Psychosynthesis Research Foundation Inc.

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October 16, 1970

Dear Colleague:

The second meeting of the 1970/71 series of Psychosynthesis Seminars (held on the third Friday of each month) will be held on Friday, November the 20th at 7:30 P.M.

Our speaker will be Dr. Stanislav Grof, Chief of Psychiatric Research, Maryland Psychiatric Research Center, Baltimore. Dr. Grof's long and intensive experience in the use of LSD in psychotherapy has led him to some far-reaching conclusions about the nature of personality and its development. In his talk, he plans to relate his experiences to Dr. Assagioli's paper on "Symbols of Transpersonal Experiences."

We hope it will be possible for you to be with us at this meeting.

Cordially,

JACK COOPER, M.D. 914-669-5105
FRANK HARONIAN, Ph.D. PLaza 9-1480

DATE & TIME OF MEETING: Friday, November 20, 1970 at 7:30 P.M.

PLACE: Directors' Room, Mezzanine floor, Park Sheraton Hotel, 7th Avenue & 56th St., New York, N.Y. (Please consult notice-board in hotel lobby in case of room change.)

SPEAKER: Stanislav Grof, M.D.

TOPIC: Research findings in relation to symbols of transpersonal experiences.

NB: SPECIAL MEETING

We have asked Dr. Grof to hold a three-hour seminar for mental health professionals on the morning of Saturday, November the 21st, and he has agreed. This would provide an opportunity for more intensive discussion.

If you are interested in this supplementary opportunity to meet with Dr. Grof while he is in New York City, please send your check for $10.00 to P.R.F. before November 13th. If there is sufficient interest, a room will be booked and a meeting held; otherwise, your check will be returned.

PSYCHOSYNTHESIS SEMINARS

1970-71 Series

Second Meeting: November 20, 1970

Speaker: Stanislav Grof, M.D.
Maryland State Psychiatric Research Center
P.O. Box 3235
Baltimore, MD 21228

Subject: Findings from LSD Research regarding Personality Theory and Transpersonal Experiences

Participants:

Bernard Aaronson, Ph.D.
George Bailin, Ph.D.
Bruce Bernstein
Jack Cooper, M.D.
Rena Cooper
Jean Drake
Fella Friede
Piero Ferrucci
Roy Gendron
Judy Gould
Joyce Goodrich
Frank Haronian, Ph.D.
Laura Huxley
Iris Herman
Frank Hilton
Hilda Hilton
Alex Imich
Jason O. Janus
J. Jacobson
Joan Kellogg
R.F. Kellogg
Ruth Lofgren, Ph.D.
Joseph R. Mixer
Thomas A. Mikula
Nicholas Morano, Ph.D.
Mrs. Morano
Ruth Rafael
Arline M. Rubin, Ph.D.
Milton Robin, Ph.D.
Mrs. Robin
Judi Striano
Birger M. Salberg
Shirley Winston, Ph.D.
Alfred Yassky
(and five others)

PSYCHOSYNTHESIS RESEARCH FOUNDATION
Room 314
527 Lexington Avenue
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Introduction

Dr. Haronian: Dr. Stanislav Grof's work with LSD is probably more extensive and extends over a longer period of time than that of anybody else I know personally. He has come up with some conclusions and some observations which have been incorporated into a book which is now in the hands of the publisher and which will be available late next year. Tonight, we're going to get a preview of some of the conclusions that Stan has come to through 14 years of work with LSD.

Dr. Grof was born in Prague and got his M.D. from Charles University. While completing his work at Charles and shortly after, he had a Freudian analysis and was working with LSD in research. For the following ten years, he worked in clinical research with LSD in Czechoslovakia. In 1967, he came to this country as a research fellow and worked at Johns Hopkins, at the same time doing some work at Spring Grove State Hospital in Maryland. He is presently Chief of Psychiatric Research at Maryland State Psychiatric Research Center.

He is going to talk tonight about the kinds of experiences - personal and transpersonal - that he himself has had and that he has noted in his patients and his research subjects. He will discuss the relationships of these experiences to symbols that Roberto Assagioli speaks of: - symbols of transpersonal experiences.

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Dr. Grof: Before I start talking, I would like to thank you for your invitation and tell you that it's a real pleasure for me to come here and be able to present some of the work we have done and discuss it; especially in this circle, because I think that besides the Jungian analysts, people working in psychosynthesis probably have the best experience, the best background, to talk and to consider the kind of data which I would like to present today.

Let me start by elaborating a little on what Dr. Haronian has just said. I am presently working at Spring Grove in the Maryland State Psychiatric Research Center, which happens to be one of two places left in the United States where it is still permitted to use LSD. We have had several research projects. One study that has already been concluded was of 140 alcoholic patients who were given LSD in what we call psychedelic psychotherapy. Most of you are familiar with what psychedelic psychotherapy means, but let me very briefly recapitulate it.

It means to work for about 15 to 20 hours with the patient in preparation for the session. In the preparation we go through the patient's past history from childhood till the present time. We try to give him some understanding about how his past problems are related to his present problems; about how his symptoms are related to his various conflicts, to his life history, and so on. And last, but not least, we prepare him specifically for the drug session. In other words, we discuss with him what LSD does, what he can expect will happen, what is the best approach to the drug experiences, and so on.

There is a very important aspect of psychedelic therapy which is different from Freudian psychoanalysis. As you know, in Freudian psychoanalysis there is a lot of emphasis on psychopathology. Most of the time you spend in psychoanalysis you discuss symptoms; and there is also a lot of emphasis on negative potential, so that you can associate for months or years and not learn anything else about yourself but that you have death wishes toward your nearest relatives,

that you have incestuous tendencies, that you have cannibalistic tendencies, that you like to play with your feces, and so on. There is hardly any talk about your positive potential. Now psychedelic therapy is very different. Although you still talk about symptoms - you still talk about psychopathology - it is presented as a barrier which separates the patient from his real potential. And the therapist tries to relate to whatever is left. No matter how crippling the symptoms of the patient are, there will be a tendency to find the positive potential and to explicitly communicate to the patient the belief that he can transcend his pathology and that he can find himself.

So, this is, in a nutshell, the preparation for the psychedelic therapy. Then, as far as the drug session goes, the very aim of the session is to reach what we call a psychedelic experience, which basically is a mystical, religious experience. Usually it's a death-rebirth experience. When this happens, an experience of unity follows in which the ego boundaries are transcended. The patient experiences unity with other people, with nature, with the universe - with God, if you will. It has been found empirically that those patients who have an LSD session of this kind, who are able to achieve the mystical or religious experience, have the best therapeutic results - get the most out of the session.

You might ask to know how we facilitate the experience and what are some of the variables involved. In addition to those specific aspects of the preparation which I have already mentioned, the setting of the psychedelic session is especially important. We run the sessions in a very nicely furnished, homelike treatment room. There is a lot of emphasis on aesthetic elements: colors, pictures, flowers, various natural objects - we sometimes use shells, stones, gems, various things that somehow represent all the creativity of nature. And during part of the session, usually later in the evening, we take a walk, and the patient looks at the trees, the flowers, the sky, and so on. Finally, there is a "psychedelic dinner" where there is a lot of color, various textures, fruits, nuts, and so on.

The basic idea is to bring that kind of far-out, mystical, religious experience back to earth and to project it onto elements of the patient's everyday experiences: the people with whom he socializes, the food he eats, elements of nature, and so on.

So, that is the procedure which we used with alcoholic patients. Recently we have applied the same procedure to hard-drug addicts, people who had been in prison, who were put on parole, and who were then split into two groups. They were randomly assigned to the control group or the LSD, psychedelic group; again with the idea to find out whether LSD therapy can add something to the patient's adjustment.

We have completed another study with neurotic patients under very similar circumstances. Half of the patients were assigned to group psychotherapy the other half to the psychedelic psychotherapy.

Probably the most interesting project which is going on at the present time is one with terminal cancer patients - not with the idea of curing cancer, but the basic issue is to prepare people for death or to reduce somehow the suffering that is associated with the terminal illness and with imminent death. The preparation is very similar. Of course, with patients who know that they are dying, you can discuss these issues openly. There will be specific modifications because you are preparing them for death rather than for life.

We are also trying to work with some shorter-acting hallucinogens. At the present time it's DPT, Dipropylotriptamine,which is very similar to LSD but lasts only about three or four hours. And we are starting a project with MDA, which is Methylindoxyamphetamine, a psychedelic drug that seems to have different effects than LSD. So, this, in a nutshell, is what we have been doing at Spring Grove. This work has been published. Those of you who are interested can get reprints and read about it.

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I would like to focus tonight on the work that I did in Prague before I came to this country because from many points of view, this could be more interesting to you. That project had to do with what we call psycholytic therapy which differs from psychedelic therapy, which I have just described. The term psycholytic contains the idea that LSD therapy has a kind of releasing or dissolving effect on the psyche. It is the same route as in hemolysis. It's a very specific term which is used in Europe for psychoanalytically oriented psychotherapy in which small doses of LSD or some other psychedelic drugs are used as adjuncts in order to intensify and accelerate the psychotherapeutic process.

Psycholytic therapy differs in several important variables from psychedelic therapy. There is also a preparatory period of about two to three weeks when you use drug-free psychotherapeutic interviews. Of course, it doesn't have the specific features which I described for psychedelic therapy. In other words, there would be much more talk about psychopathology, about problems and conflicts. There would be very little emphasis on positive potential, growth, and so on. At least, this is where I started; as time went on, I had to assimilate the things that I observed in the sessions. So, by the time I was leaving for the United States, I was very, very close to the psychedelic concept of therapy. So, it wasn't very difficult for me to shift to psychedelic treatment.

Going back to my work in Prague, during this drug-free preparation, the idea is not only to give the patient some self-understanding but also to give him an opportunity to learn a lot about you. The patient must be willing to accept you as a guide and to trust you during an LSD session; you can't walk into a session as strangers. There has to be a lot of interaction. He has to have a lot of information about you and he has to have a fairly deep relationship with you to start with.

After this drug-free preparation, when the therapist feels that the patient is ready, we start the LSD sessions, usually with 100 micrograms. We then build up in each additional session with about 50 micrograms until we found a dose which we consider optimal for that particular patient.

There are tremendous individual differences between patients. Patients who are on the hysterical side seem to be tremendously sensitive to LSD. Fifty micrograms for them is a high dose. They will have very dramatic experiences. They can regress to the breast on 50 micrograms. They will have a lot of visual imagery. They will have a lot of interesting body sensations and so on. The whole session can be very dramatic with only 50 micrograms. But severe obsessive-compulsive patients seem to react in the opposite way. Some patients to whom I gave as much as 500 micrograms barely showed any effects from it. The rest of the patients will be somewhere in between.

So we usually started with 100 and then added in subsequent sessions until we found a dose which we felt was best for that patient in that it allowed him to go deeply into his inner experiences but at the same time be able to maintain enough contact - enough therapeutic contact - with us. So he could still relate, he could report, and he could be helped in working through whatever was coming up.

Since this was research - you have to remember that - I started working with LSD in '56 and very, very little was known about what LSD did or what LSD was about. It was very much an orientative study. It was like an exploratory venture into completely unknown territory. Give people LSD; then try to be supportive, be helpful, and wait for what's going to come up. For this reason, we kept very detailed records of each session, written by the therapist, who was the "sitter", and the patient. And we also kept detailed records about the free intervals between the sessions. We wanted to find out whether we could understand anything about the basic dynamics of the LSD session.

We had done some previous research which was mainly of a descriptive nature. It was done within what was called the "model psychosis" approach. At that time there was the hypothesis in psychiatry that what we get with LSD is actually a model of schizophrenia and a model of endogenous psychosis in general. So, we gave LSD to different people and we measured various parameters. We then measured the same parameters in schizophrenics and looked for similarities and differences. And in this study, we made a tremendous number of absolutely flabbergasting observations. For example, when we gave LSD in the same dosage under the same circumstances to 200 people, each of them had a completely different reaction. Some of them had more or less ecstatic trips. They saw beautiful colors and patterns; they had optical illusions, there was a tremendous release of fantasy; they magnified very colorful movies or kaleidoscopic shows, and so on.

Other people, under the same circumstances just felt miserable, felt physically sick; they felt nauseated and vomited. They felt like collapsing. They sweated profusely. And there were absolutely no visual changes or any of the other experiences which we noted in other people. If you were to ask them what LSD does, they would say it just produces physical symptoms. In other words, these people were able to somatize the whole experience.

We had several people in this group who developed actual schizophrenic-like symptoms, if you want to call them that. They had panic anxiety, delusional thinking; they were paranoid - some kind of weird plot was going on, everything was prearranged. They were trying to escape the situation, and so on. On the other hand, we had two people in that group for whom the whole LSD experience was just a sexual trip. Tremendous sexual tension was built up and then released in an orgastic experience; and then the whole thing was repeated. They didn't have any visions, any other symptoms, just sexual experiences. If we asked them what LSD does, they would say that it's the most powerful aphrodisiac you can imagine.

We had quite a few people who had real Freudian trips, who regressed into childhood and reported reliving of childhood experiences, castration complexes, oedipus complexes, electra complexes - you name it! And they felt that LSD was just a tool for deep self-exploration. Then finally we had several people who, with the same dosage, under the same circumstances, had a very profound mystical, religious experience such as given in the Upanishads or some of the ancient religious texts.

As you can imagine, this was an extremely puzzling experience. Here was a drug, very clearly chemically defined, given to various people in the same dosage, and it produced a tremendous range of reactions from ecstatic experience through symptoms of physical illness to mystical, religious experiences. For this reason, when we finally came up with the idea of giving repeated sessions for diagnostic purposes or for experimental treatment purposes, we decided to keep very detailed records in order to try to understand why different people have such tremendous differences in the types of their experiences.

Our patients had a long series of LSD sessions. We gave the sessions usually in ten-day to two-week intervals. We spent about five hours with each patient in each of the sessions, and we talked with them in the intervals between the sessions, trying to find out what the last experience was like, trying to help them to integrate it with their experiences, and sometimes even preparing them for the next session if they had some apprehensions, some specific problems. As far as the number of the sessions was concerned, again there were tremendous differences among patients. For some the whole series was about 15 sessions. With others, we went up to as many as 80 or 100 sessions.

When this whole series was completed, we had collected data from all the sessions of the series and from all the free intervals. So, it was now possible to reread this material during one single day, refresh your memory, and get an overview of the treatment. As you can imagine, if you treat ten patients at the same time, with the tremendous richness of the LSD material, sooner or later you start forgetting how things fitted into place for any single patient. You can easily start to confuse the experiences of various patients. Whereas if you have all that material typewritten, you can read it within a single day. That way, you get a very accurate picture, a condensed picture, of what actually transpired during the course of treatment.

So, after the series of sessions with each of the patients was finished, I would retrospectively analyze the whole procedure and try to find some cues as to what was the nature of the process. What sense could I make of it? Were there some repetitive patterns? Were there some basic, underlying trends? Were there some specificities of the LSD experience that were related to diagnosis or to the past or present situation of the patient? In other words, can we understand anything about LSD, or must we just accept that it's just absolutely unpredictable? You know, if you give LSD to an individual, just about anything can happen. He may become physically sick. He may act like a schizophrenic. Or he may act like an enlightened saint. And also, in terms of the outcome of the session, he may feel purged, purified, reborn. But he may also have prolonged negative reactions, and in some people the session could end up in a psychosis. So, if you work with LSD, you have to anticipate this tremendous range of responses. Is there anything that you could understand, that you could predict? This was the basic question behind this whole retrospective analysis.

I should also tell you that over the years, we ran a whole series of LSD sessions with over 50 patients. There were several specific characteristics of that group. First of all, they covered the whole range of psychiatric diagnosis. We did this on purpose because we wanted to see if there is some therapeutic potential in this procedure; was it better for some patients than for others? For example, does it work better with anxiety neurosis than with obsessive-compulsive neurosis? What happens to the schizophrenic? And so on.

So, we had a wide range of psychiatric diagnoses. But there were two very definite biases in the selection of subjects. One of them was that we selected patients with more than average intelligence, for obvious reasons. Because this was an exploratory study we needed very accurate introspective data. The experiences you have after LSD are very difficult to verbalize anyhow. People mention ineffability as a very essential part of it. We wanted people whom we knew could really do a very good job. So, we selected those who had better-than-average IQs.

The second bias was towards very poor clinical prognoses. We chose people who had very deep emotional disorders, where the problems had lasted over years, where most of the conventional treatment had been without success. This second bias was more or less for ethical reasons; we wanted to be reasonably certain that these people couldn't be helped by established measures. We knew that in spite of the fact that LSD had been tested for safety on animals, it was still very new, and there could be all kinds of unpredictable side effects. So this was still an open possibility.

So, there were very severe disorders in this group. My forthcoming book gives a lot of condensed case histories. If you read it you'll be able to make your own judgment as to how difficult those patients were. Many of them were suicidal. There was a real risk that if we didn't do something dramatic with them they could suicide any day. Others were drug addicts, for example, who would take unknown quantities of unknown drugs under unsupervised conditions if we didn't keep them under close surveillance. So, there were various reasons why we felt justified in using this drastic and poorly understood procedure on these patients.

I have a graph which will make it much clearer (p.6a). I would like to draw some curves representing the typical courses of psycholytic treatment in three categories of people. One of them would be the neurotic group. The other would be people who were psychotic when we started giving them LSD. And the third group would be "normal" people; in other words, people who had not needed to be treated on an out-patient or in-patient basis in the past - those who were in training sessions, psychologists, psychiatrists, medical nurses, some philosophers, and some artists who went through this procedure.

In this graph, the horizontal axis represents time. It is cut into regular intervals by the sessions. In other words, this would be the first, second, third, fourth session from left to right. On the vertical axis we have a rough measure of "degree of adjustment." This (C.) would be the range of psychotic symptoms. This (B) would be the range of neurotic symptoms. This (A) would be normal adjustment.

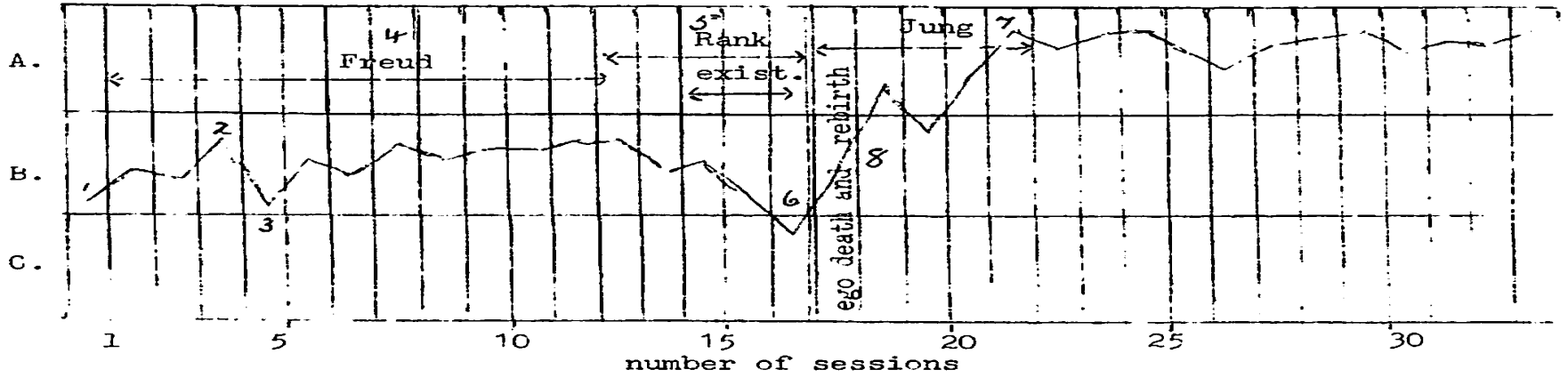
Don't confuse it with the three groups I mentioned before. There were three groups: - normals, neurotics, and psychotics. But this shows the <u>range of adjustment</u>. Often the patients were moving - for example, somebody who was neurotic could temporarily move into the psychotic level of adjustment. On the other hand, a psychotic patient could improve and show neurotic symptomatology. Somebody who didn't originally have neurotic symptoms could show them at a certain period. So the curves for these three groups of subjects move from one of these adjustment ranges to another.

I will start with the neurotic patients, and I would like to show you what happens to a typical neurotic patient during this procedure. And then, after

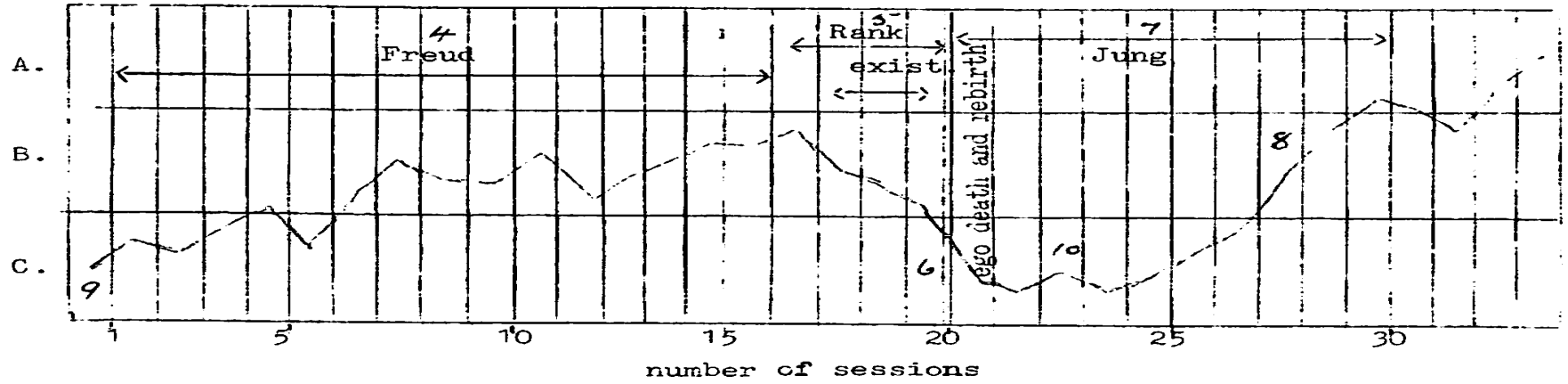
Clinical Condition of Subjects between Treatment Sessions

A. Normal adjustment
B. Neurotic behavior
C. Psychotic symptoms

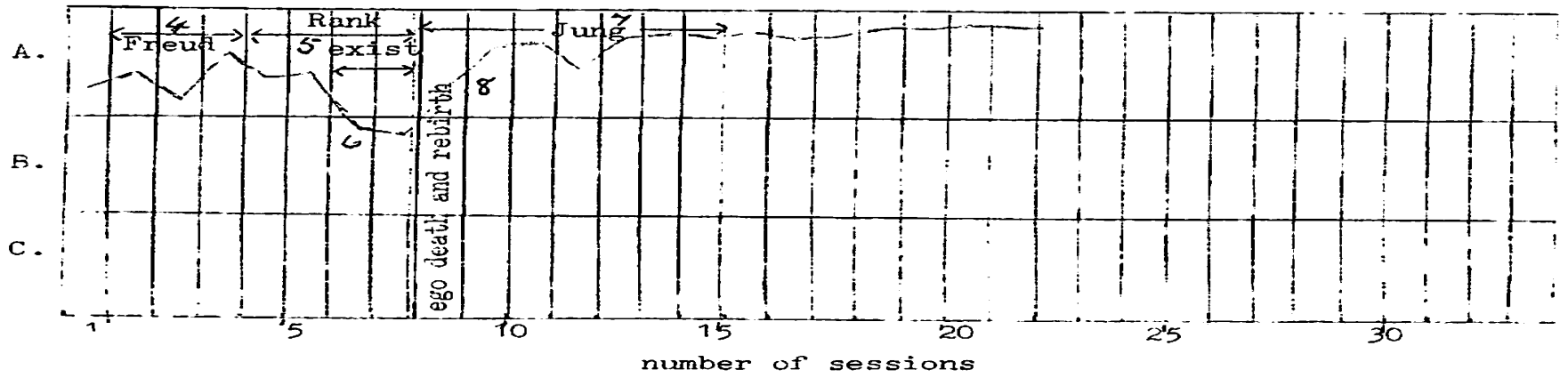
Neurotic patients:



Psychotic patients:



Normal subjects:



we finish with them, I would like to tell you in what way the psychotic patients and the normal people differed from this neurotic curve.

The typical neurotic patient was very severely ill. Many of them were pretty close to a psychosis. In other words, they could be labeled borderline.

Maybe some of you might question whether it is justifiable to put neurosis and psychosis on the same continuum or whether these are phenomena of a different dimension. It seemed from our LSD work that they were on the same continuum. We saw psychotic patients moving into the neurotic realm, and we could actually see the psychotic symptoms transformed before our eyes into neurotic symptoms, and vice versa. So that a typical neurotic patient would start somewhere here. (1 on graph) He would show very severe neurotic symptoms. The nature of the symptoms, of course, would depend on his clinical diagnosis. It could be obsessive-compulsive symptomatology; it could be a phobia; it could be a psychosomatic symptom, and so on. The graph suggests the depth of that particular symptomatology.

When you start giving them LSD, you find that after some sessions, there is a very dramatic improvement. The previous symptoms will be alleviated or some of them will even disappear. The patients will feel that almost all their problems are solved and they can now make a new beginning (2). If you continue, however, in the next session you may not have that much luck and you'll get something like a relapse. You can also have a session in which the condition of the patient returns to just about what it was before. (3)

If you continue, this is how it goes (indicating on blackboard).

We had very detailed records not only about what happened in the sessions, but also of what the patient told us he experienced in the sessions. We were interested in finding out whether we could understand after what kinds of sessions people felt better and after what kinds of sessions there was a prolonged reaction or a worsening of the clinical condition. It now seems to us that it doesn't have anything to do with LSD as a pharmacological agent, but that it has something to do with the dynamics of the unconscious. And it seems that the critical period is the second half of the session. If in the second half of the session the patient makes some good partial resolution and good partial integration, then the rest of the session will be a positive experience, a tension-free kind of floating experience; and there is a very good chance that the patient will show a good clinical condition after the session.

If, on the contrary, during the second half of the session a new problem-area is opened up - let's say a traumatic memory is brought to the surface but the effect of the drug isn't strong enough to help the patient to work it through, or there are resistances, or the therapist doesn't help sufficiently, doesn't enable the patient to work it through - then the patient will come out of the session as if under the influence of that particular problem area. If you then work with him between LSD sessions, when you give him another LSD session, he can finish the working-through and you can get a very dramatic improvement. In other words, this relapse doesn't seem to be unpredictable; it's not something that can happen at any time and that you can't understand.

Of course, you can usually understand restrospectively what it was. For example, it will come out and show, in the free interval, a very specific

behavior - such as certain emotions or physical symptoms. I had a patient, for example, who limped after a session; he was feeling pain in a certain part of the body. They can be depressed, can have guilt feelings, have anxiety; they can have headaches; just about any symptom can persist after a given session. Sometimes the symptoms appear weird. I had people who, for example, after an LSD session had the feeling that they were losing hair althoughthere was no objective reason for this. Other people had a feeling of a small body image,or that a part of the body felt small; for example, the penis felt frightfully small. But when you gave them LSD again, they would finish reliving that particular memory. And then, retrospectively, you could understand that they had felt that way after the session because of the nature of the experience that had been activated but which they had not been able to work through. For example, that symptom of fear of losing hair was traced back to a memory from early infancy when that person didn't have hair at all. It happened that that part of the archaic body image had been activated and had persisted after the session. When that memory was relived in the next session, the patient could return to the adult level. The same with the size of the penis.

But sometimes, the symptoms were very specific, like the limping. I remember a patient who relived an experience in which she had suffered an injury to the knee. She felt that pain till the next session. She also took protective postures exactly as you would expect from traumatology. But with subsequent complete reliving the pain, it disappeared. So many of the phenomena of prolonged LSD reactions can be understood as related to an underlying unresolved problem or memory.

Today, after many years of experiences, I can usually foresee what kind of memory is going to come up, but in the early years of my work I could only understand the symptoms retrospectively, after the patient told me. I was always flabbergasted at how accurately the problems of the free interval reflected the unresolved underlying problems.

As you can see, the psycholytic LSD procedure will be characterized by ups and downs of a quantitative nature. The pre-existing symptoms will either be alleviated after some sessions or intensified after other sessions. You can see a much more interesting phenomenon during this procedure, namely a qualitative transformation of the symptoms. All of a sudden, the old symptoms disappear in the session, but something completely different replaces them. In this connection, I think of a patient in whom this was most dramatic. A very short clinical history will give you a much better idea than if I just talk about it in an abstract way.

This was a 26-year-old male homosexual who had suffered from an almost constant depression for four years. He had made six serious suicidal attempts during that period. One of them was with rat poison - reflecting his self-esteem, you know; every other method was too good for him. He didn't feel part of humanity. In addition, he had a lot of other problems: anxiety, psychosomatic symptoms, precordial pain, and very severe insomnia; he couldn't sleep for more than a couple of hours a night. After 18 sessions, the patient made a very good partial integration of the kind which I described before. All of a sudden, he came from a session without any depression; he exhibited exuberant joy. There were no signs of anxiety, no psychosomatic symptoms. He could sleep like a baby. But all these symptoms were replaced by a complete paralysis of his right hand which had all the classical hysterical features, even "<u>la belle indifference</u>". This is very different

from an organic patient who has paralysis. I was extremely depressed about this, but the patient calmly said, "I can't move it, so I'll probably start training my left hand," or something of that kind. He showed a very inappropriate emotional attitude to it.

I already knew that if one had prolonged reactions or any kinds of problems after a session, it's not the result of LSD; it's due to some underlying problem. And I have a very deep trust that it can be worked through, whatever is there. So, I just continued giving him LSD, and an extremely interesting thing started happening. First of all, when the LSD began to have its effect, the patient all of a sudden found that he could move his hand. And the first thing he did with his hand was to threaten to hit my face. Of course, at first I made all kinds of protective movements. But after a while, I found out that he always stopped about two inches in front of my nose. He never completed the blow. So then, I developed trust and I just sat still while his hand moved like this (indicating) for hours.

The family background was very interesting: The patient had an autocratic despotic father who was an alcoholic, and who used to beat him and his mother in a very cruel way so that the patient had to be taken to the hospital several times with broken bones and bleeding. In his adolescence, he had homicidal tendencies toward his father, fantasies of killing him. In this session he was reliving them; he was experiencing all kinds of memories of when his father had actually beaten him. He also had a lot of symbolic experiences reflecting the patricidal problem, from mythology or from various movies or books in which the son would kill the father. I don't know if you are familiar with John Nichols' Villa Mala, which deals with the murder of the father. Greek mythology, of course, is full of it. So, he had lots of symbolic stuff, but he also relived his own actual experiences with his father. In that LSD session he saw me as his father, and he was acting out this conflict. On the one hand, he had violent impulses to hit me. On the other hand, there were, of course, contrary impulses. His superego didn't allow him to hit me. So, the compromise was this kind of discharge of contrary impulses that went on for hours.

There was a second area underlying this paralysis; this was a conflict concerning masturbation. Again, he felt like masturbating in a session; he felt like touching his genitals and so on. And there too, his hand was oscillating in a very spastic way for hours. He was getting a lot of sexual images at this time, and he related some episodes when he was caught masturbating by his father.

Finally after eight sessions, this material, this category, was exhausted. He then had another ecstatic experience of unity and came out of that session with neither the previous symptoms nor the paralysis. Very soon afterwards, he had the first heterosexual relationship in his life. So, this is one dramatic example of those qualitative transformations. When you work with LSD, this is what you see almost constantly.

I saw people losing symptoms and developing symptoms. For example, when they were approaching some unacceptable material dealing with toilet training or attitudes toward excretions, they would develop compulsive washing; they felt dirty and washed their hands 40 times a day.

It's not only emotional symptoms that you can evoke and then remove, but also, all kinds of clinical symptoms. I saw, for example, various eczemas come and

go, developing in front of my eyes. There was a patient who had experienced seduction by her step-father, actually rape by her step-father. During a session, she relived the scene. A major point of contact with her step-father during the rape had been her elbow. In front of my eyes in about three minutes an eczema appeared. The skin was absolutely infiltrated so that it looked like a leather sole with all kinds of skin eruptions on it! It lasted for a week, and then it disappeared overnight after the next session.

I saw something similar with psoriasis: the eruption of psoriasis during a session of several hours. When I called the dermatologist, he made the diagnosis. But when he examined the patient two weeks later, there was absolutely no sign of psoriasis. So, he started questioning his original diagnosis because it has never been shown that psoriasis can last a week or ten days. Instead of accepting the possibility that this was psoriasis lasting a week, he questioned his own diagnosis!

Also, I saw psychogenic asthma coming and disappearing. This is the kind of thing you have to be prepared for when you work with LSD. I think that all these phenomena are nothing special, nothing exceptional. It can happen during psychoanalysis, but of course it would take much longer and be much less dramatic. Very frequently a patient, before he makes some kind of dramatic breakthrough or is approaching some unacceptable material, can have an intensification of his symptoms. A worsening of the clinical condition. You can also see transformations of symptoms. For example, the symptoms of schizophrenia change first to an obsessive-compulsive neurosis, then to hysteria, and so on. What you see are a series of ups and downs, with quantitative and qualitative changes. But by and large there is a trend toward improvement, until in the retrospective analysis you can find that in most of the patients there is something like a plateau, a level of good clinical improvement, where the symptoms are alleviated and patients can be discharged. They all started out as in-patients. After improvement, they were discharged. They then would come just once a week for their sessions. They made all kinds of positive changes in their lives. And this probably would have been a good time to discontinue treatment if we had known more about the procedure. But, as I mentioned before, we didn't know anything.

So, for various reasons, I continued beyond this point. One of them was just sheer ignorance. The other reason was that, as I mentioned before, I had an orthodox psychoanalytic training; and in spite of the fact that patients were in fairly good clinical condition, if when I gave them LSD, there were still elements of anxiety and depression, various physical symptoms and so on; then, to my Freudian type of thinking, their improvement could only be symptomatic. And I believed that there was still more underlying unconscious material to be worked through in order to prevent a relapse.

Another thing that seemed to be supporting this approach was that basically, in these sessions, the patients had very much Freudian types of experiences. As I mentioned before, they would regress into childhood, they would relive various traumatic childhood memories, they would solve the oedipus-electra problem, and they would work through various conflicts in the erogenous zones. And before this happened in the sessions, I would get a lot of very early material, basically oral material: good-bad breast, various frightening experiences in infancy, and so on.

So, again, since I had had Freudian training and I felt they were already back to the breast, how much further can you go? There can't be too much left.

So, I thought that what we had to do was to work through the residual problems. Everybody knows that human development starts at the breast. At least within the psychoanalytic framework, this is where you start thinking about the factors that form the individual.

Because of all these things that I mentioned, I call this stage (4 on the graphs) Freudian, because by and large, what was happening to the patient during this period could be understood best in Freudian terms, with some minor modifications. If we continued beyond this point, extremely interesting things started happening; and here we are, I think, at the frontier of the personal and transpersonal.

Let me divide into two categories the things that happened here: One of them would be what happened to the content of the sessions. In the first, in the Freudian stage, each patient would have sessions of his own. The patients belonged to different clinical categories; they also had different life histories; and since the material was coming from their individual lives, they would have very different sessions.

This wasn't true for the sessions that followed, when I continued beyond this plateau. Here, all the sessions tended to be very similar, very uniform, presenting very typical types of problems. By this I don't want to say that the sessions were identical, but they presented very typical categories of problems, whereas here (indicating 4 on the graph) the content was very variable.

What was the nature of these sessions, the uniform sessions? Basically they all dealt with agony, dying, death, and rebirth. When I try to talk about agony, death, and rebirth, I find it very difficult to communicate to you the depth and intensity of the experience. If you deal with death, it doesn't mean that you see funerals or that you see yourself in a casket. It's a very "gutsy" experience; to the point that some of the patients experiencing it can lose the feeling that this is just a session. They can have the feeling that they are actually dying. This can entail hours and hours of very dramatic phenomena which are convincing not only for the patient but for the therapist, too. The symptoms were very convincing for me at the beginning when I saw them happening several times in the initial phases. I was truly frightened that the patient was really dying. Patients developed cramps which, for somebody who has a medical background, is a very bad omen. I saw all kinds of twitches, muscular jerks, twisting movements. I saw the patient changing color, becoming pale, purple, bluish. I saw him sweating profusely, which is another very bad sign in clinical medicine. The patient was telling me that he was dying; he was showing tremendous anxiety, which again added to the overall picture of my fright.

What I usually did in the early sessions was to grab the patient's hand, pretending that I was comforting him. But really, I was looking for the pulse! But that didn't help me too much because the pulse would go up to 180, or 200! I could barely feel it. It was kind of threadlike. I had to see this happening several times before I became completely comfortable. Ultimately, when somebody said he was dying, I could say, "Wonderful, just go with it; die. You will be reborn," or something of that sort. But the early sessions were really bad, both for the patients and for me. And I know that I was so frightened that I was not much help to them.

When the patients faced death, they inevitably experienced an existential crisis. They started questioning the meaning of life: "If we have to die, what is the meaning of our life, the meaning of our existence? What makes sense? Does it make sense to accumulate money? Does it make sense to strive for status or position? Does it make sense to study, to spend hundreds and thousands of hours going through books, and so on? You can't take with you any of these things."

These sessions can represent the meaninglessness of life in a very vicious, very convincing way. If the values you stick to are status, money, power, position, it's very easy for the images of these sessions to show you how absurd this is. You may get all kinds of images of dying kings who had all the power and all the money. If anything, these images made the process of dying more difficult because they were trying to hold on to what they had accumulated.

I think here of the story of Alexander the Great during the conquest of India. When he meets a rishi who is supposed to have precognitive powers, he asks him about the success of his conquest: "Am I going to be successful?" The rishi thinks for a while and says, "All you are going to need is about six feet of ground.'

So that is the kind of sessions you can have. You may go through the agony of dying, which you may experience either as foreseeing the end of your life or as a reliving of your birth agony - or dealing with the fact that we are mortal on a philosophical or transcendental level. But very frequently it is circular type of thinking - we are born in agony and we have to go in agony; the beginning is the same as the end, so what is the point about whatever is in between?

I remember my own session when I was in this situation: I was struggling desperately, trying to find any meaning in life. Whatever importance I could attach to money or building houses or buying something or moving up in the academic hierarchy from an assistant professor to associate professor or whatever, it absolutely didn't make sense. But then, I finally came up with the idea that learning is the thing; taking secrets from nature - that really makes life meaningful! And then I saw the hundreds of hours that I had spent on studying medicine, going to the libraries, sacrificing evenings and weekends and forgetting part of it right away, another part later. Then the final blow: I saw myself as 70 or 75 years old, with severe arteriosclerosis, drooling, and I was desperately trying to remember what I had had for dinner the day before! (Laughter)

People who take LSD on their own; if they get into this kind of thing, might do just about anything, because the experience of existential despair can be incredibly painful. Basically, this whole second stage (5 on graph) will have this problem of agony, death, and rebirth, but there will be two typical clusters within it: In the early sessions, the subject will be more or less in the situation of a helpless victim. It will be a typical no-exit situation, with the feeling of being encaged, being trapped, with tremendously powerful forces imposed upon you. And one will experience oneself as the victim of a concentration camp, victim of the Spanish Inquisition. At this stage, people experience explosions of a volcano in the passive role, or a tornado, or tidal wave, or some kind of overwhelming force that you just can't do anything about, such as air raids.

If you have visions that are related to the world this will be what's happening in the world. But you can have other dimensions of this experience, and the deepest one will be that of hell. You can experience it also as a metaphysical situation of no exit where you go through unbearable torture. A typical feature

of that situation is that there is no way out; you can't possibly figure out how you could get out, either in space or in time. It's an endless situation without exit. A mitigated form would be, for example, the depiction of hell in Sartre's play "No Exit," where hell is represented on an interpersonal level.

At this stage, you can get all kinds of images of the hells of different religions, or you can get typical images from Greek mythology - for example, Sisyphus, Tantalus, or Prometheus chained for eternity to the rock and the eagle eating his liver; and the liver grows and the eagle comes again, and this is as if it is going to go forever; absolutely no exit.

If you look into the later sessions, there will still be agony, dying, death, rebirth, but the whole scheme will be different. It will be experienced as a fight with a very powerful enemy. In other words, you are not a passive victim anymore. You are fighting back and even if it's a hopeless fight, you are trying. Here, you may get symbolic images of medieval battles - El Cid, for example; masses of people riding horses in armor, and everybody wielding a sword, cutting and being cut, and after awhile, there is blood all over the place, and you don't know whether you're killing or being killed. Sometimes it's mythological, like a fight with a monster of some kind, a chimera or dragon.

Even later, just about here (6 on graph), there will be an experience where you encounter lots of fire symbology. People usually see exploding volcanoes, exploding thermonuclear bombs, A-Bombs, launched missiles, for example. But in comparison with the prior stage, you are not the victim; you can also <u>be</u> the exploding volcano. Or you can be oscillating between the role of the one who is endangered by these forces and the force itself.

There is a very narrow realm in which the fire usually is followed by some scatological experiences. All of a sudden, people will fear that they are eating feces or being in an Augean stable, something of that kind, drinking urine, or simply, tendencies to do it. So this could be the deepest clinical source for the perversions of drinking urine, eating feces, and so on. Quite a few people have experiences of cunnilingus, oral-genital sex, and so on.

I have described the negative parts of this stage; but they don't last long. There is usually a sequence of these experiences of agony and then, experiences of being reborn, where the whole experience opens up into clear light or heavenly blue. You can see peacock colors; you can see a rainbow spectrum, and so on. But in either the same session or in the subsequent session, you have to go back into the agony. So it's like a working through of that area, namely, the sequence of agony, dying, being reborn, etc. But, by and large, if you look at the sessions, these early ones will have much more of the no-exit situation, of the victimized subject. The later sessions will have much more of the struggling, ascending situation.

It is interesting from the point of view of psychosynthesis that just about everybody facing death will become religious, no matter what his previous background was. I have worked with Marxists, people who lectured on Marxism, which, as you know, is absolutely incompatible with any religion, any mysticism - not only incompatible but is actively, violently opposed to religion. But when they were encountering death, they just couldn't help being religious.

In this stage, the religious element is represented by something like "the dark night of the soul" or hell in these earlier sessions. Later, it's represented within the framework of religions that somehow glorify or at least require bloody sacrifices. A typical example would be the Aztec religion, the slaughter of thousands of captives done within a religious framework. It would also be Christianity. Quite a few patients going through the agony, death, rebirth would identify with Christ or have visions of Christ's humiliation, the bearing of the cross, the crucifixion,and the resurrection.

I didn't mention that in addition to all these symbolic religious mystical experiences, people would have also lots of biological material. Quite a few patients independently told me that the only way they can understand these experiences is by relating them to biological birth. It's like actually reliving the situation of passage through the birth canal. The no-exit situation would be the situation when delivery starts, when the uterine system closes in on the individual; but the way out isn't open. Of course, the struggling out would be the propulsion through the birth canal. And finally the feeling of being reborn, the opening up, would be actually reliving the moment of one's biological birth.

Because patients repeatedly referred to the biological birth, I went to the library and borrowed Otto Rank's book on birth trauma. I was really flabbergasted to discover how many of the phenomena which I had seen in these sessions and in-between had been described in Rank's book! This was remarkable in view of the fact that he supposedly extrapolated from the regular couch situation, probably adding some of his own far-out experiences.

Let me remind you that this curve represents the clinical condition of the patient between the sessions. To my very unpleasant surprise, there was a very rapid deterioration, sometimes to the point that somebody who was neurotic to start with was having temporary psychotic experiences.

If the sessions stabilized in this no-exit situation - if the patient was experiencing that hellish, closed-in situation in the second half of the sessions when the effect of the LSD was wearing off, then this is where he would get stuck! I would see a very classical image of a depression, almost of an endogenous character. Nothing made sense to the patient. He would feel absolutely worthless. He suffered from agonizing inferiority feelings, agonizing guilt, and feelings of depression to the point that sometimes the world was without color, just black and white. It's this overwhelming pan-anxiety, overwhelming free-floating anxiety, and usually, feelings of physical oppression. The chest is oppressed. You can't breathe very well. There will be some preoccupation with the heart, as if you are going to have a heart attack or the heartbeat is going to cease.

If, on the contrary, the session stabilizes in that experience of volcanic ecstasy, that striving, struggling, tremendously aggressive tension, you see a very different image. Now the emphasis is on aggressive tension, this tremendous energy; and the aggression will oscillate between an outward orientation and inward orientation. The patient will question whether he can control his aggression - maybe he will attack somebody, hurt somebody, kill somebody; or maybe there is a danger he could, if his violent tendencies get out of control, kill himself.

There is a very interesting relationship between these polar stages and chosen modes of suicide. We might go into that during the discussion. People who get stuck in the depressive no-exit situation will tend to choose non-violent

suicide. They tend to prefer an overdose of sleeping pills, tranquilizers, or the gas oven. This would be typical. Sometimes drowning or even freezing; going into snow and then just falling down, being fatigued, and freezing. There are many descriptions of people who were rescued and who described what actually happens in the terminal stages of freezing. They say that you feel wonderfully warm and you fall asleep and"melt."

On the other hand people who get stuck in this situation of struggle will tend toward violent suicide. They will be attracted by images of violent death: how wonderful it would be to be torn by the wheels of the train or jump from a roof or a window, to stab oneself, to commit hara-kiri, or to blow one's brains out. Actually, what you find when you analyze it is that they have the feelings already; they feel as if they were torn inside, and they believe that if they would just act it out, they would find a logical balance between what they feel and what's happening. Everything around is peaceful, but they feel torn to pieces. They feel crazy. They feel there is a fantastic discrepancy between their feelings and external reality. To me, it seems likely that this has something to do with the choice of kind of suicide. People chose suicide that is compatible with the feelings that they have before they commit that type of suicide.

There is a typical cluster of phenomena which can persist in these sessions; physical phenomena. Such as pressure in the head. A dull headache is especially typical of those who had a birth experience. It would seem to relate to the pressure of the uterine cervix on the head. Here we find problems with breathing like those sometimes seen in neurotic patients who feel that they can't get enough oxygen. A typical feeling during the free intervals is nausea to the point of vomiting. Tension may be discharged in jerks; patients can be seen twitching between sessions.

I don't know if any of you have seen these symptoms in people who had bad trips on their own. I have seen a few of them, and they seem to have the same problems which my patients had in these difficult areas. It seems that this is the major area from which the bad trips come in people who take LSD on their own.

I mentioned that this Rankian period is characterized by a sequence of dying, death,and being reborn, until finally we come to a point where the patient undergoes a final experience of annihilation. In the LSD literature we usually refer to this as ego death. It is experienced as complete annihilation on all the levels you can possibly imagine. It involves a sense of physical death, feelings of being a complete failure on the intellectual level, on the social level. And, finally, this is the feeling of the absolute destruction of all vanity, a kind of hitting the cosmic bottom. Nothing more can possibly happen to you. You have had it.

Then, from that point, the experience changes into one of rebirth, salvation, redemption, or whatever name you choose to call it. Again, this will usually be experienced within a religious framework. I don't understand why patients use the settings that they do; they often don't seem to be related to their previous educational and religious backgrounds. Some of them experience resurrection within the Christian framework. Some of them have the Hindu experience in which death is mediated by Shiva the Destroyer. And this feeling of union, going into life, will be experienced as the Atma-Brahma union. Other patients would refer to the Isis-Osiris mysteries of the Egyptian framework. Some of them can have it in a mythological framework. For example, suddenly understanding the symbology of the phoenix, the bird that builds its nest, lays an egg,

and then burns the nest. The death of the parental bird is accompanied by the hatching of the egg and the new phoenix flying into life.

Once the patients reach this point, they enter a new stage of the LSD treatment to which this bloody biology doesn't come back anymore. Some of the patients refer to that period as butchery - the sado-masochistic experiences of being smothered, torn to pieces, cut to pieces, and so on. But from now on, all of the sessions will be mystical and religious. The negative experiences will, instead of being experiences of dying, being smothered, and so on, will be experienced as encounters with metaphysical evils, forces, demonic apparitions, evil spirits, malefic astrological forces, something of that kind. And this will alternate with the type of ecstasy that - in contra-distinction to the volcanic ecstasy which has a lot of tension and aggression in it - could be called melted ecstasy or all-is-one ecstasy. It is characterized by a sense of transcendence of the ego boundaries. I mentioned it initially, the feeling of unity with everything else, the all-is-one experience; or you can use the Hindu phrase and call it Atma-Brahma union.

In addition to these, there will be some other interesting types of experiences: First of all, patients who never heard about Jung will discover the typical Jungian archetypes. They will talk about the golden egg, about the Great Mother versus the Terrible Mother, about the Cosmic Man. Without using those names they will give the descriptions that exactly fit the Jungian framework. Jung seems to be the only psychiatrist who was aware of these levels and who systematically described them.

I usually refer to this as the Jungian stage (7 on graph), in spite of the fact that the phenomena which you see here seem to be broader than what Jung described. For example, you also see here experiences that impress you as, or that could be understood as, biological regression. Patients repeatedly will talk about intrauterine experiences, being in the womb in various stages of embryological development, sometimes experiencing intrauterine traumatization. For example, mother is sick, or mother is angry, or mother is anxious or tense, or mother may be going through some kind of mechanical concussion.

Sometimes you get ancestral memories. The patient feels that he has been exploring his ancestral lineage, feeling the influence of the family of his father, the ancestors of his father, his mother, then, the way these two family traditions mixed and created intrapsychic conflict in him, the product of this union.

Finally, this regression can continue to the point of phylogenetic memories, where the patients in a very convincing way identify with turtles, snakes, fish, etc. This can go back to jellyfish and even unicellular organisms, back to the primeval ocean, and so on.

Now, if all this hasn't been far out enough, there is one more category of experience in which the patients report that they have experienced that they relate to remote centuries and remote countries, very frequently to one of the ancient cultures. This will have the character of the experience of a prior incarnation. They will have the feeling that this is a memory. Moreover they will feel continuity, i.e., that this ancient experience happened to the same entity that is now experiencing the LSD session. This probably is more interesting than the fact of experiencing these things in itself, the element of memory. You can

see the parallels, for example, with Indian religions, philosophies, or some other ancient religions. Very frequently there is some kind of karmic framework. They get instructions about the law of karma, and they come to believe that whatever they are suffering now is somehow related to what they have done in the past.

Interestingly enough, usually one of the ancient cultures prevails. Some people go repeatedly to ancient Egypt rather than ancient India. Other people will go to Central America. This occurs for reasons that I wasn't able to understand, because there definitely isn't any relation between their choice and what they have read or what they like or what they have experienced in their individual lives.

Probably the best framework is either the Jungian concept of the collective racial unconscious or the religious conception of the karmic experiences.

Between the sessions, there is usually a very rapid improvement in this group of patients. It goes beyond what I would call average adjustment. I wouldn't like to call it supernormal adjustment, because it's a qualitatively different adjustment. In the people who have the experiences of the melted ecstasy, the experiences of unity, you can see very specific transformations of personality which involve dramatic changes in their hierarchies of values. For example, there is less emphasis on power, money, position, and status; there is much more emphasis on simple human relationships and more satisfaction drawn from simple, ordinary things of life like nature, music, food, human interaction, rather than from grandiose daydreams or fantasies.

There is a very definite change in relation to time orientation - with much more emphasis on the here and now. They stop ruminating about the past. Also, there is much less preoccupation with the future in terms of building of wind castles. As you know, a typical patient, and also many an average person, lives more in the past and the future than in the here and now. So, this seems to be changed.

There is a dramatic improvement in the clinical condition. There is also a change in interest. The interest in ancient cultures, in art, or in spiritual things will persist from those sessions. Quite a few of them have taken on yoga lessons, or some kind of meditation exercises. To compare them with the hippie culture, I was very much interested when I came to this country to go to places like Haight-Ashbury or East Village or Kenyon Road in Santa Fe and talk with these people and to discover to what extent they had features similar to my patients. There were basic differences in spite of many similarities. For example, the similarities were in the here and now orientation, the loss of interest in the past and the future, the interest in literature. My patients would choose the same literature that you find in the psychedelic shops. It would be Herman Hesse, it would be ancient literature, mystical religious literature, and so on. On the other hand, among my patients, there were absolutely no changes in external appearances. Nobody felt like growing long hair or long beards. No one wore beads or any kind of ancient costumes. They were externally indistinguishable from the rest of the population, but there were significant internal transformations. I think this difference has something to say about whether what we see in the hippie movement is just a mechanical consequence of "dropping LSD". I don't believe that. I think that there are very important kinds of social-

cultural elements, political elements if you want, probably also elements of self-selection, because out of many people who had been taking LSD in this country, only a small proportion of them do it in a setting like Haight-Ashbury. Many others probably have been taking it, but they haven't changed their appearance in spite of the fact that they went through dramatic inner changes. So, not everybody who has taken LSD repeatedly can be identified by his external appearance. So, I think what we find in the hippie movement is a mixture of these two elements.

Let me now just shift to the symbols of the transpersonal experience as Dr. Assagioli talks about them. I haven't found parallels for all of them in this procedure, but quite a few of them could be located on this graph. Assagioli talks about introversion, the turning inward as compared to the typical orientation of the modern man, which is toward the external world, achievements, activities, the outside. This could apply to the whole LSD procedure. Whenever you take LSD, there is immediately a preoccupation with inner content, yourself, especially if you take it in a higher dosage and you take it in a setting where you are open and willing for self-exploration. There are some people who will take low dosages and who will move around. I don't see any point in taking LSD this way. When I talked with some of these youngsters, they told me that five of them dropped acid in Boston and they all got in a car and drove from Boston to New York, then went to Central Park and walked around and looked at things. So, there wouldn't be too much introspection, because this kind of thing would enable you to run away from the inner experiences. What you would have to do actually would be to fight whatever is coming from within. But if you take it under reasonably good conditions the whole procedure will be a kind of exteriorization of the contents of your unconscious, various levels of your unconscious.

Dr. Assagioli uses the concept of descent, and he gives many examples from literature. Of course the most famous of them is Dante's Hell. Dante is in the forest and he wants to reach a mountain-top. But he finds out that he cannot make it unless he goes down first. Only then, after going through the underworld, can he get to the top of the mountain. This is a very frequent experience in the LSD sessions. It is especially the experience of descent that many patients have identified as the beginning of the birth process. Beginning with this kind of floating, undifferentiated experience in the womb, all of a sudden, things start closing in. This is very frequently represented either as a journey into the underworld or entering a cave. The symbol of caves or caverns is extremely frequent in the LSD sessions at this stage. Or the beginning of labor may be experienced as being swallowed by a gigantic monster, which can be a fish like in the Biblical legend of Jonah, or it could be a gigantic octopus, or a spider, or a python; just about any mythical monster.

But this whole experience could be experienced as being swallowed, retained, and then spit out or expelled by a gigantic monster. And this descent can be experienced as going into a gigantic mouth. A very frequent symbol is a gigantic maelstrom or whirlpool which rotates and draws you down into the center. So, very frequently in these sessions you will find many of the symbols of descent.

On the contrary - of course, these later sessions (8 on graph), will be characterized by images of ascent. Here one sees the idea of fighting one's way out, and at the same time, ascending. So, very frequently the whole sequence is like going to hell, through purgatory, and finding salvation or redemption in paradise

I have had patients whose experiences exactly parallel the sequence of

experiences found in the LSD sessions. These patients dealt with paradise, hell, purgatory, and redemption or salvation, as parallels to the clinical stages of delivery. For them paradise was the kind of free-floating womb experience before labor starts. The hell experience occurs when the uterus is closing in on the foetus,torturing it. There seems to be no chance of getting out because the cervix isn't open yet. The next part of the experience would be the purgatory. It includes a lot of suffering, but it's not a no-exit situation. You feel that you are struggling to get somewhere, and that finally, after a lot of suffering, you're going to end up in a better place.

Finally, there is the breaking out into the open which the child will experience as the clear light coming into the darkness, much as we know it from many religious pictures. It would be the element of redemption, salvation, after this unendurable suffering. All of a sudden you are facing this divine grace.

I don't want to derive these experiences all from biology. I am just demonstrating some parallels or coincidences or synchronicity, if you want to use the Jungian term. Here it seems to me that several of Assagioli's symbols coincide. For example, he uses liberation, which also seems to stand for exactly this kind of experience - from the darkness, from the maya, from the ignorance, you break through into the illuminating light. He also uses separately the symbol of rebirth, which seems to coincide with this. It's rebirth which is kind of synchronistic with both illumination and liberation.

He uses the element of love as one of the symbols. This is very typical for this state (8 on graph); people coming out of those tortures and experiencing the divine light feel that they are melting and fusing into the "all-is-one" experience. Quite typically, they feel flooded with love themselves and also are feeling love for their fellow men. They would like to invite everybody, help everybody - very much like the old-time Christians.

There is another symbol I can remember, the transfiguration,which Dr. Assagioli relates to alchemy. On the one hand, this whole procedure, especially in this stage (8), can be understood as a kind of transfiguration or purification. But, in addition, people very frequently really see alchemical symbols in this particular period. The most frequent of them seems to be the peacock tail, which is a very frequent symbol for the transfiguration.

I think I will refer to just one more symbol, which is fire. Fire, in my experience, always immediately precedes the experience of being reborn. As I mentioned before, it could be experienced as gigantic conflagration, as explosions of volcanoes,and so on. Very frequently it is experienced as a purifying fire; all the aggression is leaving you and then you end up in a very, very peaceful experience.

I mentioned something that Dr. Assagioli doesn't mention, which is the scatological experience. But you can find it, for example, in the Isis-Osiris mysteries, in the Hermetic tradition, where the adept has to go first through the threat of death, which is described as a pit with a ladder. All of a sudden, the ladder ends and the person finds himself in a dark pit. After awhile, he gets adapted to the darkness and he finds a hole in the wall of the pit. He then continues and comes to fire. He has to go through the fire. It's like an optical illusion. They describe it as actually a corridor with torches on either side so that by virtue of the physical perspective, you get the idea of solid fire,

a furnace which you have to go through. But once you have enough guts to go there, you find out that the fire is opening up and that you can pass through unharmed.

Also, according to the descriptions, there is the element of dark water, which is kind of oily, muddy stuff of some kind which they have to go through.

And then the last stage is usually described as a temptation by a very sensual woman. They used the Lydian women for that. It is interesting that this is part of the experience which you get with the fire usually- tremendous sexual excitement, tremendous sensual involvement. And then, if you overcome the temptation, if you overcome the seductive scene, then you go into union with the divine Isis, which is the Great Mother archetype, which would exactly fit this particular experience.

I took the pains to study the various descriptions of the Temple Mysteries, the Eleusinian, the Orphic Cult, the Egyptian, some of the Indian practices, and it's very interesting to what extent you can find parallels between those ancient rites and this procedure done with a modern chemical in the 20th century.

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DISCUSSION

Jean Drake: I am most interested in the difference between the normal and the psychotic.

Grof: We are working with two more groups: one of them the so-called normal, the other one the psychotic. If you take normal people, the Freudian stage (4 on the graph) would be very, very short. Usually people who don't have serious emotional problems don't have to go through many of the traumatic childhood experiences. But, with a sufficient dose, they will very quickly go into the Rankian stage (5 on graph), go into the problems of meaning in life, the death-rebirth type of experience. If they have any important relivings from their individual life, it usually has something to do with operations, with real experiences of emergency - for example, situations of injuries, operations, or situations of near-drowning. People who have been through concentration camps will relive really drastic situations where life was in danger.

It was fascinating to see that people seem to be able to relive feelings from operations that were done under deep narcosis. So, the fact that we get narcosis is only to keep those feelings from the ego, but they are still evidently recorded on some level in the central nervous system.

There are a couple of other differences. First of all, it seems that the Rankian stage is shorter in people who are not patients. I have seen people going through this whole stage in four, five, or six sessions. But in patients, it can take 15 or 20 sessions. Whether it implies more of birth trauma in the population of psychiatric patients, I don't know. This would have to be tested.

The last difference I saw was that in normals, you don't get deterioration in this stage of adjustment after the Rankian stage. You can get some neurotic problems around this period. For example, for some time there may be persisting headache or tension. Frequently I saw sexual tension which could only

be satisfied by a number of sexual encounters. Sometimes, there was some awareness of the cardiac area, and so on; minor neurotic symptoms. So that normal people seem to have in each of these sessions three or four hours of hellish experience, but they manage to resolve each session and the reentry is good, if not ecstatic. They can end up actually with an experience of being reborn in each of these sessions. I have never seen a prolonged reaction of any serious kind in somebody who didn't have real emotional difficulties.

In contrast, it was fascinating to see the psychotic patients who, of course, would start somewhere here (9 on graph). For some time, you would get various kinds of psychotic symptomatology. And finally, after a number of sessions, they will come from a session with critical insight into their psychotic symptoms and they will then present basically neurotic symptomatology. Then you have to go through this whole history. As you know, there is no psychotic patient who hasn't had a very difficult childhood. So, if anything, there are more problems in the childhoods of the schizophrenic patients than in those of the neurotic patients. Basically there doesn't seem to be much difference between neurotics and psychotics in the latter half of the Freudian stage.

For a while, there seems to be a great parallel between the neurotics and the psychotics. But a very unpleasant surprise came at this point (10) with the psychotic patients I saw. After the final ego death, they didn't show the kind of dramatic improvement which I saw usually in the neurotic patients. On the contrary, I saw the recurrence of the original psychotic symptoms. The psychosis would be very similar, with only one exception - it was now what Freud might have called a transference psychosis.

In other words, the person who was sitting with the psychotic patient during all the sessions would now attract all the psychotic symptomatology. For example, I had a female patient who had a kind of erotomanic delusional system with hallucinations involving her boss. She fell in love with him. She felt that he also was in love with her, and she started hallucinating his voice, which was telling her that he loved her, that she could come and live with him, that he had arranged for her divorce, that everything was going to be wonderful, that they were going to have a beautiful future, and so on.

In the evening, she would imagine having distant sexual intercourse. She was very frigid in her normal life, but when she imagined her boss making love to her, she enjoyed the most wonderful sexual feelings for hours every evening.

This completely disappeared when we were dealing with her childhood problem. And again she went into all this agony of death and rebirth; the psychological "Hiroshimas," you know. Then at this point, all of a sudden, she didn't "come back" from a session; her large eyes were full of hidden meaning and full of love. When she was supposed to come out of the session, I could tell that something was wrong from the amorous way she was looking at me. When she started talking, it became evident that I had taken the role of the boss. Now she kept hallucinating my voice. It was I who was telling her that she can live with me. I had arranged her divorce and told her to bring her children to my apartment.

What was fantastic to me was that psychotherapy was continuing within the context of her hallucinations! For example, when I went to Amsterdam for an LSD meeting, she was in Prague, hospitalized in between the sessions. She gave

herself 16 hours a day of psychotherapy in which she was bringing up issues, telling me things, and I was giving interpretations! What was amazing was that some of the comments attributed to me were statements that I could easily have said. In other words, she had somehow assimilated me, then extrapolated me, and just carried on in my absence. She added also another thing; she called it hypnogamic lessons. In the evening, instead of her boss, it was I who was making love with her. She was learning and I was teaching her how to experience sex: touching her and finally bringing her to the point of experiencing it in an orgastic way. This led to a very difficult situation. She had to be kept, of course, in the ward.

Haronian: How long did it go on that way? (Grof: About five weeks.) Then what happened?

Grof: After a certain point a very surprising thing happened. I gave her LSD, and when the drug started working she became normal, absolutely normal, with critical insight. And when the effect of the drug was wearing off, she would go back into the transference psychosis and become crazy. After a couple of more sessions, she finally had a session which was just a blissful experience of unity, cosmic unity, and she came from that session without any psychotic symptoms.

I didn't continue beyond that point. With some fluctuations, she worked it out and she hasn't needed psychiatric treatment for about four-and-a-half years, not even on an out-patient basis. She now is absolutely independent. It was a kind of improvement in a psychotic patient that I have never seen before with tranquilizers or insulin or whatever. But, of course, as you can imagine, it was a very difficult way.

Haronian: How long was the course of treatment altogether with that patient?

Grof: About 90 sessions. Pretty close to two years (Question: How long is each session?) It depends on how you want to define them. I usually was with her for about five hours. After that, she was supervised by the nurses and listening to music. But the lingering effects of the drug may last 8 or 10 hours.

Cooper: Once a week or what? (Grof: Say ten days, a week.) Ten days between sessions; five hours per session.

Mixer: What would be your experience with normal people? Would they tend to go through that entire cycle in condensation, a condensed period?

Grof: Yes. For example, they could often make it through the Freudian stage in less than ten sessions. Again, it depends on the dosages. But if you use something like 200, 300, they would go through this (6 on graph) probably under ten sessions. And then, all the sessions they would have after that would be kind of Jungian, mystical, religious. And then after that, it seems that the procedure is absolutely endless. I have never given more than 100 sessions, but I have met people who have had up to 500 sessions. I met others who had like 400, 300; and they say that the archives of the psyche are inexhaustible; no matter how far you go there is always another place to go. Basically what seems to happen is that if you expand your consciousness - and this is one term that Dr. Assagioli is always using, the idea of expansion - beyond your present ego so as to encompass your past history, you can have broader and broader experiences that cover larger time periods. And you also seem to expand in space so that instead of experiencing your own self and your own body, you start identifying with groups of people.

For example, you may identify with prisoners of the concentration camps or Jews suffering persecution. Then it can extend to the whole of mankind. You can feel you are mankind. Then you can go to the lower life forms and you can feel that you are all life on this earth, the totality of it. People can describe planetary consciousness, in which they feel that they have encompassed all the phenomena on this planet. Then they can have all kinds of galactic experiences. For example, not infrequently in the very advanced sessions, there are such experiences as the Hindu cosmology - the yugas, when you think in terms of billions of years and light years, in terms of space, and you can actually feel it. I've had these experiences myself. It is just beyond imagination what dimensions you can subjectively experience.

When I talk like this, there is usually somebody in the room who tells me that this whole thing was in my head before and that I have influenced the patients; they were just telling me what I wanted to hear in the way that Freudian patients learn that the psychoanalysts want to hear about their sexual experiences rather than anything else. But I had Freudian training and, if anything, I felt very uncomfortable when the patient started moving into these other areas. As I mentioned to you, it wasn't easy to see somebody dying, and to believe that he actually might be dying, that you were killing him. For a long, long time the patients were ahead of me. If I influenced them, I must have done so unconsciously. But I know that no such model of a human being was in my mind at that time. I very strongly believed that life starts after birth.

Goldstein: My question has two parts, one with the past and one with the future. The first is: What in your own personal life moved you into psychedelic therapy, if you could talk about that? From a psychoanalytic training in Czechoslovakia, what made you--?

Grof: I read Freud when I was about 17, and I was fascinated by the perspectives he offered; I felt that new horizons were opening. I actually went to study medicine with the intention of becoming a psychoanalyst or a psychiatrist. After I graduated, there was a man called Dr. Robicek in the School of Medicine in Prague. He was on very good relations with Sandoz and he got one of the first samples of LSD that came out. He was interested in EEG and in the painting of psychiatric patients, the psychopathology of art, and he was looking for experimental subjects. His view of the LSD experience was of a model psychosis, like: "Who wants to experience a trip into the schizophrenic world?" I was, of course, extremely curious. I couldn't have missed that kind of experience. So, I had a session with 100 micrograms. I happen to paint, so Robicek was very glad to have me as a subject.

By present standards, it was a very lousy setting, because he gave me the drug, left me, made his rounds in the hospital, and then he went to the court to testify. When he came back at one o'clock, he said, "Do you understand more of what schizophrenia is all about?" I had had a very beautiful, very powerful session which was basically of an ecstatic nature - colors, shades, release, fantasy, and so on. It was extremely exciting to watch it. But I had had about half and hour of the EEG examinations during and after the sessions because this was the focus of the experiment. Robicek was testing some hypothesis by imposing the frequencies of a stroboscopic light on the occipital wave patterns. So, part of the time, I was exposed to a stroboscope. When that stroboscope hit me, it shifted the experience to a completely different level, to a very, powerful cosmic experience. I think that this was the real reason why I generated interest, if I analyze it

now. After that, I really started being interested. I felt this was a very important thing. I started collecting papers, and very soon, I started running sessions myself. Then all of a sudden, I found that I could combine my interests in psychoanalysis and LSD.

Goldstein: The second part: Have you or any of your patients had futuristic experiences or phenomena on the LSD trip?

Grof: In a fairly advanced session, when you can identify with life in general (it is very difficult to describe, but it's like life in the Platonic sense, the idea of life, the totality of life), a few people have told me that they could follow the evolutionary pedigree from the beginning of life and follow its evolution; and that they felt that there was some kind of in-built conflict at the very beginning of life which ultimately will lead to its destruction. First man went through the whole phylogenetic development, then he developed technology, then he started polluting his environment, and devised weapons that can wipe out life. My subjects felt that something went wrong, both in the very basis of life and also, in the structure of man, in terms of some kind of schism between intellect and emotion. The emotions have remained as primitive as in the Stone Age while the intellect has been developing at a tremendous rate. We have developed weapons like thermonuclear bombs and intercontinental missiles, but we are using them with a degree of maturity which isn't much different from the way the Stone Age man used a club. These subjects claim to foresee that unless something very powerful happens, this is going to end in a disaster, that life is going to exterminate itself. There is some kind of germ of self-destruction in man's nature, if their hunches are right.

Yassky: I have a two-fold question. One this: I heard you say that psychotic patients seem to come down, to regress to a significant degree. I wonder if any of these patients have committed suicide or gone into an irreversible psychosis. Do they come back, and if so, to what point?

Grof: No. I was surprised that we had only two suicidal attempts in this group. Both of them were with drugs and they were reversible. We didn't have any successful suicides. And also, I imagine that quite a few patients had temporary psychotic episodes. Not only the psychotics, where it seemed to be almost a rule at a certain point in the treatment, but also some of the neurotic patients showed either borderline or unequivocal psychotic symptoms somewhere along the line. But everything could be worked through; nothing irreversible occurred.

Yassky: The psychotics, to where did they come back or stay in the end, more or less?

Grof: They came back at least to the neurotic level. I have never seen a single one who remained psychotic.

Yassky: Secondly, I wonder, rather than a Rankian-Jungian explanation for the second and third stages, whether you could have thought of them in terms of the English analytic school. For instance, I would think of it in terms of Fairbairn, or the things that Guntrip writes about; in terms of giving up parts of yourself, and therefore the death of part of yourself. Also Searles' concept of the symbiosis that he goes through with very psychotic patients.

Grof: We know several different models. We know, for example, that the Jungian explanation could be applied to the Rankian stage (5), and that you could use the spiritual death-rebirth model, an archetype of Jung, or the Terrible Mother archetype for this stage. But it seems that none of these other explanations cover the whole range of the phenomena. For example, why would that stage be accompanied by suffocation? Why would it be accompanied by changes in color, tachycardia? Why would you see images of fetuses? Or why would you see breasts at the same time,for example? Some people who have had this experience of redemption, of salvation, have felt that they were one with the universe on another level, because you can experience several levels simultaneously in a session. They would feel that it could also be like nursing at a good breast. It could also be like lying in a good womb. It's also like being embraced by the Great Mother. And then, too, it's like being one with nature. So there are many partial observations from the sessions related to biological birth for which the Rankian model seems to fit better than others.

Of course, it always involves giving up part of yourself.

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