THE PSYCHOLYTIC TREATMENT OF A CHILDHOOD SCHIZOPHRENIC GIRL

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INTRODUCTION

THIS paper is a description of a psychotic child's experiences with psychedelic drugs and some judgments as to what these experiences were about. We believe that there was considerable value in utilizing these psychedelic drugs in the psychotherapeutic treatment of this child who was schizophrenic. Our position is not one of simple broad endorsement of LSD and other psychedelics in the treatment of children grouped in this classification. If there is anything to be learned from this treatment attempt it is that little of what may be called health or growth can occur without intimate and honest relationships between people. The drugs were, however, in our judgment, of extreme importance in making the psychotherapeutic experience.

The hypothesis used in the research and treatment program involving Jeannie and eleven other children diagnosed as childhood schizophrenics is that psychosis is a massive defensive system of repression-avoidance-denial in the service of protecting the individual from experiencing his feelings. The experiences which have aroused such painful and frightening feelings are repressed and the feelings denied existence. The tendency to deny and to defend generalizes to more and more stimuli such that a great part of all experience is either denied or misinterpreted to fit delusional explanations of experiences. The individual exists isolated in a world of no feeling and meaninglessness and this renders him unable to meet social expectations and to relate with other people. The individual has committed psychological suicide—he lives but in the solution of massive retreat he has virtually died.

The rationale behind the use of psychedelic agents with psychotic children was that these drugs have the capacity to activate or chemically energize various areas of the brain to an extreme degree resulting in vivid experiencing in the area of perception, emotion, memory and feeling. In addition, these agents seem to inhibit the higher brain centers which are considered responsible for such functions as inhibition, intellectual abstractions and cognition. The psychedelic drugs tend to release experiences of phenomena normally repressed or denied or not considered essential in meeting the demands of one's own and others' egos. Experiences and feelings ordinarily denied awareness receive proportionately more energy causing them to break into a state of consciousness which is less strongly dominated by the usual defenses and values which one has developed. Without the usual complicated defensive structures and censures, the individual is able to re-experience himself in a far less distorted way and to re-evaluate the worthiness of his essential self.

The Setting

The present case is a report of one of twelve autistic and schizophrenic children who were experimentally treated with lysergic acid diethylamide and psilocybin in a research study which began in early 1962 and terminated in mid-1963. The setting was a large state institution for the mentally retarded and the

population included many severely emotionally disturbed children. All the children in the study were on one ward, a ward which housed some sixty acutely psychotic and behavior problem children and young adolescents. All the children were management problems and the atmosphere of the ward could be described as constant pandemonium. There were all the usual problems of a large state institution—inadequate staff, high staff turnover, overcrowding, insufficient clothing and laundry problems, constant and inadequate physical repairs and the constant need of medical attention because of the hyperactive, destructive and assaultive nature of the children. The ward was bleak and barren as it was impossible to maintain any furnishings due to the wanton destructiveness. As well as the hyperactive, screaming, assaultive, feces-smearing children, there were of course the severely withdrawn, totally autistic children who seldom moved and who lay dotted throughout the ward. An atmosphere little conducive to stimulating mental health.

The Treatment Team and Approach

The writer acted as the head of the treatment team and the ward psychiatrist was the responsible physician. Since none of the staff had any previous experience with psycholytic treatment, the first phase of the program was to train the staff. This consisted of having them become familiar with the then-available literature, having extensive group discussions on the nature and philosophy of the psychedelic experience and then having one (and on occasion, two) psychedelic treatment session themselves. This session was followed up by both individual and group meetings. Consequently there developed a team of co-therapists who worked together closely, intimately, and with amazingly little friction. The team consisted of one nurse, three nurses' aides, and four graduate students in psychology. A detailed account of the development of the treatment approach cannot be given here. However, at the time of the study we had no prior knowledge of effective techniques to utilize with this patient population and consequently we tried various techniques. In our initial sessions we utilized techniques which had proven successful with alcoholics (e.g., Chevelos and Blewett, 1959) but soon discovered that we had to become much more active in the treatment, utilizing interpretation, role playing, and very directive measures. Because the treatment sessions were often excessively long (some lasting to fifteen hours) and often physically arduous and exhausting, we utilized multiple therapists. About midway in the research program we decided to intensely treat the six most responsive of the patients and one team member was assigned as responsible therapist for that child, being assisted by other staff members in the actual treatment sessions. In some very difficult sessions, we would "go through" (or wear out) all six or seven of the treatment team members.

The Patient

The patient is a twelve year old girl who was diagnosed as a childhood schizophrenic. She was born prematurely after a seven month pregnancy. Birth weight was two pounds, thirteen ounces. Retrolental fibroplasia was diagnosed early as was a congenital dislocation of the hips and knees and a congenital heart murmur. Her early development was slow—she held her head up and sat alone at six months and walked at four years. Single words were spoken at nine months but shortly after this time she discontinued speech until four years. At age three she broke her collar bone and at age five she suffered a head injury from a fall down a flight of stairs. At age five she was hospitalized for a

"nervous breakdown," the record showing no details of this episode. From age five on she was taken to several hospitals, institutions and clinics and was given a variety of diagnoses including CNS pathology, childhood schizophrenia, mental retardation, severe emotional disturbance and severe brain injury from birth. Her behavior from age six, as described by these various diagnostic centers, was characterized as being bizarre, grossly regressive, retarded, hyperactive, assaultive, erratic and destructive. She never attended school because of her severe disturbance although special classes were attempted unsuccessfully at age seven.

She was evaluated for state institutionalization at age ten and was described as indulging in loud screaming, wild jumping about, impersonating a baby through a doll she carried and involving herself in a hectic interplay of scolding with the doll. The intake worker described the patient as reaching a state of physical exhaustion caused by her constant hyperactivity. It was not possible to obtain the patient's cooperation on any examination or testing procedures. She was admitted to the institution seven months later, at age eleven.

Jeannie's mother had her first psychotic episode eight years prior to Jeannie's birth, and presumably following her husband's accidental death. She has had several miscarriages and only two successful deliveries, the patient and a boy who was born when Jeannie was five years old (the age at which she was hospitalized for a nervous breakdown). The brother died at age three years due to strangulation following an acute bronchial disorder. The mother has had several hospitalizations for paranoid schizophrenia since Jeannie's birth and has had extensive somatic treatments (ECT and IST). The father is a career Army officer and reportedly seen as a stable individual.

Hospital treatment for Jeannie had consisted of a number of drugs and a series of ten ECT treatments, none of which had resulted in any improvement.

When Jeannie was seen for evaluation for psycholytic treatment, she was acutely psychotic and had virtually no contact with anyone. She was a rather large girl for her twelve years, quite blind, apparently only able to see very little when she held an object within a couple of inches of one eye. When she moved, she bounded, with a pronounced lurch and limp and it was amazing she had as few falls and crashes as she did. Her hair was rather long, oily and stringy and her skin was covered with severe acne. She always appeared dishevelled and was quite an ugly sight. Her typical day was spent sitting in a corner of the ward with two major activities, one was protecting herself from the assaults of other children and the second was twirling bits of paper in her long fingers, constantly rocking herself, masturbating, and talking word-salad almost incessantly. When other children would come within range she somehow detected them and swung out with her arm to hopefully knock them flying. If a child would be too persistent in his attack, she would resort to screaming belligerently and make some greater effort to locate him and physically assault him. At times she had a transistor radio which she held right against her ear. However, the radio never functioned too often. She apparently was having hallucinatory experiences, mostly auditory although it was difficult to specify the girl's experiences. She repeatedly talked of riddles and her phrases were often meaningless—when spoken to she would often repeat the last few words of the examiner or else ignore him. On one occasion she said that Tide means "to live," Fels Naptha means "to die" and Blue Cheer means "sick." She often was seen to shout at unseen persons and become distressed by them. She often used a number of pitches in her voice in order to carry on conversations among a number of people although these conversations lacked continuity or meaning. She was able to feed herself, toilet herself and dress herself.

PSYCHEDELIC TREATMENT REGIMEN

Treatment No.	*Date*	*Days between Sessions*	*Drugs Utilized*
1	7-24-62		100 mcg. LSD
2	10-2-62	70	100 mcg. LSD
3	10-16-62	14	200 mcg. LSD
4	11-14-62	28	10 mg. Librium 5 mg. Methedrine; 10 mg. Psilocybin; 200 mcg. LSD
5	12-3-62	18	10 mg. Librium; 5 mg. Methedrine 300 mcg. LSD
6	1-7-63	35	200 mcg. LSD
7	1-21-63	14	300 mcg. LSD
8	2-4-63	14	10 mg. Psilocybin
9	2-18-63	14	30 mg. Psilocybin
10	3-4-63	14	200 mcg. LSD
11	3-11-63	7	200 mcg. LSD
12	3-18-63	7	50 mcg. LSD
13	4-12-63	24	200 mcg. LSD
14	5-13-63	31	10 mg. Librium; 200 mcg. LSD
15	5-22-63	9	25 mg. Librium; 200 mcg. LSD
16	6-24-63	33	200 mcg. LSD

EXCERPTS FROM SESSION NUMBER ONE

(J is patient; F is male therapist; S is female therapist.)

9.30 a.m.: Drug administered.

9.50 a.m.: Drug appears to have taken effect. J is becoming giddy, silly and hyperactive; talks about the Scribble Head Riddle. J asks with profound seriousness, 'How can you make me talk better?" Starts laughing, bounces on couch with great vigor; begins to hold her fingers close to her eyes, move her fingers and laugh and smile at her finger movements. Is becoming very hyperactive and finally yells, "Hold me, hold me," to which F responds by holding her very tightly.

10.20 a.m.: J is pinching and scratching F; F responds by returning the same treatment and J becomes very angry. J says, "My finger nails like you."

10.30 a.m.: J hyperactive and aggressive; F attempts to quietly hold her, reassures her and suggests that she relax and listen to the music. J continues to struggle and F is persistent in his attempting to quiet and soothe J, telling her repeatedly to lie down, relax and listen to the music. J finally gives up her bodily struggles, lies back and softly begins to sob. Her crying becomes more intense. While crying deeply she says, "I'm very sad; I want to go home." Her crying eases somewhat and she holds F and asks with intense feeling, "Why do you make me like this?" She again begins to sob and cry and is full of tremendous anguish and sorrow. She repeats, over and over again, "Leave me

alone; leave me alone; leave me alone." This crying anguish with these words interspersed frequently, lasts for about one hour. She is emotionally exhausted.

11.30 a.m.: S enters room and J says, "Mommy," and then says therapist's name. J reaches out to S, holds her and sobs incessantly. She cries, "I'm afraid —I can't see. I'm afraid—I can't see." When J becomes extremely agitated she releases S and goes into a fetal position. This quietens her and she then returns to holding S and crying.

12.15 a.m.: Beginning to moan but appears more relaxed and less desperate. Begins to say, "Scribble Head Riddle." Begins to relax and rest although still crying, but softly.

12.30 p.m.: Beginning to move around again; some gentle pinching; moaning and groaning; says, "I don't feel good."

1.00 p.m.: Becoming much more agitated; begins to yell—no content, just yelling. Now crying in an aggressive manner. This starts a new sequence; she is becoming excited and angry; starts to scratch T's and after she has done so, bites her own hand; lies on her side and begins her first rocking movements; her speech now becoming disorganized and deteriorative; grabs towel and starts to stuff it into her mouth; rocks vigorously with towel stuffed in her mouth. She now gets up and moves about room; finds some food and gobbles it down; starts picking up any item and attempts to eat it; she demands food which we give her; eats voraciously. Gradually relaxes after eating. F sits with her and holds her quietly. F asks, "Why did you cry, J?" to which she replied, "Because my poor little mother made me."

Evaluation of Session No. 1

Attempts to prepare the patient for the experience were probably of no benefit as it was impossible to get her attention in any sustained way or to establish any communication. The first indication that she was having any reaction was an increase in motor and verbal behavior. She bounced around the couch, giggled and laughed, and appeared to be delighted and excited with perceptual changes. Her first words were, "How can you make me talk better?" This is the question to which J has returned so many times and the eventual understanding of its meaning has helped us a great deal in understanding her psychotic process. It appears that for J talking and thinking are one and the same, and she thinks if she could only organize her speech in a satisfactory, coherent or better way, she could then think coherently and thereby control the confusions she experiences. This is one reason why she is constantly talking and trying to master by voice imitation such significant persons or images as the baby, the child, the mother and the father; for it is these figures which cause her painful feelings. It is through organized speech and therefore organized thinking that J hopes she can understand and control her impulsive chaotic feelings. And it is her thinking that is a defense against these feelings which she cannot accept.

J's excitement with her new perceptual experiences progressively increased and she cried out, "Hold me, hold me," expressing her desire for physical contact and probably control over these new sensations. After an hour or so she became anxious, her movements and gestures became exaggerated with a restless driven quality and quickly mounted to hyperactive behavior. Later she scratched the therapists. J's hyperactive behavior was a result of a preconscious awareness of overwhelming anger. Her hyperactive behavior served as a way of

shaking her attention and deterring threatening wishes from becoming manifest and at the same time allowed her to release this tension in a less incriminating way. In later sessions J frequently expressed herself with hyperactive behavior and we were later able to confirm this as being both a defense against, and a release of, her aggressive feelings.

J was encouraged to lie down and listen to the music. She quieted down and began to cry with great anguish. She said, "I'm very sad; I want to go home." Her crying and grief continued periodically for more than four hours and the depth and the honesty of her self pity and anguish surpassed all our expectations for we did not anticipate that J would experience feelings so profoundly. She began referring to her mother and it appeared that she was re-encountering and struggling with this relationship. She asked F sobbingly, "Why do you make me like this?" and later cried out repeatedly, "Leave me alone, leave me alone." These sentences appeared not to refer to F but to her mother and communicated to us J's great burden of her mother—both the guilt she felt over her rage toward her mother and her desire that her mother release her. At these times, J's social conscience arose more powerfully than we would have guessed and engulfed her hostility causing her this experience of intense guilt and self pity. When the emotionality became exhausting, she assumed the fetal position and became quiet.

Later in the afternoon as the power of the drug receded, she again became hyperactive, scratched the therapists and then turned her aggression inwards and bit her own hand. Her speech regressed and deteriorated and she indulged intensively in oral activity. She stuffed a towel into her mouth and at other times tried to eat nearly everything in sight. This oral regressive behavior was interpreted as an attempt to do something about her tremendously unfulfilled oral needs. In the days following the session, some attempts were made to have J communicate about her experiences. The day following the session J told us that in her session she had visited the real Scribble Head Riddle and that the Scribble Head Riddle hated her mother and loved her father. Further, she said that the Scribble Head Riddle's mother was dead and then asked, "Is my mother dead?"

When asked where she had gone, she replied, "Into the dark." When asked if it was all dark, she said, "No, it was light too. The Scribble Head Riddle likes the light." She was able to discuss, with some appropriateness, parts of her session where she had laughed or cried and was able to be minimally reflective about those experiences. One week later she appeared to be better, the rocking movement which was almost constant had ceased. She seemed very anxious to talk but started to talk word-salad and "nonsense." When told that the therapist wanted to talk to her but would only talk about sensible things, she immediately stopped and asked, "What's sensible." When asked what she thought was sensible she began to name concrete items and topics. She then tried to make comments about items or topics. She asked what the word "relation" meant and then attempted to verbally categorize and specify relationships between items. Her speech and affect were noticeably improved and she demonstrated such a serious attempt to be sensible. She gave up her word-salad barrage and her constant reference to the Scribble Head Riddle. She very much wanted the contact with the therapist and was quite anxious to learn how to relate and talk to him.

EXCERPTS FROM SESSION NUMBER TWO

9.00 a.m.: Drug administered.

9.30 a.m.: J: "Will I lose my voice? Will my voice go away? I want my voice!" J is rolling around on couch, fairly agitated. She was assured she could keep her voice if she wanted to.

9.40 a.m.: "I feel retarded." J herself and the rest of us laugh as the tone was humorous. J: "I want a peanut butter sandwich." (Such sandwiches are the big treat on the ward.) J takes F's hand, holds it, feels it thoroughly and then says, "Your hand feels retarded." Again J and staff laugh. She seems to be in a sophisticated humorous mood.

9.50 a.m.: J starts mimicing other patients' symptoms, including stereotypic and repetitive speech, hand movements, gesturing, posturing, etc. She does this in a rather light hearted, laughing and humorous manner, identifying the patients she is mimicing. (We are surprised that she knows all this as we had assumed she was too blind to see such phenomena and too withdrawn to observe or be interested in them.)

10.00 a.m.: J begins to kiss her own hands. This activity increases to kissing her arms. She appears to be becoming agitated. F asks, "What's happening, J?" to which she yells back, "Nothing!" She now begins to cry and as she becomes more sad, she starts kissing herself more frantically and as she kisses herself more, she sobs louder and deeper. She then starts moaning, "I'm a girl, I'm a girl." J begins to rub her face, mouth and head. She then holds her mouth open as wide as it will go and starts jamming her hands into her mouth—throughout all this activity she cries with great anguish and depth. She uses great force in getting her hands inside her mouth and staff is afraid she will injure herself. Female therapist (S) takes J into her arms and J clutches onto S and cries intensely. With great grief J cries, "I didn't do anything." F: "What did Mamma do?" J: "She left me." F: "Was it your fault she left you?" J yells, "Love, love love, love." F: "What was it you put into your mouth?" J: "Nothing, nothing." F: "What did you want?" J: "Food, food." F: "No one fed you." J: "I want to feed myself now." F: "Jeannie, you were never fed. Mamma never fed you. Now you want to gobble up the whole world. You're mad because you never got what you wanted." J yells, "No, no," and wildly lurches out to strike at F. After striking him, she looks shocked and says, "I'm sorry, I'm sorry," and strokes him. She then says, "I know," and F asks, "What?" and J replies, "Oh, ice cream bars, and everything." She then begins to cry again and her crying is full of anger, self pity and anguish.

11.00 a.m.: J seems quite distressed in a diffuse, agitated manner. F: "Why are you so unhappy?" J: "I'm not unhappy. I'm happy." F: "No, you're not happy. What happens when you don't like yourself?" J: "You die!" (with emphasis.) F: "Do you like it that way?" J: "No." F: "What can you do about it?" J: "Stay alive." F: "How can you come alive?" J: "I don't know. I don't know." At this point she returns to stuffing her hands into her mouth, pulling and probing, begins to cry. F: "What would you like to be?" J: "A boy and a girl." F: "Then what?" J: "Be sick." F: "Do people love you more when you're sick?" J: "Yeah, yeah." Again many minutes of wailing and crying. J: "Boy, boy, boy." F: "Who wanted a boy?" J: Yells, "Nobody!" F: "Did they want a boy?" J: "Boy, boy, I'm a boy, I'm a boy. I want to be a boy." Now she becomes extremely agitated, starts lunching and screaming, "No, no." She continues this extreme agitation and yells, "I'm a girl, Mommy, I'm a girl. No, I'm a boy, I'm a boy. Mommy, mommy. I'm a girl, Mommy. No, no, mommy, I'm a boy." This repetitious material continues for some time. The therapists attempt to intervene and have J accept her mother's rejection of her. This appears to increase her agitation. She begins to become disorganized and her psychotic defenses begin to appear. She begins calling out ward numbers, begins to bang her fist on the wall, and stuff her hands into her mouth.

12.30 p.m.: Patient is yelling and screaming. It is difficult to understand what she is saying. She laughs loudly and falsely. She attempts to cry but can't make it. She calls out, "Scribble Head Riddle, Scribble Head Riddle, I want to feel funny."

1.00 p.m.: Suddenly she stands up, throws her fist into the air and screams with anger, "Oh, I'll kill you, mother." F: "You want to kill mother." J: "No, no, no, I *love* my mother," and as she says this she smashes the wall fiercely with her fist. She then goes into a flurry of mumbling and ward naming which continues for some time. She is very agitated. After this, she begins to growl like an angry animal. She screams, "I want to stay alive." F: "Did you kill your mommy?" J: "I killed my mommy. The Scribble Head Riddle killed my mommy. Ward 33 killed my mommy. I'm 12 and I'm a ward. I want to kill ward 18. Ward 31 is God. Ward 14 is the Devil. I'm going to kill Ward 18's parents, and Ward 17's parents. Oh, I love Ward 3. I'm going to kill Ward 11's mother." She then became very quiet and very soft and says, "Ward 31 is God. I hate Ward 31. I love Ward 31. It's the Riddle, It's the Riddle." She then goes into a frenzy of activity and this continues for two and one-half hours. Finally she is becoming exhausted, as are the therapists—and 50 mg. of thorazine is administered IM which begins to quieten her. She rambles on incoherently for another hour, is fed, and put to bed and she goes to sleep.

Evaluation of Session No. 2

J was apprehensive at the beginning of the session and expressed serious concern over the possibility that LSD would change her voice or take it away entirely. This statement refers not only to her anxiety over losing her speech-thinking defense mechanisms, but also suggests that she was afraid of losing her only means of relating with others, for loss of speech to J also means total isolation.

We were rather amazed to see J's sense of humor—she was able to feel and relate in a very human way in the beginning of the hour and it was quite startling to observe this. The bulk of the session was devoted to her conflict over being a girl and being rejected by her mother. She began to experience her rage against her mother but had tremendous difficulty in admitting to that rage. When she would begin to deny her rage she would immediately start indulging in her psychotic behavior. It was also of interest to get a hint of some of the meaning of the "Scribble Head Riddle." Part of that riddle has to do with her both loving and hating something, probably most notably her mother, at the same time. When commenting on this, her tone was one of quiet perplexity.

EXCERPTS FROM SESSION NUMBER THREE

9.00 a.m.: Drug administered.

9.30 a.m.: J is tense; she wants to talk to us but we insist she be quiet and listen to the music; she begins to cry and rub her hand on her forehead and mouth. She moans and sighs and is distraught—cries, kisses her hand and says, "I want to like myself"—repeats this numerous times. Occasionally she bounds off the couch and smashes her fist against the wall.

10.00 a.m.: J: "I'm a girl, I'm a girl.' 'Alternately cries and laughs. Growls and whines. Stuffs a rag into her mouth. Occasionally screams out "No!" When staff try to touch her, she withdraws and says, "No, leave me alone."

10.40 a.m.: J: "My chest feels like I'm the Scribble Head Riddle, I'm not! Hey, S, I want this to go away. I don't like it like this." She then begins to carry on one of her dual conversations about wards, then stops herself and says: "No, you're not supposed to talk like two persons. I'm not going to talk too much."

10.50 a.m.: "I'm well now. I feel different. I feel like a girl. S, please help me." S moves to her and takes her hand. J responds by trying to communicate with S. J: "A girl and a boy. S, is this different or is it the same? How come I have to be a girl? Why do I have to talk this way? Am I supposed to act this way? I'm gonna do just what I want when I feel this way. I have feelings and they're stupid. I guess I could get out of bed for awhile. I'm just not gonna talk two persons any more." J holds S closely and with great affection, kisses her occasionally. Her speech is slow and soft, not driven and harsh as is usual. J appears to go into a reverie-like state which is characterized by calmness. J: "I want to be the mother. Why do I feel this way, S? I'm gonna be a mother. I have a good mouth. I grow back into a girl now, S. Let me try and do something different. Now, love, that's me and S loving each other. I feel so good. I can't make things start over again." She now becomes very soft and gentle, speaks as though she is speaking gently to herself—"I could feel this way if I like. I love to get along with people. I'm a girl and a good one. I'm making the things I'm not supposed to feel, feel this way. Oh, I feel like I'm supposed to feel! I'm not going to do what I did last time! I feel like I'm a new baby. Turn on the gas—no, no—I didn't mean that (a little agitated). I feel different. I feel good and I can help other people too. Oh, I wish I was sick." F asks: "What's bad?" J: "I feel good." F: "Is there such a thing as bad?" J. "No!" (with great emphasis.) She then laughs and asked: "Would it feel good if I died?" to which S replied, "Yes." J: "I want to die." J then laid down with a deep sigh, closed her eyes, relaxed and stopped talking. She becomes extremely peaceful looking and maintains this state for about twenty minutes. She then mutters softly, "Yeah, this is it, this is it." She strokes S's hand softly and smiles, and says, "I'm a girl." Her expression is positively beatific. She takes S's head in her hands and whispers, "I love you." There is a remarkable grace to her hand and body movements. F: "Did you get to die?" J: "Yes, and I came back alive, see?" Ten minutes later she said, "That's the way it's supposed to be. I can be anything I want." She then becomes quiet and repeats the word "See?" in a questioning manner, to mean "You see, now do you understand."

1.00 p.m.: J begins to talk about good and bad wards— a flurry of rambling speech—in the middle of this she suddenly stops and says, "I want to die again." She then appears to become a little anxious and says, "I can do anything I want to do. See, I'm a good girl." F: "Let's be bad for awhile." J: "Why? I'm a good girl." Appears to be a little agitated with this suggestion. J: "Shall I die? It's fun." D: "What do you want?" J: "To be a good girl." D: "What does that mean?" J: "To get along with everyone." D: "What would happen if you didn't get along with someone." J: "I'd die." Later J says, "Scribble Head's mother is dead," and proceeds to go into an autistic discussion of all the wards in the hospital. She then becomes agitated, talks intermittently about being good or bad and about whether she is a boy or a girl. She proceeds on this track and our attempts at intervention are to no avail.

Evaluation of Session No. 3

In this session, J reached a state of deep acceptance and experienced profound feelings of love and personal integration. At the beginning of the session she was visibly tense and less talkative than usual. There was an almost grave aspect to her feeling tone in contrast to her usual loose, uninhibited and inappropriate behavior. Soon after taking the drug she tried to engage us in conversation but we thwarted these attempts viewing them as a method of hanging on to the world she knows and her defensive psychotic posturing. For two hours, J quietly cried and smiled, engaged in familiar oral activity, expressed anger and kissed herself. Then her feeling tone changed. She became happy, relaxed and full of warmth—she appeared to be overwhelmed with feelings of compassion and love for herself and for us. J was expressing wonder and delight and her voice was relaxed and her words spoken softly and slowly as contrasted with her usual rapid tense mode of speech. Her warmth of feeling increased dramatically, and she reacted to these feelings and physically and verbally expressed love for herself and for S. She has never behaved this way before. We interpret much of what she said to mean that she was experiencing feelings of love and acceptance for the first time and she was quite amazed at this. Her fear had always been that would annihilate herself and others if she expressed her feelings because the primary feelings that she knew at some level were her tremendously angry ones. We felt that she had been able to achieve a significant state of self-acceptance and love during this session. Her whole manner, speech, feeling tone, bodily movements and appearance was one of profound self-acceptance and peace. This was a very dramatic experience to observe and was very similar to experiences observed, during psychedelic states, with mature and stable adults.

Later in the day she became very much involved with good and bad; and then we asked her to try being bad for a while. She seemed to become anxious at this suggestion and repeated that she had to get along with everyone and that she wasn't so bad. Her anxiety increased and she began a discussion of what one should or should not do; she became increasingly anxious and attempted to define and control her experiences and feelings in the context of good or bad.

After the session, pronounced and quite sudden changes occurred in her behavior and perceptions of her world. Her entire delusional system solidified into an absolute clear-cut dichotomy of good and bad and their respective proponents, God and the Devil. God was good and stood for every socially acceptable value J had ever heard of. He told her to help the staff, to love everyone, not to talk crazy and to do what she was supposed to do, which, as far as we could determine, meant doing what everyone told her to do, staff as well as every patient. She saw the Devil pretty much as an evil temptor who, if she did not resist him, was somehow able to make her do bad things, such as break windows, say bad words, hit other children, scream and yell, get mad, roll her head on the bench and so on. J was never at a loss to tell us how she hated the Devil, which in truth was the strongest part of her. It appeared that in one

dramatic act J had chopped her self in half trying to affirm the good, the socially acceptable and the "should" while denying her tremendous anger and antisocial impulses, projecting them to an external force, the Devil. Actually the good was also externalized, for as J told us herself, she was not good unless every one thought she was good. She had reduced herself to a mechanism capable of certain responses which hopefully would elicit reward and approval from others. There was very little Jeannie Drake involved at all. She vehemently emphasized that if someone, any one in the world, did not love her, she would kill herself, choke herself, turn on the gas and die, tear off her spout (vagina), rip open her stomach, etc. Needless to say, her behavior was painstakingly and horribly good. In the battle between her hostility and her cruel, immature conscience (based on her fantasies of mother and her inability to accept the fact of an unloving mother) her conscience was victorious because she so needed mother's love to verify that she herself was worthy. She was incessantly besieged with feelings of worthlessness and evil and directed her death wishes onto herself while at the same time trying to find a way to get out from under the superego's relentless attack. Thinking that she was evil, she attempted to eradicate all traces of herself as a person and externalize her battle between good and evil to God and the Devil. She took a totally passive attitude and was at the mercy of the world. Everyone in the world stood in judgment of her and she undertook the most tremendous task of all, a control of the world. She had to control everyone's attitude towards her. The slightest kind of disapproval from anyone excited feelings of such failure and worthlessness that she wanted to die. At the same time, the expression of hostility on the part of other patients launched her into a frenzy for this caused her to experience dreadful impulses to aggress which threatened the betrayal of her delusional system, thus setting up her ultimate destruction.

We viewed this "personality adjustment" favorably and as a change which included more of reality than she could previously recognize. In part she was attempting to isolate her rage and to become socialized. She did realize that her day to day behavior had something to do with her being where she was psychologically and environmentally, and she started to take initiative in helping around the ward. A couple of weeks later she established a consistent and friendly relationship with a female patient a few years younger than herself. This attempt to "adjust" on her part was a courageous effort to again face reality, and attempt to understand something in life and to establish a new spot for herself. If she did express any hostility, she blamed it on the Devil. (Later we realized that in her fantasy life she gained a lot of satisfaction by having the Devil and the Scribble Head Riddle "kill people's parents." She would then "bring them back alive" and would thus maintain an immaculate image of herself.)

Session No. 4

During the initial phases of this session J experienced genuine grief and sorrow and cried. In response to these feelings she frequently extended her arms upwards and said she wanted " to go up" and "to go up there, to heaven" which meant that she did not want to experience her sorrow but wanted only feelings of comfort and happiness. She further verbalized this desire by saying, "I am trying to kill hell," and "I am trying to love myself." She then began to devote her time to bring about pleasant and good feelings through the use of her voice

and intellect. She repeated hundreds of times, "I am trying to find out why" and "I am trying to make me love myself." She was caught up in such perseverative patterns off and on for the rest of the day. At the end of the day she became very violent and tried to choke herself and others and had to be restrained.

Session No. 5

In this session J was completely unable to tolerate any affect induced by arousal of unconscious material and drove herself into an acute psychotic state involving perseverative manic-like verbal defense and frenzied motor activity. It was impossible to make ourselves known to her and she was completely out of control and encapsulated and isolated by her defense. An additional dosage of 100 mcg. LSD around noon served only to intensify the ongoing reaction.

Session No. 6

During the initial phases of this session J talked much as she had before, saying that she was going to try to love herself and learn things. She appeared to be looking forward to this experience and was extremely anxious to cooperate. It was important for her to follow our instructions and she seemed to feel that we could help her. All this behavior had been J's way of relating to everyone ever since her third session. What was significant for us was that during the session when she began to get anxious and talked in a defensive manner she would stop herself and say, "No, I'm supposed to lie down and listen to the music," and would do just that. One might argue that we were only reinforcing and encouraging her "be good" game but we feel that her ability to resist her usual defensive methods even for someone else was excellent progress for her. After the first hour she remained quiet and still for almost three hours. It appeared that she was allowing herself new experiences. She laughed loudly and with genuine gusto, which we had never seen her do before, and for long periods of time she simply appeared very relaxed, calm, quiet and happy. During the latter phases of the session her compulsive controls reemerged and she was anxious and agitated. We felt that this appeared to be provoked by her difficulty in reentering her more usual state of consciousness. We felt that it was quite significant that she was able to cooperate with the therapists, follow our directions to become quiet, to listen to the music and to learn, and that she was able to surrender these defenses and allow herself new experiences.

The quality of the quietness of the session was also significant in that this type of behavior usually indicates that the individual is exploring internal phenomena, and the quality of the session was in marked contrast to the two previous ones wherein she was extremely defensive and psychotic.

Session No. 7

Throughout most of the morning J was relaxed and content to remain quiet and still. The few times she did speak she launched into a typical discussion of good and bad, God and the Devil. Some two hours later she began referring to apparently traumatic sexual oral events to which she had alluded from time to time. Although this material was not made precise, it appeared that she had been subjected to forced oral copulation. She appeared to be choking and then spitting vehemently. In addition she moved so as to try to remove her mouth from some presenting object. We directly interpreted the symbolism she presented in this connection but we received little response from her. Soon after this, however, she became anxious and told us "I am trying to think."

In the afternoon her perseverative behavior dwindled and she began to whine and plead apologetically which grew to great and genuine grief over "killing" people. It seemed that she had been confronted with her hostility and death wishes and that these wishes had come true for her. Thus, she was forced to abandon her denial of hostile wishes and was now suffering the consequences. This to us was an important step forward for her. We attempted to communicate to her that she need not be ashamed of her wishes and that in truth she had killed no one. She did not respond to this "support" and continued to grieve and crucify herself for these murderous deeds.

Significantly, she identified these wishes with the past and was unable to accept that these wishes still existed. She begged for forgiveness and pleaded, "Hurry, mother, come back alive," and would deny the existence of any hostility at the present time. However, we felt that this session was a significant one for her.

Sessions 8, 9 *and* 10

J's 8th, 9th and 10th sessions were quite different from those previous ones and were so similar that they can be described together. In general she remained quiet and still, spoke only when spoken to and experienced little anxiety at any time. We were somewhat dismayed over this change and wondered if perhaps she had found a way to shut off the drug effects and prevent herself from getting herself involved in any significant material. Yet the absence of any defensive behavior suggested that she was having little difficulty tolerating her experiences, whatever they were, and this was encouraging. The specific content that did emerge was related to her relationship with her mother. She discussed, rather quietly, that it was not good to get mad at her mother and how sorry she would be if her mother got hurt. In describing mother, J said, "Mother is crying, mother is mad, mother thinks I'm lying, mother is crazy." She said that if she hated her mother, she herself would die. She was able to talk about her mother's threat to leave her and the ambivalence she felt about it. She also said that she wanted to leave her mother, but that would be a terrible thing to do. She continued to deny her mother's rejection of her saying that if she died, then her mother would die, because her mother loved her so much. At one time J said, "I hate my mother when she cries and gets mad at me." D: "Tell her that." J: "Mother, I want to tell you something. . . . No, I don't, mother, I love you." In retrospect, it appeared that she had indeed done some productive working through for in her 11th session there was a significant breakthrough in her defensive maneuvers and she experienced freedom.

During the month in which these three sessions occurred she was more quiet, demonstrated little hyperactive behavior, head rolling or bizarre behavior. She sat quietly by herself and very infrequently indulged in her perseverative speech patterns.

Session No. 11

J lay quietly for some three hours and appeared to be experiencing more pleasure and delight than she had since her third session some five months previously. At about noon she appeared very much in contact with her surroundings and still very accepting of her experiences. We began to communicate to her our interpretation of her delusions. She made no remarkable response to these interpretations so we stopped. Soon, however, she began spontaneously to verbalize

and we suddenly witnessed her description of the destruction of her psychotic world. J: (in a loud booming voice) "I love the Devil! I am the real Devil and I am the real Scribble Head Riddle! The Devil and the Scribble Head Riddle are my imagination and I am really the Devil and the Scribble Head Riddle!" She stood up and walked around the room, laughing in amazement and continued to say, "I've been bad and I don't care. I think it is just great." She repeated, "I think it is just great," at least fifty times. She reenacted many past scenes with her mother, taking both parts. Taking the part of mother, she would whine and say, "Jeannie, are you being a good girl?"and in a booming response, J would yell, "Hell, no, hell, no hell no!" She told us she could say all the bad words she wanted to and proceeded to do so with great passion. She began to toy with her fear of death as reprisal for the expression of her feelings. She said, "I hate mother and God and everybody," and then dramatically fell to the floor as if struck dead and then leapt back to her feet, announcing, "I have just died and I don't care and this is just great!" Many times she compulsively repeated the sequency of expression of hostility, death, and the rebirth. Finally, she said, "Let's not have any more of this goody, goody stuff." On several occasions she berated the staff and imitated us in humorous and unflattering ways.

This type of material went on for four hours. Near the end of the day she began mentioning concern over her "good things" and pretended to carry them about in her hand asking for a safe place to keep them. When questioned as to what these good things were, she stated that they were the nice things that happened to her, the good feelings she had, and the future. From what we surmised, her good things were her insights which she wanted to salvage from the wreckage of her good and bad world. Perhaps the destruction of that which she had previously tried to maintain caused her to feel there was little with which she could start over. We assured her that her good things would not leave her, only her useless, crazy things but she remained in doubt over this matter. We took her back to the ward early in the evening—she was a tired, dazed and happy girl clutching her "good things." It is an understatement to say we felt a lot had been accomplished.

The next day she was extremely anxious to talk, and we talked to her about her session. She knew that we knew all about her and she was happy. Still she made some feeble references to the Devil, but laughed when we reminded her of events in her session. She laughed with great warmth and genuineness, saying, "The Devil and the Scribble Head Riddle—yeah, they're me alright!" It appeared that on a very superficial level she wanted to continue with her old ways, but at a deeper level, however, she was ready to drop her psychosis and learn something new.

Session No. 12

This session was almost entirely spent in J's reenacting out traumatic events with her mother. This included many scenes which were painful for J and she compulsively and repetitiously went through them, perhaps trying to abreact all the affect out of these events. Her affect would change as she repeated these events and often she would go through one in a light-hearted and humorous manner. When she had finished with one scene, she would start another different one. She also spent considerable time being mischievous and bad and she enjoyed this tremendously. She also indulged in alternately beating and loving a large air-filled rubber mannikin which she identified as mother. She also

attempted to nurse on the mannikin. Several sessions earlier when the therapist had verbalized his hate for his mother, J had become terribly concerned, rushed over to him, placed her hand over his mouth so he couldn't speak and said, "Oh, you must never say that." When he also hit the mannikin and screamed, "I hate you, mother," this also sent J into a panic and she physically controlled the therapist from hitting the mannikin. Now, in this session, she was acting out this ambivalence toward mother, through the mannikin, both verbally and physically. She also continued to hold the "good things" in her hands and seemed to suck and nurse on these things. She said there was nothing really in her hands but yet these were things that she liked to have that made her feel good. She had difficulty verbalizing the nature of these good things, but when pressed, named a number of things she liked, including candy, peanut butter sandwiches, staff members, a boy patient she had recently taken to associating with, and money.

Session No. 13

In the first two hours of this session, J lay quietly and made no movements or verbalizations. She then sat up and in a perplexed manner said, "Why do you sometimes get hit by a truck when you go out on the highway of life?" After this she lay quietly for a short time and then started to become agitated. She tried to allay this agitation by trying to express positive feelings for the therapists but soon the shallowness of this attempt was obvious as she started to become aggressive, angry and assaultive. She ended up by screaming desperately, "I want to go out on the highway and get killed." She then would become frightened and yell, "No, no, I don't want to be killed." Perhaps in some existential manner, she was dealing with the question: should I give up my living death (psychosis) and take my chances with the world of reality? It seems that the resolution of the "Riddle" the pressure of positive and negative feelings (of good and evil, the Devil and God) in oneself and the acceptance of that seeming paradox was the key to her entering "the highway of life." In this dilemma, J is not alone and facing such existential questions is often the core work of the psychedelic experience. When transcendance of the ego-state is achieved, the paradox is resolved and the seeming contradiction of conditions is experienced as a unified state. We feel that J had had glimpses of this unified state, but as with everyone except the saints, the human perception of opposition conditions maintained itself and conflict resulted.

Sessions 14, 15 *and* 16

J's mother had been released from the hospital and came to see her. This apparently was exceedingly stressful for J and she became very disturbed. During the 14th session she became totally involved with fear of punishment and reverted back to trying to be good. This undoubtedly was related to the conflict over her rage being activated by having to see her mother. She became manic in her massive denial during this session and it was felt to be very unproductive. During the 15th and 16th sessions, she was excessively quiet, somewhat morose but did have long periods where she appeared to be in a very tranquil and peaceful state. During this time, she spoke softly and gently, only to herself, saying—"Yes, yes, this is it. It's alright." During this period of time we were preparing J for discontinuation of drug sessions as the project was being terminated. She also knew that two of the staff that she had been closest to were leaving and this was distressing to her.

DISCUSSION

The experimental project came to an end at the time when drug laws were enacted which necessitated a long and difficult procedure to obtain these drugs. Consequently, we were forced to tell J that she would no longer be able to have any sessions with these drugs. The conversation that ensued was as follows: F: "J, because of certain problems we're not going to be able to get any more of the drugs we have been giving you and so we are going to have to do without them." J: "Isn't there any more of those drugs?" F: "Well, yes, there's still more of the drugs but we're not able to get them." J: "Why not?" F: "Well, it's a very long and difficult story but we just aren't going to be able to get any more." J: "Do you know who has any?" F: "Yes." J: "Who has it?" F: "Well, the man who distributes it is called H.A. and he is a representative of the drug company and he lives in San Francisco." J: "Well, just go there and tell him that you need some more drugs." F: "That just won't work." J: "Why not?" F: "He just wouldn't give it to us." J: "Well, just hit him over the head and take them." F: "Then the police would come and get us." J: (In a serious and determined, yet pleading voice) "Well, just go to the man and tell him that Jeannie Drake *says* that she *really* needs it and can't she *please* have some."

One question that is most often asked concerning the results we obtained with these psychotic children is—"But wouldn't you get the same results without the drugs by just giving the time and devotion you gave to these children?" As can be seen, J evaluated the drugs as being an important aspect of her psychotherapy and the writer concurs with J's judgment. The writer had spent over two years experimenting with psychotherapeutic techniques with this type of child and the results were negligible. If one is very familiar with the severity of the problems encountered in these very psychotic children, one can more realistically judge the results of this present work. One extremely important factor which came to be of paramount importance was the constant chaotic and physically stressful environment to which these children were constantly subjected. They had to survive on a sterile ward with sixty other acutely disturbed and acting-out psychotic children. How anyone could maintain a trace of sanity under these conditions is a mystery. The writer often thought that a psychotic withdrawal would be a healthy reaction to having to live in such an environment.

It was obvious that J became much better. She ceased her isolated, autistic behavior to a very large degree—she no longer sat in a corner, twisting papers, masturbating and talking word-salad. She had chores which she did on the ward. She talked to people rationally and helped with the smaller children. Her comments about other patients, and sometimes staff, were painfully accurate. She tried to learn but found it almost impossible because of her blindness. She did go to the hospital's rehabilitation department and the music instructor discovered, within one hour, that J could learn to play piano "by ear." He was overwhelmed and enthusiastic and highly recommended she be given this chance to learn to play. Nothing came of it. She was able to carry on very sensible conversations with staff, gave intense and undivided attention to her co-therapist when they met between sessions and was able to describe her concerns, reactions and finally, her own dynamics. She developed a very meaningful and intense relationship with the co-therapist. They had a totally gratifying experience with each other, the co-therapist describing J as "one of the most human, one of the

best people I know." When the therapist and co-therapist left, they had much more difficulty in the separation than she and it was quite amazing the depth of acceptance she had concerning the necessity of terminating the project and her relationship with both the therapist and the co-theparist. In fact, she was very reassuring and supportive to them and seemed to exquisitely sense their deep feelings of guilt and shame at the abandonment of her and the rest of the children. In short, she carried on in a rather remarkable fashion and with a maturity that literally awed us.

FIVE-YEAR FOLLOW-UP

The patient was discharged in June, 1968 to her parents who had moved to another state. She has not been seen by the writer since May of 1963 and the distance mitigated a personal follow-up. The patient's chart at the state institution was made available and was searched for progress notes for that five-year period. Unfortunately, the record was scanty but it was possible to glean some indication of her psychological condition.

The first notation in the chart was at the termination of the treatment in June, 1963. The psychiatrist's progress report read, "Patient is in good contact with reality; she has fairly good insight; requires no regular medication; cares for all of her own needs and is no management problem; definite improvement."

The writer left the institution in May of 1963 and the co-therapist left a few weeks later. Within three months the majority of the treatment staff had left. Consequently, the patient had virtually no one with whom to continue her therapeutic work.

In February, 1964 a notation was made that she asked one of the ward workers, "When will my craziness wear out?" She also offered the information that she must be happy with her craziness as she didn't want it to leave. In August, 1964 a student worker had Jeannie in a group therapy situation with a number of adolescent girls. There is no data as to the length of time these sessions had occurred but a progress evaluation by the student therapist reveals the following information: "Jeannie loves attention and acceptance and is very pleased when praised; she is a big help to me when I take the group off the ward. It seems as if she is living another life in her mind. She told me, "I'm out to see the world—but how many are there?" She also told me, "Everything is a thousand years old and everything is getting better and better." She converses with herself a lot and in these conversations she is usually mad at herself and talks of her mother .She shows concern about being sick and dying. As we were walking the other day, she very intently told me to listen to her talk and then to answer the questions. One day when she was talking to herself, I went over to her and asked her what she was concerned about. She laughed and answered, "Oh, don't bother, I'm just talking!"

In May of 1966 a progress report indicates that she was not a behavior problem but that her behavior oscillated between hyperactivity and withdrawal. A notation was made that she verbalized concern over fear of drying, of evil, and commented that cleanliness was good.

In October of 1967 she was presented to a consultant psychiatrist who interviewed her before a staff. He noted that she was in good psychological contact "despite her rocking motion." He felt that there had been improvement following her LSD treatment and suggested a manic-depressive psychosis diagnosis based on her alternating between hyperactive and withdrawal moods.

At the time of her discharge in June, 1968 she was described as making rocking movements, that she might be having hallucinatory experiences and that often when eating she would stuff her mouth. She was also noted to participate well in the ward activities, that she did her ward chores, that she spoke coherently and well and that she was a co-operative patient. A final note was that "Jeannie is an enjoyable person."

Unfortunately, the follow-up information is scant and meager. It would appear from these notes that Jeannie generally maintained the progress she had made in her treatment but that she had not resolved her essential conflicts. Apparently she was able to live somewhat in two worlds—the world of her psychotic preoccupation which was dominated by her impulse of rage toward her mother and the world of external reality. This conclusion is based on her ability to interact appropriately with demands made upon her by ward personnel, her ability to communicate reasonably, her participation in activities and work and the fact that she was seen as not only human, but as an "enjoyable" human. While wrestling with her own stated craziness, she was also able to relate and participate in the real world. This degree of integration is certainly a far superior one to that which she possessed prior to her treatments.

The writer feels that it was Jeannie's great determination to know and to become more powerful than her "craziness" and that was the key facet in her maintaining some degree of sanity. She would actively seek out people and make attempts to understand her chaotic world and had a belief that she was going to get some answers one way or another. Her attitude towards her unintegrated and confused psychic state was one of tolerance with an unrestrained determination to overcome. The writer often felt, very deeply, that this was one very courageous human being.

OTHER RESEARCH UTILIZING PSYCHEDELIC DRUGS WITH AUTISTIC SCHIZOPHRENIC CHILDREN

Mogar and Aldrich (in press) have recently reviewed the literature on the use of psychedelic drugs with schizophrenic children. They review the work of Bender, Goldschmidt and Sankar (1962); Bender, Faretra and Cobrinik (1963); Freedman, Ebin and Wilson (1962); Peck and Murphy (in Abramson, 1960); Rolo, Krinsky, Abramson and Goldfarm (1962) and Simmons, Leiken, Lovaas, Schaffer and Perloff (1966), as well as some preliminary unpublished data from our own work. Of the total of 91 children treated with psychedelics, 55 were treated by Bender, who gave daily dosages over a relatively long term period (45 to 60 days) but without attempting to conduct psychotherapeutic sessions. The primary purpose of the studies by Rolo *et al* and Simmons *et al* was explicitly methodological whereas Freedman *et al* were attempting to study the schizophrenic process and did not have any therapeutic intent. Our own work was the only one which attempted to create an atmosphere which would optimize the therapeutic process. Mogar and Aldrich state: "Inconsistent findings become much more understandable if the psychedelic experience is viewed as a dynamic configuration of intimate patient-therapist-milieu transactions. In short, the administration of LSD is inextricably embedded in a large psycho-

social process which should be optimized in accordance with particular treatment goals."

Despite the diversity along major dimensions known to influence drug response and treatment effectiveness, Mogar and Aldrich make the following conclusions based on their evaluation of the results of the seven studies reviewed. (1) all children were refractory to all other forms of treatment; (2) only slight differential responsiveness as a function of age, diagnosis, duration or severity of illness; (3) most effective results were obtained with at least 100 mcg. doses given daily or weekly over relatively extended periods of time; (4) greater therapeutic benefit was related to (a) the degree of active therapist involvement, (b) an opportunity to experience meaningful objects and interpersonal activities, (c) congenial settings that were free of artificiality, experimental or medical restrictions and mechanically administered procedures; (5) the most consistent effects of psychedelic therapy included: (a) improved speech behavior in otherwise mute children, (b) increased emotional responsiveness to other children and adults, (c) an elevation in positive mood including frequent laughter, (d) decreases in compulsive ritualistic behavior; (6) although differences in patient attributes, treatment techniques, research design and other non-drug factors seemed to effect the *frequency* and *stability* of favorable outcomes the types of improvements found were essentially the same in each study.

The reviewers conclude that the collective findings argue strongly for more extensive applications of psychedelic drugs in the treatment of this type of child.

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