months of life. On the average, pain disappeared for twelve hours and was reduced for two to three weeks; patients slept better afterward for about ten days. Forty-two patients felt some anxiety, and seven became panicky for a short time, but there were no adverse medical reactions (Kast 1966). In still another study of eighty patients, sixty-eight said they were willing to take LSD again; fifty-eight found it pleasant and seventy-two thought they had gained insight from it. The impact on their lives was described as profound; morale was improved and a new sense of community developed. During the LSD trip and to a
lesser degree for about ten days afterward, they felt less pain and depression; often they recollected the experience with a surge of elation. Kast believes that their pain was controlled by "attenuation of anticipation," a liberation from anxiety about loss of control through death (Kast 1970). Sidney Cohen gave LSD to several dying persons and confirmed Kast's conclusions in an article he wrote for Harper's in 1965. He quotes a patient: "Ah yes, I see what you have done. You have stripped away me. This is a touch of death—a preparation for the big one when the No Me will be permanent- (Cohen 1965, p. 72).

Beginning in 1965, the experiment of providing a psychedelic experience for the dying was pursued at Spring Grove State Hospital in Maryland, and later at the Maryland Psychiatric Research Institute. Walter N. Pahnke, the director of the cancer project from 1967 until his accidental death in 1971, was a doctor of divinity as well as a psychiatrist, and he first reported on his work in an article for the Harvard Theological Review in 1969. Seventeen dying patients received LSD after appropriate therapeutic preparation (essentially, becoming familiar with the psychotherapist-guide and the effects of the drug and discussing the problems to be examined); one-third improved "dramatically," one-third improved "moderately," and one-third were unchanged by the criteria of reduced tension, depression, pain, and fear of death (Pahnke 1969). The results of later experiments using LSD and DPT have been similar (Pahnke et al. 1970b; Richards et al. 1972; Grof et al. 1973; Richards et al. 1977). These studies lacked control groups, and there is no sure way to separate the effects of the drug from those of the elaborate therapeutic arrangements that were part of the treatment; but it is worth noting that Kast provided little special preparation or attention in his early work.

In a book published in 1977, Stanislav Grof and Joan Halifax summarize this and much other research on dying. They discuss the psychedelic experiences, with and without drugs, of those near death, and recount several long case histories of psychedelic drug treatment for the dying. They emphasize that even after the emotional afterglow fades, religious and philosophical insights that remain make death easier to bear. Some of their patients obtained the same relief from severe physical pain reported by Kast, but the effect was too unpredictable to be described as a pharmacological analgesia. It might last for weeks or months after a single session, and the extent of pain relief was not correlated with dose or even with the depth of the LSD experience: in one case pain that had been intolerable disappeared completely for two months after an apparently superficial experience. Even when the pain remained, sometimes patients were now able to keep it from claiming all their attention. But pain reduction was not consistent enough to reduce the average consumption of narcotics. Grof and Halifax suggest several explanations for this: the inertia of routine, development of tolerance, and the possibility that formerly ineffective doses of narcotics were now working (Grof and Halifax 1977).

Pahnke and his colleagues published the following account of LSD treatment of a dying man in
Case D-2: This sixty-five-year-old, white, married Jewish male began complaining of episodes of severe and lancinating bilateral abdominal pain in the upper quadrants, associated with a feeling of fullness. Three years prior to LSD treatment, the patient was found upon exploratory laparotomy to have a lymphoblastic lymphosarcoma. Since that time, he had several readmissions for attempts to control his increasingly severe abdominal pain which then became associated with episodes of syncope and a general deterioration in his condition.

When the patient was evaluated for LSD therapy he was depressed, anxious and preoccupied with various bodily complaints, mainly his pain for which he was receiving Demerol on a regular basis.

Prior to his LSD session, the patient was seen in preparation for a total of 9 hours (6 interviews). During this time, reasonably good rapport was established; the "psychology of pain" was discussed at some length, and specific preparation for the LSD session was accomplished. The question of diagnosis was not raised by the patient. The patient's wife was also seen during this time, both alone and with her husband.

The patient was given 100 mcg. of LSD by mouth, followed by a second 100 mcg. dose 45 minutes later. During the early hours of the session there were several occasions of meaningful catharsis and intense emotionality. Patient's periodic complaints of pain were all transient to the extent that attention was focused on other sensory inputs. Four and one-half hours into the session the patient had a positive emotional experience associated with "heavenly" imagery, and stabilized in an elevated affective state for the remainder of the session. The therapist rated positive psychedelic content at 5 on a 0-6 scale. Whenever he experienced pain, he responded in an autosuggestive fashion and pain consciousness would recede. At the end of the session, the patient was in a distinctly elevated affective state.

In the days following this LSD experience, the patient's condition was dramatically changed from a number of perspectives. He neither requested nor required any pain medication. Whereas in the five days prior to LSD he had received 950 mg. of Demerol, he now needed none. His depressive and anxious mental state was replaced by a sense of well being and optimism which was a complete surprise for his wife and the hospital staff. He was eager to leave the hospital and felt that he had discovered "new will power." His general attitude was quite positive and he seemed realistically oriented as to the permanence of his disease. He was discharged to his home five days following the LSD sessions.

The patient got along fairly well for a period of approximately two months without asking for any opiates, but then needed to be readmitted because of intolerable pain, shortness of breath (from bilateral pleural effusions) and anorexia. The explicit purpose of this readmission was for another LSD treatment at the patient's request. For the second treatment, preparation was accomplished in one two-hour interview, and the next day the patient received a total of 200 mcg. of LSD by mouth. He had a psychedelic experience of similar intensity and content to the first.

In the days following LSD he was alert, happy and able to handle his pain without discomfort, but he did complain of moderately severe shortness of breath while walking up and down the hall. The patient was discharged on the tenth day post-LSD in good spirits. He continued to do well and be comfortable without pain medications for more than six weeks in
spite of the progressive course of his neoplasm, but was readmitted because of shortness of breath, pleural effusion, and abdominal pain which radiated from the back and was suspected to be due to retroperitoneal pressure. His liver was noted to be large and tender, and he was given cobalt radiation to that area.

On the eleventh hospital day, this time after three hours of preparation which included his wife, the patient received his third LSD treatment (200 mcg.). His response was again strongly positive and post-LSD he felt much more comfortable, complained less of pain, again tolerating his pain without narcotics, but he had to be readmitted within two months because of severe pain and bilateral pleural effusions. Two separate thoracenteses produced 1200 cc. of fluid each time.

During this admission, the patient received his fourth LSD treatment. This time he was administered 300 mcg. with the objective of obtaining a more profound reaction. During the early phase of the reaction there was more emotional distress than in previous sessions. Nevertheless, the change in mood and outlook was again dramatic with an experience similar to the other three. There was much joyous emotion and the patient -felt like dancing.- The love of his wife was uppermost as it had been in the previous session. There was also considerable resolution of a long standing resentment which he had harbored toward one of his sons. He displayed the typical psychedelic afterglow, namely freedom from anxiety and expression of a positive mood, feeling very warm and friendly toward people. He later went for a walk on the ward and told the nurse that it was the happiest day of his life. The next day he felt good and was no longer taking any pain medication. There was a considerable reduction in physical distress. He was discharged six days post-LSD without the need for pain relieving drugs.

Unfortunately, the plural effusion rapidly reoccurred and within a week after discharge the patient was readmitted in intractable pain for more drainage of fluid. He was placed on analgesic therapy, but continued on a rapid down-hill course. He died 20 days after his last LSD treatment from acute intestinal obstruction.

Several months after the patient's death, the therapist received a note from the patient's wife, expressing her appreciation for what had been done to make more meaningful the last months of her husband's life. She felt that the last six months had been made much more livable for both the patient and herself in a human sense because of the LSD treatment. (Pahnke et al. 1970 b, p. 66)

Complications of Psychedelic Drug Therapy

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; actually the dangers in work with LSD do not seem obviously greater than in comparable forms of therapy aimed at emotional insight. Cohen and Ditman give an example of -LSD treatment with equivocal effects:

The patient was a white, married male who teaches hypnosis. He complained of episodic anxiety, a variety of pains, depression, and visual distortions for seven months since taking LSD about 25 times for psychotherapeutic purposes. At present he has feelings of impending doom, at times he wants to climb the walls. The periodic illusions and emotional upsets come on when he is under stress. During these episodes he sees animals and faces moving on the wall. He claims that prior to the LSD treatments he had no anxiety, but was unproductive and zombie-like. At present he is writing five books and wonders, "Do I have to pay for this higher level of functioning with anxiety and pain?" (Cohen and Ditman 1963, p. 477)

Grof warns that as in psychoanalysis, symptoms may worsen from time to time during treatment when the patient finds himself living under the influence of some situation from the past that has come into consciousness during the drug session but has not been resolved and integrated. Another phenomenon Grof notes (again with analogies in psychoanalysis) is drastic changes in symptoms, which may or may not be improvements, as the patient comes under the domination of different unconscious complexes, especially those that Grof calls the perinatal matrices. He believes that, as in psychoanalysis, the only way out is through further LSD treatment. However, there are some reports of psychedelic drug therapy discontinued because the patient's condition was becoming worse. A Danish psychiatrist found that two of Sandison's patients at Powick Hospital suffered a long-term deterioration: one was a hospitalized neurotic who developed schizophrenia, and another patient was cured of alcoholism and a tendency to abnormal blushing and sweating, but developed a paranoid condition instead (Vanggard 1964).

The most serious danger is suicide. Charles Savage reported the case of a schizophrenic girl who under the influence of LSD passed from delusions of being dead to rage and resentment against her parents and the therapist. When allowed to go home for a visit, she threw herself under a train (Savage 1959). A group of Danish psychiatrists discussing the hospital treatment of 129 patients with LSD described four suicide attempts, all by patients who were previously suicidal or had attempted suicide before; one was successful (Geert-Jorgensen et al. 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 drug research and also to 2,230 randomly chosen members of the American Psychiatric Association and American Medical Association. Of the 127 answering in the first group, none reported any suicides caused by psychedelic drugs, and eighteen 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 and Funkhouser 1970).
Masters and Houston show how ego dissolution and reintegration can alleviate suicidal impulses by providing a substitute for self-annihilation:

Although the guide did not know it at the time, S-1, a businessman in his late forties, had definitely made up my mind to kill myself, and for me LSD was the straw the drowning man clutches at. Although I kept quiet about my intention for fear I would not be given the drug, this decision to have an LSD experience was the last plaintive outcry for help of a man who was standing on the edge of a precipice and getting ready to jump."

After several hours, S abruptly regressed to an infantile state, curling himself up into the "foetal position," in which he remained without speaking for perhaps thirty minutes. He then emerged from this state and rather tersely acknowledged the regression. After that, he seemed slightly euphoric but otherwise unchanged. At no time did he discuss his plan to take his own life. . . . Only two weeks later did the subject disclose what had happened to him during the session. He revealed the existence of a long-standing "chronic depression" that had resisted the efforts of several therapists and finally had helped to lead him to "the very brink of suicide." Since the psychedelic experience, S reported, this depression had been "totally absent." . . . He had "died" and then been "reborn," awakening to find himself "all curled up like a foetus in the womb." Once he had "pushed free and unrolled from that position" he had -entered into a new life exactly like someone who has died and been reborn, leaving behind all the torments of the old life.

"There was this inescapable and irresistible feeling that I must die. I am absolutely certain that had I not 'died' in the LSD session I would have had to die in some other way, and that could only have meant really dying. Committing suicide, destroying myself, as I surely would have done. . . .

"The other day I read a magazine article about LSD that warned that this drug might cause people to kill themselves. Let me tell you, LSD can prevent people from killing themselves. I know it is still too soon to say with any certainty that I have really been 'reprieved.' I am convinced, though, that it is true, and I cannot imagine ever having been in such a desperate state of mind." (Masters and Houston 1966, pp. 188-189)

This subject stayed in touch by telephone with his guide weekly for six months; a year after the session he was still doing well.

All available surveys agree that therapeutic use of psychedelic drugs is not particularly dangerous. In 1960 Sidney Cohen made sixty-two inquiries to psychiatrists and received forty-four replies covering 5,000 patients and experimental subjects, all of whom had taken LSD or mescaline—a total of 25,000 drug sessions. The rate of prolonged psychosis (forty-eight 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. For example, in 1966 B. Bhattacharya examined 581 cases in which psychedelic drugs had been administered 2,742 times; he found no psychoses, no suicide attempts, and no uncontrollable behavior (Bhattacharya 1966). In 1968, Nicholas Malleson sent a questionnaire to seventy-four British psychiatrists who had used psychedelic drugs. All but one replied; they had given psychedelic drugs to 4,300 patients a total of 49,000 times and also to 170 experimental subjects a total of 450 times.

Among all these there were three suicides and nine attempted suicides (none during drug sessions), thirty-seven psychoses (ten chronic, nineteen recovered, eight details unknown), one attack of grand mal epilepsy, one death from an asthma attack twelve hours after taking 100 micrograms of LSD, and one mysterious death of a 41-year-old man interested in psychic research during a drug session. The suicide rate was 0.7 per thousand, and the rate of prolonged psychosis was 9 per thousand; Malleson regards these as low for a population of severely disturbed psychiatric patients. Although publicity about the dangers of LSD was near its height that year, forty-one of the seventy-three psychiatrists were still using it, and only five thought it too dangerous (Malleson 1971).

In another study R. Denson recorded the complications from LSD therapy at a hospital in Saskatchewan over a period of ten years in which 237 patients, including 114 alcoholics, had taken LSD a total of 412 times. During treatment there were six incidents of major complications (1.5 percent) and twenty of minor complications (4.9 percent). There was sufficient follow-up (he does not say how long) after treatment in 346 of the 412 drug sessions; of these 346 cases, eight, or 2.3 percent, produced major complications (persistent dissociative reaction, depression, obsessive rumination) and sixteen, or 4.6 percent, produced minor complications (distressing flashbacks, nightmares, persistent headache, residual perceptual changes). Denson emphasized that all these aftereffects were temporary and concluded that LSD is less dangerous than many other drugs (Denson 1969).

In a ten-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. Twenty-six of the 247 reported some harmful effects: nine 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
Chapter 6 Therapeutic Uses
Written by Lester Grinspoon

psychosis requiring hospitalization for a week. Most of the subjects regarded the experience as beneficial. Sixty had had bad trips at some time; many regarded them in retrospect as useful (McGlothlin and Arnold 1971).

Psychotherapists and researchers describing their own work find an equally low proportion of adverse reactions. Ling and Buckman report one attempted suicide and three patients who had to be hospitalized for a while among 350 outpatients treated with LSD over four years. Chandler and Hartman mention one psychosis lasting a single day in 690 therapeutic LSD sessions. In all their work with neurotics, alcoholics, narcotic addicts, and cancer patients, psychiatrists at the Maryland Psychiatric Research Center report no adverse reactions of any consequence.

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 fifteen years by hundreds of competent psychiatrists who considered them reasonably safe as therapeutic agents, and no one has effectively challenged this opinion.

Conclusion

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. Later psychiatrists fail to obtain the same results as their pioneering predecessors; as Sir William Osler said, "We should use new remedies quickly, while they are still efficacious." Along with the therapeutic failures, more and more serious adverse effects are reported. If a drug is involved, it may reach the streets and appear on the black market. At that point research may be said to reveal that it has a high potential for abuse and no legitimate therapeutic uses, and it will be banned or severely restricted.
This has happened in varying degrees to a number of drugs, including amobarbital (now being revived as a psychiatric tool, however), cocaine, and methamphetamine, but the rise and decline of LSD took an unusual course. In 1960, ten 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 the extravagant therapeutic claims backed mainly by intense subjective experiences. Twenty years after its introduction it was a pariah drug, 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 advocates of psychedelic drug use have become much more modest in their claims about 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. The Dutch psychiatrist G. W. Arendsen Hein has written most thoughtfully about this subject, referring not only to his therapeutic work but also to his own intense psychedelic mystical experience. He does not doubt that it was authentic in some sense, but he considers it inadequate as a guide to life and blames himself for naïveté in trying to "live above my spiritual level" for two years afterward. He says that the experience was like first love: nothing seemed to matter more at the time, and yet ultimately the feeling of intense meaningfulness became hard to recapture and impossible to justify. He fears the denial of everyday reality in the name of psychedelic reality, and he insists on the need for disciplined work to make the effects of the psychedelic experience last; he doubts whether in modern industrial society we can create forms of community that permit psychedelic drugs to work therapeutically (Arendsen Hein 1972).

Nevertheless, psychedelic drug therapy did not die a natural death from loss of interest; it was killed by the 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 and a few who continue to use them...
Chapter 6 Therapeutic Uses
Written by Lester Grinspoon

illegally. There are reports of an underground network of respectable East Coast clinicians doing psycholytic therapy (Asher 1975). Obviously some psychiatrists believe that the law is depriving their patients of a therapy that is sometimes useful. Many laymen who agree use LSD for self-analysis in a way that is all but formally therapeutic (see Langner 1967, p. 128; Cheek et al. 1970; Walzer 1972). As with most forms of psychotherapy, there are no proofs of effectiveness—just plausible case histories, the good opinion of some reputable psychiatrists, and an incomplete theoretical basis either in an analogy with religious experience or in some variant of psychoanalytic doctrine.

No one who has studied the matter closely doubts the authenticity 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 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. The ability to experience new emotions can be useful for some patients by giving them an idea of what to strive for in therapy; for example, a man described as schizoid is quoted as saying, "I know now that I never knew what people were talking about when they talked about feelings till I took LSD" (Stafford and Golightly 1967, p. 195). In addition, MDA, harmaline, ketamine, nitrous oxide, and other psychedelic drugs with unique effects still need to be evaluated therapeutically. Some of them are shorter-acting than LSD and therefore more convenient for certain purposes. And their special characteristics allow the drug taker to concentrate on one aspect of the sometimes too changeable and confusing LSD experience: emotional depth, recovery of lost memories, symbolic dramas, or self-transcendence.

As examples of the kind of opinion that persists but has lost all public voice over the last decade, we quote letters sent to us by two psychiatrists in 1977. The first is from Dr. Kenneth E. Godfrey of the Veteran's Administration Hospital in Topeka, Kansas:

Resistance to this research has been continuous and increasing up to a point where we have decided that without some new personnel and finances, as well as administrative support, we will not reopen it, though we still have the license to do so. We strongly feel that responsible research in the area of psychodelic [sic] drugs should be done. We feel that many severely ill people can get well by the use of these drugs as adjuncts to psychotherapy. We certainly do not see LSD or any of the other so-called hallucinogens as being the treatment in themselves. We see them only as tools to be utilized by a capable therapist.
The second is from Dr. Leuner of Göttingen:

*Though in several European countries therapists in this field could apply for license to continue using drugs, the government authorities over the years started to make things difficult. I suppose the attitude of the WHO, mainly influenced by the F.D.A., was the pacesetter in this situation. . . .

I myself was convinced that science does not depend on ideologies. This seems to be an error. The continuation of psycholytic therapy during the last years led us to new techniques and conceptions. The results in practical therapy are even more convincing than before. We would not like to stop doing psycholytic therapy. Optimistically, I hope that in time we can publish these results. For so many patients there is a tremendous need for deep probing and intensity in psychotherapy which psycholytic and related therapies could fill. The value of psycholytic therapy, when properly indicated and applied, cannot be overestimated.*

A persistent misunderstanding about psychedelic drug therapy creates special problems in evaluating it. Even when the complexity of their effects is recognized, and verbal obeisance is paid to the importance of set and setting, 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 a 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 Hui-chois accordingly 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.

Neither the virtues nor the dangers of this method, then, are those of ordinary drug therapies. Patients are not maintained for a long time on LSD as they are on tranquilizers or antidepressants. The psychiatric use of LSD has produced nothing that can be properly 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. No one contemplates making these illegal, like a pill for which there is no proof of effectiveness; only psychedelic drugs have the misfortune of falling into a classification rightly or wrongly reserved for special treatment in our society.

The mixture of mystical and transcendental claims with therapeutic ones 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. Preindustrial cultures seem to tolerate more ambiguity about whether a medical treatment or a spiritual rebirth is being offered. (We have commented on this implicitly in describing the therapeutic uses of psychedelic plants by American Indians.) 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 or faith in the therapist; 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. Jung compared psychoanalysis to an initiation rite, and Theodore Roszak now predicts: "We may expect to see the psychotherapy of the coming generation take on more and more the role, if not the actual style, of the old mystery cults to which troubled souls turned not for adjustment or gratification but for spiritual renewal- (Roszak 1977 [1975], p. 208). With the aid of more ancient traditions, psychotherapy becomes a Way and its exploration of the self a spiritual journey."

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; an eclectic psychiatrist like Roquet adopts the techniques of Mexican shamans along with his own interpretations of psychoanalysis and Christianity. And some drug users, as we said, 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. Leary invokes it grandiloquently:

The role of the psychedelic guide is perhaps the most exciting and inspiring role in society. He is literally a liberator, one who provides illumination, one who frees men from their life-long internal bondage... Awe and gratitude, rather than pride, are the rewards of this new profession. (Leary et al. 1964, p. 110)

But elsewhere he calls the work emotionally draining and disillusioning as well as glorious. He could be talking about psychiatry or a religious ministry as well. This social role, or, as Leary calls it, profession, 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.

Spokesmen for the drug culture liked to compare the actions of the law and medical establishment with the Spanish suppression of Mexican psychedelic plants. In some ways this analogy is a poor one. It falsely assumes that psychedelic drug users are as much a distinct culture as the Mazatecs or the Hui-chois. Besides, Spanish priests and physicians in Mexico did not devote years of sympathetic interest to peyote and psilocybin mushrooms before outlawing them; they simply declared them an invention of the devil. And our laws deny the drugs only to the majority, including its priests and physicians, rather than to the subordinate culture (the peyote eaters), which is granted a special religious exemption. Nevertheless, the present situation resembles Mexico after the Spanish conquest in at least one way: psychedelic drug therapy goes on underground. People would not continue to practice it under difficult conditions unless they believed they were accomplishing something. Many regard it as an experience worth having, some as a first step toward change, and a few as a turning point in their lives. It would simplify matters if we could be sure that they were 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 epiphanies. Nevertheless, the field obviously has potentialities that are not being allowed to reveal themselves.
1 Other (uncontrolled) questionnaire studies of this kind are described in Weil et al. 1965.

2 For a literature review and bibliography of work on psychedelic drug treatment of disturbed children, see Rhead 1977

3 For further information, see Castaigne 1968; Leary 1968a, pp. 192-211.

4 For example, consider this mild comment by R. D. Laing, who stopped giving LSD to patients in 1973, when it became illegal in Great Britain: -I never became disillusioned with LSD because I never had any illusions about it.... There’s no one I gave it to who has ever said to me that they were sorry they took it.... There is nothing about their lives that looks as though they are the worse for it. Some seem the better for the experience. It does not change a sow's ear into a silk purse or vice versa.- (Wykert 1978, p. 33)

5 For further discussion, see Watts 1961; Lévi-Strauss 1963 [1958]; Fingarette 1963; Lewis 1971; Torrey 1972; Frank 1974; Lévi-Strauss also warns about some questionable aspects of this process, and Phillip Rieff (1966) offers an intelligent criticism, from a Freudian point of view, of the tendency for knowledge to "transform itself into faith."