SINGLE CASE STUDY
PROLONGED LSD FLASHBACKS AS CONVERSION REACTIONS

DONALD R. SAIDEL, M.D.1 AND RAYMOND BABINEAU, M.D.2

This paper presents a case study of the background and treatment of a patient with prolonged LSD flashbacks. The hypothesis that flashbacks can be psychologically determined symptoms is supported by the dynamics of the case and the course of treatment. A second focus is a partial explanation for the often made observation that obsessive-compulsive personalities are at increased risk for LSD flashbacks.

The literature on LSD flashbacks consistently describes schizoid and obsessive personalities as those personality types most vulnerable to prolonged flashbacks. Prolonged flashbacks are defined as a period greater than 6 months. However, except for references to the loss of control while "tripping," little effort has been made to explain this as a psychologically determined phenomenon in closely studied case histories, nor have there been any efforts to explain the association (7) with particular personality types. Physiological stress, particularly fatigue and driving, often precede flashbacks (2, 6), but the mechanism underlying this relationship is unclear.

One etiological hypothesis (5) is that anxiety sets off a complex physiological and psychological reaction that leads somehow to a return of symptoms. At the physiological level, Zeidenberg (7) equates drug-induced flashbacks with the results of electrical stimulation of the brain, and concludes that the "work of Penfield and others on electrical stimulation of the superior and lateral surfaces of the temporal lobe leaves no doubt that the flashback is a genuine experiential state ... " (p. 15).

1 At the time this work was done. Dr. Saidel was a third year resident in psychiatry at the University of Rochester Medical Center, Rochester, New York. He is presently a staff psychiatrist at Womack Army Hospital, Fort Bragg, North Carolina.

2 Send reprint requests to Dr. Saidel, 150 Summer Hill Road, Fayetteville, North Carolina 28303.

The same author suggests a biochemical etiology, that hallucinogens may be taken up by synaptic vesicles and then gradually released, causing the subjective experience of flashbacks.

This paper is a case study of one patient who suffered debilitating flashbacks which were conceptualized by the senior author as falling somewhere between a conversion symptom and the symptom of a traumatic neurosis, and treated accordingly. An attempt is made to delineate some of the personality and situational variables that predisposed the patient to this type of symptoms, as well as to explain the observations that obsessive-compulsive personalities are at risk for prolonged flashbacks.

In addition to recurrent visual hallucinations, the term "flashbacks" includes distortions of perception in any sensory modality that are experienced during the drug experience and afterward. They intrude repeatedly into awareness long after the drug effect has worn off (2).

CASE REPORT

The patient was a 20-year-old junior who came to the University Health Service complaining of a 3-year history of frequent visual distortions, mostly in the form of shimmering and blurring images and auditory distortions. A common phenomenon for him was for words on a page he was reading to first blur, then they seemed to move around on the page. As he became more tired and tense, the book would seem to float or dance in front of him. Subsequently, he would have to give up his reading.
He also complained of more recent free floating anxiety and confusion in various interpersonal situations. Although he had ingested no hallucinogenic drugs for 3 years, he considered the perceptual distortions to be a continuation of his prior drug experiences, specifically, 15 LSD trips, five experiences each with amphetamines and mescaline, all within an 18-month period. Although he often suffered a baseline visual fuzziness during those 3 years, his symptoms flourished when he was fatigued, when studying for exams, and when he was frustrated in tackling a difficult problem.

A bright, highly intellectualized, somewhat phobic, cautious, and obsessive young man, he was the second of two sons of university-educated parents; his father was a scientist, his mother a librarian. His father was a respected teacher but in the family was perceived by the patient as uninvolved and ineffectual to the extent that both brothers could remember only once that he stood up to their mother. She was dominant in the family and with our patient was controlling, guilt provoking, and intrusive.

When he was a child, the patient had been her favorite, but in high school there was increasing strife between his mother and him, ostensibly over his provoking her with knowledge of drug use by his friends and him, something she disapproved of intensely. Believing that every contact with her led to an argument, he withdrew and as a result she became more intrusive, reading his mail, and listening in on his phone calls. (A vivid demonstration of her continuing intrusiveness occurred later when the patient was in therapy. She phoned the senior author to ask how she could be of help, and then requested that her call be kept secret.)

The summer before his senior year of high school his brother warned him that their parents were considering "disowning" him. The patient assumed that this would be because of his defiant reticence with his mother, his drug use, and his challenging his parents with the news that he was considering not entering college. Although no such steps were actually taken, his guilt was sufficient for him to ruminate fearfully about "disownment" his senior year.

It was during that year that the majority of his drug use occurred, including his most traumatic trip. During that trip, he called a friend to stay with him as his panic worsened because of grotesque, haunting, bleeding faces that surrounded him, and convulsing, withering trees and hills that left him "nowhere to turn, but inside." He had lost all confidence in his senses and was just "hanging on to [his] awareness," fearing for his sanity, and aware of the frightening possibility that his senses would never return to normal. The most terrifying moments were when he lost all sense of himself as an observer.

For several months after that episode, his flashback symptoms were at their worst and he clung to his girlfriend for support, sometimes literally. For example, when he was distressed, his distortions flourished and his visual environment was so chaotic that he could not find his way around familiar routes. He had a fear of becoming "imprisoned by [his] thoughts," i.e., so overfocused on his thoughts and perceptions that he relinquished much of his attention to the outside world in favor of his ruminations. An increasingly worrisome rumination was that his distortions were due to an organic brain lesion resulting from his drug use and were therefore irreversible.

What precipitated his eventually coming to therapy 3 years after the onset of the flashbacks was his helplessness in controlling the distortions which impaired his ability to meet the challenge of two life events. One was the demand of career choice following graduation. The other was a conflict between his mother and his girlfriend, with his mother objecting strongly to their liaison, his girlfriend objecting to his mother's intrusion, and his perception that he was being forced to choose between them.

Therapy consisted of psychodynamically oriented psychotherapy comprising a total of 20 1-hour sessions on a once weekly basis. In the transference relationship, he was quite dependent, treating the therapist as a benign authority. The positive transference was used as a base from which the therapist could challenge repeatedly the patient's fear that he had suffered organic brain damage. Six weeks into therapy he began to give up the organic theory and the hopelessness of which he had been painfully conscious. At the same time, he gradually accepted the therapist's alternative explanation of the importance of affects and of life crises insufficiently resolved.
With that, progress came in a rush. The perceptual distortions remitted over a 2-week period. For the final 3 months of therapy, he suffered only one flashback episode, around the issue of termination, in contrast to his pretreatment record of distortions at least once every 2 or 3 days. Simultaneously, he made two major moves toward separating and individuating himself from his mother’s influences. He decided to get married, and he switched from a major in English literature, an identification with his mother’s area of interest, to engineering, his father’s field, and an area of concentration where he felt more talented. He regretted that at home no one had helped him in the battle with his mother, so it seemed that in the positive transference he found the alignment he had been seeking.

In the remaining 10 weeks of therapy, gains were consolidated and the focus shifted to his feelings of confusion and anxiety which had previously been partially bound by the symptoms. At the time of termination, he felt that his major problem was a “nervous temperament” with which he felt he could cope adequately. In review, he thought that a benefit of therapy was the improvement of his ability to recognize and label his feelings, therefore preventing the panic which previously was associated with his flashbacks. Follow-up correspondence 1 year after termination revealed two brief episodes of distortions, judged by him to be slight. Both occurred when he was exhausted, studying for exams and were relieved by sleep.

**DISCUSSION**

A constellation of factors can be delineated to explain the fact of symptom choice. For a person with an obsessive-compulsive character style who takes LSD, and suffers flashbacks, those factors are numerous. First, the need for control, orderliness, and predictability are all violently disrupted by the upsurge of images and affects. McGlothlin has noted that experimental subjects who prefer structure are less likely to report a profound LSD effect (4). When members of this group do experience a strong effect from either the strength of the drug or the weakness of defense, they are more likely to fall victim to the trauma and become symptomatic. Particularly disrupted by the vivid imagery of the LSD experience are the closely allied defenses of isolation and intellectualization. Affect becomes unavoidable. “The compulsive neurotic, being afraid of his emotions, is afraid of the things that arouse emotions. He flees from the macrocosm of things to the microcosm of words” (1, p. 295). Relying as much as he does on these defenses, he leaves himself vulnerable to pain, chaos, and helplessness during an LSD experience.

After the traumatic drug experience, the patient resorted with newly driven vigor to the use of intellectualization to prevent a recurrence of the unmanageable fears. Two contrasting episodes demonstrated his need for cognitive mastery of his environment. Lost in a maze of underground tunnels at college, he felt impending panic, but because he was able to think his way out of his plight, and because he never lost a sense of his awareness, he mastered his anxiety and had no perceptual distortions.

At another time, he became increasingly frustrated because he was unable to repair his car engine. When he realized he had run out of potentially successful approaches to the problem the engine seemed to “shimmy and break up” before his eyes and he was forced to abandon the project.

The exact form of flashbacks is readily adaptable to the obsessive character. McGlothlin (4) notes, “There is some evidence of a more introspective and passive orientation . . . in the experimental group of drug users” (p. 532). Others note the increased concentration of drug users on their own imagery and thoughts (2). For a socially phobic obsessive it was apparently a process of substituting ruminations about his perceptual distortions for his previous ruminations.

At first, this patient sometimes enjoyed and indulged in the perceptual phenom-

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3 One case report concerning extinction of flashbacks by desensitization (3) demonstrates the necessity for working through the traumatic drug experience, but pays little attention to the broader psychological issues of the meaning of the symptom at the time of its appearance.
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As long as he felt generally in control of himself, but when the demands of his life increased, when he neared time for career choice and marriage, the regressive pleasure of the perceptual distortions became a hindrance rather than an enjoyment. Needing all of his faculties intact to face future challenges, he found the distortions increasingly distracting and therefore ego dystonic. A previously accepted experience became a symptom when it interfered with development.

Another aspect of thinking that makes it a vulnerable target for symptom formation in an obsessive character is the fact that for them the mind is often a highly cathexed organ. In addition to the intrapsychic importance of thinking, thinking can have an interpersonal significance, as in this patient's family where intellectualization was a primary mode of relating.

Why the perceptual system should be cathexed is less clear, unless perception is taught of under the same influences as thinking. The introspective nature of obsessive-compulsives, especially those who are led to hallucinogens, involves a heightened interest in and attention to their own perceptual processes which are accentuated by drug use. Perception, too, becomes a highly cathexed area with an increased vulnerability to symptom formation.

The fact that flashbacks lasted for a few years in this patient, while others have isolated bad trips was a function of his being in a developmental crisis which was symbolized by his symptoms, and also a function of the prolonged lack of resolution of that crisis. Because of his preoccupation with his perceptual distortions, he experienced little conscious grief or fear over leaving high school, or his family. Most of the anxiety was bound by his symptom. Symptom relief occurred concurrent with significant resolution of his developmental crisis (2).

As for secondary gain, his being so incapacitated fostered a clinging and nurturant relationship with his girlfriend, a replacement for the mother he feared was disowning him. Furthermore, because of his symptoms, he was unable to consolidate and develop his career plans, and was thus unable to attain the independence he feared until therapy intervened.

Conclusion

This case is presented as an example of one way in which LSD flashbacks may persist, maintained by the same psychodynamic processes as any other neurotic symptom. Treatment based on that assumption was successful. Of particular interest is the way personality characteristics of LSD users, LSD adverse effects, and obsessive-compulsive phenomena related to each other. This may help clarify the previously unexplained observation that obsessive-compulsive characters are at higher risk for prolonged LSD effects.

References