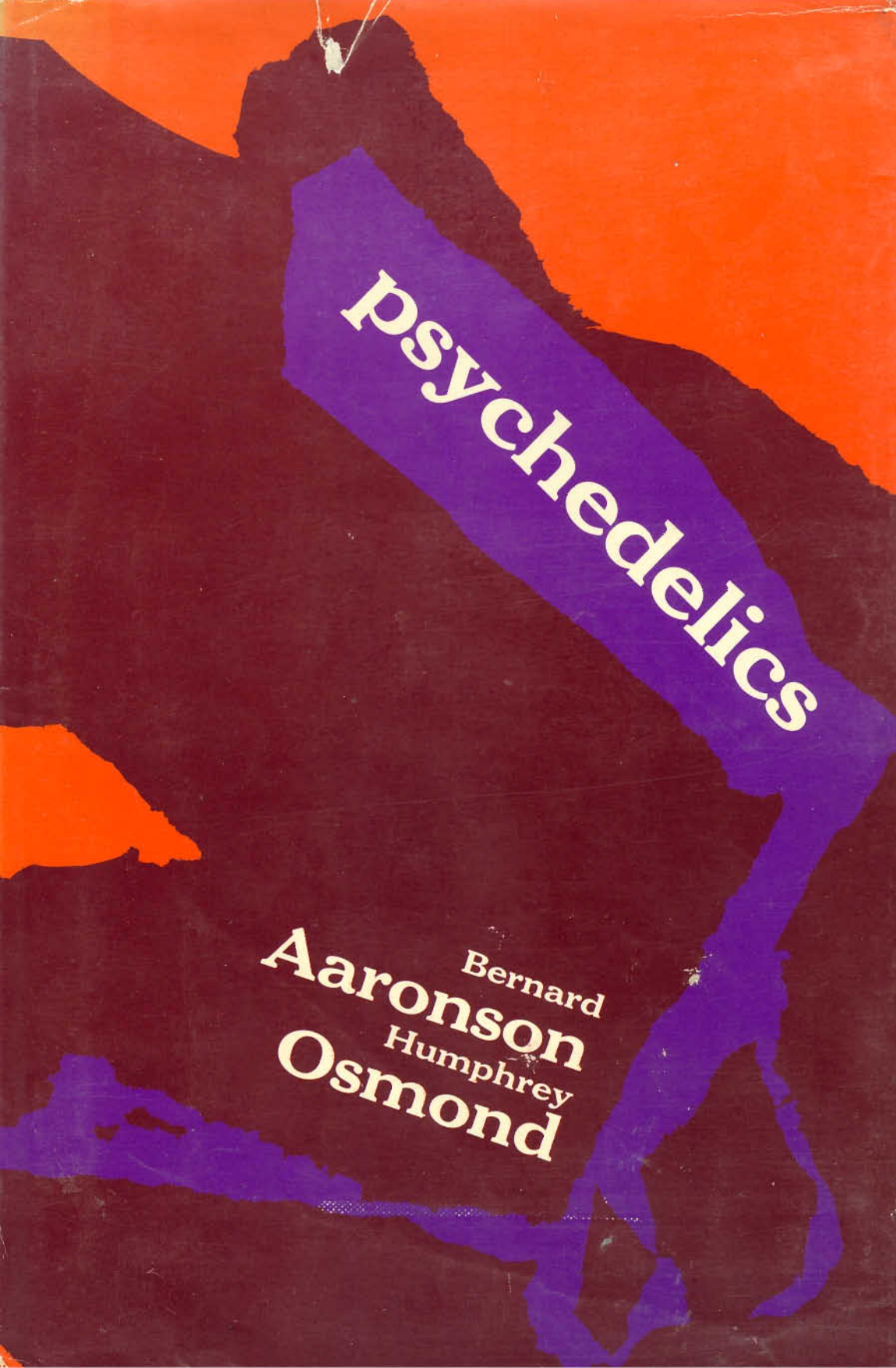
psychedelics
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Psychedelics

The Uses and Implications of Hallucinogenic Drugs

EDITED BY

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death. It is also an example of a new area for treatment, in which the use of LSD might be of great service.

The paper by Izumi is reminiscent of the era in which therapists took the new psychedelics in order to better understand their patients. In this case, the drug was taken to facilitate the design of a mental hospital that would provide a properly therapeutic environment for patients. The hospitals that have been built as a result of these experiences have been the first major innovations in mental-hospital construction in many years, and herald an era in which buildings will be people-oriented, in contrast to the present, when people are required to be building-adapted.

TOWARD AN INDIVIDUAL PSYCHEDELIC PSYCHOTHERAPY

ROBERT E. L. MASTERS AND
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Widespread therapeutic use of LSD-25 and similar psychedelic drugs did not begin until the 1950s. By 1965, there had appeared in scientific journals more than two thousand papers describing treatment, of thirty to forty thousand patients, with psychedelics (Buckman, 1967). Since 1965, the literature has continued to grow and now includes book-length works as well as the shorter reports published in journals and anthologies. Yet spokesmen for the American psychiatric establishment continue to tell the public that there is no evidence to demonstrate the value in therapy of psychedelic drugs.

Reports of therapeutic successes have come from hundreds of psychotherapists working in many of the countries and cultures of the world. The psychedelic drugs have been used as "adjuncts" or "facilitating agents" to a variety of existing psychotherapeutic procedures. Some efforts have been made to develop new, psychedelic therapies specifically grounded in the drug-state phenomena and the new models of the psyche that have been suggested by the psychedelic experience.

The diversity of the approaches to therapeutic use of psychedelics makes the evidence supporting their value for therapy all the more impressive. Individuals and groups of therapists of various persuasions have worked with one or more of an ever-expanding family of psychedelic drugs and with a great many drug combinations. Dosages administered have varied enormously—in the case of LSD, anywhere from 10 to 1500 μg or more. The psychedelic treatment has been considered as consisting of from one to well over one hundred drug sessions.

In general, therapists working with small doses—such as 25–50 μg of LSD—do so only to facilitate conventional therapy, most often psychoanalysis. Such doses may heighten suggestibility and facilitate recall, association, and emergence of unconscious materials. This type of treatment might involve weekly sessions that continue for months or even years.

When the very massive dose is administered—LSD: 750–1500 μg—the intent is to achieve the therapeutic result in a single, overwhelming session. The patient's values are changed and personality otherwise altered by means of a transcendental-type experience akin to a religious conversion. This type of treatment has been used mostly with alcoholics.

Other therapists work with a "moderate" dose—LSD: 150–400 μg. Exact dose is individually specified on the basis of the patient's body weight, drug sensitivity (if that can be determined), and personality factors. The dose should be sufficient to allow for a full range of psychedelic response; at the same time, the patient should not be overwhelmed or made confused or unable to communicate effectively. A brief therapy, one or a few sessions in a few weeks or months, is the aim.

Types of conditions repeatedly stated to respond favorably to treatment with psychedelics include chronic alcoholism, criminal psychopathy, sexual deviations and neuroses, depressive states (exclusive of endogenous depression), phobias, anxiety neuroses, compulsive syndromes, and puberty neuroses. In addition, psychedelics have been used with autistic children, to make them more responsive and to improve behavior and attitudes; with terminal cancer patients, to ease both the physical pain and the anguish of dying; and with

adult schizophrenics, to condense the psychosis temporarily and to help predict its course of development.

Almost all therapists reporting these successes have stated that the incidence of recovery or significant improvement was substantially greater than with other therapies used by them in the past. The treatment typically required much less time and was accordingly less costly for the patient.

Treatment with psychedelics has most often been described as ineffective in cases of hysterical neurosis and hysteria, stuttering neurosis, infantile personality, and long-term neurotic invalidism. Despite reported successes, compulsive syndromes, criminal psychopathy, and depressive states are also mentioned as contraindicated. The risks frequently have been considered too great for paranoids, severely depressed persons, outpatient psychotics and prepsychotics, and those with a history of suicide attempts or who may be currently suicidal. However, as we have previously suggested (Masters and Houston, 1966), psychedelic therapy may be indicated in cases where suicide seems probable and imminent. By his being enabled to die symbolically and then be reborn, the patient's need to die may be subsequently eliminated.

That psychedelic drugs have value for psychotherapy has usually been most vigorously challenged or denied by therapists who have done no work at all with the drugs. Lack of adequate controls to allow more-objective assessment frequently is mentioned. However, it is very hard to devise fully satisfactory controls where such drastic alterations of consciousness are involved. Some veteran workers with psychedelics believe meaningful controls to be impossible. On the other hand, what one research team regards as adequate double-blind conditions has been achieved by administering a light dose of LSD (50 μg) to the control group, while the experimental group received 450 μg. The small dose produced definite changes in consciousness but did not permit a full-fledged psychedelic reaction (Unger, et al., 1966).

Other charges from opponents of psychedelic therapy have attributed bias and excessive enthusiasm to workers with the drugs. Certainly, some of the early papers were extravagant, as tends to happen with new therapies. But the time has long passed when psychedelics could be hailed as a panacea; and

it should be remarked that the bias of the advocates only rarely approaches that of some "distinguished" critics. Some of these critics seem ideologically and emotionally threatened by psychedelic therapy. This has been especially true of psychiatrists heavily committed to psychoanalysis. Psychedelics emerge at a time when analysis is increasingly under strong attack. Much of the opposition to the drugs is thus understandable, but also unjustifiable.

Finally, psychedelic therapy has been assailed as too dangerous. Very definitely, the evidence does not bear this out; and in fact, when the drugs are administered by those therapists and researchers who are most effective, the "dangers" are negligible. This is borne out by studies involving many thousands of patients and experimental drug subjects.[1]

Selection and Preparation of the Patient. Ideally, the patient for psychedelic therapy should be intelligent, well educated, imaginative, strongly motivated to recover, and physically healthy. These are not essential, but they do increase the prospects for a successful treatment. Severe heart and liver conditions, and pregnancy, can rule out psychedelics altogether. In general, the disorder should be one considered responsive to psychedelic therapy. However, exceptions might be made in the case of the patient who, apart from his particular illness, is mature and presents most of those personality and background factors mentioned as conducive to therapeutic psychedelic experience.

Once the patient is selected, he is prepared, over a period of at least several weeks, for the psychedelic session. In a series

[1] For example, Pollard, J., Uhr, L., and Stern, E. (1965): no "persistent ill effects" in experiments with eighty subjects over a five-year period; Masters, R. E. L., and Houston, J. (1966): no psychotic reactions or unfavorable aftereffects in 206 sessions over a combined fifteen years of research; Unger, S., et al. (1966): one adverse reaction in 175 cases treated, and that one "readily reversible"; and Cohen, S. (1960): in one thousand LSD administrations to experimental subjects, less than one in one thousand psychotic reactions lasting over forty-eight hours. In therapy patients, per one thousand administrations, there were 1.2 attempted suicides, 0.4 successful suicide, and 1.8 psychotic reactions. The results compared favorably with incidence of complications following electroshock treatments in common use. As compared to almost any other therapy, LSD seems outstandingly safe when properly used.

of interviews, the therapist establishes rapport and instills a strong belief in the possibility of successful treatment. The patient is advised about what to expect, a thorough case history is taken, and there may be some preliminary psychotherapy. In our own work, the research subject was made to look beyond relief from his symptoms to his whole life situation and his hopes for the future. The therapy should aim not just at symptom relief, but at effecting maturation and actualization of potentials.

Psychedelic Psychotherapy. In our experience, LSD usually provides the more-profound and multivarious psychedelic experience. Other researchers prefer other drugs and drug combinations; and we, too, have effectively utilized psilocybin, mescaline, and peyote. Which psychedelic is most effective has yet to be determined.

Selection of the LSD dose is on the bases indicated earlier. In most cases, we have worked within the range of 200–400 μg. Some persons have reacted intensely to only 100 μg. We conceive of therapy as consisting of from one to five sessions at approximately weekly intervals. The patient should understand that his treatment will not last beyond a few sessions at the most, and possibly only one. Failure to achieve success within five sessions indicates a need for non-drug therapy. After six months to a year, and if the problem remains, another psychedelic session might be scheduled. Often, analytic therapies bring a patient to the threshold of recovery, but then require subsequent psychedelic therapy to push the patient into health.

The LSD treatment is conducted in a comfortable, aesthetically pleasing, spacious room, in no way suggestive of a clinical setting. In this supportive and stimulating setting, the therapist wears ordinary street clothes or something more casual, depending on the needs of the patient. No medical or scientific "uniform" should be worn. The session should be presented less as therapy than as educational and developmental experience. The therapist steps out of his role as "doctor" and becomes more the patient's mentor and guide, who will lead him through the unique world of psychedelic experience and enable him to profit from it.

We always introduce the analogy of Vergil and Dante in

the *Divine Comedy*. As Dante was led by Vergil through all imaginable spheres of reality, so the patient is led through the wonders of the psychedelic world. Just as Vergil was not Dante's psychotherapist, but effected important therapeutic changes in the poet, so the guide may also effect therapeutic changes, but again, in a context pre-defined as much more than simply therapy. *Therapy* is here too limited a concept, and may impose limitations both on the patient's experiences and the benefits he can derive.

LSD alters consciousness in numerous and dramatic ways, and many of these are therapeutically utilizable. Psychological effects of LSD-type drugs include the following (Masters and Houston, 1966):

> Changes in visual, auditory, tactile, olfactory, gustatory, and kinesthetic perception; changes in experiencing time and space; changes in the rate and content of thought; body-image changes; hallucinations; vivid images—eidetic images—seen with the eyes closed; greatly heightened awareness of color; abrupt and frequent mood and affect changes; heightened suggestibility; enhanced recall or memory; depersonalization and ego dissolution; dual, multiple, and fragmentized consciousness; seeming awareness of internal organs and processes of the body; upsurge of unconscious materials; enhanced awareness of linguistic nuances; increased sensitivity to non-verbal cues; sense of capacity to communicate much better by non-verbal means, sometimes including the telepathic; feelings of empathy; regression and "primitivization"; heightened capacity for concentration; magnification of character traits and psychodynamic processes; an apparent nakedness of psychodynamic processes that makes evident the interaction of ideation, emotion, and perception with one another and with inferred unconscious processes; concern with philosophical, cosmological, and religious questions; and, in general, apprehension of a world that has slipped the chains of normal categorical ordering, leading to an intensified interest in self and world and also to a range of responses moving from extremes of anxiety to extremes of pleasure. These are not the only effects of the psychedelic drugs, but the listing should suffice to convey some idea of their potency and the range of experiences they afford.

According to the functional model of the drug-state psyche advanced by us previously, there are four major levels of consciousness in the psychedelic experience. Each has its characteristic phenomena, and each can be of value in the therapeutic process. The tendency is for the patient to move through progressively "deeper" and more-complex levels of

awareness. These four levels of consciousness we term *Sensory, Recollective-Analytic, Symbolic,* and *Integral.* The patient ideally proceeds from the first, comparatively shallow, Sensory level, through the Recollective-Analytic and then the Symbolic, to the deepest, Integral level. The terms describe the major phenomena, and the deeper the level reached, the more profound the personality changes that may occur.

The progression only rarely is completed. The patient may never get beyond the Sensory level, although this only happens rarely and in cases of very poor management by the therapist or extremely strong resistance by the patient. Much more often, the deepest level reached will be the second or the third. It also happens that the patient may move back and forth among the first three levels, and there are border areas where experience cannot be precisely identified in terms of the schema. Despite qualifications, the model seems to us more valid and useful than any other.

Psychedelic experience begins on the Sensory level. Probing into personal problems should not begin before the patient has adequately experienced that level. Experiences include altered visual perceptions, with objects changing form, and a heightening of colors; synesthesias (cross-sensing: seeing sounds, hearing colors); changes in the body image; and intensification of all the senses. With eyes closed, vivid eidetic imagery may be seen. Awareness of time is altered as mental processes accelerate, and the patient feels that "hours" of subjective experience occur within a few minutes of objective (clock-measured) time. The patient has been told previously that such changes may occur and that he should accept and delight in them. The instruction is now reinforced, as the therapist emphasizes the beauty and wonder of the patient's experience. Resistance and attempted reimposition of normal categorical orientation results in confusion or anxiety.

The patient has previously been given to understand the distinction between subjective and objective time, and how much more, in the psychedelic state, he can experience within any clock-measured unit. On the Sensory level, he is taught ways to profitably use the time distortion. For example, he may be told to create a short story within two or three min-

utes of clock time, while being told that he will have more than enough subjective time to do so. Some patients create elaborate vignettes under these conditions. Later, on a deeper level, they can utilize this ability to condense lengthy memory sequences or other materials beyond the usual condensation of psychedelic time distortion.

The extent to which mental processes are accelerated in psychedelic experience remains to be measured, and few researchers have even shown much interest in the phenomenon. However, in mental-experiential terms, it is clear that the ten to twelve hours of objective time of the LSD session may be at least the equivalent of three or four times that period. This could be a major reason for the unusual effectiveness of psychedelic therapy as a "brief" therapy. Just on a subjective time basis, the LSD session may be the equivalent of fifty to one hundred hours or more of other treatment without time distortion.

The patient should be exposed to a rich variety of sensory stimuli on this first level. Objects, when touched, may seem vibrantly alive, and when looked at, may seem to breathe or undergo successive transformations. An orange that is handed the patient may appear to be a golden planet; from a piece of cork may emerge a series of striking "works of art." Joyous music usually is played to help direct him emotionally. Typically, the patient will announce that he is hearing music as if for the first time. All the senses are given an opportunity to respond "psychedelically." What we are aiming for by encouraging these types of experience is perfectly exemplified in the following statement by a young woman:

> After I had felt that hours must have gone by and then learned that it was only five minutes! after I had seen flowers open and close their petals and held in my hand a peeled grape that became, before my eyes, a tiny brain! and after I had closed my eyes and seen one beautiful vision right after another! well, then I decided that *anything* must be possible, including the transformations of character and personality I had heard about, and to some extent believed, but which only now I really felt confident could happen.

Thus the Sensory-level experiences have the important function of deconditioning the patient from his old ways of thinking and feeling. He should come to regard the psyche-

delic drug state as one in which "anything can happen." He should feel that his mind has resources never tapped before and that now have been made constructively available: these can be utilized to resolve conflicts, do away with habitual destructive response patterns, and effect still other beneficial changes.

Eventually, the patient should begin to find everything increasingly meaningful. A stone, a sea shell, or some other object may be contemplated intensely and at length until the patient initiates a philosophical or religious inquiry into the nature of the universe and man's place in it. From this he will go on to examine his particular situation in the world. The emotional tone deepens and intensifies perceptibly. The visual and some other sensory distortions yield to more-normal perceptions. As these and other reactions are noted, and as concern focuses on personal problems, the patient is considered to have reached the Recollective-Analytic level of the psychedelic experience. This deepening of consciousness almost always will occur spontaneously in sessions predefined as therapeutic or developmental. In any case, we emphasize again that the therapist should not force the patient into premature examination of his problem. The patient cannot be allowed to remain indefinitely on the Sensory level, but he must be permitted to have a full experience of it. Otherwise, there is little chance that the deepest, most therapeutic levels of awareness will be reached.

The problem of resistance is most troublesome on the Sensory level. It frequently takes the form of a somatic complaint, perhaps nausea or pain. Less often, but much more dramatically, it may take the form of extremely intense pleasure sensations that the patient will not want to relinquish. Some psychedelic therapists deal with resistance by interpretation or just by identifying it for what it is. The resistance can be handled more effectively and profitably, however, if drug-state phenomena are utilized. For example, a patient complaining of a pain in his shoulder can be asked to transfer the pain to a foot, then an elbow, and finally to his hand. Often this will be done, and then the patient is handed some not-too-sympathetic object and is told to "put the pain in the object." Then the therapist places the object out of sight and

begins to talk about something else. The patient has had evidence that therapeutic change can come about in unusual and impressive ways in a psychedelic session. Naturally, such a technique would not be used unless the pain is clearly functional.

Since the patient's heightened suggestibility is such a major factor in psychedelic therapy, it is helpful for the therapist to be familiar with the literature of clinical and experimental hypnosis.[2] Aaronson (1967c) is probably correct in stating that there must be important relationships between the hypnotic and the psychedelic states.[3] However, phenomenological differences are great, and in psychedelic therapy the patient should be a much more active participant than the patient in hypnotherapy.

On the Recollective-Analytic level, a large part of the phenomena are familiar ones in the literatures of psychoanalysis and hypnosis. The unconscious materials are unusually accessible, and the patient may recall or live through traumatic experiences from his early life. The events may be seen (eidetic images), or felt to be occurring, or vividly remembered. The patient, perhaps assisted by the therapist, can immediately review the recollection or age regression with an adult consciousness that interprets the events more appropriately than the child did. Even as the trauma is recalled or relived, a coexisting adult consciousness can draw mature conclusions. Even if abreaction does not occur, interpretation by the mature consciousness may still prove therapeutic.

On the Recollective-Analytic level, the concern is with literal life-historical materials—persons, events, behaviors, values—past and present. Some therapists ignore the patient's remote past and emphasize analysis of recent behavior. The

[2] *Cf.* Cooper, L., and Erikson, M. (1959): We have profitably utilized modified versions of Erikson's hypnotic techniques on countless occasions.

[3] Aaronson, (1967c) has suggested that the patient, to experience symbolic dramas, must have spontaneously entered a hypnoidal state. However, after, or even during, the dramas, a critical intelligence may be operative, and the patient may describe and even look for meanings in what is occurring. Possibly *a* consciousness has entered a hypnoidal state, while another, secondary consciousness, remains outside that state and observes.

patient is made to examine in detail irrational, illogical, and self-damaging attitudes and behaviors. He admits the need for change, considers alternatives, and, alone or with the therapist's help, restructures his values. With some frequency, here, unconscious philosophical assumptions become conscious. (A recurrent emerging recognition, in our work, has been the patient's sudden knowledge that he always has considered matter, including his own body, to be evil or inferior. This notion, he feels, was forced upon him early, by his church or his parents. It may have been causative of sexual or other disorders, and usually has impaired sensory perception in one or more spheres.) The value-changes include improving the self-image. Most undogmatic psychedelic therapists probably would agree that (Unger et al., 1966):

> In general, pathological functioning in the patient is presumed to have been determined by a reinforcement history which would have predisposed toward root "defects" in the self-system (self-image, self-esteem, self-trust, sense of basic worth), and associated value-attitude distortions and "inadequacies." The major effort of psychedelic therapy is reconstructive, premised on the possibility—via the psychedelic reaction—of rapidly establishing and then consolidating the patient's functioning on a core of positive self-acceptance and regard.

When therapeutic change is effected by essentially persuading the patient to restructure his values, increase his self-esteem, and begin to behave in more-effective ways, the success of the brief treatment owes even more than usual to the patient's suggestibility, prolonged concentration, and intense affect in the psychedelic state. These are factors conducive to learning and behavioral change.

There also occur on this level therapeutic events more characteristic of psychedelic experience, although hypnotherapy can provide some rather similar examples. These cases sound bizarre, but the benefits, however strangely arrived at, are genuine. For instance, one research subject (S) was a woman in her thirties who, two years earlier, had become frigid and begun to experience intense pain at the time of her menstrual period. No organic cause was found. During her session, S's life was reviewed in great detail but without apparent benefit. Later, however, she began to insist that she was aware of a "second self" that in everyday life was constantly rebuking

her and calling her an evil and unworthy person. This second self, she said, would speak to her daily in a voice that was heard by her "subconsciously." Now the voice was louder, and she was fully conscious of it. S then entered into a dialogue with the second self. With our encouragement, she refuted point by point the various, actually unfounded, accusations as the voice made them. Finally, S became very jubilant and told us the second self had been vanquished, had admitted being a "malicious liar," and had promised not to trouble her again. S said she now knew that she was a good person who did not have to punish herself by denying herself orgasm and inflicting menstrual pain. In fact, she was subsequently free of the frigidity and pain. Three years later these gains were preserved.

It may be argued that S found it easier to abandon her symptoms than to admit their cause. Other interpretations also might be made. In any case, there was no replacement by another symptom.

In another of these curious cases, a mannish female, who denied homosexual tendencies, had been discussing at some length the combination of facial expressions and gestures and ways of speaking that made her appear masculine despite her strong wish to look feminine. She felt that if she looked into a mirror she would be able to isolate the components of her mannishness and eradicate them, and then go on to develop feminine replacements. When she looked into the mirror, however, she immediately started to weep, became extremely nauseous, and ran into the bathroom. She came back, sat silently for a while, and then appeared more composed. Questioned, she said she had seen the face of her brother when she looked in the mirror.

This woman had brought with her to her session, "for some reason, I just thought it might be important," a five-by-seven-inch photo of her brother. He had quite distinctive features, and it now became evident that her own facial expressions were a mimicking or even, as she suggested, a caricaturing of those features. As she continued discussing his mannerisms and way of walking, she moved around the room, and the mannishness seemed to be falling away. She felt "frightened at something coming up inside me, maybe femininity," but

was urged to continue "permitting your own real femininity to emerge." The final "freedom," she said, came when she complied with an instruction to, calmly and without fear or anger, tear up the photograph and slowly drop it, piece by piece, into the wastebasket. The feminization achieved in the session was striking; we thought it best not to explore the relationship to the brother and why she might have chosen to imitate or mock him.

It is always important to follow up the patient for weeks or months after the therapeutic session, until the new behavior patterns become firmly entrenched. Contact with the patient during the first two or three days after the session is especially important. The patient's remaining hypersuggestibility to the therapist makes reinforcement particularly effective. Supportive counseling with praise and encouragement and assignment of behaviors made possible by the therapeutic change may be all that is required. In other cases, a more elaborate postsession psychotherapy will be needed. Without proper follow-up care and the patient's co-operative efforts to preserve his gains, there are frequent partial or total relapses.

"Descent" to the Symbolic level usually depends on the previous occurrence of important insights along with a thorough examination of personal problems, goals, and other values. These allow subsequent symbolization of the psychodynamic and other materials, and participation by the patient in symbolic dramas that can lead to major therapeutic gains. The prolonged concentration on personal problems, with a deepening, intensifying affective climate, also helps effect transition to the more-profound levels of consciousness.

Few of the drug-state phenomena have greater therapeutic potential than the Symbolic-level participation by the patient in mythic and ritualistic dramas that represent to him in terms both universal and particular the essentials of his own situation. Acting out the myth or ritual can produce profound catharsis and "rebirth," and so effect personality changes deeper and more sweeping than those possible on shallower levels of consciousness.

Here, eidetic images become of major importance as an instrument for therapeutic change. The patient closes, or is told to close, his eyes. Spontaneous or suggested first experi-

ence on this level is likely to be of historical events and then evolutionary processes. When the historical events are experienced, the patient may observe or feel himself a participant in famous battles, coronations, the building of the pyramids. He may walk along the Piraeus with Socrates, or bear witness while a witch is tried or a saint martyred. The events may be eidetically imaged in intricate and voluminous detail.

Similarly, the patient may observe or feel himself to be a part of evolutionary process. He might "become," or be told to become, "that primordial piece of protoplasm floating in an early ocean." After that, he may experience a reliving of the evolutionary sequence on up through the emergence of man. The descriptions may be extremely rich and go far beyond the patient's capability under non-drug conditions. If tapes are played back later, he will typically deny conscious knowledge of much that he experienced and described at this point. These episodes facilitate later experiencing of more-therapeutic imagery.

The Symbolic-level "world" of myth and ritual, the world of legendary and fairy-tale themes and figures, of archetypes and other timeless symbols and essences, is more profound and meaningful than the historical and evolutionary sequences. Here, where the symbolic dramas unfold, the patient may find facets of his own existence in the persons of Oedipus, Faust, Don Juan, Parsifal, or similar figures; and he plays out his personal drama on these allegorical and analogic terms. Or he finds ways of attaining new levels of health and maturity by participation in rites of passage and other ceremonies and initiations.

Those who have not experienced them find it difficult to understand what is meant by eidetic images. It is somewhat as if a technicolor motion picture were being projected inside one's own head, with the possibility that one may become an actor in the drama. The images are usually seen with the eyes closed, although sometimes they can be projected into a gazing crystal or upon a flat, blank surface. They are typically brilliantly illuminated and vividly colored, exceeding in beauty and richness anything seen in the external world. Not all patients have eidetic images, and some see only abstract

forms or swirling masses of color. However, especially with adequate drug dosages, representational imagery, too, has occurred in most persons with whom we have worked.

Eidetic images may be related to dream images, but are much more vividly experienced by a waking consciousness. On the deeper psychedelic levels, eidetic images are organized into highly structured dramas wherein the symbols arise from the personal-historic data, and insights become viable and plastic to the myth-making process by the patient's evocation and examination of them on the Recollective-Analytic level. The meaning of the symbols is clear, or becomes so, and the dramas unfold without the incoherence and illogic of the dream. The dramas tend to be purposive and to aim at the healing and growth of the person. The patient has no sense that he is creating them—it is as if, by applying proper stimuli, a previously inhibited entelechy has been made free and functional, "choosing" the symbolic dramas as a means to effect its healing goals.

Ideally, the patient's participation in the symbolic dramas will be total, including ideation, affect, sensation, and kinesthesis as integrated dynamic constituents of the drama. The dramas also can unfold on a verbal-ideational plane without eidetic imagery, but then there may be lesser response intensity. In the psychedelic theater of symbols, the chief function of eidetic images seems to be to enhance imaginary events by drawing into the image-ideation complex the additional factors of affect, sensation, and kinesthetic involvement, in order to add full richness and transformative power to the experience.

In one of our cases, a professor of philosophy, deeply religious, brought to his session complaints of a castration complex (diagnosed by a psychiatrist), inadequate sexual functioning, general sensory impairment, an "abstract, intellectualized approach to life," various tensions, a Rorschach diagnosis of latent homosexuality (which he thought to be incorrect), and an over-all sense of being "cut off" from full participation in life. He did not want to deal with the castration complex directly, but hoped to become better able to "relate to things and others more completely," establish bet-

ter contact with the sensory realm, "experience life as a creative person," and reorient some of his attitudes and values with regard to sex.

His experience of the Sensory phenomena was pleasurable. On the Recollective-Analytic level, he re-experienced, with profound emotion, the death of his grandmother when he was not quite four years old. There was also a vivid recollection of identifying sexually with a little neighbor girl. He recalled believing he had killed his grandmother by a "magical act," the smashing of a doll, and when she was buried he had felt that "a part of myself was being buried with her." This incident, he said, had left him cut off from "the concrete world" and also had been a "symbolic autocastration." He felt, too, that he still had to liberate himself from identification with the neighbor girl. These, with other regressions, memories, and insights, continued for some time, producing emotional discharge and recurring episodes of nausea. He lay down on a couch to consider his need to achieve a full manhood by overcoming the old guilt, the effects of the "autocastration," and the feminine identification. Symbolic drama experience began, consisting of a series of vividly imaged rituals, which he describes:

I suspended my thoughts for a while, and the material simply began to come up. I soon had an image of a group of people dancing. They seemed to be primitive people, but of white skin. They were dancing around something raised, a pole or platform, and there was a snake associated with this ceremony. They were dancing, dancing, trying to bring something to life. I had a sense of labor and duration. At this point I was lying on the couch and was having periodic spasms of the legs, seeming to come from that point of tension at the base of the penis. These spasms continued through the long series of primitive rituals.

This rite he did not understand except that it seemed to be a preliminary to something more important still to come. Next was a puberty rite:

In the next ritual there were boys present, and they were having intercourse with an older woman, with the earth mother. Then I saw the image of a huge female figure over me and, at that moment, there was a bursting reaction as of liberation, and the figure seemed to move quickly away. I became very ill and dashed to the bathroom

to vomit. I retched violently. This was the most intense of the vomiting spells and seemed to involve my whole body. I had a sense of spitting up deep anxiety—from the innermost part of my body, from my very toes. There was a realization that I was vomiting up my identification with the Female—an identification which had led to terrible anxiety about being castrated. As long as I identified with the Female, I seemed to be castrated, and unless I got to this level and liberated myself, contact with women in my life would ultimately lead to a sense of castration.

There then followed two additional sequences, one a "warrior initiation rite," and the other an unnamed primitive-Christian ritual that "accomplished the salvation" of the patient and "made [him] whole." In all episodes, participation was on all levels: imagery, emotion, ideation, physical sensation, kinesthesia.

I returned to the couch again, and again saw dancing, this time faster and more violent, like a war dance. I think this was the initiation ceremony for new warriors. . . . Then I saw a group of boys killing an older man. This was the father. Then they began eating him. I felt that I was also there mutiliating this man. I pulled off his penis and testicles and, at that moment, saw vividly his mutilated body and the wound in his groin. I felt a deep release of tension and, I believe, I vomited again.

Then I returned to the couch and saw more dancing. This time the people were dancing around a raised platform, on which people were tied by their arms on supports, perhaps two or three males. Then I had the awareness that I was lying down on my back and that someone was placing hot coals in a circle on the lower part of my abdomen, near my penis. I was afraid. Then I accepted the situation and entered into the ritual. I ritualistically accepted my own castration. At that moment, a man appeared in front of me, in the same position that the large woman had been in the first ritual. I knew that he was the Savior. I could not discern his features. His face seemed to be white, without any features, and I could see only his bust. As soon as he appeared, I threw over his left shoulder a piece of animal skin; it seemed to have hair and to be a piece of goatskin. At this moment I knew I was saved from castration.

Then I noticed that the people were on a field and were tearing the Savior to bits and eating his flesh. Then I felt that I was the Savior and was lying on my back being nailed to a cross. Then the cross was lifted up, and at this moment I was a spectator viewing the Savior from a distance as he was being lifted up on the cross on the top of a hill for all the people. From the time the Savior appeared, I had a deep sense of peace and integration. I felt that I was saved and that I was whole.

Therapy on the Recollective-Analytic level can provide insights essential to growth, remission of symptoms, and even elimination of neuroses; but Symbolic-level work can abruptly and in fundamental ways transform the personality, freeing creative talents and actualizing potentials, as well as accomplishing usual therapeutic goals.

In the case just summarized, the patient afterward felt more masculine, more tranquil; and self-esteem was heightened. He was more energetic, with more-intense sensory experiences. One week after the session, "everything" seemed to be going extremely well. In succeeding weeks, he accepted leadership positions he would not, and felt he could not, have accepted previously. He resolved with his collaborator on a book some long-standing conflicts that had made the project seem hopeless. His philosophical understanding was improved. Five months after the session, the book collaboration was progressing excellently. He was "really discovering what scholarship means." There was "a continual stream of penetrating insights and deepened philosophical understanding." He now had "an integrated view of the world." Personal relationships no longer were "on an abstract level." Instead, he had a "continuous sense of immediacy, a sense of existing in the moment, a total commitment to what is being done at the moment." There was a "continuously heightening relatedness to nature—something qualitatively new, a sense of belonging to nature that was not present before. This relatedness to nature has had an important effect upon my relationship with my wife . . . now there is a shared feeling level to the relationship that never existed before. I have also a deepened sense of what it means to be a father and, along with this, a much better relationship with my children. I think, and apparently my students agree, that my teaching never has been better." A year later he felt that he was continuing to make developmental gains. Objectively, he was achieving more. He reported himself aware "of a positive dimension of sex as a means of relating to the world." "In short," he summarized, "I am happier with myself than I have ever been, and others seem to be happier with me too."

All this was the product of a single LSD session, with oc-

casional supportive follow-up. In the magnitude of the gains, it is exceptional, but it does show what is possible.[4]

Integral-level experiences may follow successful experiencing of the Symbolic level. These are religious and mystical experiences, intensely subjective and private, and once they have begun, the therapist no longer has any part to play. The emotional content is extremely powerful, but serene. The patient feels that he has reached the ultimate depth level of consciousness, there to experience fundamental reality, essence, Ground of Being, or God. The effects are the well-known ones of overwhelming religious conversion, "cosmic consciousness," or "peak experience." As mankind's religious literature abundantly records, the personality can be instantly and profoundly transformed. Subsequent changes in behavior can be extraordinary.

Unfortunately, Integral-level experiences are rare, even with normal subjects. Possibly, with further research, we might be able to bring them about much more frequently. If we could, we would be able to achieve what some men throughout most of human history have pursued with single-minded dedication—and, achieving, have sometimes been able to alter history's course.

Only the religious experiences are therapeutic, effecting a basic change in values from which most of the other benefits seem to flow. Those who have mystical experiences (with "fusion" and loss of self-awareness) on this level are mature, well-developed personalities with little need for change. Their accomplishments already are commensurate with capacities. The mystical experiences are awe-inspiring and beautiful, but tend to confirm the individual's life pattern. Possibly the most fundamental value changes occur in a religious context because, in our society, religion is the source of basic values for most persons. One goes back to this source; and then new, mature, and self-actualizing values replace the immature and distorted ones deriving from childish interpretations of and responses to sectarian dogmas. The profound emotion of this

[4] This case is given in much greater detail in our book *The Varieties of Psychedelic Experience*, along with other detailed Symbolic- and Integral-level cases. The complexity of these deep levels and the experiencing of them can be only suggested here.

level may "imprint" the person with insights and the experience of harmony with a basic and beneficent substratum of reality.

Concluding Remarks. It should be clear that expanded therapeutic and research use of psychedelic chemicals is warranted. Given the present extent of mental illness, it should also be considered urgent. It also is essential that we develop effective, specifically psychedelic, psychotherapies. The psychedelic drug as an "adjunct" to old, and in some cases obsolete, therapies will not provide us with equal benefits.

THE PSYCHEDELICS AND GROUP THERAPY

DUNCAN BLEWETT

The psychedelic drugs offer certain rather profound advantages in the group psychotherapy situation. Examination of these, as well as the disadvantages or hazards related to the group psychedelic process, requires a comparison of group psychedelic experience with that of the more conventional situation. Any group process depends upon the development of the individual subjects within the particular context of the group. Since in group psychedelic sessions this process is so compressed and accelerated, it is advisable first to consider the effect of the drug upon the individual and then to trace the reflections of this in the group process.

Psychedelic and Conventional Group Therapy

In psychedelic and non-psychedelic groups, there is a similar development of basic trust between members, which increases group cohesiveness and permits greater freedom of expression and self-exploration. This leads, in turn, to therapeutic advance through the broadening of self-understanding. In this process, each group member acts both as a mirror and as an alternative pattern of adjustment for each of the other members. Each person finds himself in a gradually growing environment, in which his perspectives may