Use of \textit{d}-Lysergic Acid Diethylamide in the Treatment of Alcoholism\textsuperscript{1}

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\textbf{T}his report is a follow-up of two previous reports by Smith (1, 2) on the use of \textit{d}-lysergic acid diethylamide (hereafter \textit{LSD}) and mescaline in the treatment of alcoholics. As stated in the previous reports, the idea of using these drugs to treat alcoholism was derived from discussion of one of us (A. H.) with H. Osmond and later with A. M. Hubbard who treated a large series of alcoholics with \textit{LSD}. Sandison and his co-workers (3, 4, 5) Frederick (6), Abramson (7), Lewis and Sloane (8) and others mentioned the usefulness of these drugs in psychiatry but did not specifically study alcoholism. Many of our medical and nursing staff had \textit{LSD} experiences while participating in a study of its psychotomimetic, biochemical and psychological aspects. The reports from patients and volunteers suggested the occurrence of marked loosening of repression and greater facility in recognizing conflicts. Favorable personality changes frequently occurred in volunteers and staff, even though this was not the purpose of the experiment.

Proceeding from this slim background of knowledge, Smith treated a series of alcoholics with \textit{LSD} and mescaline. The first sample of 24 was a group with an extremely unfavorable prognosis.

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as can be seen from the frequency of unfavorable diagnostic categories, the lack of any response to previous treatment and the frequency of complications of alcoholism.

In general, the most difficult cases were taken into this study. All but 4 of the patients had tried Alcoholics Anonymous and failed in the program. The characteristics of the group were described by Smith (1). There were 8 patients with character disorders, 12 psychopaths, and 4 with borderline or actual psychoses. Most had experienced complications of alcoholism such as delirium tremens, severe tremor, frequent blackouts; and some had cirrhosis of the liver, barbiturate addiction and peripheral neuropathy. Antisocial behavior with prison terms, marital disharmony, broken homes and poor work history occurred frequently, as well as other complications. The average period of uncontrolled drinking was 12.1 years.

Since this original sample, an additional 16 patients have been treated. They constitute a group which on the whole seemed to be fairly similar although possibly slightly less severely ill. The average period of uncontrolled drinking was 11.6 years. Coincidental with the beginning of the second sample certain modifications in the method were made and for the time the two groups will be considered separately. The results of treating the enlarged group are reported. Certain factors which appear to play a role in the therapeutic response will be discussed here.

**Initial Method**

The patients in the first group were admitted to the psychiatric ward of the University Hospital in Saskatoon and were assessed clinically for a period of about 1 week, during which some degree of rapport was established and the patient's problems were studied.

The alcoholics generally showed much less response to LSD than did nonalcoholic volunteers. Consequently, fairly large doses (200 to 400 microg. orally per person) were used. Even then occasionally the response was so mild that mescaline was used to gain a response. One subject failed to respond to mescaline. Most of the patients received one dose of 200 microg. of LSD but those who did not respond subsequently received a larger dose of mescaline in an attempt to get a response. Two patients in the series had no appreciable drug response. The patients were seen by the attending therapist several times during the day of treatment in a private room with a member of the nursing staff. At no time were they left alone while under the influence of the drug.

Usually a prolonged interview was carried out at the height of the
experience, 2 to 4 hours after ingestion, with shorter interviews at other times. The patient was encouraged to verbalize the experience and to think about and discuss his problems, while under the influence of the drug. During this period, strong suggestions were made to the effect that he discontinue his drinking.

Each patient was asked to write an account of his experience during the next day or two. Over the following few days, events and discussions that took place in the LSD experience were again discussed with the patient in an attempt to give him more insight and acceptance of the discoveries he had gained. The patients were usually discharged less than a week after the LSD experience. In most cases, for geographical reasons, it was impossible to carry on psychotherapeutic follow-up. The patients’ condition was followed by periodic reports from A.A., their physicians and families.

All the patients were encouraged to try the A.A. program. It was thought that the A.A. program and the learning gained under LSD were complementary.

An assessment was made of each person’s experience. This was roughly divided into one of four categories of intensity: no response, mild, moderate and intense.

The side effects mentioned by Smith, which interfered with the therapeutic relationship, were varying degrees of tension or depression during the experience. Also, there were a number of reactions, with withdrawal and paranoia, which made discussion extremely difficult. Nausea and other somatic complaints during the early phases of the experience were not unusual. No permanent side effects were noted, however, and there was no evidence that any patient’s condition was in any way aggravated by the treatment.

Revised Method

Following this original series, our research group was in contact with Hubbard, who had demonstrated a somewhat different approach. We have adopted some of his modifications and have introduced others.

We had noted before from our studies of the psychotomimetic properties of this drug that the environment and particularly the attitude of the people around the person undergoing the LSD experience seemed to influence his reaction profoundly. Staff members who have had an insightful LSD experience or who have participated in many sessions as observers are more able to aid the subject during his experience. On the other hand, unsympathetic, hostile and unfeeling personnel bring about fear and hostility with a marked increase in the psychotic aspect of the experience. Allowing staff members an LSD experience automatically changed attitudes by greatly increasing empathy with the person undergoing the experience.

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The modifications used since January 1958 are as follows. The environment surrounding the patient taking LSD was changed by the addition of auditory stimuli, visual stimuli, emotional stimuli and a change in the attitude of the people in contact with the patient.

The auditory stimuli consisted mainly of music supplied by a record player. Usually classical, semi-classical and relaxing music was played. The person was encouraged to lie down, relax and listen closely. Visual stimuli consisted of various pictures which the patient examined and concentrated on intently. Other visual stimuli such as cut flowers were sometimes used. The auditory and visual stimuli served to show the person the great enhancement of perception, but, what appears to be more important, they aided him in getting his mind off himself. He was reassured that it was not unusual to have visual imagery in the experience. For emotional stimuli, photographs of relatives were often used. The subject was encouraged to study these closely for long periods. The suggestion was made that he could become markedly aware of unhealthy attitudes toward the people in the photographs and he was assured that his thinking in the area would be clear and free of rationalizations and thus more useful to him later on. He was also asked to concentrate on a list of questions that he had previously compiled about his problems.

We believe that it is absolutely necessary for every therapist to undergo the LSD experience; we feel that doing so substantially increases understanding of the patient’s experience and that the therapist’s attitude becomes much more accepting, thereby making him more effective not only during the experience but in terms of after-care. The patient was encouraged to accept himself during this period while his thinking was more emotionally charged and he was less likely either to rationalize or to have guilt feelings. The therapist avoided all forms of reproach but at the same time he stressed the patient’s own responsibility for the perpetuation of his difficulties and for the removal of the unhealthy attitudes from which these difficulties arose. Optimism is important and it was emphasized that the subject, by becoming aware of his pathological attitudes, could modify them.

Frequently a discussion of religion and its various aspects developed as a result of patients’ queries about the nature of this unusual experience. We have noticed that patients of diverse racial and religious backgrounds have had similar experiences of a religious nature. What have been called by Sessions (9) “ego religion and superego religion” were contrasted in these discussions and the desirability and reasonableness of ego religion was stressed. Sessions wrote:

“Superego religion is that religion in which tradition and authority blindly dominate the field and in which the concepts of guilt and retribution prevail. It is the religion in which the unworthiness of the individual is emphasized and its effect is to encourage the individual’s ascetic or self-punitive tendencies. It tends to repudiate various aspects of reality; it clothes certain phrases and ceremonials with a mag-
ical quality; and, being dissatisfied with anything less than an impossible perfection of the individual, it encourages punitive, intolerant and morally judgmental attitudes.

"Ego religion, on the other hand, is eminently reasonable. While it respects authority, it transfers a substantial measure of responsibility to the individual reason and conscience. It emphasizes the individual's personal relationship with God as opposed to the vicarious one. In ego religion, love, faith and optimism are pronounced, contrasting sharply with the pessimism and the air of impending calamity which characterize superego religion."

The need for attitudes of "love, faith and optimism" was stressed and the lack of these was equated to interpersonal difficulty. This was discussed directly with the patient or with another observer if necessary and the patient generally assessed this thesis himself after his attention was drawn to it. The rationale for this approach will be discussed later.

**RESULTS**

The results will be discussed in two groups: Group I, the original 24 patients discussed in another paper by Smith (1), and Group II, the 16 cases treated subsequently by the modified method. The results are presented in Tables 1 and 2.

The average period of follow-up in the first group is about 18 months; in the second group it is approximately 6 months. The follow-up investigation was carried out largely through A.A. contacts with the patient, his family, and other members of A.A. The results of treatment were classified as follows:

1. Much improved, i.e., complete abstinence.
2. Improved, i.e., definite reduction in alcohol intake. Objective observers confirmed substantial reduction in alcohol intake.
3. Unchanged, i.e., no fundamental difference in drinking habits. This included those patients who showed temporary improvement but subsequently returned to their former drinking habits.

**TABLE 1.—Results of Treatment, by Diagnostic Categories, in Groups I and II**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>No. of Cases</th>
<th>Much Improved</th>
<th>Improved</th>
<th>Unchanged</th>
</tr>
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<tbody>
<tr>
<td>Character disorder</td>
<td>8</td>
<td>4</td>
<td>1</td>
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<tr>
<td>Psychopathy</td>
<td>12</td>
<td>2</td>
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<td>0</td>
</tr>
<tr>
<td>Borderline and actual psychosis</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>3</td>
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*Group I from Smith (1).
<table>
<thead>
<tr>
<th>Patient</th>
<th>Age</th>
<th>Years of Heavy Drinking</th>
<th>Diagnosis</th>
<th>Type of Reaction (^1)</th>
<th>Length of Follow-Up (months)</th>
<th>Results (^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>35</td>
<td>10</td>
<td>Psychopathy</td>
<td>4 to 6</td>
<td>9</td>
<td>x</td>
</tr>
<tr>
<td>2</td>
<td>42</td>
<td>5</td>
<td>Character disorder</td>
<td>4 to 6</td>
<td>9</td>
<td>x</td>
</tr>
<tr>
<td>3</td>
<td>41</td>
<td>15</td>
<td>Psychopathy</td>
<td>5</td>
<td>8</td>
<td>x</td>
</tr>
<tr>
<td>4</td>
<td>38</td>
<td>6</td>
<td>Character disorder</td>
<td>5</td>
<td>7</td>
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<td>5</td>
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<td>50</td>
<td>16</td>
<td>Character disorder</td>
<td>2, 5</td>
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<td>x</td>
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<tr>
<td>7</td>
<td>38</td>
<td>10</td>
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<td></td>
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<td>8</td>
<td>52</td>
<td>15</td>
<td>Psychopathy; schizoid</td>
<td>4 to 6</td>
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<td>9</td>
<td>48</td>
<td>6</td>
<td>Cyclothymic personality</td>
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<td>x</td>
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<td>11</td>
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<td>40</td>
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<tr>
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<td>4</td>
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<td>35</td>
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<td>3.5</td>
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<td>46</td>
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<td>Character disorder</td>
<td>3 to 5</td>
<td>2</td>
<td>x</td>
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<tr>
<td>16</td>
<td>44</td>
<td>20</td>
<td>Character disorder</td>
<td>2</td>
<td>2</td>
<td>x</td>
</tr>
</tbody>
</table>

\(^1\) Based on classification of effects of LSD into six constellations or types of experience by Blewett (11).

\(^2\) I = much improved; II = improved; III = unchange.
Smith has tabulated the relationships between diagnosis, therapeutic results obtained, and the intensity of the LSD reaction.

Since, at present, there is no basis for quantification which would permit the use of methods of examining variance components, it is impossible to state categorically what the effect of the drug alone may be. The experience is a compound of the patient’s attitude, the effect of the drug, and the surroundings while he is under the effect of LSD.

In the assessment of treatment of Group I (Table 1), it was found that psychotics and borderline psychotics did poorly. The response in psychopathy was encouraging, considering the usual prognosis. The best results were obtained with the group diagnosed as character disorders.

In general, the more intense the experience without actual tension or anxiety, the better were the results. In the 7 subjects who demonstrated some withdrawal or paranoia in the experience, only one was in the improved group, the others remaining unchanged. Considering the refractory nature of the group, the short period of contact with the patient, and our ignorance as to what was happening in the experience, the results were sufficiently encouraging to warrant more extensive trials. The second group of 16 patients represents the first of these further trials.

Discussion of the LSD Experience

Since the most effective method of using LSD must be dictated by the nature of the experience, we will give as comprehensive a description as present knowledge and space will permit. There are two orders of changes—physiological or biochemical, and psychological. The former have been discussed by Hoffer and Osmond (10) and others. In the present report we are concerned with the latter changes.

For two reasons the LSD experience does not lend itself readily to verbalization. First, the sensory aspect of the experience is out of the bounds of the usual experience for which our language is intended. Secondly, the experience is mainly in the sphere of emotions or feelings which are difficult to objectify at the best of times.

The following are the changes most commonly reported by subjects, followed by typical illustrative quotations from reports written by patients and volunteers.
1. A feeling of being at one with the universe. “I had finally understood by experience the feeling of union with the cosmos.”

2. The experience of being able to see oneself objectively, or a feeling that one has two identities. “If we had the gift to see us as others see us, well, I did this morning.” “There seem to be two of me and there seems to be a conflict between these two.”

3. A change in the usual concept of self with concomitant change in the perceived body. “I had the feeling of leaving my body and drifting off into space. I had no worldly connections and felt as if I was only a spirit.”

4. Changes in perception of space and time. “I was looking deeply in the picture until the objects in the picture were beside me.” “At times each moment seemed to be a lifetime.”

5. Enhancement in the sensory fields. “The flower was a thing of inestimable beauty as was its scent. It quite transfixed me in essential contemplation, ecstasy and timelessness.”

6. Changes in thinking and understanding so that the subject feels he develops a profound understanding in the field of philosophy or religion. Associations of ideas are much more rapid and clear and one tends to see many alternate solutions to each problem; there is a great tendency to think analogically. “I found I was outside our bounds of space and time and had an understanding of infinity.”

7. A wider range of emotions with rapid fluctuations. “During this period I was swept by every conceivable variety of pleasant emotion from my own feeling of well-being through feelings of sublimity and grandeur to a sensation of ecstasy.”

8. Increased sensitivity to the feelings of others. “I was conscious of an extremely acute sense of awareness of perception of another’s mood, almost thoughts. I likened it to the recognition of emotional atmosphere that the child or animal seem to have.”

9. Psychotic changes. These include illusions and hallucinations, paranoid delusions of reference, influence, persecution and grandeur, thought disorder, perceptual distortion, severe anxiety and others which have been described in many reports on the psychotomimetic aspects of these drugs.

One can see on studying the list that there is a close relationship between these various experiences, but, on the other hand, some are paradoxical, e.g., the increased clarity of thought and thought disorder. One of us, D. B. B. (11) has taken these various effects of the drug and grouped them into six constellations or types of experience. These various levels of experience would seem to represent points along a continuum. Several of them are likely to occur within a single session. The tendency is to shift from experience Number 1 gradually to experience Number 6, if not in the same session, in subsequent sessions. The reverse type of shift tends to
occur much less readily. The underlying factor of the continuum along which these experiences are ranged appears to be the degree to which the subject is able to surrender his usual self-concept.

1. The first type of experience might be called a "flight into ideas." In this type the experience is denied by concentrating on concepts or things outside the self. The patient attempts to control the emotional component and diminish the physiological and psychological change which markedly alter his perception. This gives rise to almost unbearable tension and irritability, and the patient is likely to say afterward that very little happened.

2. In the second type of experience, the patient tends to concentrate on the physiological mechanisms which are interpreted as being disturbed. Increased emotional involvement increases the physiological disturbance, altering the perception to a still greater awareness of bodily discomfort and malfunction. Anxiety is largely somatic and the person may have an intense fear of dying. In any case he develops physiological symptoms of various kinds, frequently including violent nausea, palpitations, feeling of constriction in the throat and chest, pain at the base of the skull, numbness of the limbs and violent headache. This type of reaction seems to be correlated with an inability to attend to things outside oneself and the person having this type of reaction is likely to say that all the drug does is make one terribly sick. Hoffer and Osmond (10) have suggested that these first two types of experience occur concomitantly with a low production of adrenochrome in response to LSD whereas the adrenochrome level usually rises markedly after the administration of this drug.

3. The third type of experience is characterized mainly by confusion and perceptual distortion. This is much like an intensified schizophrenic reaction. In this level of the experience disturbances of perception become so overwhelming that they cannot be interpreted; the intellectual rationalizing processes are swamped and attempts to establish order fail. The patient is acutely aware of the confusion of visual and, sometimes, auditory perceptions which become a vast jumble, usually frightening and unpleasant.

4. The fourth type of experience in this classification is characterized mainly by paranoia. The patient rationalizes the unusual experience as being the result of having taken a drug which has made his perceptions unreal. The perceptions are almost completely clearly delineated and differentiated and the amount of confusion is variable, but tends to be less than in the third type of experience. In spite of the fact that the patient is experiencing certain perceptions or feelings, he questions their validity or reality. He interprets his state as delusional and thereby implies that he is incapacitated and at the mercy of his environment, particularly of the people about him. At the same time, he has a marked tendency to hide this incapacity or weakness which he feels he must have and of which he feels that those about him must be aware. The
fact that he feels that those about him are aware of this weakness yet act as though they are not aware of it, makes him feel that they are either toying with him or are too embarrassed to mention it. This causes him to withdraw and think referentially. He then tends to feel that they are really talking about this weakness but in a disguised fashion and almost any comments are interpreted referentially. This distrust of self leads to feelings of inadequacy and intense unworthiness and he feels that his behavior must be very peculiar, although no one comments on this. Insight is much reduced. Referential thinking develops and the person becomes very paranoid. Occasionally a grandiose pattern of behavior develops when the person reacts with aggression rather than with withdrawal in this situation. This produces a manic type of reaction with contempt for the other people around the patient.

5. At the fifth level of the experience, the patient seems to be aware of a dual reality and accepts the experience as another equally valid sphere of reality and his experience tends to be quite stabilized. He accepts as genuine his apparently enhanced intellectual capacity and his ability to empathize with and to appreciate, accept and understand, others. His thinking may be somewhat disrupted by a frequent involvement in what Levey has termed “the dilemma of alternates” in which there is a sort of parallel awareness of opposites which impedes the usual flow of thought. He finds himself increasingly aware that he is thinking analogically, that there is a tendency to extend logical classification beyond the usual bounds, and his perception increasingly tends toward the break-down or to the fusion and synthesis of usual gestalts. In this state the person is keenly aware of the possibility of slipping into a psychotic state or to madness that appears an ever present possibility, and he feels that he is walking a razor’s edge, gaining slowly in confidence as he goes.

6. The sixth level of the experience, like the fifth, is classified as a stabilized experience, but here reality becomes unified. The experience is accepted by the patient as offering a new and richer interpretation to all aspects of reality. He feels strongly that there is a unifying principle underlying all things, an essence with which he feels in complete accord. He may feel that he is part of all things and all things are a part of him. His self-concept is in no way limited by the usual restraints of body image. These feelings or beliefs are accompanied by feelings of reality so intense that conviction is inevitable. William James in speaking of such intense feelings of reality says, “They are as convincing to those who have them as any direct sensible experiences can be and they are, as a rule, much more convincing than the results established by mere logic ever are.” At this level of experience no doubts remain as to the reality and usefulness of the experience and the individual freed from this concern feels no possibility of unpleasant or psychotic features developing. Once this level is attained it is doubtful if

\[\text{A. Levey, University of Saskatchewan. [Personal communication, 1958.]}\]
any manipulation of the environment could induce a psychotic state in the experience.

Some feel that the individual has already, by accepting the experience as reality, fallen into a delusional or psychotic state, and, indeed, there is no ready criterion to determine whether or not this is actually the case. The only method of assessing this possibility seems to be the pragmatism of William James, “By their fruits shall ye know them.”

We can now resolve the paradoxes in the experience by understanding that the psychotic aspects are produced by the person's own manipulation, either by his denial of the reality of the experience, or by his trying to maintain his usual self-concept when the drug demands a much wider self-concept.

One can see how the various aspects of the experience are interdependent, e.g., if one takes as the point of departure the change in the usual concept of self in which one feels outside of his body, then obviously he will also feel detached from his body. His body seems no more important to him than the rest of his environment; therefore he feels that he sees himself objectively or has two identities, i.e., the new concept of self and the old concept of self, and at the same time, he feels at one with the whole universe. The individuality of people and things tends to break down or fuse into one unified principle, for by concentrating on any object, he sees through it at once into the microcosm and into the macrocosm and becomes aware wherever he looks of an infinite number of aspects of the objects perceived. He comes to the conclusion that infinity is everywhere and that he himself is infinite.

By being outside himself and not concerned about himself, he therefore becomes increasingly sensitive to the feelings of others and also comes to see associations and relationships much more readily. On reaching this final stage, he gains great confidence in himself when he realizes that in essence he is infinite. He feels this with conviction since this is essentially a feeling or emotional experience and the understanding is synonymous with what is called emotional insight in psychiatry. Being able to look at himself objectively he is able to find the solutions to his difficulties and sees these with conviction.

He comes to the conclusion that his usual sense of self is at the root of his difficulties in that self-consciousness and anxiety are synonymous. With concentration outside himself, he erases his difficulties. He may test this many times in the experience and will find that a smooth, useful, and comfortable experience is re-
lated to accepting himself and to concentrating outwardly. The converse is also true. But before he can reach this stage, he must accept himself completely. This is synonymous with the self-surrender discussed by Tiebout (13, 14) in alcoholism and like the religious conversion discussed by William James.

Because the drug makes him feel he is infinite in essence it is much easier for him to accept himself completely and it readily becomes evident that he can only accept the outside world to the exact degree that he accepts himself. The patient feels, at the same time, that this is not only true in the LSD experience but also outside it; that this process is only telescoped under LSD. He then sees that lack of faith or acceptance that he is essentially infinite is the exact counterpart of anxiety and that faith and anxiety cannot be experienced at the same time. He also sees that guilt is disrupting in that it is a denial of this infinite self which is the same for everyone. This equalizing effect tends to remove any form of pride, prejudice, guilt or anxiety. The person then sees that faith which is the acceptance of himself as infinite and love which is the acceptance that everything around him is equal to him in substance is the clue to a smooth, pleasant, useful LSD experience, and he generalizes this to everyday experience. The patient then ceases the tragedy of desiring to be other than he is in essence and realizes that he can only be other than he is in terms of his acts. The energy diverted from attempts to alter his basic nature can now be used to alter his feelings and acts in a way which makes his life more peaceful and satisfying and his outlook more compassionate.

It might appear that complete acceptance would lead to apathy and complacence. However, complete acceptance implies acceptance in substance but not necessarily acceptance of action, depending upon the nature of the act. Since the drug experience is highly subjective there is no objective way of measuring this change toward acceptance which can only be judged by the person's subsequent behavior.

The person then comes to realize that the nature of his feelings is intimately related to the direction of his attention, that is, he feels bad and uncomfortable when he is feeling self-concern and he feels well when he is feeling benevolent. He also realizes that he feels self-concern only if there is some aspect of himself which he has not accepted. He realizes also that, once having learned this, he can feel as he pleases, but this takes some practice, as one
learns to walk by walking so one learns to love by loving. He finds that contrary to his usual opinions, he has a choice of what he feels and he realizes that although his feelings fluctuated previously, this was because he had not understood his ability to direct them and had instead accepted the rationalization that he had no control over them.

It becomes evident, then, that the root of the therapeutic value of the LSD experience is its potential for producing self-acceptance. Logically this must be reflected in an atmosphere of complete acceptance of the patient thereby permitting him to gain self-acceptance.

The alcoholic then sees that his experience is in keeping with the A.A. program of emphasis on spiritual values and the ego religion discussed by Sessions. The experience is discussed with him, with emphasis on the fact that the same attitudes which produced stability and understanding in the LSD experience are those stressed by A.A. and those best suited to the outside world, and that he needs constant effort and self-reminding to maintain these attitudes until they become largely habit. Then he will be able to maintain peace of mind with little effort.

**SUMMARY**

A report on the therapeutic efforts of LSD in 40 alcoholic patients is presented with a description of the psychological aspects of the LSD experience. From growing knowledge of these aspects a therapeutic method which makes optimal use of the experience has been evolved. The conclusion is reached that self-surrender and self-acceptance are more easily achieved in the LSD experience and the thesis is developed that from the psychological point of view the resolution of the problem of the alcoholic lies in this surrender. Results of a preliminary trial and of a further more extensive trial are given.

**REFERENCES**


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