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Treatment of Childhood Schizophrenia Utilizing LSD and Psilocybin

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Now that the FDA has permitted research with LSD and psilocybin to resume, we feel it is important to share examples of a remarkable experiment, the results of which were not sufficiently taken into account because this line of research was prematurely halted in the mid-sixties due to political considerations. Childhood schizophrenia is still a difficult problem to treat and causes much suffering. It is a terrible shame that research done 35 years ago is still the last word on the use of psychedelics to treat these conditions. - Ed.

Hypothesis

The working hypothesis of this study is that psychosis is a massive defensive system of repression-avoidance-denial in the service of protecting the individual from experiencing early childhood trauma. The repression is so massive that the individual ceases to experience himself with any validity. The individual exists isolated in a world without feelings and this world becomes meaningless. One of our little patients told me that he lived in a world of "no nothingness." It was hypothesized that the psychedelic drugs could break through this massive repression wherein the child would re-experience these traumatic events and release the pain bound to those experiences. He or she would acknowledge his own history. Furthermore, through experiencing the loving attention of the staff in a milieu of total acceptance, the child could begin to experience himself as a positive and valid person. The team consisted of a psychiatrist (who chose not to have an LSD experience but was medically responsible for the research), four psychology graduate students and three psychiatric nursing technicians. The author acted as lead therapist of this group. For any one session there were usually three to four staff, relieving each

other throughout the day as the sessions were extremely intense and required very active participation by the staff. All staff had had their own experience with LSD and psilocybin, as it is accepted practice that in order to understand what was going on with the children one had to have had personal experiences with the drugs. As we progressed with the work it emerged that one staff person would become the primary therapist for each patient. Each session was continuously recorded for the verbalizations and behavior of the patient. Besides spending time with the patient during the treatment session itself, a total program had to be developed for each patient and that program communicated to all ward personnel to attempt consistency in the therapeutic approach. We were careful to include ward personnel who were not part of the treatment team in the ongoing progress of each patient and to enlist their cooperation in the development of a consistent attitude. As the ward personnel began to see the remarkable changes occurring in the children, they became involved and supportive in the ongoing care of each child.

Ward Conditions

The ward in which these children lived was in a state of constant pandemonium. The ward housed some sixty children ranging in age from four to twelve who were the most severely disturbed children of a larger hospital population. There was constant screeching, fighting and destructive behavior. Many children were destructive towards the environment, to each other, to the staff and to themselves. The primary duty of the ward personnel was damage control. The noise level was always high, as many of the children were extremely hyperactive and vocal. Other children were very withdrawn, involved in repetitious physical motions and when interfered with would lash out at the intruder. There was little interactive or parallel play and any toys or material brought into the ward were soon destroyed. Feces smearing and random urinating were a constant problem. To say the least the environment was not conducive to good mental health.

New Behavior

After nine months of the program and fifty-eight treatment sessions it was decided to continue the program with five patients of the initial twelve. The children discontinued from the program were characterized by a lack of speech and infantile autism and were the least responsive to treatment. They were extremely withdrawn and had no ability to relate to other children or adults. In spite of their severe limitations, all of them did have some marked response to the treatments. During the sessions they showed little responsiveness although some of them became hyperactive and were obviously having some sensory experiences and more interaction with the staff. One girl had a prolonged fear

response. Marked changes occurred in the days following the sessions. They showed much more interest in relating to the treatment staff, became animated and playful and remarkably less withdrawn. One girl evidenced extreme frustration at not being able to verbally communicate as she had no language development. The youngest (four years old) and least developed child kept trying to lead a treatment staff person down to the room where we did sessions. They all had interest in making physical contact with the treatment staff and one very autistic child became quite demanding to be held. This was all new behavior for these children. Consequently they all had behavior changes but their potential in relation to other patients was much more limited and we had limited time available to treat them.

Among the children with whom we discontinued treatment, one twelve year old girl had progressed so remarkably that she was able to attend public school during the day and return to the hospital in the evenings. It was felt that she had sufficiently improved, was function ing satisfactorily in the school system and that further treatment was not crucial. Patty was the only patient who was not psychotic. She responded to the treatments more rapidly than the more disturbed patients. A short summary of her treatment will help illustrate the work.

Patty's First Session

Patty had three sessions over a period of three months. Dosage for the sessions were 100 micrograms of LSD, 100 micrograms of LSD with 10 milligrams of psilocybin, and 200 micrograms of LSD. She was hospitalized because of her inability to function at home, in the school or in the community. Her behavior fluctuated from being withdrawn and uncommunicative to very aggressive and sadistic towards smaller children. She stole food and other items from other smaller children and when thwarted in her behavior had violent temper tantrums and had to be physically restrained and isolated. Although her IQ was tested at 72, her low functioning seemed to be caused by severe personality problems and it was estimated that her potential was near the normal range. During the first session she spent the entire seven hours regressing to an infantile oral state. She incessantly repeated, "I'm hungry" and when asked what she was hungry for, she did not reply but only restated her hunger. During the entire session she chewed and sucked on her clothes or others, her fingers, arms and anything or anyone she could reach. She was given an empty baby bottle with cotton stuffed in the nipple and she chewed and sucked on this for hours. It was clear that she was trying to draw nourishment from anything in her environment. During the session one staff member would sit with her, holding her hand or arm and gently hugging her or stroking her. We gave her constant tactile care. For about two hours she aggressively bit the

nipple, stretching it and gnawing on it. She finally appeared to become exhausted and uncommunicative for almost an hour. In the latter stages she held hands with staff and smiled quietly without verbalizing. She appeared to be making genuine interpersonal contact.

The Second Session

In the month following her treatment Patty was much more subdued and did not want to talk a great deal about the first session. During the second session she spent a great deal of time sucking on the baby bottle but this time she said she wanted milk in it and we complied. She then went into a panic-like state and talked a great deal of her fear of being rejected by her parents. She insisted that we call them immediately and have them come and take her home. She was extremely anxious that she would be abandoned by them and at one time sadly said of her mother, "She doesn't love me." After some three hours of constant turmoil concerning her familial relationships and her severe agitation over the rejection by her parents, she slipped into a quiet state for a period of time. She then suckled on the milk bottle and when she took it out of her mouth she would repeat, "I am loved." After some four hours she said "I love my mother, my father, my brothers and my sisters, I never felt this way before. I love them." She said that she had never felt that she was loved and the feeling of being loved and loving that she was now experiencing was new to her. She then went into a state for about two hours which is best described as a deep trance state. She was completely still with no movement whatsoever, and was unresponsive to all verbal or tactile stimuli. She finally came out of it and started smiling but still remained unresponsive to any of our inquiries. After about another hour she got up and wanted to go for a walk outside. She was happy and smiling and occasionally would laugh out loud.

Following this session Patty again was much more subdued, her behavior changed remarkably in that her temper tantrums ceased and she was relaxed and content. She interacted with new maturity toward the staff and had a very positive relationship (it looked like adolescent adoration) with one of the male psychology students. They spent a good deal of time with each other.

The Third Session

The third session, two months later, was initially characterized by more oral regressive behavior. She asked for the baby bottle with milk and spent over two hours, biting on it, suckling it trying to swallow the whole bottle, but this behavior did not have a desperate quality to it. She seemed to be more playing with it, enjoying it, and her demeanor was quiet and content. She suckled for

long periods and would drift off into a peaceful, tranquil state, completely relaxed, smiling at the sitters when making eye contact. She wanted to be quiet and we were quiet with her - touching her, hugging her, holding her hand when she reached out. She responded to visual stimulation such as a rose with delight and amazement. She thoroughly enjoyed the attention and affection of the staff. Again following the session she was much more mature, interested in relating to adults and wanted to go to school with kids her own age. Her temper tantrums and rage reactions and her stealing behavior had completely ceased. It was felt she was ready to try school off hospital grounds. She was excited about this new situation and did not have any relapses. Patty did not seem to experience fear of the new situation but was excited about the opportunity to be in new surroundings and she did very well. She continued to stay at the hospital after school hours and continued her supportive relationship with the staff. She became a very affectionate and loving child and her personality was fairly subdued and quiet.

Timmy

One ten year old severely autistic boy was continued on the program more as a challenge, as he was very resistant to abandoning his psychotic defenses. He was given a series of ten sessions over a period of ten months, with dosages up to 400 micrograms of LSD. Before treatment he was highly encapsulated, repeating a few phrases and displaying repetitive and catatonic posturing. His only contact with people was looking up their sleeves, he seemed to be checking if and how arms were attached. He would not allow himself to be touched and had no interaction whatsoever, other than attacking other children if they approached or touched him. His treatment sessions were characterized by agitation, fear, panic and anxiety. Occasionally he could relax and allow staff to hold him, rub him and gently feed him. He had long periods where he was totally out of contact with his surroundings. During a later session after some two hours of being out of contact, he sat up rather suddenly, his eyes widened with astonishment and he whispered, "I saw God." During later sessions he evidenced a much larger vocabulary and abandoned his echolalia and repetitive speech.

Timmy's first four sessions were almost exclusively devoted to biting, chewing and aggressive oral behavior. We observed this with all patients, evidencing extreme oral rage. In later sessions patients would attempt to eat us and everything in sight to fill the emptiness they felt. In spite of us not witnessing a lot of what we could identify as conflict resolution during the sessions, his behavior underwent a marked change. His physical attacking behavior subsided and he became interested in relating to other boys his age as well as the treatment staff. He wanted physical contact, became playful and enjoyed

himself. His parents began taking him home for weekends due to these behavioral changes and they repeatedly told us that they were amazed at his improvement.

Jenny

This nine year old girl had eight sessions over a period of six months. Her IQ at age five was eighty-two. She had good verbal ability. Her behavior was impulsive, erratic and unpredictable. She was often very aggressive to other children, especially smaller ones, and attacked them viciously without provocation. When she attacked it was often with very flat affect, not associated with anger or retaliation. She was very oral, eating anything she could obtain and attempted to eat inedible objects. She would make sexual advances to adult males. She was socially isolated, did not participate with others, and showed a pronounced inability to make any meaningful relationship with anyone, children or adults.

Jenny's sessions were characterized by her reliving sexual abuse and her fear and alarm and ambivalence over the attention given her. She regressed back to her early infancy and gave repeated evidence of her neediness from her mother and her anger at not being properly cared for (both parents were alcoholics). She was extremely orally aggressive and had to be restrained a good deal as she acted out her anger by biting, scratching, pinching, kicking and attacking staff. Much of the time that she was acting out her affect was quite flat, other times she would be screaming and there was a great deal of conflict over toilet training and power struggles related to this event.

In later sessions Jenny became much more stabilized and she started verbally expressing her hatred of both males and females and wanted to kill babies and children. Behavior changes on the ward were significant. The affect became much more appropriate and she developed a buddy relationship with another one of the female patients, a twelve year old girl. Her erratic, aggressive behavior towards younger children completely subsided; she became much more interested in doing activities with her friend and interacting with adult ward personnel. She began to see herself as more grown up and took pleasure in her new identity. She went to school and was able to function satisfactorily in that setting. Her changes were remarkable and she became quite functional and was no longer a management problem.

Stevie

This nine year old, very small boy had a total of thirteen sessions over a ten

month period. Prior to treatment Stevie was extremely withdrawn and isolated and responded to no one. He vacillated between extreme catatonia and excited catatonic rage reactions. He would become assaultive and destructive and especially physically aggressive towards younger and more helpless children. During these times he had to be placed in camisole (full straight-jacket) and seclusion. He never spoke to anyone, made no eye contact and lived exclusively in his own world. What was unique about this boy's psychedelic experiences was his ability to enjoy sensory experiences that are commonly experienced by the normal person. During the first two hours he would delight in the visual and auditory experiences and constantly comment about what he was experiencing.

We soon discovered Stevie had an extensive vocabulary which he never used in his usual state. He would say such things as "the music is following the designs," he would laugh and say, "I love you, designs. Heart designs, ahhh, what a beautiful lady, a whole house full of changes." He rhythmically moved his body very gracefully to the music. He became extremely animated, smiling, sometimes giggling and appearing very much enchanted by his experiences. The long duration of this type of reaction was most unusual with these children. He would also become extremely quiet and peaceful, radiating a serene countenance that is witnessed when individuals are experiencing transcendental states. After the first few sessions he became very excited when told that he was going to have another session. He would run down to the treatment room and participate in preparing it by setting out the things that we would typically bring - fruit, cookies, flowers, pictures, record albums and so forth. When the room was set up he would take a wash cloth, dampen it with cool water, fold it and lay down on the couch and cover his eyes with it, a ritual we would frequently use in attempting to get patients to travel inwardly. He would then want the music started. He was acting like a typical normal person in preparing themselves for a session.

In the second phase he would exhibit intense turmoil, conflict, fear and agitation. He indulged in the entire gamut of behaviors and emotions, biting, spitting, profuse and prolonged swearing and extreme hyperactivity, destructiveness and total catatonic withdrawal. He would carry on extended dialogues between two or possibly more people, evidencing conflict between his mother, father and himself. There was a great deal of anal and genital content to his conversation, with endless repetitions about "shit, piss, penis, nasty, black BM, death, black hearts, throw up, black breasts, black diarrhea, chew it, afraid, burn it hurts." He would interrupt these dialogues by going to the bathroom, standing in front of the toilet, turning in a few circles and then urinating and when he ran out of urine he would continue this behavior twenty to twenty-five times. After an exhausting three to four hours he would appear

very beaten up and would allow staff to sit with him, touch him and hold him, feed him and nurture him.

Touching moments would often occur with these small patients, near the end of one session a male sitter was sitting beside Stevie, holding his hand and Stevie opened his eyes and said, "Will you talk to me, David?," David said, "Yes Stevie" and after a moment said, "I don't know what to say?" to which Stevie replied, "Just talk to me with your eyes." This coming from a child who in his usual state was either catatonic or wildly destructive. Very often we had no idea how to interact with the children when they were obviously back in time wrestling with the demons of their pasts. They would be unaware of our presence and often the most we could do was to sit it out with them. Remarkable changes occurred with this boy. He started to relate to treatment staff and wanted to be touched and held. His manic and destructive behavior disappeared and he started relating to boys of his own age and older ones and struck up a bond with another boy on the program. They became good buddies. He became well enough to attend school and was able to function well in that setting. His parents were amazed at the changes and started to visit him and then began taking him home every weekend. He was very verbal, became very playful with the treatment staff and was behaving like a normal boy.

Floyd

This ten year old boy had a total of sixteen sessions over a period of eleven months. He had a history of extreme deprivation. His mother was an extremely agitated, narcissistic woman who made no effort to relate to him at all. For the first two years of his life, he was confined to a crib without any toys or any kind of stimulation. Prior to treatment he was constantly hyperactive and agitated, not wanting contact with others. He spent his days in the yard being completely involved in finding and looking at small bugs. When not in the yard he looked at two books which were about insects and bugs. When staff attempted to interact with him, he would only ask repetitive questions about bugs but was uninterested in any one responding to his questions. He appeared to be actively hallucinating much of the time. He would not carry on a verbal exchange.

In his first session Floyd had a remarkable response to the drug. Within thirty minutes he was obviously experiencing sensory changes and became relaxed and smiled a genuine human smile. His first words were, "What did you do with me? He's not dead yet." He looked at pictures in his book and said, "I'm not making it real, no I'm not." A staff member said "You're alive, aren't you?" to which he replied, "No, no, no, I can't be alive, this is too good." He looked back at the book and said, "Okay, it can't be, turn it off, turn it off, who's doing

it." Looking at one of the staff he said, "Oh Judy, don't be real, don't be real." He touched another staff member, looked in his eyes and said, "Don't be real, don't be real, I've got to get out of here. I don't want to be alive, I am afraid of me, turn that off. Tom, don't be real. I'm not real no more. I'm blind. No, no, no, I can see." He then relaxed, looked at various staff members and said, "How come we are all the same?" He didn't ask this in an inquiring way but more as in a declarative way. He then drifted off, listening to the music and went into interior experiences. This lasted for some five hours. Finally, he started to become aware of his present time, became agitated and tense and started to cry, and sadly said, "I want outside." He kept repeating this phrase which we took to mean that the expanded experience he had was receding and he did not want to go back into his isolated world. This was a very painful time for the staff as well and we didn't know how to help him stay alive. This was a unique experience for us in that Floyd had such an immediate response and was able to leave his psychotic defensive posturing and experience himself as a real living being.

During the next session, a month later, there was a similar reaction to the drug. After he started experiencing sensory changes he asked, "Is it real? Is the music real?" then incredulously stated, "We're real, are the feelings doing it?" He was told that having feelings made life real. He then repeatedly asked, "Is it real?" to which we gave affirmation. He then drifted off and started smacking his lips and making lots of movements with his tongue and lips. He said, "I am with Mommy, Daddy is here too, why don't you love me?" His speech then became incoherent and he remained in this state for two hours. Finally he desperately started crying and said, "I want out. I want outside. I want out of here. Please, please, help me open the door, help me, help me, I'm real, I'm Floyd and I'm real. My own little boy." He then looked at staff and said, "Give me some more, please give me some more." We asked more of what and he replied, "Pills. Just give me some more, I want to get out." Staff told him that essentially he had to make himself real, that the pills let him know that he was real but that the pills wouldn't do it, that he had to do it. Floyd finally settled down out of this agitation and became very pensive and very, very sad looking. He went to a window, looked out and quietly said to himself, "Fountain View State Hospital. What a funny place to come back to." Obviously this was incredibly touching and the staff were tearful. The empathy we felt for him was deep, as we all had had the same feeling after coming out of a profound experience back to our usual normative reality.

The next four sessions were very similar to each other and markedly different from the earlier two. These sessions were characterized by his regression to earlier experiences where he had been physically abused and threatened. He repeatedly called the phrases, "I'll be good from now on. I'm sorry. I promise,

don't hurt me, stop, stop, help me, help me." He frequently yelled, "Oh, oh, ouch, it hurts," and was physically trying to get away from being beaten. He would also have periods when he would attempt to strike out at the staff, smash himself against the wall and plead to be left alone. He was also very orally fixated and we gave him a baby bottle which he could suck, chew on and then violently fling away.

The seventh session was markedly different in that he did not appear to regress but rather stayed in contact with staff but became very belligerent, aggressive and sexually provocative. He would want to be cuddled by a female, rest his head on her breast and then make an aggressive biting gesture at her breast or suddenly start pounding her breast. He would also climb on a female, make undulating hip movements on her body and would attempt take his pants off. He would also approach a male, be sensual and want to be held and cuddled and then aggressively grab at the male's genitalia or scratch or bite his face. He would run around the room attempting to slap and punch everyone. He would growl and make guttural sounds, howl and become feral and aggressive.

The following three sessions were similar in many respects in that he acted out alternately oral aggression and his need to orally take in good things in the universe. At one time he took the author's fingers, sucked them, opened his mouth as wide as he could and attempted to swallow my hand. He put his hand on my elbow and pushed it in an attempt to eat my hand and arm. I said, "You are so empty you want to swallow me completely." His eyes became very wide and he vigorously nodded his head affirmatively acknowledging that's exactly what he wanted to do. He would also swing into seductive sexual behavior and alternate between being tender towards staff and then biting and trying to eat us. In subsequent sessions, he became obsessed with wanting to be taken to our homes. He would verbalize this precisely saying, "I am very unhappy here, I want to go to your home. I want you to take me to your house." Various staff would take him home after a session and he invariably was very calm, serene, extremely happy to be there and behaved admirably. He was affectionate, ate well, went to bed when told and evidenced none of his hyperactive, anxiety-ridden behavior. He also totally abandoned all preoccupation with bugs and stopped asking endless, meaningless questions.

After a number of these home visits a lot of Floyd's session time was spent in trying to convince staff to let him live with them permanently. He started to attend school and was also able to function well in that setting. He developed a positive relationship with his teacher and developed intense relationships with three of the treatment staff and wanted to dominate their time. However, when they were with other patients he did not become aggressive to the other patients as he had earlier but patiently waited his turn. It was very painful for

staff not to be able to meet all of his needs. He did start to relate to other children his age and had meaningful interaction with another boy his age but always preferred to be with the attending staff. His withdrawn, isolated behavior never reoccurred. He attended school and was well behaved on the ward, always looking out for staff to be with and to talk to.

Nancy

This eleven year old girl was the most difficult and challenging person we treated. When first introduced to me, she was in complete retraints twenty-four hours a day. She was in full camisole and her legs were tied to the bed. This was necessary due to her extreme self destructive behavior. If her hands were free, she would gouge out her eyes, hit herself in the head as hard as possible, bite her fingers, tear out her tongue. She was totally emaciated, covered with swellings and bruises, black eyes in sunken sockets. She was incontinent and refused to eat. She was IV fed, she looked like a beaten up, starved, wild, eighty year old woman. She made no eye contact, did not respond to any physical stimuli, attempted to make guttural noises and spit, but unsuccessfully, as she was so exhausted. The attending physician felt that she would probably die. All known drugs had been tried. It was frightening to treat her with LSD, as my concern was her extremely frail physical condition and that she might die during a session.

Nancy was to be our first patient to treat and the physician's attitude was essentially that she was going to die anyway so we may as well attempt LSD as nothing else was available. I was fearful that this would be our first and last LSD session. She was given 200 micrograms of LSD. The session was very long and tumultuous. After thirty minutes she started intense screaming. She briefly stopped, muttered very softly, "I'm sorry" and went back to screaming. She looked petrified, made rocking motions, furtively looking around as though she were trying to avoid being attacked. She began to verbalize "Gary, hold on tight, hold on tight, hold me." She would scream, "Mummy, ow, oh, hurt, oh." She would go in and out of contact with her surroundings. She remained extremely agitated and frightened, alternating vehement screaming with animal growling. After about seven hours of this violent behavior and screaming, out of exasperation and exhaustion I said to her, "How long are you going to scream?" She stopped flailing about, became very quiet and still, looked at me very directly in the eyes and said very quietly, "I am going to have to hurt for a very long time, so just leave me alone." She then proceeded to flail around, resuming her screaming.

In the following session she was markedly different. She developed a voracious appetite, was very talkative with the staff and required no restraints.

As she went by the dining room she stopped, looked in and said with amazement, "My God look at that, they're eating, that's nice." She then regally flourished her hand and said, "Let them eat." Later in the day she told one of the staff, "We went to see Dr. Fisher, Gary, didn't we? I had a camisole test. It was good." The next session, a week later, she was looking forward to the session, telling me in the early morning, "Let's get the test now." She was much more verbal and a great majority of the time was spent in regressing back to conflict with her grandfather. It was obvious she was reliving a sexual trauma, wailing and screaming, "No Grandpa, no, I can't stay like this. I can't do it, hurt Grandpa, hurt, bye Grandpa bye, I don't have to." She would moan and wail. She then began to attack herself and had to be restrained.

The following few sessions were characterized by extreme conflict over pleasure and pain, much of it sexual in nature. In her regressions she would evidence marked sensual/sexual pleasure, laughing, giggling and saying "Don't do it. Oh Honey, no fair. Oh Honey let go, let go. They will kill us. No more. Love me, love me." She would then alternate to fear and anguish, become agitated, start lashing out at herself. When physically held by staff she would bite, spit, claw and scratch at them. This alternation between indulgence and conflict went on hour after hour.

After five sessions, Nancy's ward behavior was totally different. She wanted lots of interaction with the treatment staff, became very demanding of attention and was jealous of other children getting attention. She became bossy, started ordering other children around and took on an "I'm in charge here" attitude. She wasn't hurtful to them, only making it clear that they were inferior and that she knew what was best for everyone. When another child was going to have a session, she would attempt to maneuver her way to the treatment room and when removed became verbally, but not physically, angry. When told one day that she couldn't have a "test" (her word for the session) whenever she wanted it, she said, "Oh, then let's talk. Let's go down to the visitor's room (where sessions were held) and talk." Once there she would lay down on the couch, close her eyes and tell us to be quiet. I went over, pulled her up and sat her in my usual chair and I lay down on the couch. She got quite indignant and told me, "You don't need help, I do. I want the test." She began evidencing behavior which indicated she considered having a session a privilege. She went on her best behavior when informed she was going to have the next session - helping other children, being polite and neat, smiling and being very charming. Prior to her seventh session one of the ward staff, Van, asked her what she was going to see during her next "test," she replied, "God and Van." He laughed and asked her how she could tell the difference. Very seriously she replied, "I'll show you. You'll be there and I'll show you." Van asked, "Where will that be?" She replied incredulously, "Why, in the visitor's room. That is

the only place you can see God."

During the next few sessions, Nancy's behavior became quiet, she was always wanting to be in physical contact with one of the staff and especially with one of the males. She would pet and stroke his arm, softly caress his face, smile and sing softly. She wanted to be cuddled and not interrupted in her pleasure. Coming out of the session was usually stressful, she would cry and occasionally revert to soft biting. When told she couldn't bite, she would lick and kiss.

After five months of treatment the focus became on her self-destructive behavior. It was felt that she was no longer psychotic and was using her hitting herself as a way of manipulating and controlling staff for whatever she happened to want at that moment. This was a sure way of getting attention, it was very clear that she wanted to be the sole focus of staff's love, attention and care. We decided that everytime she hit herself we would pinch her, step on her toes, and if we were outside, grab her and run her until she was exhausted. She was extremely indignant about this and gave up most of her self-destructive behavior. One day in a fit of pique she said, "Well I can't fool the A. M. staff anymore but I can still fool the P.M. staff." I looked at her directly and her mouth dropped open as in, "Oh, oh, I shouldn't have given that one away." That evening I met with the P.M. staff, made Nancy sit in the meeting, told them what she had said and clearly outlined how they all had to behave, just like the A.M. staff. She looked daggers at me but she knew that she had been nailed. She then took to placing small pieces of paper on her hands, telling us that the paper prevented her from hitting herself. When we saw her with a piece of paper we would go over and knock it out of her hand and dare her with our stares, to do anything about it. She would often mutter, "God damn" and either pick the paper up or walk away. She then gave up the paper and started to carry kleenex around with her. When we would see this kleenex she would say, "Oh, I've got a cough" or "My nose is running and I need it," we would just look at her and mutter, "oh yea, I bet" and look at her with a message "How dumb do you think I am?" Soon she gave up the Kleenex routine.

The staffperson who was primarily working with Nancy left at the end of the fifth month and she was badly shaken by his departure. Her response was amazingly mature, she became depressed, sad and mournful and cried a great deal. She did not act out against herself or others. Another male student from the treatment staff, whom she knew well, took his place and she was grateful for his attention. She would become frustrated at her lack of sufficient language in trying to describe her feelings to him. Sometimes she just held him and sobbed about her loss.

She began to attend school on half days and was able to adjust to the setting. It was hard for her to share adult attention and other children her age did not have her sophistication. She was very bright and didn't miss a thing. She had become affectionate and warm, loved to be physically touched, and smiled happily a great deal of the time. She had given up her self-destructive behavior and wanted to identify with the treatment staff and to be included in the grown-up world. Unfortunately she was often bored because there was a gross lack of stimulation available for her in the ward setting.

Jeannie

Jeannie was a girl who, when initially seen, lived in a totally encapsulated world. Her behavior consisted of hyperactive twirling, yelling a meaningless "word-salad," screaming, and violent attacks towards anyone who came within her personal space. She would work herself up into such manic frenzy that she would collapse in physical exhaustion. During her treatment course with psychedelic therapy Jeannie experienced a number of transcendental phenomena which established the core recovery from her psychosis.

In spite of being blind, burdened with congenital dislocation of hips and knees and raised by a completely psychotic mother, this girl overcame horrendous madness in a devastatingly sterile and chaotic environment of a state hospital ward, to become one of the most tender, loving, compassionate and courageous persons the author has ever known. If Jeannie had had the opportunity to continue her sessions in a benign, safe and nurturing environment, she would have become a functionally superior human being. Our experience with this one girl was all the proof that was needed to attest to the dramatic usefulness of psychedelic drugs in treating the most seemingly intractable psychotic states.

It is most noteworthy to report that at least four of the children had identifiable transcendental experiences and were capable of communicating such experiences to us. It may be that some of the other children had similar experiences but were unable to communicate to us. However, given the age and degree of psychopathology of these children we were amazed that these spiritual experiences occurred.

The Work Ends

Our work was cut short by the political climate that developed after LSD hit the streets. Our project was closed down very quickly in mid 1963 and the staff

associated with the project soon left. The abandonment of these children was an extremely painful experience for all of us. We were very surprised and touched with how supportive and acccepting the children were of our departure when we said our good-byes. A follow-up was attempted ten years later but proved to be futile. The administration of the hospital was extremely agitated that the media would learn that LSD therapy was done there in the early sixties, as in the early seventies the political landscape around LSD was still very volatile.

To separate out the contribution of the drugs from our intense, devoted and caring commitment to these children was not an issue with which we struggled, although it was an issue often raised by other professionals. The author had worked for over four years with psychotic children in these same settings without drugs with very minimal success. The psychiatric technicians on staff had worked with these same children for many years, again without any significant results. It is only through personal experience with these compounds does one appreciate the potential they offer. However, a strong cautionary word is offered. These materials are so potent that a person interested in using them must have very clear his intention and needs to have guides attend him who are experienced travelers in the realms of consciousness that are unfolded and revealed. We used to say that the most important ingredient in LSD was the person taking it. The second most important ingredient is the guide who sits with that person.

One issue that is generally not addressed in the literature is the vulnerability the psychedelic therapist feels which is inherent in this work. Often included in the expanded state of awareness achieved by the drug-taker is intimate knowledge of the therapist and his state of grace - or lack thereof. The therapist cannot hide from being "seen." Experienced therapists know this well (and hence the emergence of counter-transference) and one's vulnerability is total when sitting with a psychedelic voyager. We had not anticipated this phenomenon to occur with these children as they all appeared to be so disturbed and out of contact with "reality." We were amazed when, in sessions, they would tease us by mimicking us, sorely hitting our most vulnerable and protected spots. Happily, this was done with compassion, humor and acceptance, but nevertheless we got the message. Our humanity and humility were often tested and we were stunned by the children's perceptiveness and their ability to embrace us in our shame - we had so much and they had so little.

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