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Memorandum to

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From

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Re LSD IN A COERCIVE MILIEU THERAPY PROGRAM.

The enclosed copy is subject to publication in C.P.A.'s Journal.

Could we have your approval as well as comments.

L. A. Moricz, B.A., M.H.A.
Administrator.

LAM:PH
Encl.

c.c. Dr. E. T. Barker
Mrs. P. Buck.

Form 86 — A5

LSD IN A COERCIVE MILIEU

THERAPY PROGRAM

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INTRODUCTION

Over a four year period thirty patients in a maximum security mental hospital were treated with LSD (500 mcmg. I.M.) to obtain some idea of the usefulness of this drug relative to Sodium Amytal, Methedrine, Scopolamine, and Dextro-Amphetamine Imipramine[1] as already in use in the hospital as so-called defence disrupting drugs. (Reference 1). In addition, we wished to obtain some idea of the comparative usefulness of LSD in the treatment of what could loosely be called psychopaths and schizophrenics, the two diagnostic categories we are treating.

Since the administration of the drug formed an integral part of a coercive milieu therapy program, it is necessary to describe briefly the context of its administration in a maximum security mental hospital. The development and precise nature of the program has been dealt with at length elsewhere. (References 2 to 5).

THE OVERALL TREATMENT PROGRAM

Since 1965, we have been developing intensive patient-run programs of milieu therapy in the Oak Ridge Division of the Mental Health Centre at Penetanguishene, Ontario. From a beginning on one ward, these programs now involve four of the eight 38-bed wards in this maximum security hospital, which accepts patients from the entire province in three main streams. First, the Courts send persons found not guilty by reason of insanity, and unfit to stand trial. Second, reformatories and penitentiaries send inmates thought to need intensive psychiatric care not presently available to them in their own institutions. And finally, other provincial psychiatric facilities send patients whose aggressive or destructive behavior cannot be adequately managed in more open settings.

Oak Ridge was built like a traditional prison, with individual barred rooms ranging down long, heavily-gated corridors. Patients involved in our milieu therapy programs are usually under thirty, not mentally defective, and do not as a rule suffer from manifest personality disorganization. Many have killed, raped or assaulted. For most patients, the duration of their stay is measured in years.

[1] Dexamyl-Tofranil

From its beginning in 1965, the first milieu therapy ward had by 1967 developed a program of patient-organized groups which ran for over one hundred hours each week. The philosophy of the program hinged on the principles that mental illness could functionally be viewed as a problem in meaningful interpersonal communications, and that the psychiatric and legal condition of our patients was such that intensive treatment measures were necessary to assist in sufficient recovery for safe release to society. It was a major objective of the program to make the most complete possible exploration and discussion of intra- and inter-personal events. This need to expose publicly the innermost thoughts and feelings of the patients led first to the long hours of structured program, then to the abandonment of tranquillizing drugs, and finally the use of drugs calculated to disclose rather than stifle unconscious or otherwise hidden conflict.

Thus, in early 1966 we frequently gave Amytal Methedrine interviews: by fall of 1966, combinations of Methedrine and Scopolamine were in regular use for psychopaths, and later a combination of Dexamyl and Tofranil for latent schizophrenics. In early 1967 the Federal Food and Drug Administration granted permission to purchase LSD for clinical use.

By this time, an elaborate system of patient observers had evolved out of the need to deal with the increased risks of homicide and suicide that accompanied the program. Since segregation from his peers, or tranquillizing medication seemed counterproductive, the challenge was to guarantee the safety of patients while maintaining the full depth of their involvement in the community. We achieved this by using lockable canvas straps joining by the wrist a patient judged to be dangerous to himself or others, to another patient who was not at that time so defined by his fellow patients and staff. (Reference 6).

ADMINISTRATION OF THE DRUG

LSD was administered only to patients who expressed high personal motivation to receive it, and for whom, in the opinion of the treatment staff and the patient's peers, other methods of treatment were unlikely to be successful in expediting the patient's release from hospital. The

prospective subject was obligated to obtain the informed written consent of his next of kin. Usual dosage was 500 mcmg. injected intramuscularly. On occasion we found that intravenous injection of 15 to 30 mg. of Methedrine two to six hours after the LSD helped the subject to talk more freely.

All sessions were videotaped for the first four to ten hours. Other patients and staff were able to follow a session in progress from closed-circuit television monitors. The subject was fully aware of, and in agreement with these observation arrangements. After the conclusion of the session, the subject was placed under 24 hour observation by his peers, and not left alone until he was judged not to be a risk to himself or others - usually a period of three to four days.

Our interviewing procedure underwent several transformations, stimulated by our increasing awareness of the vulnerability of the subject to the biases imposed by the interviewer.

1. Medical Model The patient lay on a standard hospital bed and was interviewed by a group comprising the male psychiatrist, a female nurse, and the patient's best patient friend. Attempts were made to evoke responses from the subject by providing a variety of stimuli - family photographs, a mirror, father and mother figures, etc. We believed that on seeing the videotape records of the session a day or two later, the subject would be able to recall and discuss the feelings evoked by these stimuli.

Since many of the patients had killed or been violent prior to their admission, security concerns shared by staff and patients alike, led to the use of restraints. After administering the drug without serious difficulty to five patients who had killed and three patients who had been sexually assaultive, our anxiety decreased enough to discontinue the use of restraints. After twelve sessions conducted along this medical model, we seriously questioned whether or not the approach itself determined the course and nature of the patient's experience. Discussions with persons who claimed extensive use of LSD "on the street" suggested that the use of different procedures would influence the subject's experience in quite a different direction. We therefore experimented breifly with what may be called "The Responsible Street Model".

2. Responsible Street Model The hospital bed was abandoned in favour of mattresses and cushions on the floor, and the room was liberally furnished with flowers, incense, and bright pictures. A record player with a large supply of popular "acid" music was used almost continuously. It was very surprising to find that vomiting could be terminated by encouraging the patient to "go with the music", usually a particular song - the Beatles' "All You Need Is Love". After only three sessions with this model, however, it was apparent to those of us with medical orientation, the great extent to which this interviewing procedure was influencing the subject's responses. Where in the medical model the subject was led through an underworld of father and mother figures, death, guilt, violence and insecurity, here the subject was wandering through a usually pleasant but apparently equally imposed rose garden of pretty colors, fascinating sounds, and cosmic sentiments. We then turned to the final procedure, which was designed in an effort to minimize the influence of others on the subject's experience.

3. The Non-Directive Model By mid 1968 we had developed the Total Encounter Capsule at the hospital in an attempt to provide a small quiet setting where highly specialized types of programs could be carried out. (Reference 7) The "Capsule" is a specially constructed, sound proof, windowless but continuously lighted and ventilated room, eight feet by ten feet, which provides the basic essentials - liquid food dispensers, washing and toilet facilities - and in which it is possible for a small group of volunteer patients to live for many days at a time, totally removed from contact with the outside. It is equipped with closed-circuit television and monitored around the clock by paid patient observers (an Industrial Therapy assignment) whose responsibility is to continuously follow the activities of the patients in the Capsule, to maintain the food supply, to keep a written record of what is going on, to videotape significant events, and to intervene if there is a serious risk of violence - an exceedingly rare occurrence.

In an attempt to remove as much as possible the input of "helpers" during the LSD session, we developed the following procedure. The subject would spend forty-eight hours in the "Capsule" with the

patient friend of his choice prior to injection of the LSD. During this time the subject's main task was to review with his friend those aspects of his personality which he himself felt were most troublesome, least understood by him, and which he was hoping to gain some insight into with the drug. When the pair had become comfortable and settled in this different environment, the LSD was administered and videotape recording commenced. The subject's friend was instructed to offer no direction and to attempt no interpretation of any sort, but simply to "be with", and attend to his friend as empathically as possible. Frequently, but not always, patients chose a friend who had previously taken LSD in the hospital to be with them during their experience. During the following day, the recordings would be played back to the two patients who were encouraged to discuss them with one another. They usually left the "Capsule" some two or three days after the administration of the LSD.

RESULTS

While it is true that eighty per cent of the patients treated with LSD are no longer in Oak Ridge, few of the staff or patients of the hospital are of the opinion that the LSD had much, if anything, to do with their release. All the patients who received the drug felt that the experience was exceedingly beneficial and that they had obtained important insights into themselves. Other patients and staff could not see this subjectively reported benefit translated into an improved mental state or behavior. Conversely, no one appeared to get "worse".

"Chromosomal studies were undertaken on each of the patients in the LSD group as well as eighteen other of their peers on the ward who did not receive the drug. "Blind" analysis on both groups showed that the LSD group had an increased frequency of breaks (7.4%) with individual maximums varying from 0.0% to 17.3%. The control group showed an average of 4.05% breaks with a range of 0.0% to a high of 5.7%. The latter frequency is similar to that routinely encountered in the cytogenetics laboratory. These findings are comparable to and complement other published studies and while the biological significance of the breaks in cultured cells from LSD users is not known, it is unlikely that the chromosomal "damage"

produced by the drug will result in somatic malformations." (Reference 8)

Through informal contact with released patients, it is known that 25% (6 of 24) of the patients who received LSD in the hospital experimented with its use on the street after release. Given that one of our criteria for selection of subjects in hospital was their high motivation to receive the drug, and understanding the particular patients involved with usage later, and the nature of that usage, it is the author's opinion that the administration of the drug in the hospital was not a major factor leading to the patient's subsequent usage on the street.

Aggressive behavior occurred with each of the three "interview techniques" - a total of six patients grabbing, punching or kicking at someone near him. There was not always a clear understanding of the meaning of this behavior either at the time, or subsequently, by either the subject or those with him. All of the patients who acted out under the influence of the drug fell into the loose category of pathological personality.

LSD, perhaps because it is used less frequently, but more likely because of its inherently fascinating effects, provides an event of considerable significance for the individual patient to look forward to and back upon. In long-term treatment programs this effect is of value in itself, in the same way as has been found for other defence disrupting drugs used in this hospital.

CONCLUSIONS

Using LSD in the manner described above we found no particular difference in its effects upon patients diagnosed as schizophrenic compared to patients diagnosed as psychopathic with the exception of a propensity to acting out by the latter category.

Compared to the other so called defence disrupting drugs used in this hospital we would conclude that LSD is equally safe, but provides a more intense individual experience than the others.

Our experience with this drug indicates the great degree to which the content of the experience can be influenced by the interviewing procedure and the biases of the interviewer.

SUMMARY

Over a four year period thirty patients in a maximum security mental hospital were treated with LSD (500 mcmg. I.M.). Since the use of this drug is only one facet of a complex intensive coercive milieu therapy program, an overview of the total program is given.

Three different styles of interviewing procedure evolved with experience: a medical model, a "responsible street model", and a non-directive model. The interviewer's orientation appeared to significantly affect the patient's perception of the LSD experience. Since it was not felt by the author that any one set of biased inputs has any demonstrable merit over any other, (except in satisfying the interviewer), the non-directive model was deemed most reasonable.

Although all patients reported that the experience was of great benefit, no one else could see changes for better - or worse. Chromosomal studies showed the usual increased frequency of breaks. It is noted that cytogenetic experts do not now see this finding as a contraindication to the use of the drug. It was not thought that the LSD administration in hospital was a significant factor leading to use of street drugs after release. The only difference noted on administration to psychopaths and schizophrenics was that one third of the psychopaths (6 of 18) acted out by punching or kicking at someone near.

When used with the safeguards described, the drug seemed safe and valuable to use in our communities of long stay patients, because of the high morale engendered.

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