The Role of Psychotropic Drugs in Individual Therapy

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Certain effects produced by psychotropic drugs in man are examined in order to illustrate the means by which methods of treatment based on psychotherapy can be modified or improved.

It is suggested that tranquilizing drugs may be used in association with psychotherapy in four ways: for controlling symptoms; for releasing unconscious material; for controlling disturbances associated with such release; and for removing inhibitions. These ways are critically examined, and in particular the use of lysergic acid diethylamide (LSD) in psychological medicine is dealt with in some detail. The psychological mechanism of action of LSD is examined.

Some space is devoted to the use of the major tranquilizers in the treatment of psychosis, and the possibility of managing major psychoses outside the mental hospital is examined.

The history of psychotropic drugs in England and, indeed, in other European countries suggests that for many years there has been a marked antagonism between the chemical control of mental illness and the psychotherapeutic, or, as it was called in earlier days, the moral approach (Pinel, 1806). This particularly arises out of the use of drugs as an alternative to, or in addition to, mechanical methods of restraint. Thus in many of our mental hospitals fifty years ago patients were being given large doses of bromides, paraldehyde, Sulphonal, hyoscine and morphia. Little control was exercised over these drugs and many of the patients existed in an almost permanent state of stupor induced by them (Sargent, 1956). Those reformers whose task it was to remove methods of mechanical restraint, to unlock doors and to give greater freedom to patients at the same time thought it desirable to diminish or do away with the sedative drugs which the patients were receiving. In some cases the drugs were used to reinforce the so-called moral methods of treatment which were much in vogue a century ago, and in some cases these moral treatments became debased into a kind of chemical sadism against the patients. Thus patients were frequently purged and bled, the former being carried out, in some cases, with unpleasant drugs such as croton oil. In some hospitals in England it was a practice to inject turpentine under the skin of the patient, producing painful and aseptic abscesses. There is no doubt that these harsh methods achieved some success, but they could not be tolerated in the more humanitarian age which succeeded their use and which was marked by the advance of psychoanalytical methods. At the present time there is a marked movement away from the use of drugs given for purely sedative purposes, and in some hospitals where patients suffering from neuroses form the larger part of the inhabitants medical superintendents take active steps to avoid patients having drugs of any kind.

Sargent (1956) has reviewed the present position which the tranquilizers occupy in psychiatric treatment and concludes "May I again stress the importance, with all these new chemical tranquilizers flooding the market, of trying to find the limited and definite indications for any new ones used... We should always be on the lookout for even the smallest clues to help us in our differential search". In the more specialized field of analysis Jung has condemned the use of abortive drugs on the grounds that they diminish the patient's power to integrate the unconscious material.

Analysts are, no doubt, divided in their views concerning the role of psychotropic drugs in individual psychotherapy.
USES OF DRUGS IN PSYCHOTHERAPY

Four categories of drugs may be recognized, as follows:

(a) Drugs which diminish the intensity of symptoms and help the patient to overcome those more severe symptoms which may assail him as a result of the disturbance of the unconscious which accompanies analytic treatment. The drugs in this group are the barbiturates used for promoting sleep and diminishing tension, the minor tranquillizers (e.g., meprobamate) for diminishing anxiety and tension, the excitatory drugs (amphetamine and allied compounds) for combating depression, and occasionally the major tranquillizers (e.g., chlorpromazine) for controlling more serious mental disturbance such as threatened psychosis.

(b) Drugs which disturb the unconscious and release unconscious material. These drugs include lysergic acid diethylamide, amphetamine and its derivatives and possibly abreactive drugs, such as ether and carbon dioxide.

(c) Drugs which control disturbances in the unconscious produced by the drugs in group (b), for example, chlorpromazine and the barbiturates.

(d) Drugs which diminish consciousness and remove inhibitions, enabling the analyst to explore the psychological situation more deeply than normal consciousness allows. These include thiopentone and sodium amylobarbitone and are usually given intravenously.

The use of these various methods will now be critically examined.

Use of tranquillizers

Arguments have been put forward both for and against the use of drugs to control symptoms during psychotherapy. Those who oppose their use do so on the grounds that the patient cannot come to grips with his psychological situation if his anxiety and aggression are diminished by the use of drugs. They believe that the symptoms themselves force the patient to continue the analysis. Those in favour of the use of drugs consider that their use is justified, particularly for disturbed patients who would be unable to continue psychotherapy without some help of this kind. Much has been said about the undesirable consequences of giving tranquilizing drugs inasmuch as they are said to reduce aggression. It is by no means clear whether the tranquilizers produce a true fall in the total aggressive drive of the individual. In many cases patients receiving the mild tranquillizers experience an increase of energy and creative ability following the reduction of anxiety and tension. Furthermore, such patients, because of their reduced preoccupation with their symptoms, may be better able to take an active part in their own treatment. Barbiturates used for promoting sleep may, again, be most useful in reducing the anxiety occasioned by insomnia, and in the author's experience there is no evidence that their use interferes with psychotherapy. It has been stated that many people are taking these drugs unnecessarily. Just as a diagnosis of hysteria frequently carries an attitude of social condemnation, so the person who is known to require tablets over long periods to secure sleep is likely to experience censure. Whereas I have known patients who exaggerate the degree to which they were unable to sleep, I have not yet known a patient who really sleeps soundly to demand sleeping tablets. The enormous quantities of sleeping tablets which are taken are therefore a commentary on the prevalence of neurosis and on our failure to find remedies for it. No doctor would fail to prescribe a remedy for a patient in pain, and there therefore seems little consistency in refusing to reduce insomnia, anxiety and tension in neurotic patients.

A further question does arise, however, concerning the transference. The doctor who provides tranquilizers for his patients tends to find himself in a maternal role. He becomes one who provides for the comforting of symptoms, and a demanding and dependent patient may take advantage of this to claim more and more tablets from a doctor. On the other hand, an opportunity is given for the patient to try out his sense of responsibility by operating with the doctor as to the precise dose required, by reporting faithfully on his symptoms and resisting the temptation to take an overdose of the tablets if he should become suicidal. Thus the drug aspect of the treatment can assist in the process of psychotherapy.

USE OF LYSERGIC ACID DIETHYLAMIDE (LSD)

After Stoll (1947) carried out his experiments a number of investigators studied the effects of lysergic acid diethylamide (LSD) on normal subjects. One of the things which was noticed in the course of these studies was that the psychological effects of taking the drug varied considerably in different people. This observation holds good for almost any drug which affects the central nervous system, for
example, alcohol. In the case of LSD, however, the variation from person to person appears to be particularly great. It was this variability of action which suggested that the psychic effects of the drug might be associated with the temperament and personal psychology of the person taking it. It therefore led some investigators to give LSD to psychoneurotic patients.

As far as can be discovered, the first authors to use the word "treatment" in connexion with the administration of LSD were Busch & Johnson (1950) from the St. Louis State Hospital, Missouri, USA. They gave LSD to 29 patients, eight of whom were psychoneurotic. Four of the psychoneurotic patients are reported to have re-lived childhood experiences while under the influence of the drug, and another patient re-lived a disturbing experience which had occurred when he was in the Navy. It was the preliminary observations of these two authors which led us at Powick Hospital to start a large-scale investigation on the use of LSD as a method of treatment for psychoneurotic patients. The results of the treatment of the first 36 cases were reported in the Journal of Mental Science in 1954 (Sandison, Spencer & Whitelaw); more recently we have reported on 92 cases in all (Sandison & Whitelaw, 1957), well over a hundred having been treated to date. In the meantime other investigators have used LSD for a similar purpose. Among them are Benedetti (1951), Savage (1952), Katzenelbogen & Ai Ding Fang (1953), Frederking (1953-54), Sloane & Doust (1954), Anderson & Rawnsley (1954), Cohen & Eisner (1959), and other workers in the United Kingdom whose studies are not yet published.

Significance of recovery of early memories

We should ask ourselves why the recovery of early memories occasioned by the LSD treatment excited so much interest and appeared to offer possibilities in the treatment of neurosis. The following observation of Freud (1953) from the Three Essays on the Theory of Sexuality may be of interest.

"The reason for this strange neglect [namely, of the study of infantile sexuality] is to be sought, I think, partly in consideration of propriety, which the authors obey as a result of their own upbringing, and partly in a psychological phenomenon which has itself hitherto eluded explanation. What I have in mind is the peculiar amnesia which, in the case of most people, though by no means all, hides the earliest beginnings of their childhood up to their sixth or eighth year. Hitherto it has not occurred to us to feel any astonishment at the fact of this amnesia, though we might have had good grounds for doing so. For we learn from other people that during these years, of which at a later date we retain nothing in our memory but a few unintelligible and fragmentary recollections, we reacted in a lively manner to impressions, that we were capable of expressing pain and joy in a human fashion, that we gave evidence of love, jealousy and other passionate feelings by which we were strongly moved at the time, and even that we gave utterance to remarks which were regarded by adults as good evidence of our possessing insight and the beginnings of a capacity for judgement. And of all of this, we when we are grown up have no knowledge of our own! Why should our memory lag so far behind the other activities of our minds? We have, on the contrary, good reason to believe that there is no period at which the capacity for receiving and reproducing impressions is greater than precisely during the years of childhood."

Freud assumed that this infantile amnesia was an almost universal phenomenon but that it was more evident in psychoneurotics. He also compared the absence of early memories to the amnesia which frequently occurs amongst hysterics and he thought that in both cases the phenomenon was brought about by repression of early memory traces. He believed that these memories were not destroyed and that they could be recovered by psychoanalysis. Work on the physiological aspect of memory is tending to show that it is impossible for more than a small proportion of past memories to be retained in consciousness. The fact remains, nevertheless, that some people can remember much more of their childhood than others, although generally memories of life before the age of two years are uncommon.

We noticed quite early on in the LSD experiments that the patients were experiencing changes in their thoughts, their feelings, in their own bodies and in the environment which reminded them of past events. The chief ways in which the past is revealed to the patient are as follows. The patient may feel very tiny compared with his environment. For example, door handles which would normally be accessible to the adult appear far away and out of reach, as they would be to a small child. The patient may look at his hands and notice that they are small, the grasp of an adult's hand being proportionately large. The patient may behave as he did in childhood. One patient, for example, found herself unable to read and demanded picture books such as might interest a child of two or three years of age. In other cases these apparent physical changes may not occur; the patient merely feels as if he were of a particular age and as if he were
experiencing something which happened at that time. The patient may genuinely re-live some event of psychological importance which occurred during his childhood. This re-living is normally accompanied by emotional release and is a true abreaction of great benefit to the patient.

How far back can we go and to what extent do fact and fantasy mingle in these LSD experiments? T. Ling (personal communication, 1957) and N. Lake (personal communication, 1958) believe that patients can vividly remember details of their own birth experiences and cite several convincing examples in which patients who appeared always to have been on unsatisfactory terms with their parents realize on going back to the first few days of life that there was a time when they were loved by their mothers and felt secure. Are we to accept their experiences as real memories? The physiologists put forward valid objections on the grounds that the visual pathways of the baby are not sufficiently developed to transmit these detailed experiences. Experience with patients suggests that the earliest memories are a mixture of fact and fantasy, and that they are re-lived with much vivid and colourful detail. From the psychological point of view it does not matter greatly whether the experiences really occurred; it is the living out and acceptance of the whole emotional complex which is the healing process. They may therefore be either the reality itself or the archetype of all such experiences, and as soon as reduction and regression have reached their limit, creation and growth commence.

It is difficult when giving examples of the early experiences of patients which are revealed under LSD to describe their emotional content and the emotional release which frequently accompanies them. Aggressive, anxious, depressed or elated affects frequently occur, often in quite violent form. This does not apply only to remote memories. One of the most violent abreacts I ever saw occurred in a patient who had been a prisoner of war and who released all his hatred and frustration in an alarming and destructive manner.

*Significance of abreaction of early memories*

Hitherto opinion has been divided on the value which can be attached to abreaction. It has been fairly generally established from the work of Sargant & Sharvon (1945) and others that where an adult experiences a dangerous or frightening situation in which he is not able to express his fear, for example, in battle, the experience may become the starting-point for a neurosis. Under the influence of drugs such as ether or Methedrine the patient re-lives the experience which is accompanied by the appropriate emotional response. The results of abreactive treatment in cases of battle neurosis are, with very few exceptions, good, although it is probably true to say that the greater the time elapsing between the incident and the treatment, the less satisfactory the results. It is known and was first established by Breuer (Freud & Breuer, 1924) that hypnosis can enable a person to re-live a traumatic experience, but hypnosis as a method of abreaction is not often satisfactory as the patient may repeatedly abreact with little relief. One of the striking things about LSD treatment is the way in which the majority of the patients regress into childhood and appear to remember things which were apparently forgotten. In a number of cases it has been possible to ascertain from other sources that the events described by the patient did, in fact, happen, and this has been confirmed by some of my colleagues. The more difficult question is whether these particular memories are related to the patient’s neurosis.

Experience with this abreactive aspect of LSD treatment confirms Russell Davis’s contention that it is not the abreaction itself which matters but that the experience abreacted to should be re-assessed in the light of the patient’s present emotional attitudes (Davis, 1957). In the author’s view it is of little importance whether the psychologically traumatic incident has been forgotten or not. The value of abreaction lies in the facility of the abreactive agent to release the emotion with which the event has become associated and to re-assess this affect in the light of mature and present-time emotional judgement. LSD appears to be the most suitable agent for doing this, and combination with methylamphetamine may make it even more useful. Some situations can be uncovered which would probably never come out in the course of psychoanalysis, and this is particularly true in the case of obsessional neurotics and psychopaths.

*Contribution of LSD therapy to the nature of memory*

At the present time we must preserve an open mind on the whole question of the way in which memories are stored and the degree of development of the perceptual pathways in young children. The unmodified evidence from LSD experiences suggests that detailed vivid memory is possible from the moment of birth. There is evidence from those who work with children that a discussion between parent
and doctor in the presence of a young child concerning the child's case will sometimes bring about a marked improvement. Language is not just a question of words. Tone and inflection may convey much more to children than they do to adults. Much more external evidence is needed which could confirm or refute the nature of "memories" recaptured after the ingestion of LSD.

Some of the observed clinical effects of LSD can be classified as follows:

1. Physiological effects, e.g., dilatation of pupils, nausea, urinary frequency. We may note that LSD has no peripheral vascular effects, whereas amphetamine produces vaso-constriction and the barbiturates produce vaso-dilatation.

2. Non-specific sensory changes, e.g., sensations of heat or cold, of lightness of the body, of increased loudness of sounds, and visual sensations of colours and "seeing" of sounds.

3. Increased vividness and speed of thought; this is usually accompanied by increased emotional tone.

4. Cinematographic effects. The patient experiences an endless procession of memories vividly seen and felt; these are often accompanied by much emotion.

5. Concentration on one event remembered or forgotten, with appropriate emotional release, i.e., abreaction.

6. Regression and regressive behaviour which almost invariably accompany the abreaction when it relates to events occurring in childhood. The form taken by the regression is unique to the LSD experience, although modifications of it are seen during recovery from insulin coma.

An examination of the abreactive phenomena induced by LSD leads one to the following conclusions:

1. The abreaction to a single traumatic event in the patient's past life produces the most rapid, effective, dramatic and long-lasting cures among the good results which are claimed for the use of the drug in psychotherapy.

2. The memory abreacted to may be either recent or remote.

3. The significance of the LSD reaction is that the original emotion becomes re-attached to the experience. This it shares with other abstractions but it happens under LSD in a clear setting of consciousness, which can be discussed between patient and therapist both at the time and subsequently.

Psychological interpretation of LSD phenomena

The various LSD phenomena may be interpreted according to the following schema:

1. The recovery and re-living of childhood memories are usually closely related to the conflict from which the neurosis stems.

2. The LSD fantasies and emotional phenomena result from the activation of the unconscious produced by this drug. Further evidence for this is that patients taking LSD once a week say that their entire outlook changes between treatments. They start to think more seriously and to turn over in their minds ideas which had never occurred to them previously. They start to dream, and these dreams frequently reveal material showing continuity with the LSD experience itself.

3. Much of the LSD material is of a non-personal nature and in quality and content corresponds to much that Jung has to say about the collective unconscious. Jung (1956) writes:

"A person sinks into his childhood memories and vanishes from the existing world. He finds himself apparently in the deepest darkness, but then has unexpected visions of a world beyond. The 'mystery' he beholds represents the stock of primordial images which everybody brings with him as his human birthright, the sum total of inborn forms peculiar to the instincts. I have called this 'potential' psyche the collective unconscious."

This is a clear description of the LSD experience and large numbers of patients have referred to the experience as being one of withdrawal and depersonalization, accompanied by a sense of timelessness and a sense of being in an ancient land, e.g., Egypt or Greece.

The integration of this material into consciousness may form one of the tasks of the therapist during LSD treatment and its result is to develop and modify the personality and character of the patient.

4. There are grounds for believing that the frequent thrusting to and fro from outer (i.e., normal) consciousness to inner consciousness (the experience of the unconscious during LSD treatment) and back again has in itself a healing value to the patient.

5. These interpretations satisfactorily explain the theory of the LSD state being a model psychosis. Jung (1956) says:
If the conscious mind proves incapable of assimilating the new contents pouring in from the unconscious, then a dangerous situation arises in which they keep their original, chaotic and archaic form and consequently disrupt the unity of consciousness. The resultant mental disturbance is therefore advisedly called schizophrenia, since it is a madness due to the splitting of the mind."

This is what often happens temporarily during the LSD intoxication, the difference between this and true psychosis being that the person under LSD can return to normal within a few hours and can sometimes do so by an effort of the will alone.

6. Transference phenomena must not be overlooked and occur just as regularly in the LSD treatment situation as in ordinary analysis. They are susceptible to analysis and interpretation and the need for this cannot be over-estimated in view of the dramatic nature of the treatment, which may cause the patient to make violent psychological projections on to the analyst. By choosing to give LSD to patients one enters a field fraught with the gravest moral, religious and philosophical considerations. It is characteristic of the LSD phenomenon that it may cause a patient to feel that he has glimpsed the ultimate truths of the universe and that he has discovered the real secret of life. Some writers such as Aldous Huxley (1955) have claimed that these experiences go as deeply as the religious experiences of great mystics, but this attitude has been severely condemned, chiefly by Roman Catholic writers such as Professor Zaehner (1957), on the grounds that an experience gained through merely taking a drug cannot in any way be compared with the mystical experiences of the saints who worked for years to gain their glimpses of the supernatural. The situation becomes easier to understand if we think of LSD as a means of raising the archetypes briefly into the region of consciousness. The experiences, therefore, have something more in common with insanity and with those of the nature mystics than they do with religious mysticism. For example, it is the schizophrenic who believes he has found the secret of life. It is therefore of the greatest importance to persuade the patient that although these experiences are, in a sense, illusions, yet they are at the same time images of something real and that if he is prepared to put in the necessary work the fruits of the experience may be assimilated. Much more research is needed by which LSD experiences can be compared with the experiences of the nature mystics and of the religious mystics. So far the issue has been confused by those observers like Huxley who have attempted to compare the experiences with those of the ancient religions, particularly in the East.

Drugs which control or antagonize LSD reactions

It is known that the bromides, barbiturates and phenothiazine drugs diminish or stop the LSD experience and at the same time diminish the tension and anxiety which commonly accompany the treatment. The value of these drugs lies in circumscribing the experience, in preventing physical and mental exhaustion, and in keeping up the patient's morale. The mode of action of these drugs is not clearly understood. The most effective are the barbiturates, whose seat of action is the reticular formation, where it is believed LSD is also concentrated after its ingestion. In fact, it was experiments with the barbiturates which led one to speculate whether LSD might be used as a means of fortifying the effects of electro-convulsions, on the grounds that the use of barbiturates tends to diminish the beneficial effect of electro-convulsive therapy. The other possible use of tranquillizers combined with LSD concerns the possible benefits which may be obtained with LSD in psychotics provided the reaction is controlled with Largactil. The method and some results have already been reported on (Sandison & Whitelaw, 1957) but some further observations may not be out of place here. It has hitherto been assumed that, because LSD commonly intensifies the psychosis when given to schizophrenics, its use in the therapy of schizophrenia is not rational. A probable explanation for the lack of research in this field is a general "instinctive" feeling that antagonistic therapy is more rational than homeopathic therapy. When one compares schizophrenia with the LSD response one notices important differences. Although affect may be diminished after taking LSD, a common response is an increase in the emotional tone, both subjectively and objectively. Furthermore, the administration of LSD to a non-deteriorated schizophrenic results frequently in the patient showing emotion. If the hallucinations become intensified he begins to fear them, tears and laughter may become more congruous and more genuine. The role of chlorpromazine in this type of therapy may be questioned, but it seems to prevent the psychosis getting out of hand, although one cannot be certain to which drug, LSD or chlorpromazine, any improvement may be attributed. Further research in this field is required.
USE OF BARBITURATES AND OTHER DRUGS FOR ABREACTION

The modus operandi of abreaction is not clearly understood. Hysterical patients can abreact violently under hypnosis without any improvement occurring. They will do the same, under the influence of ether, methylamphetamine, or thiopentone. If the emotional situation is of recent occurrence the results are better but relapse tends to occur. The therapist often finds that the drug analysis uncovers personality problems which may require a full analysis and he should be equipped to deal with this situation. The benefits obtained through the close rapport and transference have probably been underestimated. Some patients require a drug like thiopentone to reduce inhibitions so that they can talk more easily, and under these conditions memories at the fringe of consciousness make their way into the patient's speech. The drug has therefore obtained the reputation of being the "truth drug". This is unjust, as patients who really wish to withhold the truth can do so under thiopentone, and psychopaths and pathological liars continue or even elaborate their fantasies. The indications for drug abreaction may therefore be thought of as follows:

(a) Exploratory, the patient being able to discuss his material in a relaxed state. A focus or emotionally charged complex is frequently brought to light.

(b) Abreactive, in cases where recent psychological trauma has been the start of the neurosis.

These treatments may be criticized on various grounds, e.g., that they are passive, that the patient may be relatively unaware of the content of his material, and that consciousness, that vital integrating mechanism, is dulled.

These methods, originated by Breuer as a hypnotic treatment for hysteria, fell into disrepute in the 1930's. They have been revived in the past twenty years largely because traumatic war neuroses responded so well to drug abreaction. The work of Sargent (1949), Sargent & Shorvon (1945) and Grinker & Spiegel (1945) is relevant. These authors use either sedative drugs such as amylobarbitone, or stimulant drugs, such as ether or methylamphetamine, to promote abreaction. LSD is thought to have a rival place in abreactive techniques, but has not yet become firmly established in this respect.

GENERAL USE OF MODERATE DOSES

The best results of the phenothiazine drugs are obtained in psychotics and the best method of using them is that of long-term maintenance treatment. The author is treating a number of schizophrenics in this way—mostly with chlorpromazine—some of which are in their fourth year of treatment. Most of them are now out of hospital and all attend the clinics for "psychotherapy". The word is used cautiously as one is not clear in what way these visits help the patient. It is well known that many schizophrenics can be kept in better health and relapses avoided just by occasional visits to a psychiatric clinic without drugs being used at all. The cases I have in mind, however, are more severe and they tend to relapse if the drugs are withdrawn. Again one does not know whether this is a true withdrawal effect or whether it is a psychological phenomenon. I am inclined to think that thought disorder is kept under control by chlorpromazine and therefore the resultant affective disorder is prevented. The effect of giving chlorpromazine to an acute psychotic is that the thought disorder and hallucinations improve first and the affective disorder clears up later. Individual therapy should be directed towards establishing rapport with the thought disorder. Contrary to many people's ideas, encouraging a schizophrenic to discuss his delusions frequently has a beneficial effect, and when the emotional power of the delusions is under the control of a drug it is far safer to do so. I therefore have been in the habit of treating quite florid schizophrenics as out-patients with moderate doses of chlorpromazine and discussing the patients' thought content with them at frequent intervals. The results are often gratifying.

Anaclitic therapy with chlorpromazine

The term "anaclitic therapy" has arisen within the last year or two to describe a state of regression induced by the drugs. Azima & Wittkower (1957) have recently surveyed the literature and describe the technique for achieving extreme regression by means of large doses of chlorpromazine. The theory is that each organism has a compelling need to control its environment and it is thought that this mechanism is brought into play as soon as the patient has regressed. In the author's opinion there is no significant psychological difference between
this type of regression, which Azima & Wittkower describe as occurring after large doses of chlorpromazine have been given, and the regression which occurs during recovery from insulin coma and after intensive electro-convulsive therapy given by Page and Russell’s method. Furthermore, many of the phenomena which have been observed following LSD are of the same type.

The field is clearly one demanding further research, as there would appear to be a need to investigate methods which can produce severe regression without danger to the health or life of the patient. Probably a large range of drugs will produce this regression. The author has observed it after acute aspirin poisoning, and in one case the psychological material produced was of great benefit in the treatment of the patient. Therefore the observations of the authors quoted above on chlorpromazine appear to be most interesting and promising.

Maintenance doses

Individual therapy of less florid cases on maintenance chlorpromazine is less specific and is usually directed towards maintaining the patient’s social adjustment.

CONCLUSIONS

Individual therapy is a process whereby the patient is made aware of unconscious mechanisms. He is expected to put in a lot of work to understand these and to accept them. He requires a strong and lively consciousness to absorb his discoveries. During the process, which may be prolonged, he may become depressed, disheartened, anxious, obsessed, suicidal or psychotic. The die-hards of the analytical school abhor drugs and cling to standard methods. Others, perhaps working under greater pressure, look to drugs to assist them to shorten the analysis, improve the quality of the patient’s understanding and control the associated symptoms. It is claimed LSD assists by bringing out unconscious material more quickly and by releasing material inaccessible to standard methods of analysis. The associated symptoms of an undesirable nature may be controlled by a variety of drugs, and thus less stable patients including psychotics can be selected for psychotherapy. To find a drug which widens human consciousness and understanding may be impossible but further research is needed.

RÉSUMÉ

L’auteur passe en revue certains effets qu’exercent chez l’homme les médicaments psychotropes pour montrer comment les méthodes de traitement fondées sur la psychothérapie pourraient être modifiées ou améliorées.

Il fait l’historique de l’emploi des médicaments en psychiatrie et note qu’on s’en servait pour améliorer le comportement des malades en les calmant plutôt que dans l’espoir de les guérir. Cette tendance s’est progressivement renversée et l’on s’efforce actuellement d’instituer des traitements médicamenteux d’action plus spécifique.

En psychiatrie, on distingue quatre domaines spécialisés d’emploi des médicaments:

Dans la première catégorie, on classe les médicaments utilisés pour réduire l’intensité des symptômes. Les tranquillisants mineurs, les stimulants du système nerveux central et les barbituriques font partie de ce groupe. L’auteur examine l’emploi de ces médicaments, associé à la psychothérapie, et conclut qu’il est justifié. Il faut être prudent quand on recourt aux barbituriques, étant donné que leur administration prolongée risque d’avoir pour seul effet de rendre le malade plus dépendant que jamais de son médecin et de la clinique.

Dans le deuxième groupe de substances sont classés les médicaments qui apparaissent dans la vie psychique de l’individu un trouble spécifique dont le thérapeute profite pour faire apparaître un matériel psychologiquement important. Ces médicaments sont connus d’ordinaire sous la dénomination de hallucinogènes ou de psychosomatomètes ; le plus important d’entre eux est la diéthylamidine de l’acide lysergique ou LSD. L’auteur fait l’historique de l’emploi du LSD en psychothérapie ; il attire tout spécialement l’attention sur une observation presque constante : le LSD fait souvent réapparaître des souvenirs anciens que l’on pensait oubliés. La théorie freudienne est invoquée pour expliquer l’importance de cette observation. L’article donne des exemples du type de souvenirs qui réapparaissent ainsi et signale que l’image corporelle est fréquemment modifiée sous l’influence du LSD, de sorte que le malade se trouve plus petit que d’ordinaire, alors que le milieu dans lequel il évolue lui semble devenu proportionnellement plus grand. La réapparition des souvenirs anciens s’accompagne souvent d’une décharge émotionnelle, ce qui place le LSD dans la catégorie des médicaments psychocathartiques. Ce n’est pas l’abréaction en soi qui importe ; son objet doit être réévalué à la lumière du comportement actuel du malade et, par conséquent, des attitudes affectives de l’adulte. On note que l’abréaction relative à un événement traumatique
unique dans la vie antérieure du malade provoque une guérison plus rapide et plus efficace. Il semble que la levée de l'annéosis infantile soit étroitement en rapport avec le conflit qui motive la psychose. L'auteur propose l'hypothèse suivante: les phantasmes et les phénomènes affectifs provoqués par le LSD résulteraient d'une activation de l'inconscient. Toute la perspective mentale des malades se modifie et ils commencent à rêver davantage.

Le LSD provoque encore d'autres phénomènes qui font intervenir ce fond ancestral que Jung appelle l'inconscient collectif. Le traitement peut s'efforcer d'intégrer ce matériel dans la conscience, pour le plus grand bien du malade. Il semblerait aussi que le traitement répété fasse alterner le malade entre la conscience normale et l'inconscient collectif, ce qui peut, en soi, avoir une certaine valeur curative. L'article examine les phénomènes de transfert collectif, ce qui peut, en soi, avoir une certaine valeur curative. L'article examine les phénomènes de transfert collectif, ce qui peut, en soi, avoir une certaine valeur curative.

Dans le troisième groupe de médicaments figurent ceux qui s'opposent ou constituent des antagonistes à l'état créé par le LSD: on y trouve les bromures, les barbituriques et des phénothiazines. Une association du LSD et de la chlorpromazine peut être utile dans le traitement des schizophrènes convulsifs.

Dans le quatrième groupe de médicaments figurent ceux qui, LSD mis à part, provoquent l'abréaction. L'auteur pense que ces médicaments sont utiles pour traiter les psychoses consécutives à des traumatismes psychologiques récents, mais qu'ils conviennent moins bien aux cas de traumatismes infantiles profondément refoulés.

Enfin, l'auteur étudie l'emploi de la chlorpromazine dans le traitement des grandes psychoses et conclut que les tranquillisants majeurs, en réduisant les troubles de l'idéation, améliorent la situation affective et donnent aux malades un comportement plus normal. Il pense, en outre, que cette réduction de la psychose permet le recours à la psychothérapie. L'emploi des tranquillisants majeurs permet d'envisager le traitement à long terme des psychoses hors de l'hôpital psychiatrique.

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