Anaclitic Fusion in Oregon Psilocybin Services

by Reid Stuart. 25-October-2024

Dr. Joyce Martin (1905-1969), Senior Hospital Medical Officer
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In the 1960s, the psychologist Pauline McCririck developed anaclitic-fusion therapy. McCririck practiced this and other forms of LSD psychotherapy in collaboration with the psychiatrist Joyce Martin. Although they both worked together at Marlborough Day Hospital, they practiced anaclitic fusion therapy at the Martin's palatial house on Welbeck Street in London. Anaclitic fusion was used to treat patients whose symptoms derived from emotional deprivation in infancy or early childhood. These two therapists used LSD to regress the patient to an infantile state, wherein the patient (who on one level was aware of being an adult) felt emotionally and psychologically regressed to early infancy — the period of the life span

when the emotional deprivation originated. The therapists wrapped the patient in a blanket and spent several hours lying down beside him and hugging him in order to imprint the experience of maternal love that the patient failed to receive from his own mother. The patient must be in an infantile state that does not have sexual overtones. This procedure is particularly helpful for patients who experienced rejection, abandonment, and emotional deprivation during early life.

Martin described the type of support given in anaclitic therapy:

> This active participation of the therapist is needed, since the drug regresses the patients to the earliest experiences so dynamically that they literally feel like babies and are unable to cope or fend for themselves; but this is no longer frightening if their present mother, that is the therapist, is warm and understanding and can supply their needs at that level in some practical way, such as giving warm milk, holding their hand or putting an arm round them, and also talking to them at a conscious level, since consciousness is always maintained in the treatment, and reassuring them that it is good and normal to want these things, which all babies need and want, but do not always get.[2]

The mention of warm milk suggests that unmet anaclitic needs are the basis for the “adult baby” paraphilia in which adults get erotic satisfaction by dressing in diapers and having women feed them milk with a baby bottle.

The psychiatrist Stanislav Grof suggested that anaclitic-fusion therapy should be tried on autistic children. He suggested that MDMA would be the ideal substance. He commented that while there are no strict rules about who would be a good practitioner of anaclitic fusion, he had the impression that middle-aged women would be ideal because they are more likely to be perceived as having a nurturing, maternal quality.[1] Having learned anaclitic fusion from Martin and McCririck, Grof made some limited use of this technique while practicing LSD psychotherapy in the United States.

Grof’s described a film about anaclitic fusion that probably no longer exists:

> At the International Conference on LSD Psychotherapy held in May 1965 in Amityville, Long Island, Joyce and Pauline showed their fascinating film on the use of the fusion technique in psychedelic therapy. In a heated discussion that followed, most of the questions revolved around the transference/countertransference issues. Pauline provided a very interesting and convincing explanation why this approach presented less problems in this regard than the orthodox Freudian approach. She pointed out that most patients who come to therapy experienced in their infancy and childhood lack of affection from their parents. The cold attitude of the Freudian analyst tends to

> reactivate the resulting emotional wounds and triggers desperate attempts on the part of the patients to get the attention and satisfaction that had been denied to them.
>
> By contrast, according to Pauline, fusion therapy provided a corrective experience by satisfying the old anaclitic cravings. Having their emotional wounds healed, the patients recognized that the therapist was not an appropriate sexual object and were able to find suitable partners outside of the therapeutic relationship. Pauline explained that this paralleled the situation in the early development of object relationships. Individuals who receive adequate mothering in infancy and childhood are able to emotionally detach from their mothers and find mature relationships. By contrast, those who experienced emotional deprivation remain pathologically attached and go through life craving and seeking satisfaction of primitive infantile needs.[3]

To mitigate the risk of a wayward facilitator taking sexual advantage of a client who is under the influence of psilocybin, and possibly also to protect innocent facilitators from being unfairly accused by delusional or malicious clients, Oregon Psilocybin Services (OPS) limits the facilitator's physical contact with the client during the administration session to four check-box categories of "supportive touch" as shown in the following excerpt from the bottom of page 1 of the form *Client Consent for Use of Supportive Touch During Administration Session:*

Please select whether you consent or do not consent below.

I consent to allow the facilitator(s) identified above to use the following types of supportive touch during my administration session:

- ☐ Hugs
- ☐ Placing hands on hands
- ☐ Placing hands on feet
- ☐ Placing hands on shoulders

OR

☐ I **do not** consent to allow the facilitator(s) identified above to use supportive touch during my administration session.

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By marking the first checkbox labeled "hugs", the client can give the facilitator permission to use hugs to provide emotional support during an administration session. The form also has a similar section that enables a client to receive physical support from other clients in a group session.

OPS's restriction on physical contact during the administration session is designed to prevent scandals and lawsuits that might arise from potential complaints about sexual abuse or physical violence. Yet, the "Hugs" checkbox does permit the facilitator to practice anaclitic fusion that has been jointly agreed upon by the facilitator and the client during a preparation session. In addition to marking the "Hugs" checkbox, the client should inscribe a signed handwritten note beside the checkbox saying, "Prolonged full-body hugs for the purpose of anaclitic fusion". This would remove any ambiguity by offering an explicit rationale for one or more facilitators to administer full-body hugs.

Looking online, I only found one therapist practicing anaclitic fusion. However, it is a modality that deserves to be resuscitated. The Oregon program is to be commended for being very cautious in regulating physical contact during an administration session. But by inscribing an appropriate notation, clients can legally receive prolonged full-body hugs for the purpose of anaclitic fusion.

I have attached the first article in the following bibliography about anaclitic-fusion psychedelic therapy. This hard-to-obtain unpublished paper is the only written record left by the therapist who devised this procedure.

1) McCririck, Pauline. Undated. "The Importance of Fusion in Therapy and Maturation". Unpublished typewritten manuscript from the 1960s.

2) Grof, Stanislav, M.D. 1967. "Use of LSD 25 in Personality Diagnostics and Therapy of Psychogenic Disorders". Chapter on pp. 154-190: *The Use of LSD in Psychotherapy and Alcoholism*, Harold A. Abramson (editor). The Bobbs-Merrill Company, Inc. Indianapolis; New York; Kansas City. Anaclitic fusion discussed on pp. 177-178.

3) Martin, Joyce, M.D. 1967. "LSD Analysis". Chapter on pp. 223-236: *The Use of LSD In Psychotherapy and Alcoholism*, Harold A. Abramson (editor). The Bobbs-Merrill Company, Inc. Indianapolis; New York; Kansas City.

4) Grof, Stanislav. 2006. *When the Impossible Happens: Adventures in Non-Ordinary Realities*. Sounds True Adult.

5) Grof, Stanislav. 2014. "Holotropic Breathwork: A New Experiential Method of Psychotherapy and Self-Exploration". *Journal of Transpersonal Research* 6 (1): 7-24. Anaclitic fusion discussed on pp. 13-15.

Footnotes:

1. Grof, Stanislav. 1984. Personal communication at a workshop at the Esalen Institute.
2. Martin. 1967. pp. 223.
3. Grof. 2006. pp. 11-13.

THE IMPORTANCE OF FUSION IN THERAPY AND MATURATION

by

Pauline McCririck, London

UNPUBLISHED MANUSCRIPT

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INTRODUCTION

In recent years psychoanalysts have paid increasing attention to the dynamics of the first year of life of the infant, its specific relation to the disturbances seen later in adult patients, and the technique required to deal with this early material. For example, Balint (1958) has pointed out that normal therapy being almost exclusively an exchange of words, it relies heavily on the supposition that the patient possesses a sufficiently reliable and intelligent ego to take in words and allow them to influence itself. In short, the patient is required to "work through" the material thus taken in verbally. What of the traumatic events that occurred in the life of the patient in the preverbal period of the first 15-18 months? Not every patient is capable of dealing with this early material and it is frequently with these patients that we encounter difficulties. Another important point made by Balint is that during this early period it is not so much conflictual material, such as the later oedipal level of development presents, with which the infant must deal, but one of basic needs which must be met.

Mahler (1952, 1958) has likewise emphasized the relatively little attention given to the first 15-18 months of infant life in psychoanalytic theory until the development of ego psychology

(see also Mahler and Gosliner, 1955). She has hypothesized the existence of an important symbiotic phase between the mother and child during the first fifteen months of postnatal life. According to her, the intra-uterine, parasite-host relationship is replaced in the postnatal period by the infant's being enveloped in the extra-uterine matrix of the mother's nursing care, which she refers to as a kind of social symbiosis. Others (Lichtenstein, 1961; Weiland, 1966) have given attention to the influences or disturbances of this early symbiotic phase on later development and functioning.

Psychoanalysis often requires many months or years to get the patient to overcome his strong defences, and to regress sufficiently to reexperience his very early feelings of dependency, love or deprivation. The recent use of lysergic acid diethylamide (LSD_{25}) as an adjunct to psychotherapy has markedly altered the time required for this process. Regression to infancy and early childhood states, together with the accompanying affects of this period of life, take place within the first session, and continue to unfold ever deeper areas of the human psyche, both pleasurable and conflictual, throughout the analysis.

Even where a patient in psychoanalysis succeeds in achieving this level of regression, and experiences these early states of conflict or deprivation, it is not enough to merely bring to consciousness these early emotions. There still remains the problem of the gratification of these needs of early development.

It is not sufficient that the patient symbolically gratifies his needs as some analysts have suggested that their patients are able to do. This is contrary to normal healthy development, since it returns the patient to fantasy, strengthens his old, unrealistic pattern of coping with his environment, and undermines the object of analysis which is to bring the patient into reality. Even though certain material which emerges under analysis can be "worked through" by the patient, there are fundamental emotional and behavioral needs which are as essential as adequate nutrition, and cannot be handled satisfactorily in this way. Though a patient may eventually form an outside relationship after such working through, it will not be at a mature level. The mate chosen for such a relationship will invariably be used for infantile gratifications, and hence cannot be fully satisfactory for the partner.

A method of therapy has been evolved, termed LSD Analysis (Martin, 1967) which deals with these problems in a more realistic, and I believe, more effective manner. This method of therapy embodies a) a psychoanalytic concept of psychic structure and development, b) the early establishment of a strong transference, c) the use of LSD_{25} as an adjunct to psychotherapy, and d) appropriate behavioral support and contact with the patient. This method evolved naturally when I first attempted to use LSD as an adjunct to therapy some eight years ago.

The value of LSD_{25} is that it quickly takes the patient back to infantile and early childhood states of development, and

especially to the early mother-infant fusion stage to be described below. Further, the transference is enhanced with LSD. There can be no real cure, or fundamental modification of the patient's personality without a good positive transference. A fundamental personality change, without a tendency to relapse, is dependent on the reforming of an object relationship. In all personality disturbances the object relationship with the mother has been broken, either through a) the loss or death of the mother in reality, b) the mother returning to work and absenting herself from the infant during the first months of life, or c) a fantasy of being rejected by the mother. It should be remembered that it is the infant's or child's feelings which are significant, not whether the relationship has actually been broken, or exists in fantasy. It is the resulting modified affect which sets the stage for neuroses or psychosis.

In this paper I propose to examine certain findings, derived from the use of LSD_{25} as an adjunct to psychoanalysis, in relation to their bearing on the basic needs of the developing infant during this early symbiotic period, and to describe the method utilized to gain access into this early realm of development.

THE CONCEPT OF FUSION

Whenever the infant, in the early months of life, is in physical and skin contact with the mother, provided the contact is right - i.e. there is a warm loving bond between the mother

and child - fusion takes place. This appears to be a vital requirement for normal, healthy development. Even in later months the opportunity for fusion is present whenever the child is put to the breast. These later months provide both the beginning of the period of separation from the mother, and at the same time afford the child an opportunity for intermittent fusion.

In many cases, however, the period of breast feeding, when relived under LSD Analysis, proves to be unpleasurable and not satisfactory. This is expressed by patients, who experience themselves at the breast, by saying that they do not feel wanted, that they feel cold, or that it is not a "giving" breast. In these cases fusion does not take place, even though the patient has been breast fed, due to the negative feelings within the mother.

There are cases where this method of fusion, which will be described, should not be used. It is in the diagnosis that the therapist must come to a decision - whether or not this technique is put into operation. Where the mother has been too possessive of the infant, or has used the infant for her own adult emotional needs, including the use of the infant as a substitute gratification for her own genital needs, then fusion becomes prolonged and excessive. Under these circumstances, the infant senses the mother's needs and struggles to gratify them. This, of course, is an impossible task and results in deep-seated feelings of sexual inferiority. Although it creates

a desire in adult life to supply these needs in a heterosexual relationship, such efforts are accompanied by feelings of sexual inferiority and frustration, which are then replaced by projection, and ultimately leads to broken relationships. Alternately, these too early demands by the mother on the infant's developing sexuality, leads in adult life, to impotence or feelings of guilt. At deeper levels, they are completely bound emotionally, as they were at this early period, to the mother. This is frequently accompanied by outward manifestations of anger and hostility towards the mother, because there is a tug-of-war going on inside the patient - on the one hand the desperate urge to possess and please the mother, on the other, the hatred of her for her excessive bondage.

What is this fundamental need in human development which I have termed "fusion"? It is akin to an emotional hunger to be fused with the mother, to be a part of her whole being - her legs, her arms, her pelvis, etc. I have found that this need is more vital than the need for the breast, or of early sexuality. Indeed, in some cases where fusion has been achieved, patients no longer show any interest in subsequent sessions in their breast needs. Oral gratification appears to be secondary to the primary, underlying need for fusion.

As patients have expressed this experience after reliving it in their LSD sessions with me, it is as if the flesh and bones of the mother and child become non existent, their limbs

and bodies seem capable of occupying the same space at the same time, or the patient experiences himself inside the body of the therapist. Subjectively, a fusion of their energy systems appears to be occurring. In another instance, a patient when fused with the therapist, felt a vibrant communication running down the midline through his head, chest, and abdomen to his genitals, with the subjective experience that all his sensory, intellectual, and sexual functions were completely integrated.

METHOD

The general method utilized in LSD Analysis has been described previously. An hour and a half diagnostic interview is scheduled with a prospective patient. If found suitable for LSD Analysis, a series of weekly LSD sessions are scheduled, each lasting 5½ hours. The dosage of LSD, ranging from 30-200 gamma, is determined on the basis of body weight of the patient, personality structure, tolerance for alcohol and other factors. The therapist remains with the patient throughout the session.

The predominant goal of the therapist should be to reform the patient's capacity for object relationships at deep levels. It is the original broken object relationship which sets the groundwork for the patient's inability to form or sustain a relationship in adult life. Even more than the fear of hating and hostility, most patients have developed a fear of loving, due to the fear of dependency which they experienced as too agonizing or anguishing in early life. Children often find it intolerable

when they are unable to gratify this vital need. In later life, when a patient finds himself becoming strongly involved emotionally, which reactivates the original feelings of dependency and vulnerability, he will react

a) by agression towards the loved person,

b) by cutting off the relationship, or

c) by regression into fantasy.

In essence, the patient repeats the early pattern of development. At deep levels, however, there is a crying need for such an object relationship - and so a conflict is waged within the personality. The loss of trust in early life means that the patient finds it impossible to fully trust another person. The therapist requires endless patience, understanding and warmth to reestablish a relationship (transference) with the patient at deep levels when it has been broken early in life, as in the case of depressives.

As a result of many years of working with patients, I have asked myself "How can this enormous obstacle to health, the patient's inability to capitulate, to become dependent, to trust in a love situation, be overcome?" I have been forced to conclude, as the result of experiences in LSD Analysis, that the role of the therapist sitting in a detached manner in a chair, is inadequate to cope with this problem. In this form of therapy, the acute needs of the regressed patient for this object relationship, accompanied by anguish, frustration and ultimately

primitive hostility, emerge so sharply and dynamically that greater support is required. The agression which emerges is basically the result of the frustration of these early infantile and childhood needs. It is therefore useless, under these conditions, for the therapist to continue in the old rigid pattern of sitting apart from the patient, occasionally giving him verbal support, and hoping that he will work through these early needs. It becomes obvious that in order to break the neurotic pattern, and to allow for a normal, healthy emotional development, these infantile needs must be gratified. Fairbairn (1958) has raised several interesting issues concerning the adherence to a rigid technique for all patients, when he wrote as follows:

> "In recent years, under the influence of an outlook based on the 'object-relations' theory, I have shed enough sophistication to enable me to ask myself repeatedly such naive questions as 'If the patient does not make satisfactory progress under analysis, how far is this due to some defect in the psycho-analytical method?' This is a question to which there can be no adequate answer in the absence of prolonged investigation; but it seems to me beyond question that the couch technique has the effect of imposing quite arbitrarily upon the patient a positively traumatic situation calculated inevitably to reproduce such traumatic situations of childhood

> as that imposed upon the infant who is left to cry in his pram alone, or that imposed upon the child who finds himself isolated in his cot during the primal scene. If this view is correct, then it follows that the couch technique is very far from being as 'neutral' as it is supposed to be, and that the analyst, in employing this technique, is equally far from being 'neutral.' It also follows that the data provided by the patient who finds himself isolated upon the couch must significantly be influenced by the trauma thus arbitrarily imposed; and it is difficult to believe that the therapeutic result is not similarly influenced."

Before discussing the various methods attempted, the role and qualifications of the therapist utilizing this technique must be emphasized. Since emotional involvement by the therapist at the mother-infant level is required, in LSD Analysis, it is essential that the therapist be completely free of all anxiety. This applies to both male and female therapists. If the transference technique is good the therapist, whether male or female, will be identified with the significant female figure in the patient's infantile life.

In many cases, it is the anxiety concerning this intimate relationship within the therapist which prevents the patient's progress. Provided that the therapist can work without anxiety, while utilizing this technique, I have found that well over 90%

of the patients will be markedly improved or cured, no matter how severe the neurotic or psychotic illness is. Schizophrenic patients, schizoid personalities, patients with obsessive-compulsive neuroses, and early depressives, some of whom had earlier attempted suicide, have all improved and formed meaningful heterosexual relationships, when their early infantile needs have been satisfied by the use of this therapeutic method.

When I have lectured on this technique at medical schools in the United States, the immediate reaction from the audience is that this freedom from anxiety on the part of the therapist is impossible. The therapist is never for a moment in doubt, however, that no matter what the actual age of the patient may be, under the regressive influence of LSD, the patient is emotionally an infant. If this important point is kept in mind throughout the entire analysis, even when the patient later reaches the oedipal stage, the therapist will find that he or she can become emotionally involved with the patient without the slightest cause for concern.

As mentioned earlier, various methods were initially resorted to in responding to the needs of the LSD regressed patient. An attempt was made to hold such patients and feed them with a bottle, but this effort was quickly rejected by six patients as being of little use. Although the patients were comforted by being held, a much deeper need was experienced by the patient and sensed by the therapist. Several patients were able to verbalize their distress by saying "I have never been wanted" or "I have never belonged to anyone."

How is the feeling of being wanted, loved or belonging to be conveyed? The simple answer which emerged was to lie on the bed and hold the patient, regressed to infancy, in a warm embrace, placing my body in such a position that I was making contact at all levels, with my arms, legs, chest and hips with the patient. An additionally important feature seems to be the establishment of a rhythmic pattern of breathing by the therapist which is synchronized with the respiratory pattern of the patient. But this contact with even a regressed patient cannot be made abruptly. The most important points are timing and the method of approach to this intimate relationship. The therapist must know intuitively when the time is right to approach the patient in a physical way. If the approach is premature, it can be detrimental, since the patient can interpret it as a form of attack. Although the intuitive factor is essential, indications for the approach manifest themselves as follows:

a) the therapist's awareness that a positive transference has been established, whether or not the patient has permitted conscious realization of it.

b) the patient's indication or expression, for at least two sessions, of breast deprivation, with accompanying anguish and negative feelings, and

c) the observation of hand and arm movements which are reaching out for help and love, even though not consciously realized by the patient. The therapist

must be alert to the significance of such movements, however expressed.

It cannot be too strongly emphasized that this physical approach by the therapist must never be stereotyped - it varies with the nature of the patient and his illness. For example, a rigid, obsessional compulsive patient initially should be approached with the extension of the therapist's hand, which may remain untouched on the bed for a session or even two, before the patient attempts to make contact with it. Once the patient reaches out and makes contact, the therapist may then sit on the bed and hold the patient's hand in a more loving way in the following session. Then she may place her head close to the patient, and after some time the patient may permit herself to feel the face and hair of the therapist. This skin contact forces up the positive needs and feelings of infancy and childhood which have been repressed all the patient's life.

In a subsequent session, again by intuition, the therapist may attempt to hold the patient in her arms. If the previous technique has been correct, the patient is now ready for and will accept this contact. Then it is a simple matter to lie on the bed and attempt the final stage, which is the fusion. By this time, the patient's fears have been removed, and feelings of security have been established. Again it must be emphasized, however, that patience, acute perception and appropriate timing are the essential ingredients of this technique.

RESULTS

After lying quietly in this fusion embrace with the patient in a state of deep intoxication for periods of up to 1-1½ hours, I would get expressions such as "I had the most wonderful feelings of being part of you. - For the first time in my life I felt that I really belonged to someone" or "I felt completely fused with you. - I was a part of your entire body." or "It is as if we were intertwined, with my arms and legs moving freely through your body."

The results of this experience by the patient have been quite remarkable. If the therapist successfully produces this fusion (not merely as the result of holding the patient, but by giving of herself emotionally) not only do the patient's negative feelings disappear, but all feelings of breast deprivation, depression and hostility seem to melt away.

This fusion experience is repeated in subsequent sessions on the patient's initiative, sometimes as many as 3 or 4 times, until the drug takes the patient to other areas of his or her development. Even with a single such fusion experience, however, an immediate change takes place in the patient. With each fusion experience the patient completely capitulates to his dependency needs and breaks the old pattern of distrust. Various communications from patients after the fusion suggest that the experience was literally like a rebirth for them.

The first fusion experience takes place roughly at about the eighth LSD session. Previously the patients have faced,

among other aspects of early development, their breast deprivation, anguish and primitive hostility. These areas must be experienced fully before the fusion is attempted. One cannot generalize with regard to the initiation of the fusion experience, however, since it depends upon the personality and progress of the individual patient.

After 2, 3 or 4 sessions of fusion the patient begins to move on to the area of infantile sexuality, which Freud first postulated, and experiences true genital, sexual feelings. The sex of the patient is immaterial. All infants, boy or girl, experience their first feelings of sexuality when held and fed by the mother. Here again, however, the therapist need have no anxiety about these feelings - they should be encouraged by the therapist as a part of normal, healthy development. During this phase, patients very quietly gain insight into the fact that this development of infantile genitality is linked with their need for oral gratification. Further, those depressive patients who have suffered extreme breast deprivation gain insight into the fact that many of their attempts at adult genital satisfaction represent displaced breast needs, and that all such genital activity must remain ungratified at deep levels. Behind both these needs, that of oral gratification and pregenital sexuality, is the basic need of fusion with the mother. Once the patient reaches the oedipal level of development and true genital sexual feelings are released, no further body contact is made with the patient.

If physical contact can be made with patients when they

are in a regressed state under LSD Analysis, which is as pleasurable and satisfying at deep infantile levels as the fusion experience appears to be, this is indeed a powerful weapon which is of particular value in the battle to get the patient to give up his fantasy world, wherein he controls everything, but which has no bridge with reality. In so many cases the original cause for the fragmenting of the ego, and the withdrawal into fantasy was because the reality relationship between mother and infant was not satisfactory. It now appears that the absence of a satisfactory relationship is due to the absence of sufficiently long and satisfying experiences of fusion.

If this pattern is reversed by the therapist as the result of such physical contact as described, and the reality relationship made secure and satisfying, the patient will start to come into reality, and for the first time will begin to form a real relationship. In therapy this means the turning of his feelings outwards and attaching them to the therapist, instead of turning them in towards his inner world in the old, unrealistic pattern.

Invariably in cases of early deprivation as described in this paper, such patients are either sexually inadequate in adult life, or impotent. In these cases sexual growth becomes distorted as the result of a) the breaking of object relations with the mother, and b) the attachment of genitality to a negative aggressive component rather than a positive love component. With early frustration there develops an unconscious urge

to use the sexual organ as a destructive one. This applies to both male and female development.

A question invariably asked is "What happens if the sexual feelings of the patient become too strong?" As indicated previously, the sexual feelings are encouraged to become stronger, but no problem will be encountered as long as the transference is interpreted to the patient throughout the analysis from its onset. In point of fact, the patient who reaches his oedipal stage of development through this technique, and genital sexuality, has never at any time attempted to embrace me except above the waist. Further, although the need for skin contact is necessary, as indicated by the desire of the patient to touch the therapists hands, arms and face, even kissing her neck or cheek on occasion (which is a part of the infant and child's normal development) no patient has ever tried to make contact with my mouth, since identification of the therapist as the mother at once places such an advance in the realm of an incestuous taboo. There is, therefore, no need for anxiety at this level.

To date, over 40 patients ranging from 19-46 years in age [redacted] have experienced this fusion with the therapist, and there have been no relapses over a period of ~~four~~ eight years.

LENGTH OF TREATMENT WITH LSD ANALYSIS

Using LSD as an adjunct to therapy, it has been found that completion and resolution of conflicts is obtained within a

period of 6-9 months, on a one treatment (5½ hours) per week basis. Except on rare occasions it has not been found necessary to see patients between LSD sessions. It is my practice after termination of the drug treatment to follow up with a weekly one-hour talk for a period of approximately six weeks, then once a fortnight for an additional month. After this the patient is told that the therapist will be available for consultation should it be desired, but that no regularly scheduled meetings need now be arranged. Invariably I find that the ego is by this time sufficiently strong, and the emotions sufficiently outgoing, so that further support by the therapist is not required. Nevertheless, contact with patients is never completely cut off and an occasional card or note is sent to patients, to which they reply, giving an account of their present state and progress.

DISCUSSION

The use of LSD as an adjunct to psychotherapy is not new. Abramson (1955, 1960) in the United States, Martin (1953) and Sandison (1963) in England, Leuner (1958) in Germany, Arendsen-Hein (1967) in Holland, and others have developed this valuable ally to the therapeutic process during the past fifteen years. This drug materially shortens the time required for treatment, as Sandison pointed out when he wrote "The difference between psycholytic therapy and psychoanalytic therapy lie in the greater rapidity with which unconscious material is released and the deeper level, both in personal memory and in the archetypal realm, which can be reached with

LSD and which can only be achieved in a few exceptional cases after several years under orthodox analysis."

LSD Analysis, as I have developed it in the clinic of Dr. A. J. Martin during the past eight years, adds an extremely important dimension of active behavioral support on the part of the therapist to the regressed patient. Using this method, it has been discovered that the early fusion of the infant with the mother is vital to human maturation. This discovery was made empirically, but it has since been brought to my attention that Mahler (1952, 1961) has postulated three phases of the need satisfying, mother-infant relationship as a prerequisite for normal growth. These are an early autistic phase from birth to three months of life, a symbiotic phase from 4 to 12 or 18 months of life, and a separation-individuation phase from the end of this period to 36 months of life. She points out that during the symbiotic phase the infant behaves and functions as though he and his mother were an omnipotent system (a dual unity) within one common boundary (a symbiotic membrane, as it were). She suggests, theoretically, that the toddler is not able to cope with the demands of the separation-individuation phase of development unless the preceding symbiotic phase has been satisfactory - and refers to "the fused symbiotic representations of self and object". My therapeutic experiences using LSD as an adjunct, indicate beyond doubt that there is an actual fusion period in the mother-infant relationship which is a vital part of human growth and development, and that this

should begin from birth. Searles (1958) likewise feels that the infant is object related from birth onward.

Further, Handelsman (1965), elaborating on Mahlers concept in considering the development of adult modes of sexuality from the viewpoint of object relations, writes "In persons employing a symbiotic mode of adaptation, sexuality is a means of fusing with the lost symbiotic partner. It is a restitutive or restorative process for the object-hungry person who is seeking a corrective symbiotic experience. -- The parent child relationship during the autistic, symbiotic and individuation-separation phases may be indicative of the adult's adaptation to sexuality". This is precisely what I have found, namely, that unless the experience of fusion has been properly undergone in the early mother-infant relationship the capacity for mature adult sexual fusion and gratification, i.e. psychosexual union - will be impaired. It is this capacity for adult psychosexual fusion which serves as an objective criterion for the cure of the patient.

Lichtenstein (1961) likewise appears to stress the importance of the early symbiotic relationship for later maturity when he writes:

> ".....the very extremeness of the symbiotic relation of the human child to his mother---becomes the very source of his <u>human</u> identity---thus the maternal <u>Umwelt</u> ordains an organ function to the child, at it is this primary function in which I see the nucleus of the emerging human identity."

Like other aspects of the mother-infant relationship, the fusion relationship may also be distorted. Mahler (1958) traces the part that the continued "delusion of omnipotent fusion with the mother" contributed to the identity disturbances of a $6\frac{1}{2}$ year old boy. Likewise, I have pointed out that where a mother uses the fusion relationship with her infant as the sole or primary satisfaction of her own fusion needs, disturbances of development invariably follow. Note also the suggestion of Anna Freud and Dorothy Burlingham (1944), that the child's feeling of oneness with the mother's body is paralleled by the mother's feeling that the baby's body belongs to her.

Many therapists are now finding it valuable to hold and rock the patient, to put their arms around the shoulders of a patient, to hold the patient's hands, or to give him a bottle as I have attempted. Although all this behavior is undoubtedly beneficial to certain patients, I have found that there is a deeper basic need, the fusion experience, which must be gratified in order to achieve a fundamental change in the personality. In my experience it is only this fundamental personality change which provides assurance against the possibility of the patient's relapse. Others, who have also worked in the realm of very early developmental disturbances have concluded, together with Balint, that therapists must find a way to deal with the basic developmental needs of patients, and that we cannot continue to assume that these needs can merely be "worked through" in conventional analytic fashion.

Rosen (1962), who has pioneered a method of "direct psychoanalysis" succinctly states the matter when he points out that

> "We have found that it is not enough for the individual to acquire 'insight' into the meaning of his experiences and his behavior. Indeed, if the individual is psychotic rather than neurotic, it may not be within his capacities to acquire such conscious knowledge of his own psychodynamics. Accordingly, in contrast with conventional psychoanalysts, we put much more emphasis upon the therapeutic responsibilities of the psychiatrist. He does not play the role of an unobtrusive observer during treatment sessions. We maintain that he must be as responsive to the individual in treatment as a mother is to her infant. --- In ordinary circumstances, a mother hears the cry of her infant; she comprehends the meaning of the cry; and she meets the infant's need so that his cry is no longer necessary. In a similar fashion, the direct psychoanalyst pays close attention to the individual whom he is treating. He attempts to comprehend the verbal or nonverbal 'cry' which the individual is uttering; and he attempts to supply what is needed."

Rosen goes on to point out that there are obviously limits to be observed by the therapist in meeting a psychotic individual's, or any patient's needs, just as a mother observes

limits in meeting the needs of her infant. If it is borne in mind that it is the feelings and development of the patient which is of prime importance in a therapeutic situation, not those of the therapist, it would seem to be a requirement that therapists find some way of dealing with this fusion phase of human development, not merely theoretically, but in reality in the therapeutic situation, if we are to succeed in the goal of a permanent release from mental illness. The therapist must be sufficiently mature to fulfill his own emotional requirements outside the analytical room, and thereby be free to deal with all phases of the emotional needs of the patient.

Kaiser (1965) proposed that all patients in his experience were attempting to create the illusion of fusion with the therapist, and indeed considered this illusion part of the universal psychopathology underlying all psychological disorders. My work suggests that this need for fusion can be effectively utilized in the therapeutic situation to break the patient's pattern of fantasy, to bring him into reality and direct him along the path of psychosexual maturity, which alone can relieve the pattern of separateness and alienation in which the patient finds himself.

LSD Analysis supports the striking importance of the object relationship for human development, as pointed out by Fairbairn (1958) and Guntrip (1961). From the viewpoint of therapy it emphasizes the vital significance of the role of

the transference in bringing about a fundamental change in the personality, and indicates that the primary origin of so many types of mental illness lies in this area of broken object relationships. A primary goal of therapy, at deep levels, must be to reform the capacity for an object relationship in reality, with its attendant task of working through the basic mistrust, fear of dependence and vulnerability which this goal arouses in the patient.

In cases of early depressive patients, this means providing them with adequate opportunity for reexperiencing, or experiencing for the first time, the fusion phase of the mother-infant relationship. Even where the object relationship has been broken at a later stage of development however, I would pursue the technique of fusion so that when the patient eventually reaches the traumatic moment of the original breaking of the object relationship, the new relationship with the therapist is sufficiently firm and secure. Any tendency to withdraw into the old pattern of behavior, which is bound to occur as the patient relives this period, will be counteracted by this positive relationship. With this support the old pattern of response gradually subsides and disappears.

It is now recognized that the human object relationship, and the transference phenomena of therapy which derives from it, stems from our primate heritage, as Bowlby (1958), and others have pointed out. Kramer (1968), who has also considered

human development in ethological terms, points out that various basic, primary process neuromuscular phenomena may be interfered with when the infant's primary object relationship with the mother is absent or inadequate. According to his viewpoint, what I here refer to as the central importance of the object relationship for the developing human infant, stems from the fact that the mother is the natural environment for certain phylogenetically determined sensory and motor interactions which play a role in regulating the maturation of the central nervous system, the development of sensori-motor coordinations, the maintenance of autonomic functions essential to growth, and psychosexual development. Harlow ( ) also has emphasized the basic contact need of primates. With all of this I agree, but I would point out that contact hunger, clinging, and even breast feeding of the infant frequently are the means of facilitating the fusion phenomenon, they are not identical with it.

Finally, it should be stated that LSD_{25}, together with the transference to the analyst, does have a remarkable capacity to produce severe regression, and release primary process behavior and unconscious material. When utilized with due care to correct dosage, I have found that it is a kindly drug, and does not release material that the patient cannot tolerate or is unprepared to deal with. LSD_{25} is indeed only a facilitative adjunct to the analytic work, and in no way replaces the analyst's skillful efforts. An analyst

using this drug needs to be more fully analyzed, not less. Under these circumstances, the analyst using LSD_{25} can feel safe and secure in giving more of oneself in the interest of the patient's full recovery.